ACCEPTED
03-22-00126-CV
62686046
THIRD COURT OF APPEALS
AUSTIN, TEXAS
3/16/2022 10:44 PM
JEFFREY D. KYLE
CLERK

No. 03-22-00126-CV

IN THE COURT OF APPEALS
FOR THE THIRD DISTRICT OF TEXAS AT AUSTIN

FILED IN
3rd COURT OF APPEALS
AUSTIN, TEXAS
3/17/2022 8:00:00 AM
JEFFREY D. KYLE
Clerk

GREG ABBOTT, in his official capacity as Governor of the State of Texas; JAIME MASTERS, in her official capacity as Commissioner of the Texas Department of Family and Protective Services; and TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES,

Appellants,

v.

JANE DOE, individually and as parent and next friend of MARY DOE, a minor; JOHN DOE, individually and as parent and next friend of MARY DOE, a minor; and DR. MEGAN MOONEY,

Appellees.

On Appeal from the 201st Judicial District of Travis County, Texas
Cause No. D-1-GN-22-000977, Hon. Amy Clark Meachum

APPELLEES' EMERGENCY MOTION FOR TEMPORARY INJUNCTIVE RELIEF PURSUANT TO RULE 29.3

Brian Klosterboer
State Bar No. 24107833
Andre Segura
State Bar No. 24107112
Savannah Kumar
State Bar No. 24120098
AMERICAN CIVIL LIBERTIES UNION FOUNDATION OF TEXAS
5225 Katy Fwy., Ste. 350
Houston, Texas 77007
T: (713) 942-8146
bklosterboer@aclutx.org

Derek R. McDonald
State Bar No. 00786101
Maddy R. Dwertman
State Bar No. 24092371
David B. Goode
State Bar No. 24106014
BAKER BOTTS L.L.P.
98 San Jacinto Blvd., Ste. 1500
Austin, Texas 78701
T: (512) 322-2500
maddy.dwertman@bakerbotts.com

Paul D. Castillo
State Bar No. 24049461
Shelly L. Skeen
State Bar No. 24010511
Nicholas "Guilly" Guillory
State Bar No. 24122392
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
3500 Oak Lawn Ave., Ste. 500
Dallas, Texas 75219
T: (214) 219-8585
pcastillo@lambdalegal.org

* Additional counsel on signature page.

TABLE OF CONTENTS

Table of Authorities iii

Factual and Procedural Background 3

I. Governor Abbott and DFPS Commissioner Masters Issue Directives Redefining Child Abuse and Instruct DFPS to Investigate All Reported Instances of Gender-Affirming Care. 3

II. Appellees Sue to Enjoin Appellants from Enforcing the Directives and Are Granted a Temporary Restraining Order. 7

III. The Trial Court Orders a Temporary Injunction. 8

A. Evidence Before the Trial Court 8

B. Trial Court Findings 17

C. Appeal of the Orders Granting a Temporary Injunction and Denying Defendants' Plea to the Jurisdiction 19

Argument and Authorities 20

I. This Court Should Use Its Inherent Powers and Equitable Authority Under Rule 29.3 to Reinstate a Temporary Injunction on the Terms Set Forth by the Trial Court. 20

A. A temporary injunction is necessary to preserve the status quo ante in this case. 20

B. Reinstatement of the terms of the temporary injunction issued by the trial court is necessary to protect Appellees' rights and to prevent irreparable and immediate harms. 23

II. The Court Should Consider This Emergency Motion for Temporary Injunctive Relief on an Expedited Basis and Should Set an Expedited Briefing Schedule. 27

Conclusion and Prayer 28

Certificate of Compliance 31

Certificate of Conference 32

Certificate of Service 33

TABLE OF AUTHORITIES

Page(s)

CASES

Abbott v. Doe,
No. 03-22-00107-CV, 2022 WL 710093
(Tex. App.—Austin Mar. 9, 2022) (mem. op.) (no pet. h.).....8

BST Holdings, L.L.C. v. Occupational Safety & Health Admin., United States Dep't of Lab.,
17 F.4th 604 (5th Cir. 2021).....27

In re Geomet Recycling LLC,
578 S.W.3d 82 (Tex. 2019) (orig. proceeding).....20, 26

In re Newton,
146 S.W.3d 648 (Tex. 2004) (orig. proceeding).....23

In re Tex. Educ. Agency,
619 S.W.3d 679 (Tex. 2021) (orig. proceeding).....20, 21, 22, 24

Shell Petroleum Corp. v. Grays,
62 S.W.2d 113 (Tex. 1933).....21

Tex. Educ. Agency v. Hous. Indep. Sch. Dist.,
609 S.W.3d 569 (Tex. App.—Austin 2020, no pet.).....21, 23, 26, 28

Tex. Health & Human Services Comm'n v. Sacred Oak Med. Ctr. LLC,
No. 03-21-00136-CV, 2021 WL 2371356
(Tex. App.—Austin June 9, 2021, no pet.).....22, 23, 24

STATUTES & COURT RULES

Tex. Civ. Prac. & Rem. Code § 6.001(b).....19

Tex. R. App. P. 29.1(b).....19

Tex. R. App. P. 29.3.....*passim*

To the Honorable Justices of the Third Court of Appeals:

Appellees hereby move on an emergency, expedited basis for entry of an order reinstating a temporary injunction, pursuant to the Court's inherent authority and Texas Rule of Appellate Procedure 29.3, to preserve the *status quo ante* in this litigation and to protect the parties' rights, until the disposition of the instant appeal.

Emergency relief is needed to preserve the *status quo ante* and prevent imminent and irreparable harm to Appellees and transgender adolescents, families, and providers across Texas. After a full evidentiary hearing, the trial court found that "gender-affirming care was not investigated as child abuse by DFPS [Department of Family and Protective Services] until after February 22, 2022" and that the "series of directives and decisions by the Governor, the [Commissioner], and other decision-makers at DFPS, changed the *status quo*." App. E (Order Granting Pls.' Appl. for Temporary Injunction) at 2. Appellees thus face "imminent and irreparable injury" without an injunction prohibiting Appellants "from enforcing the Governor's directive and the DFPS rule enforcing that directive." App. E at 2.

In issuing its temporary injunction, the trial court concluded that there was a substantial likelihood that Appellees would succeed on the merits of their claims that the Governor's directive was *ultra vires*, beyond the scope of his authority, and unconstitutional, and that the Texas Department of Family and Protective Services ("DFPS") and Commissioner Masters promulgated and implemented a new rule that

was improper and therefore void. Accordingly, the district court temporarily enjoined Appellants from (1) taking any action against Appellees based on the Governor's directive and DFPS rule; (2) investigating reports of child abuse based solely on an individual's prescription of or facilitation of gender-affirming care, or the fact that a minor is transgender, gender transitioning or being prescribed gender-affirming medical care; (3) prosecuting or referring for prosecution any such reports; and (4) imposing reporting requirements based solely on a person's receipt of gender-affirming medical care or status as transgender or gender transitioning. App. E at 3-4. In doing so, the trial court explained that the temporary injunction was necessary to "maintain[] the status quo prior to February 22, 2022" and that it "should remain in effect while [the trial court], and potentially the Court of Appeals, and the Supreme Court of Texas, examine the parties' merits and jurisdictional arguments." App. E at 3.

To preserve the *status quo ante* during the pendency of this appeal, protect Appellees' rights, and prevent immediate and irreparable harms to Appellees, this Court should exercise its equitable powers and authority under Rule 29.3 to issue a temporary order restraining Appellants on the same terms set forth in the trial court's temporary injunction.

FACTUAL AND PROCEDURAL BACKGROUND

On March 11, 2022, the trial court heard Appellees' Application for a Temporary Injunction, App. E, as well as the Appellants' Plea to the Jurisdiction, App. F (Order Denying Defs.' Plea to the Jurisdiction). The same day, after a full evidentiary hearing that included uncontested testimony from Appellees' three fact witnesses and two expert witnesses, the court issued orders granting Appellees' Application for Temporary Injunction, App. E, and denying Appellants' Plea to the Jurisdiction, App. F, (collectively, the "Orders"), which are the subject of the State's current appeal. Appellants did not present any testimony.

I. Governor Abbott and DFPS Commissioner Masters Issue Directives Redefining Child Abuse and Instruct DFPS to Investigate All Reported Instances of Gender-Affirming Care.

On February 22, 2022, Governor Greg Abbott sent a letter to DFPS Commissioner Jaime Masters directing the agency "to conduct a prompt and thorough investigation of any reported instances" of "gender-transitioning procedures," without any regard to medical necessity (hereinafter, "Abbott Directive"). App. A (Pls.' Original Pet. and Appl. for TRO, Temporary Injunction, Permanent Injunction, and Request for Declaratory Relief), p. 6, ¶ 17, p. 44, ¶ 171. App. H (R.R.-Vol. 3, Pls.' Ex. 02, p. 1, ¶¶ 1, 3).[1] The Abbott Directive incorporated

[1] Appendix H (App. H) contains the reporter's record from the March 11, 2022 temporary injunction hearing that was sent to Appellees by the court reporters prior to the court reporters' actual filing of the reporter's record with this Court. On March 16, 2022, both Appellees and Appellants requested that the reporter's record be filed.

Attorney General Ken Paxton's Opinion No. KP-0401 ("Paxton Opinion") and claimed that "a number of so-called 'sex change' procedures constitute child abuse under existing Texas law." App. A, p. 2, ¶ n.2, p. 6, ¶ 17. App. H (R.R.-Vol. 3, Pls.' Ex. 02, p. 1, ¶ 1). While the Paxton Opinion decreed that medical treatment, including use of pubertal suppression, hormone therapy, and surgery, for a minor with gender dysphoria could constitute child abuse, the Opinion did "not address or apply to medically necessary procedures." App. A, p. 6, ¶ 16. App. H (R.R.-Vol. 3, Pls.' Ex. 01, p. 2, ¶ 1). The Abbott Directive, however, ordered the "investigation of any reported instances" of "gender-transitioning procedures," without any regard to medical necessity. App. A, p. 6, ¶ 17, p. 44, ¶ 171. App. H (R.R.-Vol. 3, Pls.' Ex. 02, p. 1, ¶¶ 1, 3). In addition to directing DFPS to investigate reports of medical treatment referenced in the Paxton Opinion, the Abbott Directive orders, under threat of criminal prosecution, "all licensed professionals who have direct contact with children" and "members of the general public" to report instances of minors receiving such treatment. App. A, p. 6, ¶ 17. App. H (R.R.-Vol. 3, Pls.' Ex. 02, p. 1, ¶ 2).

The same day, DFPS announced that it would comply with the Abbott Directive and "investigate[]" any reports of the procedures outlined in the new directives ("DFPS Statement"), again, without any regard to medical necessity. DFPS also claimed that prior to the Paxton Opinion and Abbott Directive, it had "no

pending investigations of child abuse involving the procedures described in that opinion." App. A, p. 6, ¶¶ 18-19. App. H (R.R.-Vol. 3, Pls.' Ex. 03). DFPS immediately launched investigations into families around Texas, including the Doe family, based on their implementation of the Abbott Directive. App. A, p. 7, ¶ 21. App. H (R.R.-Vol. 1, 33:13-17, 86:7-12).

Appellees Jane Doe and John Doe are the loving parents of Appellee Mary Doe, a 16-year-old adolescent who is transgender and has been diagnosed with gender dysphoria. App. A, pp. 20-21, ¶¶ 66, 68, 71. App. H (R.R.-Vol. 1, 84:23-25, 90:22-23, 115:2-4). On February 23, 2022, Jane sought clarification from her supervisor at DFPS, where she works, of how the Abbott Directive would affect DFPS policy. App. A, p. 22, ¶ 80. App. H (R.R.-Vol. 1, 87:4-19). Jane was also deeply concerned about the Abbott Directive's impact on her own family. App. A, p. 22, ¶ 80. App. H (R.R.-Vol. 1, 87:4-9). Hours later, Jane was placed on administrative leave from her employment and under investigation solely because she has a transgender daughter whose doctors may have prescribed medical treatment for her gender dysphoria.[2] App. A, p. 22, ¶ 81. App. H (R.R.-Vol. 1, 87:23-88:1, 90:11-21). Two days later, a DFPS Child Protective Services investigator

[2] Gender dysphoria refers to clinically significant distress that can result when a person's gender identity differs from the person's sex assigned at birth. App. H (R.R.-Vol. 2, 83:17-19; Vol. 3, Pls.' Ex. 08, 3875-3876). Treatment for gender dysphoria is governed by evidence-based clinical guidelines supported by every major medical association in the United States. App. H (R.R.-Vol. 2, 118:16-119:14). If left untreated, gender dysphoria may result in serious consequences including depression, self-harm, and even suicide. App. H (R.R.-Vol. 2, 86:21-23, 126:18-22).

visited the Doe family home as part of a newly opened DFPS investigation based only on the allegation that Jane and John Doe have a transgender daughter who may be receiving gender-affirming medical care. App. A, pp. 22-23, ¶¶ 83-84. App. H (R.R.-Vol. 1, 89:15, 90:21). The Does are "living in a constant state of fear" and are terrified of "th[e] stress and th[e] pain" and other severe harms they will suffer as a result. App. A, pp. 23-24, ¶¶ 85-89. App. H (R.R.-Vol. 1, 92:4-12, 93:12-24, 94:2-11, 94:15-22, 95:17-96:1, 97:23-24). Indeed, notwithstanding Jane and John's best efforts to reassure her, Mary has expressed fear "that she was going to be taken away." App. H (R.R.-Vol. 1, 93:16-18).

Appellee Dr. Megan Mooney is a clinical psychologist and mandatory reporter under Texas law. App. A, p. 24, ¶¶ 90-91. App. H (R.R.-Vol. 2, 17:24-25, 22:14-16). She has a practice based in Houston, Texas that includes transgender adolescent patients, many of whom have been diagnosed with gender dysphoria and are receiving medically necessary care for this condition. App. A, pp. 24-25, ¶¶ 92, 94-95. App. H (R.R.-Vol. 2, 19:8-22, 21:9-12). The Abbott Directive and DFPS's implementation of it have placed Dr. Mooney in an untenable situation. App. A, p. 25, ¶ 100. *See generally* App. H (R.R.-Vol. 2, 23-29, 91:21-92:1). If Dr. Mooney fails to report her adolescent clients who receive gender-affirming care, she faces the loss of her license and the prospect of civil and criminal penalties for failing to report "child abuse." App. A, p. 25, ¶ 101. App. H (R.R.-Vol. 2, 24:25-25:16).

However, if she follows the Abbott Directive and DFPS's adoption of it, Dr. Mooney would violate her professional standards of ethics and inflict serious harm and trauma on her clients. App. A, p. 26, ¶¶ 102-105. App. H (R.R.-Vol. 2, 27:5-24). In addition, she would irreparably damage the bonds of trust that she has built with her clients and, as a consequence, could face the possible closure of her practice if clients know that she cannot maintain their trust. App. A, p. 26, ¶ 106. App. H (R.R.-Vol. 2, 27:5-20). She could also face potential loss of her professional license. App. A, p. 26, ¶ 106. App. H (R.R.-Vol. 2, 27:21-28:2).

II. Appellees Sue to Enjoin Appellants from Enforcing the Directives and Are Granted a Temporary Restraining Order.

Appellees brought suit on March 1, 2022, challenging the above-described actions of Governor Abbott, Commissioner Masters, and DFPS, asserting six causes of action, including that Appellants' actions violated the Texas Administrative Procedure Act ("APA"), were *ultra vires*, and violated the constitutionally protected separation of powers. App. A, pp. 27-45, ¶¶ 109-173. In their petition, Appellees requested a temporary restraining order, temporary injunction, declaratory judgment, and permanent injunction. App. A, pp. 46-49, ¶¶ 174-182. The trial court set a hearing on the temporary restraining order request for March 2, 2022. App. C (Order Granting Pls.' Appl. for TRO) at 1. Minutes before the hearing, Petitioners filed a plea to the jurisdiction but did not request it for submission or hearing. App. B (Defs.' Plea to the Jurisdiction). At the TRO hearing, neither the trial court nor the

parties addressed the merits of the plea to the jurisdiction. *Abbott v. Doe*, No. 03-22-00107-CV, 2022 WL 710093, at *2 (Tex. App.—Austin Mar. 9, 2022) (mem. op.) (no pet. h.). That day, the trial court issued a temporary restraining order ("TRO") and set a temporary injunction hearing to consider granting state-wide injunctive relief for March 11, 2022. App. C at 2-3.

Later that very same day, Appellants filed an interlocutory appeal arguing that the TRO "implicitly denied" their plea to the jurisdiction. App. D (Defs.' Notice of Accelerated Interlocutory Appeal from TRO) at 1. Appellees filed a motion to dismiss the appeal for want of jurisdiction. *Abbott*, 2022 WL 710093, at *1. On March 9, 2022, this Court dismissed the appeal for lack of jurisdiction, concluding that the TRO did not implicitly deny Appellants' Plea to the Jurisdiction. *Id.* at *2-3.

III. The Trial Court Orders a Temporary Injunction.

A. Evidence Before the Trial Court

On March 11, 2022, the trial court held a temporary injunction hearing to consider Appellees' request for statewide relief. Appellees presented declarations, documentary evidence, and live testimony, including from expert witnesses that the above-described actions of Governor Abbott, Commissioner Masters, and DFPS were unauthorized expansions of executive authority under both the APA and the Texas Constitution. The factual presentation before the trial court showed that the

authorized actions by Appellants have caused severe and ongoing harms to transgender youth and those who care for them by triggering unwarranted investigations into families, threatening providers and mandatory reporters with criminal prosecution, cutting off medically necessary health care to adolescents who rely on it, and infringing upon the fundamental rights of parents to direct the custody and care of their minor children.

Randa Mulanax, an investigations supervisor with DFPS, testified that the Abbott Directive and Commissioner Masters' implementation thereof led to immediate changes to DFPS policy and practice. App. H (R.R.-Vol. 1, 32:16-22, 53:2-8). Almost immediately after the issuance of the Abbott Directive and DFPS Statement, DFPS required all reports of parents with transgender children receiving gender-affirming care to be investigated without exception, thereby treating these matters differently from all other reports of child abuse and neglect. App. H (R.R.-Vol. 1, 44:17-25, 53:2-8). Ms. Mulanax testified that DFPS employees are now prohibited from designating these cases as "Priority None" cases, which are applied to cases where it is "not likely that a child is being abused or neglected." App. H (R.R.-Vol. 1, 36:4-15, 38:9-17). Under DFPS's new policy, DFPS also forbids employees from utilizing "less invasive" Alternative Response procedures. App. H (R.R.-Vol. 1, 38:20-39:5). Furthermore, DFPS instructed employees not to put anything regarding these cases in writing, a highly unusual instruction that Ms.

Mulanax considered "unethical" and that differs from the way that DFPS treats any other cases. App. H (R.R.-Vol. 1, 44:1-16; Vol. 3, Pls.' Ex. 17). In her six years with DFPS, she had never before been told to avoid putting anything in writing. App. H (R.R.-Vol. 1, 44:5-13). DFPS employees were also instructed to involve the agency's general counsel in these investigations, another requirement unique to these cases. App. H (R.R.-Vol. 1, 50:1-12). Before February 22, 2022, Ms. Mulanax was not aware of any open investigations involving medical care for transgender minors but is now aware of at least seven such cases across the state, including three within her region. App. H (R.R.-Vol. 1, 49:5-12). After these changes in policy, Ms. Mulanax resigned because she "no longer" feels DFPS acts in the best interest of children or families. App. H (R.R.-Vol. 1, 53:22-25, 54:1-4). Ms. Mulanax testified that she sees "no really [sic] end goal for these cases," as DFPS investigations are ordinarily opened "to ensure a child is being cared for, loved, and safe in their home." App. H (R.R.-Vol. 1, 54:14-19). She testified that if "pediatricians, professionals who are experienced with these fields . . . have recommended these treatments, it is not our position to step in and say that they are incorrect." App. H (R.R-Vol. 1, 54:22-55:1).

The trial court also heard testimony from Appellees Jane Doe and Dr. Megan Mooney outlining the irreparable harm they will face without an injunction. Jane testified that she was "completely shocked" upon learning she was placed on

administrative leave and her family would be placed under investigation after she contacted her supervisor on February 23, 2022 seeking clarification on DFPS policy in light of the directives. App. H (R.R.-Vol. 1, 89:15-19). The only allegations that prompted the investigation were that Jane and John Doe "have a daughter who was born male and is, 'transitioning to female,' and that she may be receiving gender-affirming care." App. A, p. 23, ¶ 84. App. H (R.R.-Vol. 1, 90:14-20). However, before February 23, a few DFPS employees, including her supervisor, knew that Jane's daughter is transgender and had been prescribed medical care for gender dysphoria, yet she had not been reported or investigated for child abuse, even though DFPS employees are mandatory reporters. App. H (R.R.-Vol. 1, 90:24-91:4, 91:12-17, 91:24-25). Jane also testified that even on February 22, prior to the issuance of the Abbott Directive but after the Paxton Opinion, a report had been received of a transgender youth receiving gender-affirming medical care and the report had been deemed "clearly not reportable." App. H (R.R.-Vol. 1, 88:17-23).

Jane testified that she has since been "terrified" for her family and has found the situation "unbelievably awful" due to the loss of security and privacy. App. A, p. 22, ¶ 79. App. H (R.R.-Vol. 1, 92:1-12). Jane testified that her daughter Mary has been "very scared," begun avoiding school, and blames herself for the stress and pain of the family. App. A, p. 23-24, ¶ 88. App. H (R.R.-Vol. 1, 92:24-94:6). On the day the investigator visited the family, Mary "thought that she was going to be taken

away" from her family "that night." App. H (R.R.-Vol. 1, 97:14-15, 23-24). Without an injunction, Jane testified that her family "will be living in fear" because, as she understands, even the closure of this investigation will not "stop more and more and more and more reports from coming in," which will cause "a continuous disruption" of her family's life. App. A, p. 23-24, ¶ 88. App. H (R.R.-Vol. 1, 95:21-25).

Dr. Mooney testified that she was "very upset" and "very concerned for both myself as a mandatory reporter, and for the children and families across the state of Texas that this would impact" upon learning of Governor Abbott's letter and DFPS's statement. App. H (R.R.-Vol. 2, 23:6-11). As a mandatory reporter, Dr. Mooney understood that there are "legal ramifications" both "civilly and criminally" and "threat[s]" to her license and "professional well-being" for failing to comply with the directives if the courts do not enjoin their effect. App. A, p. 25, ¶ 101. App. H (R.R.-Vol. 2, 25:2-6). She testified that, among other penalties, she "would expect" to lose her license. App. H (R.R.-Vol. 2, 25:11-14). Dr. Mooney also testified about the harms she would suffer if she were required to report "clients and their families for abuse or neglect for receiving medical care for gender dysphoria." App. A, p. 26, ¶¶ 102-107. App. H (R.R.-Vol. 2, 27:8-10). She testified that the "foundation of the therapeutic relationship is our confidentiality and privacy" and being forced to report clients for receiving necessary medical care would be "devastating" to her clients, "ruin" her ability to maintain bonds of trust with them, and "have a direct impact on

my business." App. A, p. 26, ¶¶ 103, 106. App. H (R.R.-Vol. 2, 27:11-20). Being required to report her clients and their families for this type of medical care would also violate Dr. Mooney's ethical obligations and could lead to her being reported of false reporting of child abuse and neglect. App. H (R.R.-Vol. 2, 27:25-28:2, 28:10-12).

As a result of these directives, Dr. Mooney has seen "outright panic" from her community. App. H (R.R.-Vol. 2, 29:3-5). She testified that "[p]arents are terrified that CPS is going to come and question their children or take them away." App. H (R.R.-Vol. 2, 29:6-7). Dr. Mooney testified that "[m]ental health professionals are scared that we are either violating our standards of the professional codes of conduct or in violation of the law" and that the directives put "medical professionals that I work with all the time in a horrible position of not being able to provide care to children and families." App. H (R.R.-Vol. 2, 29:7-13). In addition to "widespread confusion" about these directives, Dr. Mooney testified that she has already witnessed adverse "impacts on the mental health and well-being of young people," including "increased risk of suicidality, increased depression, [and] increased anxiety" as a result of the Governor's letter and DFPS's statement. App. H (R.R.-Vol. 2, 28:19-29:22).

In addition, the trial court heard expert testimony that gender dysphoria treatments are safe, effective, and widely accepted in the medical community. Dr.

Armand H. Matheny Antommaria, a professor in the Departments of Pediatrics and Surgery at the University of Cincinnati College of Medicine and an ethicist and pediatric hospitalist at Cincinnati Children's Hospital Medical Center who regularly consults on treatment for adolescent patients with gender dysphoria and works on the multidisciplinary reviews and policies pertaining to Cincinnati Children's Transgender Clinic, was qualified as an expert by the court. App. H (R.R.-Vol. 2, 77:1-17, 82:4-6; Vol. 3, Pls.' Ex. 05). He testified that both the Endocrine Society and the World Professional Association for Transgender Health ("WPATH") have developed data-driven clinical guidelines for treating gender dysphoria. App. A, p. 14, ¶ 46. App. H (R.R.-Vol. 2, 84:9-85:17; Vol. 3, Pls.' Ex. 08, Defs.' Ex. 01). Dr. Antommaria testified that both guidelines were established only after "robust," "iterative" internal procedures and have been accepted by the medical community. App. H (R.R.-Vol. 2, 84:16-23; 85:9-14). He likewise explained that justifications offered in defense of the new child abuse directives, such as the fact that the targeted treatments are prescribed "off-label," would apply to much of pediatric medicine. App. A, p. 19, ¶ 61. App. H (R.R.-Vol. 2, 90:13-91:9).

Dr. Cassandra C. Brady, an Assistant Professor of Clinical Pediatrics at Vanderbilt University Medical Center and the Clinical Director of the Differences of Sex Development Clinic and the Pediatric and Adolescent Gender Clinic at Monroe-Carell Jr. Children's Hospital at Vanderbilt, was also qualified as an expert

by the court. App. H (R.R.-Vol. 2, 114:8-20, 120:1-3; Vol. 3, Pls.' Ex. 07). She likewise testified that the treatment recommendations outlined in the Endocrine Society and WPATH guidelines are "evidence-based," "mean[ing] that they utilize data and research that's available to . . . support the recommendations," and are "widely accepted by a large number of medical organizations across the country." App. A, p. 9, ¶ 28, p. 18, ¶ 58. App. H (R.R.-Vol. 2, 118:16-119:17). She also testified that she relies on these guidelines "every day" in her current practice of providing these "medically necessary treatments for gender dysphoria [sic] youth." App. H (R.R.-Vol. 2, 119:15-17; 122:5-10).

Dr. Antommaria testified that gender dysphoria treatment is "safe" and "effective" based on "prospective observational studies that show that pubertal suppression decreases depression among individuals with gender dysphoria and improves general functioning in those individuals." App. H (R.R.-Vol. 2, 85:18-86:3). He testified that hormone therapy is "safe" and "effective" because of "similar prospective observational studies that show improvements in mental health outcomes through the use of gender-affirming hormone therapy." App. H (R.R.-Vol. 2, 86:4-12).

Dr. Brady also testified that puberty blockers are reversible, "safe and effective" and are not only used to treat gender dysphoria but have been used for many years to treat central precocious puberty. App. H (R.R.-Vol. 2, 122:24-

123:15). Dr. Brady further noted that any risks associated with the use of puberty blockers are the same, whether these are used to treat gender dysphoria or central precocious puberty. App. H (R.R.-Vol. 2, 124:2-5). Likewise, Dr. Brady testified that provision of hormones is safe and effective, used regularly in her practice to treat other conditions, and that any risks associated with these treatments are not "distinct or unique" to the treatment of gender dysphoria, but rather "very similar across the board for any condition" for which she uses them. App. A, p. 18, ¶ 60. App. H (R.R.-Vol. 2, 124:6-18).

The trial court further heard expert testimony that the cessation of gender dysphoria treatment would cause imminent and potentially deadly harms. Dr. Antommaria testified that the harms of not providing medical treatment for gender dysphoria include "high risk for depression, anxiety, self-harm, suicidality, and eating disorders." App. A, pp. 14-15, ¶¶ 45, 50. App. H (R.R.-Vol. 2, 86:21-23). He testified that "gender-affirming hormone therapy and puberty blockers are medically necessary for the treatment of gender dysphoria" and "are not sterilizing procedures." App. A, pp. 16-17, ¶¶ 52-53. App. H (R.R.-Vol. 2, 91:18-21). As a result, he testified that "they do not constitute child abuse, and that characterizing them as such puts healthcare providers in an untenable position of either violating their professional obligations or the law and causes serious harm to patients and their families." App. A, p. 11, ¶ 34. App. H (R.R.-Vol. 2, 91:21-92:1). Similarly, Dr.

Brady testified that "[t]he harms that can be associated with withholding or pausing [gender-affirming] care are significant mental health distress associated with increased anxiety, depression, and suicide, so that equates to the increased risk for death." App. A, pp. 14-15, ¶¶ 45, 50. App. H (R.R.-Vol. 2, 126:18-22). Dr. Brady testified that her "concern with the directives from the Attorney General and the Governor is that these medically necessary treatments that are safe and effective, if they are withheld, would lead to significant harm and mental health comorbidities and potentially death in these gender dysphoric adolescents." App. H (R.R.-Vol. 2, 122:11-16).

B. Trial Court Findings

Based on the evidence presented as part of Appellees' Application for Temporary Injunction, the trial court entered a temporary injunction and denied the Appellants' plea to the jurisdiction. The trial court found Appellees had met their burden of showing a probable right of relief. The trial court specifically found that "there is substantial likelihood that Plaintiffs will prevail after a trial on the merits because the Governor's directive is *ultra vires*, beyond the scope of his authority, and unconstitutional." App. E at 2. The trial court found that "gender-affirming care was not investigated as child abuse by DFPS until after February 22, 2022." App. E at 2. As a result, "[t]he series of directives and decisions by the Governor, the [Commissioner], and other decision-makers at DFPS, changed the *status quo* for

transgender children and their families, as well as professionals who offer treatment, throughout the State of Texas." App. E at 2. Therefore, the trial court found "[t]he Governor's Directive was given the effect of a new law or new agency rule, despite no new legislation, regulation or even stated agency policy" and that "Governor Abbott and Commissioner Masters' actions violate separation of powers by impermissibly encroaching into the legislative domain." App. E at 2.

The trial court also held that, absent injunctive relief, Appellees would be irreparably harmed because "Jane, John and Mary Doe face the imminent and ongoing deprivation of their constitutional rights and the stigma attached to being the subject of a child abuse investigation." App. E at 2-3. In addition, "Mary faces the potential loss of medically necessary care, which if abruptly discontinued can cause severe and irreparable physical and emotional harms, including anxiety, depression, and suicidality." App. E at 3. Furthermore, without an injunction, Dr. Mooney "could face civil suit by patients for failing to treat them in accordance with professional standards and loss of licensure for failing to follow her professional ethics if Defendants' directives are enforced." App. E at 3. Dr. Mooney also "could face immediate criminal prosecution" if she did not report her patients. App. E at 3.

The temporary injunction enjoined Commissioner Masters and DFPS from "enforcing the Governor's directive and DFPS rule." App. E at 3. More specifically, under the temporary injunction, Appellants are restrained from:

> (1) taking any actions against Plaintiffs based on the Governor's directive and DFPS rule, both issued February 22, 2022, as well as Attorney General Paxton's Opinion No. KP-0401 which they reference and incorporate; (2) investigating reports in the State of Texas against any and all persons based solely on alleged child abuse by persons, providers or organizations in facilitating or providing gender-affirming care to transgender minors where the only grounds for the purported abuse or neglect are either the facilitation or provision of gender-affirming medical treatment or the fact that the minors are transgender, gender transitioning, or receiving or being prescribed gender-affirming medical treatment; (3) prosecuting or referring for prosecution such reports; and (4) imposing reporting requirements on persons in the State of Texas who are aware of others who facilitate or provide gender-affirming care to transgender minors solely based on the fact that the minors are transgender, gender transitioning, or receiving or being prescribed gender-affirming medical treatment.

App. E at 3-4.

C. Appeal of the Orders Granting a Temporary Injunction and Denying Defendants' Plea to the Jurisdiction

Immediately following the entry of the Orders granting the temporary injunction and denying the Appellants' Plea to the Jurisdiction, the Appellants filed a notice of accelerated interlocutory appeal, wherein they assert that by perfecting the appeal, the temporary injunction had been superseded pursuant to Texas Civil Practice and Remedies Code § 6.001(b) and Texas Rule of Appellate Procedure 29.1(b). App. G (Defs.' Notice of Appeal from Order Granting Temporary Injunction and Order Denying Defs.' Plea to the Jurisdiction) at 1-2.

ARGUMENT AND AUTHORITIES

I. This Court Should Use Its Inherent Powers and Equitable Authority Under Rule 29.3 to Reinstate a Temporary Injunction on the Terms Set Forth by the Trial Court.

Texas Rule of Appellate Procedure 29.3 authorizes courts of appeals to "make any temporary orders necessary to preserve the parties' rights until disposition of the appeal." Tex. R. App. P. 29.3. Preservation of the status quo is at the heart of Rule 29.3. This Court should exercise its inherent powers as well as its authority under Rule 29.3 to issue a temporary order reinstating the terms of the temporary injunction issued by the trial court, which preserves the *status quo ante* in this case, protects Appellees' rights, and prevents irreparable and immediate harms to Appellees, as well as transgender youth, their families, and their medical providers across Texas, among others.

A. A temporary injunction is necessary to preserve the status quo ante in this case.

This Court has "great flexibility in preserving the status quo based on the unique facts and circumstances presented." *In re Geomet Recycling LLC*, 578 S.W.3d 82, 89 (Tex. 2019) (orig. proceeding). Based on the facts and circumstances of this case, reinstatement of a temporary injunction is necessary to preserve the *status quo ante* in this case.

"The purpose of supersedeas is 'to preserve the status quo . . . pending the appeal.'" *In re Tex. Educ. Agency*, 619 S.W.3d 679, 683 (Tex. 2021) (orig.

proceeding) (quoting *Shell Petroleum Corp. v. Grays*, 62 S.W.2d 113, 118 (Tex. 1933)). And "[i]n the context of injunctions, . . . status quo means the last, actual, peaceable, non-contested status *which preceded the pending controversy*." *Tex. Educ. Agency v. Hous. Indep. Sch. Dist.*, 609 S.W.3d 569, 572 (Tex. App.—Austin 2020, no pet.) (quotations and citation omitted) (emphasis added). As such, permitting Appellants to supersede the trial court's temporary injunction in this case would do the opposite of what a supersedeas is meant to do; it would alter and disrupt the *status quo ante* in this case, rather than preserve it.

The prohibitory temporary injunction issued by the trial court below preserves the *status quo ante* in this case, and this Court should issue an order enjoining Appellants from the actions outlined in the trial court's temporary injunction to similarly preserve the *status quo*. As the trial court found, "gender-affirming care was not investigated as child abuse by DFPS until after February 22, 2022" and "[t]he series of directives and decisions by the Governor, the [Commissioner], and other decision-makers at DFPS, changed the *status quo* for transgender children and their families, as well as professionals who offer treatment, throughout the State of Texas." App. E at 2.

The Supreme Court has expressly approved this Court's authority to reinstate a temporary injunction to preserve the *status quo*. In *In re Texas Education Agency*, the appellants filed an interlocutory appeal that "automatically suspended

enforcement of the trial court's order," which included a temporary injunction. 619 S.W.3d at 683. As the Supreme Court noted, "[i]nstead of preserving the status quo, however, suspension of the temporary injunction would . . . have the contradictory effect of permitting the status quo to be altered, because if compliance with the injunction were not required," the plaintiff's rights and position "could be changed from 'the last, actual, peaceable non-contested status [that] preceded the pending controversy.'" *Id.* at 683-84.

After *In re Texas Education Agency*, this Court has continued to exercise its authority under Rule 29.3 to preserve the *status quo*. In *Texas Health & Human Services Commission v. Sacred Oak Medical Center LLC*, No. 03-21-00136-CV, the appellees—like Appellees here—asked this Court to reinstate the temporary injunction under Rule 29.3 following the State Agency's interlocutory appeal of the trial court's denial of its plea to the jurisdiction. 2021 WL 2371356, at *1 (Tex. App.—Austin June 9, 2021, no pet.). Addressing *In re Texas Education Agency*, this Court explained that "[t]he Texas Supreme Court recently confirmed that courts of appeals have the power to provide relief from the State's automatic right to supersedeas under Rule 29.3," even if procedural rules would prevent the trial court from issuing a counter-supersedeas order. *Id.* at *5.

In deciding whether to reinstate the temporary injunction in *Sacred Oak*, this Court considered the purpose of the relief requested. Specifically, the Court noted

that, "as in *In re TEA*, instead of preserving the status quo, the Commission's suspension of the temporary injunction would, in this case, have the contradictory effect of permitting the status quo to be altered." *Sacred Oak Med. Ctr. LLC*, 2021 WL 2371356, at *5 (quotations and citation omitted); *see also In re Newton*, 146 S.W.3d 648, 651 (Tex. 2004) (orig. proceeding) (explaining "that the continuation of illegal conduct cannot be justified as preservation of the status quo"). The same holds true here.

The Court should enter injunctive relief on the terms set forth by the trial court because it is the only way to preserve the *status quo* while this appeal is considered.

B. Reinstatement of the terms of the temporary injunction issued by the trial court is necessary to protect Appellees' rights and to prevent irreparable and immediate harms.

The Court also has "the power to preserve a party's right to judicial review of acts that it alleges are unlawful and will cause it irreparable harm." *Sacred Oak Med. Ctr. LLC*, 2021 WL 2371356, at *5. "Rule 29.3 provides a mechanism by which [this Court] may exercise the scope of [its] authority over parties, including [its] inherent power to prevent irreparable harm to parties properly before [it] pursuant to [its] appellate jurisdiction in an interlocutory appeal." *Tex. Educ. Agency*, 609 S.W.3d at 578. Here, reinstatement of a temporary injunction is necessary to protect Appellees' rights, who would suffer irreparable and immediate harms in the absence of such a temporary injunction.

In this way, this case is similar to *Texas Education Agency* and *Sacred Oak*—"both cases involving a trial court's grant of a temporary injunction enjoining a State agency from taking or enforcing final administrative action." *Sacred Oak Med. Ctr. LLC*, 2021 WL 2371356, at *5. In *Texas Education Agency*, the plaintiff-appellee was concerned that failure to issue an order under Rule 29.3 to preserve the *status quo* "could delay remedial measures designed to protect students and improve academic achievement." *In re Tex. Educ. Agency*, 619 S.W.3d at 690. And in *Sacred Oak*, the plaintiff-appellee faced irreparable harm from the suspension of its license and continued closure. *Sacred Oak Med. Ctr. LLC*, 2021 WL 2371356, at *8. In both instances, this Court entered a temporary injunction, pursuant to its inherent powers and authority under Rule 29.3, in order to protect the plaintiffs-appellees' rights and prevent irreparable harm as the appeals were considered.

Like *Texas Education Agency* and *Sacred Oak*, this case presents "compelling circumstances that require the Court to reinstate the trial court's temporary injunction to preserve the parties' rights." *Sacred Oak Med. Ctr. LLC*, 2021 WL 2371356, at *7 (quotations omitted). As the trial court found, "unless Defendants are immediately enjoined from enforcing the Governor's directive and the DFPS rule enforcing that directive, both issued February 22, 2022, and which make reference to and incorporate Attorney General Paxton's Opinion No. KP-0401, [Appellees] will suffer imminent and irreparable injury." App. E at 2. Reinstatement of a

temporary injunction is therefore necessary to prevent immediate, ongoing, and irreparable harm to Appellees. Indeed, Appellants have already caused the Does and Dr. Mooney significant stress and fear under the threats of family separation and employment.

The unlawful Abbott Directive and DFPS rule at issue here, which create a presumption of abuse whenever medically necessary treatment for gender dysphoria is provided to transgender youth, presents the Doe Appellees and families of transgender youth with an impossible choice. Either the parents of transgender youth are subjected to an abuse investigation, finding of reason to believe they have committed abuse, and family separation, among other consequences, or they do not provide medically necessary treatment to transgender adolescents who necessitate it for their gender dysphoria. App. E at 2-3.

This catch-22 threatens immeasurable harm to the health and wellbeing of Appellee Mary Doe and other transgender youth. As Dr. Brady testified, the harms from withholding or pausing medically necessary gender-affirming care include "significant mental health distress associated with increased anxiety, depression, and suicide, so that equates to the increased risk for death." App. A, pp. 14-15, ¶¶ 45, 50. App. H (R.R.-Vol. 2, 126:18-22).

It also threatens immediate and irreparable harms to Appellees Jane and John Doe, and countless loving and affirming parents like them, who, aside from suffering

the unwarranted stigma associated with being investigated for child abuse, would have their parental rights be trampled and could suffer numerous consequences simply for being investigated. App. E at 2-3.

Likewise, Dr. Mooney and mandatory reporters like her face either "civil suit by patients for failing to treat them in accordance with professional standards and loss of licensure for failing to follow her professional ethics if Defendants' directives are enforced," or "immediate criminal prosecution," if she "does not report her patients." App. E at 3.

This case thus presents the circumstance where, "[a]bsent an appellate court's inherent power to make temporary orders to preserve the parties' rights until disposition of the appeal, the application of Rule 24.2(a)(3) would prevent a party from ever meaningfully challenging acts by the executive branch that the party alleges to be both unlawful and reviewable by courts and that it further alleges will cause it irreparable harm." *Tex. Educ. Agency*, 609 S.W.3d at 578. This Court has already "conclude[d] that under the particular circumstances presented here, where the appellee alleges irreparable harm from ultra vires action that it seeks to preclude from becoming final, to effectively perform [its] judicial function and to preserve the separation of powers, [this Court] must exercise [its] inherent authority and use Rule 29.3 to make orders 'to prevent irreparable harm to parties that have properly invoked [its] jurisdiction in an interlocutory appeal.'" *Id.* (quoting *In re Geomet*, 578

S.W.3d at 90).

Absent immediate relief from this Court, that same imminent and irreparable harm that led the trial court to issue its injunction in the first instance will persist while this appeal is pending. An order from this Court reinstating a temporary injunction on the terms set forth by the trial court would do Appellants "no harm whatsoever," as any interest they may claim "in enforcing an unlawful (and likely unconstitutional)" directive and rule "is illegitimate." *BST Holdings, L.L.C. v. Occupational Safety & Health Admin., United States Dep't of Lab.*, 17 F.4th 604, 618 (5th Cir. 2021).

The Court should enter an order reinstating a temporary injunction on the terms set forth by the trial court in this case, pursuant to Rule 29.3 and its inherent powers, to protect Appellees' rights and prevent irreparable and immediate harms.

II. The Court Should Consider This Emergency Motion for Temporary Injunctive Relief on an Expedited Basis and Should Set an Expedited Briefing Schedule.

Finally, the Court should consider this motion for temporary injunctive relief pursuant to Rule 29.3 on an emergency, expedited basis and set an expedited briefing schedule for its consideration. At stake in this case are, *inter alia*, the health, wellbeing, and very lives of vulnerable transgender youth; the ability of parents to support, love, and affirm their children; and the integrity of countless families across Texas. The trial court already found that a temporary injunction is necessary to

preserve the *status quo ante*, protect Appellees' rights, and prevent irreparable harm. Expedited consideration of this motion is therefore necessary not only to preserve the *status quo*, protect Appellees' rights, and prevent irreparable harm, but also for this Court "to effectively perform [its] judicial function and to preserve the separation of powers." *Tex. Educ. Agency*, 609 S.W.3d at 578.

Accordingly, Appellees respectfully request that the Court request a response from Appellants to the instant motion by Friday, March 18, 2022 at 12:00 p.m. Appellees further respectfully request that Court act on this emergency motion expeditiously.

CONCLUSION AND PRAYER

Appellees respectfully ask this Court to grant this Emergency Motion for Temporary Injunctive Relief and issue an order providing temporary injunctive relief on the terms set forth by the trial court until the disposition of the appeal. Such an order is necessary to preserve the *status quo* and the Appellees' rights. Appellees further request that this Court consider this motion on an expedited basis and that it request a response from Appellants by Friday, March 18, 2022 at 12:00 p.m. Finally, Appellees further request that this Court grant any and all other relief to which they may be entitled.

Dated: March 16, 2022

Respectfully submitted:

By: /s/ Maddy R. Dwertman
Derek R. McDonald
Texas State Bar No. 00786101
Maddy R. Dwertman
Texas State Bar No. 24092371
David B. Goode
State Bar No. 24106014
BAKER BOTTS L.L.P.
98 San Jacinto Boulevard, Suite 1500
Austin, Texas 78701-4078
Phone: (512) 322-2500
Fax: (512) 322-2501
derek.mcdonald@bakerbotts.com
maddy.dwertman@bakerbotts.com
david.goode@bakerbotts.com

Brandt Thomas Roessler
Texas State Bar No. 24127923
BAKER BOTTS L.L.P.
30 Rockefeller Plaza
New York, New York 10112-4498
Phone: (212) 408-2500
brandt.roessler@bakerbotts.com

Brian Klosterboer
Texas State Bar No. 24107833
Andre Segura
Texas State Bar No. 24107112
Savannah Kumar
State Bar No. 24120098
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF TEXAS
5225 Katy Fwy., Suite 350
Houston, Texas 77007
Phone: (713) 942-8146

By: /s/ Shelly L. Skeen
Paul D. Castillo
Texas State Bar No. 24049461
Shelly L. Skeen
Texas State Bar No. 24010511
Nicholas "Guilly" Guillory
Texas State Bar No. 24122392
LAMBDA LEGAL DEFENSE AND
EDUCATION FUND, INC.
3500 Oak Lawn Ave, Suite 500
Dallas, Texas 75219
Phone: (214) 219-8585
Fax: (214) 481-9140
pcastillo@lambdalegal.org
sskeen@lambdalegal.org
nguillory@lambdalegal.org

Omar Gonzalez-Pagan*
M. Currey Cook*
LAMBDA LEGAL DEFENSE AND
EDUCATION FUND, INC.
120 Wall Street, 19th Floor
New York, New York 10005-3919
Phone: (212) 809-8585
ogonzalez-pagan@lambdalegal.org
ccook@lambdalegal.org

Karen L. Loewy*
LAMBDA LEGAL DEFENSE AND
EDUCATION FUND, INC.
1776 K Street, N.W., 8th Floor
Washington, DC 20006
Phone: 202-804-6245
kloewy@lambdalegal.org

bklosterboer@aclutx.org
asegura@aclutx.org
skumar@aclutx.org

Chase Strangio*
James Esseks*
Anjana Samant*
Kath Xu*
AMERICAN CIVIL LIBERTIES UNION FOUNDATION
125 Broad Street, 18th Floor
New York, New York 10004
Phone: (917) 345-1742
cstrangio@aclu.org
jesseks@aclu.org
asamant@aclu.org
kxu@aclu.org

Camilla B. Taylor*
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
65 E. Wacker Place, Suite 2000
Chicago, IL 60601-7245
Phone: (312) 663-4413
ctaylor@lambdalegal.org

* Motion for admission *pro hac vice* pending or forthcoming

Attorneys for Appellees

CERTIFICATE OF COMPLIANCE

Pursuant to Texas Rule of Appellate Procedure 9.4(i)(3), I certify that this Emergency Motion contains 6,822 words, excluding the portions of the Motion exempted by Rule 9.4(i)(1).

/s/ Shelly L. Skeen
Shelly L. Skeen

CERTIFICATE OF CONFERENCE

Under Texas Rule of Appellate Procedure 10.1(a)(5), I certify that, on March 16, 2022, I conferred with Appellants' counsel, Ms. Courtney Corbello and Mr. Ryan Kercher, via email regarding Appellees' Emergency Motion for Temporary Injunctive Relief pursuant to Texas Rule of Appellate Procedure Rule 29.3. Counsel for Appellants indicated that Appellants are opposed to this Motion and the relief requested therein.

/s/ Shelly L. Skeen
Shelly L. Skeen

CERTIFICATE OF SERVICE

I hereby certify that on March 16, 2022, Appellees electronically served a true and correct copy of the foregoing Emergency Motion for Temporary Injunctive Relief pursuant to Texas Rule of Appellate Procedure Rule 29.3 on all known counsel of record by the Court's electronic filing system, as follows:

Courtney Corbello
Texas State Bar No. 24097533
Assistant Attorney General
General Litigation Division
OFFICE OF THE ATTORNEY GENERAL
P.O. Box 12548, Capitol Station
Austin, Texas 78711
Phone: (512) 463-2120
Fax: (512) 320-0667
courtney.corbello@oag.texas.gov

Ryan G. Kercher
Texas State Bar No. 24060998
Assistant Attorney General
OFFICE OF THE ATTORNEY GENERAL
P.O. Box 12548, Capitol Station
Austin, Texas 78711
Phone: (512) 463-2120
Fax: (512) 320-0667
ryan.kercher@oag.texas.gov

Attorneys for Defendants/Appellants

Derek R. McDonald
Texas State Bar No. 00786101
Maddy R. Dwertman
Texas State Bar No. 24092371
David B. Goode
State Bar No. 24106014
BAKER BOTTS L.L.P.
98 San Jacinto Boulevard, Suite 1500
Austin, Texas 78701
Phone: (512) 322-2500
Fax: (512) 322-2501
derek.mcdonald@bakerbotts.com
maddy.dwertman@bakerbotts.com
david.goode@bakerbotts.com

Paul D. Castillo
Texas State Bar No. 24049461
Shelly L. Skeen
Texas State Bar No. 24010511
Nicholas "Guilly" Guillory
Texas State Bar No. 24122392
LAMBDA LEGAL DEFENSE AND
EDUCATION FUND, INC.
3500 Oak Lawn Ave, Suite 500
Dallas, Texas 75219
Phone: (214) 219-8585
Fax: (214) 219-4455
pcastillo@lambdalegal.org
sskeen@lambdalegal.org
nguillory@lambdalegal.org
Omar Gonzalez-Pagan*

Brandt Thomas Roessler
Texas State Bar No. 24127923
BAKER BOTTS L.L.P.
30 Rockefeller Plaza
New York, New York 10112-4498
Phone: (212) 408-2500
brandt.roessler@bakerbotts.com

Brian Klosterboer
Texas State Bar No. 24107833
Andre Segura
Texas State Bar No. 24107112
Savannah Kumar
State Bar No. 24120098
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF TEXAS
5225 Katy Fwy., Suite 350
Houston, Texas 77007
Phone: (713) 942-8146
bklosterboer@aclutx.org
asegura@aclutx.org
skumar@aclutx.org

Chase Strangio*
James Esseks*
Anjana Samant*
Kath Xu*
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION
125 Broad Street, 18th Floor
New York, New York 10004
Phone: (917) 345-1742
cstrangio@aclu.org
jesseks@aclu.org
asamant@aclu.org
kxu@aclu.org

M. Currey Cook*
LAMBDA LEGAL DEFENSE AND
EDUCATION FUND, INC.
120 Wall Street, 19th Floor
New York, New York 10005-3919
Phone: (212) 809-8585
ogonzalez-pagan@lambdalegal.org
ccook@lambdalegal.org

Karen L. Loewy*
LAMBDA LEGAL DEFENSE AND
EDUCATION FUND, INC.
1776 K Street, N.W., 8th Floor
Washington, DC 20006-2304
Phone: 202-804-6245
kloewy@lambdalegal.org

Camilla B. Taylor*
LAMBDA LEGAL DEFENSE AND
EDUCATION FUND, INC.
65 E. Wacker Place, Suite 2000
Chicago, IL 60601-7245
Phone: (312) 663-4413
ctaylor@lambdalegal.org

Attorneys for Plaintiffs/Appellees

* Motion for admission *pro hac vice* forthcoming

/s/ Shelly L. Skeen
Shelly L. Skeen

APPENDIX
INDEX

Appendix A	Plaintiffs' Original Petition and Application for Temporary Restraining Order, Temporary Injunction, Permanent Injunction, and Request for Declaratory Relief (March 1, 2022)
Appendix B	Defendants' Plea to the Jurisdiction (March 2, 2022)
Appendix C	Order Granting Plaintiffs' Application for Temporary Restraining Order (March 2, 2022)
Appendix D	Defendants' Notice of Accelerated Interlocutory Appeal from Order Granting Plaintiffs' Application for Temporary Restraining Order (March 2, 2022)
Appendix E	Order Granting Plaintiffs' Application for Temporary Injunction (March 11, 2022)
Appendix F	Order Denying Defendants' Plea to the Jurisdiction (March 11, 2022)
Appendix G	Defendants' Notice of Accelerated Interlocutory Appeal from Order Granting Plaintiffs' Application for Temporary Injunction and Order Denying Defendants' Plea to the Jurisdiction (March 11, 2022)
Appendix H	Excerpts of Reporter's Record of the March 11, 2022 Temporary Injunction Hearing (March 11, 2022)

Appendix A

3/1/2022 9:02 AM
Velva L. Price
District Clerk
Travis County
D-1-GN-22-000977
Ruben Tamez

D-1-GN-22-000977

CAUSE NO. _____

JANE DOE, individually and as parent and next friend of MARY DOE, a minor; JOHN DOE, individually and as parent and next friend of MARY DOE, a minor; and DR. MEGAN MOONEY,	§	
Plaintiffs	§	
	§	IN THE DISTRICT COURT OF TRAVIS COUNTY, TEXAS
v.	§	_____ JUDICIAL DISTRICT
	§	353RD, DISTRICT COURT
GREG ABBOTT, sued in his official capacity as Governor of the State of Texas; JAIME MASTERS, sued in her official capacity as Commissioner of the Texas Department of Family and Protective Services; and the TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES,	§	
Defendants.	§	

PLAINTIFFS' ORIGINAL PETITION AND APPLICATION FOR TEMPORARY RESTRAINING ORDER, TEMPORARY INJUNCTION, PERMANENT INJUNCTION, AND REQEUST FOR DECLARATORY RELIEF

Plaintiffs Jane and John Doe[1], individually and as parents and next friends of Plaintiff Mary Doe, a minor; and Dr. Megan Mooney (collectively, "Plaintiffs") file this Petition and Application

[1] Plaintiffs Jane Doe, John Doe, and Mary Doe proceed pseudonymously in order to protect their right to privacy, particularly that of Mary Doe, who is a minor. The Texas Rules of Civil Procedure recognize the need to protect a minor's identity. *See* Tex. R. Civ. P. 21c(a)(3). Such goal would not be possible if the identities of Jane Doe and John Doe were public. Moreover, the disclosure of the Doe Plaintiffs' identities "would reveal matters of a highly sensitive and personal nature, specifically [Mary Doe]'s transgender status and h[er] diagnosed medical condition—gender dysphoria." *Foster v. Andersen*, No. 18-2552-DDC-KGG, 2019 WL 329548, at *2 (D. Kan. Jan. 25, 2019). "[O]ther courts have recognized the highly personal and sensitive nature of a person's transgender status and thus have permitted transgender litigants to proceed under pseudonym." *Id.* (collecting cases). Furthermore, as courts have recognized, the disclosure of a person's transgender status "exposes them to prejudice, discrimination, distress, harassment, and violence." *Arroyo Gonzalez v. Rossello Nevares*, 305 F. Supp. 3d 327, 332 (D.P.R. 2018); *see also Foster*, 2019 WL 329548, at *2. Such is the case here.

for Temporary Restraining Order, Temporary Injunction, Permanent Injunction, and Request for Declaratory Relief ("Petition") against Defendants Greg Abbott, in his official capacity as Governor of the State of Texas ("Governor Abbott" or the "Governor"), Jaime Masters, in her official capacity as Commissioner of the Texas Department of Family and Protective Services ("Commissioner Masters" or the "Commissioner"), and the Texas Department of Family and Protective Services ("DFPS") (collectively, "Defendants"). In support of their Petition, Plaintiffs respectfully show the following:

I. PRELIMINARY STATEMENT

1. After the Texas legislature failed to pass legislation criminalizing well-established and medically necessary treatment for adolescents with gender dysphoria, the Texas Governor, Attorney General, and Commissioner of the Department of Family and Protective Services have attempted to legislate by press release. Governor Abbott's letter instructing DFPS to investigate the families of transgender children is entirely without Constitutional or statutory authority; and despite this, the Commissioner nonetheless issued a statement directing DFPS to carry out the Governor's wishes and agreeing to follow a nonbinding legal opinion that did not change Texas law.

2. The Governor has circumvented the will of the legislature and, in so doing, he and the Commissioner have run afoul of numerous Constitutional and statutory limits on their power. Additionally, by their actions, Defendants have trampled on the Constitutional rights of transgender children, their parents, and professionals who provide vital care to transgender children. The Defendants have, without Constitutional or statutory authority, acted to create a new definition of "child abuse" that singles out a subset of loving parents for scrutiny, investigation, and potential family separation. Their actions caused terror and anxiety among transgender youth and their families across the Lone Star State and singled out transgender youth and their families

for discrimination and harassment. What is more, the Governor's, Attorney General's, and Commissioner's actions threaten to endanger the health and wellbeing of transgender youth in Texas by depriving them of medically necessary care, while communicating that transgender people and their families are not welcome in Texas.

3. The Governor has also declared that teachers, doctors, and the general public are all required, on pain of criminal penalty, to report to DFPS any person who provides or is suspected of providing medical treatment for gender dysphoria, a recognized condition with well-established treatment protocols. And DFPS has started investigating families for child abuse based on reports that the families have followed doctor-recommended treatments for their adolescent children.

4. The actions of the Governor, the Commissioner, and DFPS violate the Texas Administrative Procedure Act, are *ultra vires* and therefore invalid, violate the separation of powers guaranteed by the Texas Constitution, and violate equality and due process protections guaranteed by the Texas Constitution. Plaintiffs ask the Court to enjoin these violations of Texas law and of the plaintiffs' rights and immediately return to the *status quo ante*.

II. PARTIES

5. Plaintiffs Jane Doe, John Doe, and Mary Doe are all residents of Texas. Plaintiffs Jane Doe and John Doe are the parents and next friends of Plaintiff Mary Doe, who is a minor. Plaintiff Mary Doe is transgender, has been diagnosed with gender dysphoria, a serious medical condition, and is currently receiving medically necessary care for the treatment of her gender dysphoria. Plaintiff Jane Doe is an employee of Defendant DFPS.

6. Plaintiff Dr. Megan Mooney is a clinical psychologist and mandated reporter under Texas law. She has a practice based in Houston, Texas that includes transgender patients, many of whom have been diagnosed with gender dysphoria and are receiving treatment for this condition.

7. Defendant Greg Abbott is the Governor of the State of Texas and is sued in his official capacity only. He may be served at 1100 San Jacinto Blvd., Austin, Texas 78701.

8. Defendant Jaime Masters is the Commissioner of the Texas Department of Family and Protective Services and is sued in her official capacity only. She may be served at 701 West 51st Street, Austin, Texas 78751.

9. Defendant Texas Department of Family and Protective Services is a state agency that is statutorily tasked with promoting safe and healthy families and protecting children and vulnerable adults from abuse, neglect, and exploitation. DFPS fulfills these statutory obligations through investigations, services and referrals, and prevention programs. It may be served at 701 West 51st Street, Austin, Texas 78751.

III. JURISDICTION AND VENUE

10. The subject matter in controversy is within the jurisdictional limits of this Court, and the Court has jurisdiction over this action pursuant to Article V, Section 8, of the Texas Constitution and section 24.007 of the Texas Government Code, as well as the Texas Uniform Declaratory Judgments Act, Texas Civil Practice & Remedies Code sections 37.001 and 37.003, and the Texas Administrative Procedure Act, Texas Government Code section 2001.038.

11. This Court has jurisdiction over the parties because all Defendants reside or have their principal place of business in Texas.

12. Plaintiffs seek non-monetary relief.

13. Venue is proper in Travis County because Defendants have their principal office in Travis County. Tex. Civ. Prac. & Rem. Code § 15.002(a)(3).

IV. DISCOVERY CONTROL PLAN

14. Plaintiffs intend for discovery to be conducted under Level 3 of Texas Rule of Civil Procedure 190.

V. FACTUAL BACKGROUND

A. Governor Abbott, Attorney General Paxton, and Commissioner Masters Create New Definitions of "Child Abuse" Under State Law.

15. On February 21, 2022, Attorney General Paxton released Opinion No. KP-0401 ("Paxton Opinion") dated February 18, 2022, which addressed "Whether certain medical procedures performed on children constitute child abuse."[2] The Paxton Opinion was issued in response to Representative Matt Krause's request dated August 23, 2021 about whether certain enumerated "sex-change procedures" when used to treat a minor with gender dysphoria constitute child abuse under state law. Specifically, Representative Krause inquired about and Attorney General Paxton purportedly addressed the following procedures: "sterilization through castration, vasectomy, hysterectomy, oophorectomy, metoidioplasty, orchiectomy, penectomy, phalloplasty, and vaginoplasty; …mastectomies; and … removing from children otherwise healthy or non-diseased body part or tissue."[3] The Paxton Opinion also responded to Representative Krause's additional inquiries about: whether "the following categories of drugs: (1) puberty-suppression or puberty-blocking drugs; (2) supraphysiologic doses of testosterone to females; and (3) supraphysiologic doses of estrogen to males" when used to treat minors with gender dysphoria could constitute child abuse.[4]

16. In summary, Attorney General Paxton's Opinion concluded that the enumerated procedures *could* constitute child abuse. The Opinion was based on the premise that "elective sex

[2] Ken Paxton et al., Re: Whether Certain Medical Procedures Performed on Children Constitute Child Abuse (RQ-0426-KP), Opinion No. KP-0401, at 1 (Feb. 18, 2022), https://texasattorneygeneral.gov/sites/default/files/global/KP-0401.pdf.
[3] *Id.*
[4] *Id.*

changes to minors often has [sic] the effect of permanently sterilizing those minor children."[5] The Paxton Opinion specifies that it "does not address or apply to *medically necessary* procedures."[6]

17. In response to the Paxton Opinion, Governor Abbott sent a letter to DFPS Commissioner Jaime Masters dated February 22, 2022 ("Abbott Letter" of "Abbott's Letter") directing the agency "to conduct a prompt and thorough investigation of any reported instances" of "sex-change procedures," without any regard to medical necessity.[7] The Abbott Letter claimed that "a number of so-called 'sex change' procedures constitute child abuse under existing Texas law."[8] In addition to directing DFPS to investigate reports of procedures referenced in the Paxton Opinion, under threat of criminal prosecution, the Abbott Letter directs "all licensed professionals who have direct contact with children" and "members of the general public" to report instances of minors who have undergone the medical procedures outlined in his Letter and the Paxton Opinion.[9]

18. On February 22, 2022, DFPS announced that it would "follow Texas law as explained in (the) Attorney General opinion" and comply with the Paxton Opinion and Abbott letter and "investigate[]" any reports of the procedures outlined in the new directives ("DFPS Statement"), again, without any regard to medical necessity.[10]

19. Commissioner Masters claimed that prior to the issuance of the Paxton Opinion and Abbott letter, the agency had "no pending investigations of child abuse involving the procedures described in that opinion."[11]

---

[5] *Id.* at 2.
[6] *Id.* at 2 (emphasis added).
[7] Greg Abbott, Letter to Hon. Jaime Masters, Commissioner, Tex. Dep't of Fam. & Protective Servs. (Feb. 22, 2022), https://gov.texas.gov/uploads/files/press/O-MastersJaime202202221358.pdf.
[8] *Id.*
[9] *Id.*
[10] Isaac Windes, *Texas AG says trans healthcare is child abuse. Will Fort Worth schools have to report*?, Fort Worth Star-Telegram (Feb. 23, 2022), https://www.star-telegram.com/news/local/crossroads-lab/article258692193.html.
[11] *Id.*

20. Previously, on September 3, 2021, Commissioner Masters responded to an inquiry from Representative Bryan Slaton about the same underlying medical treatment and explained, "I will await the opinion issued by the Attorney General's office before I reach any final decisions on the matters you raise."[12]

21. In the hours and days following the February 2022 actions of Attorney General Paxton, Governor Abbott, and Commissioner Masters, DFPS initiated investigations into families with transgender children, which continue.

22. During the 87th Regular session, the Texas legislature considered, but did not pass, proposed legislation that would have changed Texas law to include treatment for gender dysphoria under the definition of child abuse. Specifically, Senate Bill 1646 ("SB 1646") would have amended Section 261.001 of the Family Code to add certain treatments to the definition of "child abuse." The bill would have amended this provision of the law to include within the definition of "child abuse": "administering or supplying, or consenting to or assisting in the administration or supply of, a puberty suppression prescription drug or cross-sex hormone to a child, other than an intersex child, for the purpose of gender transitioning or gender reassignment; or performing or consenting to the performance of surgery or another medical procedure on a child other than an intersex child, for the purpose of gender transitioning or gender reassignment."[13] SB 1646 did not pass. The legislature considered additional bills that would have prohibited medical treatment for gender dysphoria in minors, including House Bill 68 and House Bill 1339. None of these bills were passed by the duly elected members of the legislature.

---

[12] Jaime Masters, Letter to Hon. Bryan Slaton, Representative, District 2, Re: Correspondence (Sept. 3, 2021), http://thetexan.ews/wp-content/uploads/2021/09/Response-Letter_Representative-Slaton_Addressing-Gender-Reassignment-090321.pdf.

[13] S.B. 1646, 87th Leg. (Tex. 2021), https://capitol.texas.gov/tlodocs/87R/billtext/pdf/SB01646E.pdf.

23. On July 19, 2021, after the above-referenced legislation failed to pass, Governor Abbott explained on a public radio show that he had a "solution" to what he called the "problem" of medical treatment for minors with gender dysphoria.[14]

B. Responses to New Child Abuse Directives

24. Following the recent attempts by Defendants to change the definition of "child abuse" under Texas law, experts in pediatric medicine, endocrinology, mental health care, and social work issued statements condemning the action and warning that it was counter to established protocols for treating gender dysphoria, could force providers to violate their professional ethics, and would cause substantial harm to minors and their families in Texas.

25. In response to the actions taken by Defendants, the National Association of Social Workers issued the following statement: "The continued attempts in Texas to change the definition of child abuse are in direct opposition to social work values, principles, and Code of Ethics and pose an imminent danger to transgender youth and their families. Furthermore, these shameful actions undermine the established truth supported by every credible medical and mental health organization in the country that the concepts of sexual orientation and gender identity are real and irrefutable components of one's individual identity."[15]

26. The American Academy of Pediatrics and the Texas Pediatric Society condemned the actions of Texas executive officials explaining that "[t]he AAP has long supported gender-affirming care for transgender youth, which includes the use of puberty-suppressing treatments when appropriate, as outlined in its own policy statement, urging that youth who identify as

---

[14] The Mark Davis Show, *July 19, 2021 8am Hour*, at 11:04 (July 19, 2021), https://omny.fm/shows/the-mark-davis-show/july-19-2021-8am-hour.

[15] *NASW Condemns Efforts to Redefine Child Abuse to Include Gender-Affirming Care*, Nat'l Ass'n Soc. Workers (Feb. 25, 2022), https://www.socialworkers.org/News/News-Releases/ID/2406/NASW-Condemns-Efforts-to-Redefine-Child-Abuse-to-Include-Gender-Affirming-Care.

transgender have access to comprehensive, gender-affirming, and developmentally appropriate health care that is provided in a safe and inclusive clinical space in close consultation with parents."[16]

27. The president of the Texas Pediatric Society explained of the efforts to change the definition of "child abuse" under Texas law: "Evidence-based medical care for transgender and gender diverse children is a complex issue that pediatricians are uniquely qualified to provide. This directive undermines the physician-patient-family relationship and will cause undue harm to children in Texas. TPS opposes the criminalization of evidence-based, gender-affirming care for transgender youth and adolescents. We urge the prioritization of the health and well-being of all youth, including transgender youth."[17]

28. The Endocrine Society condemned the efforts to re-define "child abuse" explaining that these efforts "reject[] evidence-based transgender medical care and will restrict access to care for teenagers experiencing gender incongruence or dysphoria."[18] The Endocrine Society statement went on to explain, "Health care providers should not be punished for providing evidenced-based care that is supported by major international medical groups—including the Endocrine Society, American Medical Association, the American Psychological Association, and the American Academy of Pediatrics—and Clinical Practice Guidelines."[19]

29. The President of the American Psychological Association issued the following statement: "This ill-conceived directive from the Texas governor will put at-risk children at even

---

[16] *AAP, Texas Pediatric Society Oppose Actions in Texas Threatening Health of Transgender Youth*, Am. Acad. Pediatrics (Feb. 24, 2022), https://www.aap.org/en/news-room/news-releases/aap/2022/aap-texas-pediatric-society-oppose-actions-in-texas-threatening-health-of-transgender-youth/.
[17] *Id.*
[18] *Endocrine Society Alarmed at Criminalization of Transgender Medicine*, Endocrine Soc'y (Feb. 23, 2022), https://www.endocrine.org/news-and-advocacy/news-room/2022/endocrine-society-alarmed-at-criminalization-of-transgender-medicine.
[19] Id.

higher risk of anxiety, depression, self-harm, and suicide. Gender-affirming care promotes the health and well-being of transgender youth and is provided by medical and mental health professionals, based on well-established scientific research. The peer-reviewed research suggests that transgender children and youth who are treated with affirmation and receive evidence-based treatments tend to see improvements in their psychological well-being.

Asking licensed medical and mental health professionals to 'turn in' parents who are merely trying to give their children needed and evidence-based care would violate patient confidentiality as well as professional ethics. The American Psychological Association opposes politicized intrusions into the decisions that parents make with medical providers about caring for their children."[20]

30. Prevent Child Abuse America issued the following statement: "Prevent Child Abuse America (PCA America) knows that providing necessary and adequate medical care to your child is not child abuse, and that transgender and non-binary children need access to age-appropriate, individualized medical care just like every other child. Therefore, PCA America opposes legislation and laws that would deny healthcare access to any child, regardless of their gender identity. Such laws threaten the safety and security of our nation's most vulnerable citizens—children and youth."[21]

31. The Ray E. Helfer Society, an international, multi-specialty society of physicians having substantial research and clinical experience with all medical facets of child abuse and neglect, likewise condemned Defendants' actions. The Helfer Society "opposes equating evidence based, gender affirming care for transgender youth with child abuse, and the criminalization of

---

[20] *APA President Condemns Texas Governor's Directive to Report Parents of Transgender Minors*, Am. Psych. Ass'n (Feb. 24, 2022), https://www.apa.org/news/press/releases/2022/02/report-parents-transgender-children.

[21] Melissa Merrick, *A Message from Dr. Melissa Merrick in Response to Texas AG Opinion on Gender-Affirming Care*, Prevent Child Abuse Am. (Feb. 23, 2022), https://preventchildabuse.org/latest-activity/gender-affirming-care/.

such care. The provision of medical and mental health care, consistent with the standard of care, is in no way consistent with our definitions of child abuse."[22]

32. Parents and families across the state of Texas are fearful that if they follow the recommendations of their medical providers to treat their adolescent children's suffering from gender dysphoria, they could face investigation, criminal prosecution and the removal of their children from their custody. As a result, parents are scared to remain in Texas, to send their children to school or to the doctor, and to otherwise meet their basic survival needs. They are also scared that if they do not pursue this medically prescribed and necessary care for their children in order to avoid investigation and criminal prosecution, their children's mental and physical health will suffer dramatically.

33. Upon information and belief, some doctors and other providers have discontinued prescribing medically necessary treatment for gender dysphoria to transgender youth as a result of Defendants' actions, causing patients to suffer physical and mental health consequences.

34. The actions taken by Defendants have already caused severe and irreparable harm to families across the state of Texas, including the Doe family, and have put medical and mental health providers in the impossible position of either following their legal and ethical professional responsibilities or facing criminal prosecution or civil and professional repercussions under Texas law.

---

[22] *Position Statement of the Ray E. Helfer Society On Gender Affirming Care Being Considered Child Abuse and Neglect*, Ray E. Helfer Soc'y (Feb. 2022), https://www.helfersociety.org/assets/docs/Helfer%20Society%20Statement%20On%20Texas%20Transgender%20Action%2002.22.pdf.

C. Treatment for Gender Dysphoria is Well-Established and Medically Necessary.

35. The health care that Governor Abbott has directed DFPS to consider child abuse is actually medically necessary, essential, and often lifesaving medical care that is endorsed and adopted by every major medical organization in the United States.

36. Doctors in Texas use well-established guidelines to diagnose and treat youth with gender dysphoria. Medical treatment for gender dysphoria is prescribed to adolescents only after the onset of puberty and only when doctors determine it to be medically necessary. Parents, doctors, and minors work together to develop a treatment plan consistent with widely accepted protocols supported by every major medical organization in the United States.

37. "Gender identity" refers to a person's internal, innate, and immutable sense of belonging to a particular gender.

38. Although the precise origin of gender identity is unknown, a person's gender identity is a fundamental aspect of human development. There is a general medical consensus that there is a significant biological component to gender identity.

39. Everyone has a gender identity. A person's gender identity is durable and cannot be altered through medical intervention.

40. A person's gender identity usually matches the sex they were designated at birth based on their external genitalia. The terms "sex designated at birth" or "sex assigned at birth" are more precise than the term "biological sex" because there are many biological sex characteristics, including gender identity, and these may not always be in alignment with each other. For example, some people with intersex characteristics may have a chromosomal configuration typically associated with a male sex designation but genital characteristics typically associated with a female sex designation. For these reasons, the Endocrine Society, an international medical organization

of over 18,000 endocrinology researchers and clinicians, warns practitioners that the terms "biological sex" and "biological male or female" are imprecise and should be avoided.[23]

41. Most boys were designated male at birth based on their external genital anatomy, and most girls were designated female at birth based on their external genital anatomy.

42. Transgender youth have a gender identity that differs from the sex assigned to them at birth. A transgender boy is someone who was assigned a female sex at birth but persistently, consistently, and insistently identifies as male. A transgender girl is someone who was assigned a male sex at birth but persistently, consistently, and insistently identifies as female.

43. Some transgender people become aware of having a gender identity that does not match their assigned sex early in childhood. For others, the onset of puberty, and the resulting physical changes in their bodies, leads them to recognize that their gender identity is not aligned with their sex assigned at birth. The lack of alignment between one's gender identity and sex assigned at birth can cause significant distress.

44. According to the American Psychiatric Association's Diagnostic & Statistical Manual of Mental Disorders ("DSM-V"), "gender dysphoria" is the diagnostic term for the condition experienced by some transgender people of clinically significant distress resulting from the lack of congruence between their gender identity and the sex assigned to them at birth. In order to be diagnosed with gender dysphoria, the incongruence must have persisted for at least six months and be accompanied by clinically significant distress or impairment in social, occupational, or other important areas of functioning.

---

[23] *See* Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline*, 102 J. Clinical Endocrinology & Metabolism 3869, 3875 (2017), https://academic.oup.com/jcem/article/102/11/3869/4157558 [hereinafter "Endocrine Guideline"] ("Biological sex, biological male or female: These terms refer to physical aspects of maleness and femaleness. As these may not be in line with each other (e.g., a person with XY chromosomes may have female-appearing genitalia), the terms biological sex and biological male or female are imprecise and should be avoided.").

45. Being transgender is not itself a medical condition to be cured. But gender dysphoria is a serious medical condition that, if left untreated, can result in debilitating anxiety, severe depression, self-harm, and suicidality.

46. The World Professional Association for Transgender Health ("WPATH") and the Endocrine Society have published widely accepted guidelines for treating gender dysphoria.[24] The medical treatment for gender dysphoria is to eliminate the clinically significant distress by helping a transgender person live in alignment with their gender identity. This treatment is sometimes referred to as "gender transition," "transition related care," or "gender affirming care." These standards of care are recognized by the American Academy of Pediatrics, which agrees that this care is safe, effective, and medically necessary treatment for the health and wellbeing of youth suffering from gender dysphoria.[25]

47. The precise treatment for gender dysphoria for any individual depends on that person's individualized needs, and the guidelines for medical treatment differ depending on whether the treatment is for an adolescent or an adult. No medical treatment is recommended or necessary prior to the onset of puberty, however.

48. Before puberty, gender transition does not include any pharmaceutical or surgical intervention. Instead, it involves social transition, such as using a name and pronouns typically associated with the child's gender identity and dressing consistently with their gender identity.

---

[24] Endocrine Guideline; World Prof'l Ass'n for Transgender Health, Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People (7th Version, 2012), https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English2012.pdf?_t=1613669341 [hereinafter, WPATH SOC].

[25] Jason Rafferty, et al., Am. Academy Pediatrics, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, 142 Pediatrics (2018), https://publications.aap.org/pediatrics/article/142/4/e20182162/37381/Ensuring-Comprehensive-Care-and-Support-for; Lee Savio Beers, *American Academy of Pediatrics Speaks Out Against Bills Harming Transgender Youth*, Am. Academy Pediatrics (Mar. 16, 2021), https://www.aap.org/en/news-room/news-releases/aap/2021/american-academy-of-pediatrics-speaks-out-against-bills-harming-transgender-youth/.

49. Under the WPATH Standards of Care and the Endocrine Society Guideline, medical interventions may become medically necessary and appropriate as transgender youth reach puberty. In providing medical treatments to adolescents, pediatric physicians and endocrinologists work in close consultation with qualified mental health professionals experienced in diagnosing and treating gender dysphoria.

50. For many transgender adolescents, going through puberty in accordance with the sex assigned to them at birth can cause extreme distress. Puberty-delaying medication allows transgender adolescents to avoid that, thus minimizing and potentially preventing the heightened gender dysphoria and permanent physical changes that puberty would cause.

51. Under the Endocrine Society Clinical Guideline, transgender adolescents may be eligible for puberty-delaying treatment if:

- A qualified mental health professional has confirmed that:
    - the adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed),
    - gender dysphoria worsened with the onset of puberty,
    - coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment,

      the adolescent has sufficient mental capacity to give informed consent to this (reversible) treatment,
- And the adolescent:

    - has sufficient mental capacity to give informed consent to this (reversible) treatment,
    - the adolescent has been informed of the effects and side effects of treatment (including potential loss of fertility if the individual subsequently continues with sex hormone treatment) and options to preserve fertility,
    - the adolescent has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process,
- And a pediatric endocrinologist or other clinician experienced in pubertal assessment:
    - agrees with the indication for gonadotropin-releasing hormone ("GnRH") agonist treatment,
    - has confirmed that puberty has started in the adolescent, and
    - has confirmed that there are no medical contraindications to GnRH agonist treatment.

52. Puberty-delaying treatment is reversible. If an adolescent discontinues the medication, puberty consistent with their assigned sex will resume. Contrary to the assertions in the Paxton Opinion, puberty-delaying treatment does not cause infertility.

53. For some adolescents, it may be medically necessary and appropriate to initiate puberty consistent with the young person's gender identity through gender-affirming hormone

therapy (testosterone for transgender boys, and estrogen and testosterone suppression for transgender girls).

54. Under Endocrine Society Clinical Guidelines, transgender adolescents may be eligible for gender-affirming hormone therapy if:

- A qualified mental health professional has confirmed:
  - the persistence of gender dysphoria,
  - any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's environment and functioning are stable enough to start sex hormone treatment,
  - the adolescent has sufficient mental capacity to estimate the consequences of this (partly) irreversible treatment, weigh the benefits and risks, and give informed consent to this (partly) irreversible treatment,
- And the adolescent:
  - has been informed of the partly irreversible effects and side effects of treatment (including potential loss of fertility and options to preserve fertility),
  - has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process,

- And a pediatric endocrinologist or other clinician experienced in pubertal induction:
    - agrees with the indication for sex hormone treatment, and
    - has confirmed that there are no medical contraindications to sex hormone treatment.

55. Under the WPATH Standards of Care, transgender young people may also receive medically necessary chest reconstructive surgeries before the age of majority, provided the young person has lived in their affirmed gender for a significant period of time. Genital surgery is not recommended until patients reach the age of majority.

56. Chest reconstructive surgeries have no impact on fertility.

57. Medical treatment recommended for and provided to transgender adolescents with gender dysphoria can substantially reduce lifelong gender dysphoria and can eliminate the medical need for surgery later in life.

58. The treatment protocols for gender dysphoria supported by every major medical organization in the United States are based on extensive research and clinical experience. When existing protocols are followed, no minor is rushed into treatment. The process, instead, requires extensive mental health evaluation and informed consent procedures.

59. Providing gender-affirming medical care can be lifesaving treatment and change the short and long-term health outcomes for transgender youth.

60. All of the treatments used to treat gender dysphoria are also used to treat other conditions in minors with comparable side effects and risks.

61. Many forms of treatment in pediatric medicine and medicine generally are prescribed "off-label". Use of medication for "off-label" non-FDA approved purposes is a common and necessary practice in medicine.

D. Legal Status of Treatment for Gender Dysphoria in the United States

62. No state in the country considers medically recommended treatment for gender dysphoria to be a form of child abuse.

63. No state in the country prohibits doctors from treating, or parents from consenting to treatment for, minor patients with gender dysphoria.

64. Arkansas is the only state to pass a law prohibiting such treatment but the law was enjoined in court before it went into effect and does not classify the treatment as a form of child abuse.[26] When the Arkansas General Assembly passed the bill prohibiting treatment for minors with gender dysphoria, Governor Asa Hutchinson vetoed it, explaining: "I vetoed this bill because it creates new standards of legislative interference with physicians and parents as they deal with some of the most complex and sensitive matters concerning our youths. It is undisputed that the number of minors who struggle with gender incongruity or gender dysphoria is extremely small. But they, too, deserve the guiding hand of their parents and the counseling of medical specialists in making the best decisions for their individual needs. H.B. 1570 puts the state as the definitive oracle of medical care, overriding parents, patients, and health-care experts. While in some instances the state must act to protect life, the state should not presume to jump into the middle of every medical, human and ethical issue. This would be—and is—a vast government overreach."[27]

---

[26] *Brandt v. Rutledge*, Case No.: 4:21-cv-00450-JM, 2021 WL 3292057 (E.D. Ark. Aug. 2, 2021).

[27] Asa Hutchinson, Opinion, *Why I Vetoed My Party's Bill Restricting Health Care for Transgender Youth*, Wash. Post (Apr. 8, 2021), https://www.washingtonpost.com/opinions/asa-hutchinson-veto-transgender-health-bill-youth/2021/04/08/990c43f4-9892-11eb-962b-78c1d8228819_story.html.

65. In Arkansas, a simple majority of the General Assembly overrode Governor Hutchinson's veto and nonetheless enacted a ban on health care treatments for minors with gender dysphoria. In July 2021, that law was enjoined in federal court. Based on an extensive preliminary injunction record, the court found: "If the Act is not enjoined, healthcare providers in this State will not be able to consider the recognized standard of care for adolescent gender dysphoria. Instead of ensuring that healthcare providers in the State of Arkansas abide by ethical standards, the State has ensured that its healthcare providers do not have the ability to abide by their ethical standards which may include medically necessary transition-related care for improving the physical and mental health of their transgender patients."[28] The court further held that the law "cannot withstand heightened scrutiny and based on the record would not even withstand rational basis scrutiny if it were the appropriate standard of review."[29]

VI. PLAINTIFFS

The Doe Family

66. Plaintiff Jane Doe is married to Plaintiff John Doe and together they are the proud parents of Plaintiff Mary Doe, a 16-year-adolescent. Ex. 1, Decl. of Jane Doe.

67. Plaintiffs Jane and John have called Texas their home for nearly 20 years and Texas is the only home Mary has ever known.

68. Mary Doe is transgender. When she was born, she was designated as "male" on her birth certificate, but she is a girl.

69. From a very young age, Mary has expressed herself and behaved in manner that does not conform with the stereotypes associated with the sex she was designated at birth.

[28] *Brandt v. Rutledge*, Case No.: 4:21-cv-00450-JM, 2021 WL 3292057, at *4 (E.D. Ark. Aug. 2, 2021).
[29] *Id.*

70. Mary's parents have been supportive and accepting of her, giving her the space to express herself and explore who she is.

71. Mary has been under the care of the same pediatrician most of her life. Her pediatrician diagnosed her with gender dysphoria and referred the family to other medical professionals who likewise confirmed that Mary suffers from gender dysphoria.

72. The family has also done research to educate themselves about gender dysphoria and its treatment, and connected Mary with youth support groups that would permit them to have discussions as a family.

73. Following Mary's diagnosis of gender dysphoria, Mary's doctors recommended that Mary be provided with medical care to treat and alleviate her gender dysphoria. This care has included the prescription of puberty-delaying medication and hormone therapy to initiate puberty consistent with her female gender.

74. In consultation with these doctors and after extensive discussions about the benefits and potential side effects of this treatment, Jane Doe, John Doe, and Mary Doe jointly decided to initiate treatment for Mary's gender dysphoria. This treatment has been prescribed by Mary's doctors in accordance with what they believe are best medical practices and what the Doe family understands will be the best course of action to protect Mary's physical and mental health.

75. Mary was worried about having to undergo a puberty that would result in permanent physical characteristics not in alignment with her female gender. Jane and John observed how the prospect of beginning this puberty caused Mary significant distress and exacerbated her dysphoria.

76. Being able to be affirmed as who she is, including through the course of treatment prescribed by her doctors, has brought Mary significant relief and allowed her to thrive.

77. Plaintiff Jane Doe has worked in the field of child protective services at various times throughout her career. At present, Plaintiff Jane Doe is an employee of DFPS, where she works on the review of reports of abuse and neglect. Her track record as a DFPS employee has been exemplary and commended by her supervisors.

78. The issuance of the Paxton Opinion and the Abbott Letter, followed by DFPS's implementation of these to investigate the provision of medically necessary gender-affirming health care as abuse, has wreaked havoc on the Doe family.

79. Plaintiffs Jane Doe, John Doe, and Mary Doe are terrified for Mary's health and wellbeing, and for their family.

80. On February 23, 2022, following the issuance of the Paxton Opinion and the Abbott Letter, Jane communicated with her supervisor at DFPS to seek clarification of how the Abbott Letter would affect DFPS policy. Such clarification was important for her family as well as to her ability to perform her job at DFPS.

81. That same day, and just mere hours later, Jane Doe was placed on leave from her employment because she has a transgender daughter with a medical need for treatment of gender dysphoria.

82. The next day, on the afternoon of February 24, 2022, Plaintiff Jane Doe was informed that her family would be investigated in accordance with Governor Abbott's letter to determine if Jane Doe and John Doe had committed abuse by affirming their transgender daughter's identity and obtaining the medically necessary health care that she needs.

83. On February 25, 2022, a DFPS Child Protective Services (CPS) investigator visited the Doe family's home to interview Jane Doe, John Doe, and Mary Doe. The CPS investigator interviewed Jane Doe and John Doe, who were accompanied by counsel, together, while he

interviewed Mary Doe, who was accompanied by different counsel, apart from her parents. Aside from interviewing the Doe family, the CPS investigator sought access through releases to Mary Doe's medical records, which the Doe Plaintiffs refused to sign.

84. The CPS investigator disclosed that the sole allegation against Jane Doe and John Doe is that they have a transgender daughter and that their daughter may have been provided with medically necessary gender-affirming health care and is "currently transitioning from male to female."

85. The issuance of the Paxton Opinion and the Abbott Letter, along with DFPS's implementation of these, has terrorized the Doe family and inflicted ongoing and irreparable harm.

86. As a result of DFPS's implementation and the subsequent investigation of the Doe family, Jane Doe has been placed on leave from her employment. Should DFPS incorrectly find that Jane Doe and John Doe have committed "abuse" based on Governor Abbott's and Attorney General Paxton's erroneous and misguided missives and understanding of medical treatment for gender dysphoria, Jane Doe could face termination, which would result not only in the loss of income for the family but also their health care coverage.

87. Should DFPS incorrectly issue a finding that there is reason to believe that Jane Doe and John Doe have committed "abuse" based on Governor Abbott's and Attorney General Paxton's erroneous and misguided missives and understanding of medical treatment for gender dysphoria, they would automatically be placed on a child abuse registry and be improperly subject to all of the effects that flow from such placement.

88. The issuance of the Attorney General's opinion and Governor's letter, along with DFPS's implementation of these, has caused a significant amount of stress, anxiety, and fear for the Doe family. For example, Mary has been traumatized by the prospect that she could be

separated from her parents and could lose access to the medical treatment that has enabled her to thrive. The stress has taken a noticeable toll on her, and her parents have observed how their daughter who is typically joyful and happy, is now moodier, stressed, and overwhelmed. Similarly, Jane and John are now filled anxiety and worry. Jane has been unable to sleep, worrying about what they can do and how they can keep their family intact and their daughter safe and healthy. The Doe family is living in constant fear about what will happen to them due to the actions by DFPS, the Governor, and the Attorney General.

89. Plaintiffs Jane and John also worry about the potential physical and mental health consequences of depriving Mary of the medical treatment her doctors have prescribed and that she needs. Not providing Mary with the medically necessary health care that she needs is not an option for them, as their topmost goal and duty are to ensure Mary's health and wellbeing.

Dr. Megan A. Mooney

90. Plaintiff Dr. Megan A. Mooney is a licensed psychologist in Texas. For almost two decades now, she has worked with children and families to respond to and mitigate trauma and harm. Ex. 2, Decl. of Dr. Mooney.

91. Dr. Mooney is also a mandatory reporter obligated to report child abuse and neglect to DFPS. She has received and conducted trainings on mandatory reporting requirements and is familiar with Texas law on child abuse and neglect.

92. She runs a private psychology practice based in Houston that serves children, adolescents, and families. However, she also sees clients elsewhere in the state, including outside of the major metropolitan areas, by video conference.

93. She is bound by professional codes of ethics from the American Psychological Association to do no harm to her patients.

94. Many of her patients are transgender or non-binary young people under the age of 18, including youth with gender dysphoria.

95. Part of Dr. Mooney's job includes providing mental health evaluations for youth with gender dysphoria, referring youth with gender dysphoria for medical treatment, and continuing to treat young people who receive medical treatment for gender dysphoria.

96. She provides this care only after careful mental health evaluations of her clients and with the informed consent of parents and the assent of minor patients.

97. As someone who works closely with LGBTQ+ young people, she has seen first-hand the trauma and harm they face and the bullying and harassment they experience, especially in schools.

98. From a clinical perspective, Dr. Mooney has also observed the tremendous health benefits that her patients experience as a result of medical treatment for gender dysphoria. These clinical observations have been supported by the most up-to-date data and scientific studies she reviews as part of her ongoing professional obligations.

99. Dr. Mooney has seen young people who were depressed and feeling hopeless and scared for their future begin to feel happy and optimistic just by starting medications to suppress puberty or to develop the secondary sex characteristics that align with their gender identity.

100. The Governor's directive and DFPS implementation have placed Dr. Mooney in an untenable situation.

101. If Dr. Mooney fails to report her clients who receive gender-affirming care, she faces the prospect of civil and criminal penalties, the loss of her license, and other severe consequences.

102. However, if she does follow the Governor's letter and DFPS' erroneous reliance on it, she faces even more damaging personal and professional consequences.

103. Dr. Mooney would be violating her professional standards of ethics and inflict serious harm and trauma on her clients.

104. Many clients that she works with have already experienced trauma, and reporting them to DFPS simply for receiving gender-affirming care from a licensed medical provider would cause immense and irreversible harm by subjecting them to an investigation and possible family separation.

105. Being subject to an investigation would dramatically worsen the mental health outcomes of her clients, and could worsen the already tragic rate of suicide among transgender youth.

106. In addition, she would irreparably damage the bonds of trust that she has built with her clients and, as a consequence, could face the possible closure of her practice if clients know that she cannot maintain their trust. She could also be subject to malpractice lawsuits from her clients for failing to adhere to ethical guidelines and for harming her clients.

107. Dr. Mooney could also confront harsh penalties, including prison time, for the false reporting of child abuse, as she would be making a report to DFPS when she knows child abuse is not happening.

108. Thus, the issuance of the Governor's letter and DFPS' implementation has threatened and continues to threaten Dr. Mooney's morality, liberty, and livelihood.

VII. CAUSES OF ACTION

A. Request for Declaratory Relief Under the Texas Administrative Procedure Act – By All Plaintiffs Against Defendants Commissioner Masters and DFPS

109. Plaintiffs incorporate the foregoing paragraphs in support of the following causes of action.

110. Plaintiffs request declaratory relief under the Texas Administrative Procedure Act ("APA"). *See* Tex. Gov't Code § 2001.038(a) ("The validity or applicability of a rule, including an emergency rule adopted under Section 2001.034, may be determined in an action for declaratory judgment if it is alleged that the rule or its threatened application interferes with or impairs, or *threatens to interfere with or impair, a legal right or privilege of the plaintiff*.") (emphasis added).

111. The APA contains a waiver of sovereign immunity to the extent of creating a cause of action for declaratory relief regarding the validity or applicability of a "rule." *Id.*

The DFPS Statement Constitutes a Rule, and Commissioner Masters Bypassed Mandatory APA Procedures for Rule Promulgation.

112. Under the APA, a rule

> (A) means a state agency statement of general applicability that: (i) implements, interprets, or prescribes law or policy; or (ii) describes the procedure or practice requirements of a state agency; (B) includes the amendment or repeal of a prior rule; and (C) does not include a statement regarding only the internal management or organization of a state agency and not affecting private rights or procedures.
>
> *Id.* § 2001.003(6) (line breaks omitted).

113. As DFPS Commissioner, Commissioner Masters is statutorily authorized to "provide protective services for children" and "develop and adopt standards for persons who investigate suspected child abuse or neglect at the state or local level" via rulemaking. Tex. Hum. Res. Code § 40.002(b); Tex. Fam. Code § 261.310(a).

114. As a state agency, DFPS is required to follow APA rulemaking procedures when adopting or changing rules. APA's mandatory procedural requirements for promulgating agency rules, including public notice, comment, and a reasoned justification for the rule. *See* Tex. Gov't Code §§ 2001.023, .029, .033. To be valid, a rule must be adopted in substantial compliance with these procedures. *See id.* § 2001.035. The February 22, 2022 DFPS Statement conveys the Department's official position with respect to the investigation of gender-affirming care as child abuse. The DFPS Statement, issued in accordance with Abbott's Letter, is a statement of general applicability that is (1) directed at a class of all persons similarly situated and (2) affects the interests of the public at large. The statement provides that DFPS *will* implement the Abbott letter's directive and investigate allegations relating to gender-affirming medical care as "child abuse" according to the new definition formulated by the Paxton Opinion. The DFPS Statement thus applies to and affects the private rights of class of persons—all parents of transgender children—as well as members of the general public. *El Paso Hosp. Dist. v. Tex. Health & Human Servs. Comm'n*, 247 S.W. 3d 709, 714 (Tex. 2008) (holding that statement of Health and Human Services Commission had "general applicability" because it applied to "all hospitals"); *Combs v. Entm't Publ'ns, Inc.*, 292 S.W.3d 712, 721-22 (Tex. App.—Austin 2009, no pet.) (holding that Comptroller's statements constituted "rule" under the APA because it applied to all persons and entities similarly situated"); *see also Teladoc, Inc. v. Tex. Med. Bd.*, 453 S.W.3d 606, 615 (Tex. App.—Austin 2014, pet. denied) ("Agency statements of 'general applicability' refer to those 'that affect the interest of the public at large such that they cannot be given the effect of law without public comment,' as contrasted with statements 'made in determining individual rights.'" (citation omitted)).

115. The DFPS Statement prescribes a new DFPS enforcement policy with respect to the investigation of gender-affirming care to minors as child abuse, which changes DFPS policy and constitutes a rule for purposes of the APA. *See Texas Alcoholic Beverage Comm'n v. Amusement & Music Operators of Texas, Inc*., 997 S.W.2d 651, 657-58 (Tex. App.—Austin 1999, writ dism'd w.o.j.) (holding that memoranda constituted a "rule" because they "set out binding practice requirements" that "substantially changed previous enforcement policy" with respect to eight-liner machines). Prior to the DFPS Statement, DFPS had not promulgated any rule pertaining to the investigation of gender-affirming care as child abuse.[30] The DFPS Commissioner explicitly disavowed pursuing these investigations in September, stating "I will await the opinion issued by the Attorney General's office before I reach any final decisions" relating to investigations of gender affirming care as child abuse. The agency has now made a statement that it *will* conduct investigations in accordance with the Attorney General's opinion, while stating that there were "no pending investigations of child abuse involving the procedures described in [the Paxton Opinion]" when DFPS announced this policy change on February 22. Prior to the Commissioner's announcement, there were *no* pending investigations being pursued by DFPS. But now there are investigations targeting Plaintiffs and the Commissioner's statement prescribed a new policy that greatly expands DFPS's scope of enforcement. *See John Gannon, Inc. v. Tex. Dep't of Transp.*, No. 03-18-00696-CV, 2020 WL 6018646, at *5 (Tex. App.—Austin Oct. 9, 2020, pet. denied) (mem. op.) (agency statements that "advise third parties regarding applicable legal requirements" may "constitute 'rules' under the APA" (quoting *LMV-AL Ventures, LLC v. Texas Dep't of Aging & Disability Servs*., 520 S.W.3d 113, 121 (Tex. App.—Austin 2017, pet. denied))).

[30] Even if DFPS had previously promulgated a rule providing for the investigation of gender-affirming medical care as "child abuse", such a rule would have exceeded the bounds of DFPS's authority. *See infra* paras. 118-125.

116. In declaring that investigations would be initiated based on a non-binding opinion from the Attorney General, the Commissioner entirely bypassed the APA's mandatory procedural requirements for promulgating agency rules. The Commissioner did not provide public notice or an opportunity for and full consideration of comments from the public. Additionally, the Commissioner provided no reasoned justification for the policy change, nor for the implementation of the Abbott letter which goes even further than Paxton's Opinion by making no mention of medical necessity. Neither the non-binding Paxton Opinion nor the Abbott Letter—both of which conflict with well-established medical standards of care—are a legitimate basis for the rule. The rule, therefore, is also arbitrary and capricious.

117. A rule that is not properly promulgated under mandatory APA procedures is invalid. *El Paso Hosp. Dist.*, 247 S.W.3d at 715. As such, the DFPS Statement is invalid and should not be given effect, and DFPS enforcement activity implementing the DFPS Statement should be enjoined.

The DFPS Statement Conflicts with DFPS's Enabling Statute, Exceeding its Authority.

118. The DFPS Statement is also invalid because it stands in direct conflict with DFPS's enabling statute and, as such, is an overreach of DFPS's power as established by the legislature.

119. "To establish the rule's facial invalidity, a challenger must show that the rule: (1) contravenes specific statutory language; (2) runs counter to the general objectives of the statute; or (3) imposes burdens, conditions, or restrictions in excess of or inconsistent with the relevant statutory provisions." *Gulf Coast Coal. of Cities v. Pub. Util. Comm'n*, 161 S.W.3d 706, 712 (Tex. App.—Austin 2005).

120. The DFPS Statement contravenes specific language in DFPS's enabling statute. Section 40.002 of the Texas Human Resources Code specifies that DFPS "*shall* . . . provide family support and family preservation services *that respect the fundamental right of parents to control*

the education and upbringing of their children." Tex. Hum. Res. Code § 40.002 (emphasis added). As demonstrated herein, the DFPS Statement infringes on the rights of parents to direct the custody and care of their children, including by providing them with needed medical care. *See infra*, Section VII.D. The new DFPS rule thus conflicts with the obligations imposed on DFPS by its enabling statute and, therefore, is, invalid.

121. In addition to conflicting with specific statutory language, the DFPS Statement also conflicts with the general objectives of DFPS's enabling statute. *See Gulf Coast Coal. of Cities*, 161 S.W.3d at711-12. These general objectives are informed by the specific duties imposed on DFPS by the legislature and encompass the objective of protecting children against abuse while respecting parents' fundamental right to control the upbringing of their children. *See* Tex. Hum. Res. Code § 40.002(b). Not only does the DFPS Statement infringe on parents' fundamental rights, it also *causes* immense harm to minor children with gender dysphoria who have a medical need for treatment that is now considered "child abuse" under the new agency rule.

122. Pursuant to the DFPS Statement and implementation thereof, the Doe Parent Plaintiffs cannot provide medically necessary and doctor-recommended medical treatment to their adolescent child without exposing themselves to criminal liability. Precisely because this medical treatment is necessary, if the Does ceased providing this care, Mary will be greatly and irreparably harmed, including by being forced to undergo endogenous puberty with the permanent physical changes that can result. The new DFPS rule, though cloaked under the guise of protecting children, actually *causes* harm where none existed in the first place. Furthermore, the mere *threat* of enforcement has already impacted Mary by causing her immeasurable anxiety and distress: she is forced to choose between the medical care that she needs and exposing her parents to criminal liability and potentially being removed from their care or, alternatively, abstaining from such

medically necessary care and suffering the physical and mental consequences, all in order to protect their family from DFPS investigation. As such, the new DFPS rule cannot be harmonized with DFPS's general objectives as set forth in its enabling statute. *See R.R. Comm'n of Tex. v. Lone Star Gas Co.*, 844 S.W.2d 679, 685 (Tex.1992); *Gerst v. Oak Cliff Sav. & Loan Ass'n*, 432 S.W.2d 702, 706 (Tex. 1968).

123. Every major medical organization in the United States considers the treatment now effectively banned and criminalized by DFPS to be medically necessary. Such a radical disregard of medical science and the medical needs of a subset of minors in Texas cannot be squared with the agency's authority as prescribed by Statute.

124. Finally, nothing in DFPS's enabling statute authorizes it to expand the scope of statutory definitions established by the legislature. The definition of "child abuse" is provided by statute and is not within DFPS's jurisdiction. Because the DFPS Statement is not rooted in any rulemaking authority provided by the legislature, it is invalid. *See Williams v. Tex. State Bd. of Orthotics & Prosthetics*, 150 S.W.3d 563, 568 (Tex. App.-Austin 2004, no pet.) ("An agency rule is invalid if [] the agency had no statutory authority to promulgate it . . . .").

125. This unauthorized expansion of the definition of "child abuse" not only harms the Does, but also altered the duties of mandatory reporters such as Dr. Mooney, subjecting them to criminal liability for failing to report when they are aware that a transgender adolescent is being provided medically necessary treatment for gender dysphoria.

Implementation of the DFPS Statement Interferes with Plaintiffs' Constitutional Rights.

126. Separate and apart from the procedural defects set forth above, the DFPS Statement is also invalid because its application interferes with Plaintiffs' fundamental parental rights and other equality and due process guarantees of the Texas Constitution.

127. Under the APA, an action for declaratory judgment can be sustained if a "rule or its threatened application interferes with or impairs, or threatens to interfere with or impair, a legal right." Tex. Gov't Code § 2001.038(a). Agency rules that are unconstitutional can be invalidated through declaratory judgment. *See Williams*, 150 S.W.3d at 568.

128. The DFPS Statement and implementation thereof interfere with the Doe Parent Plaintiffs' fundamental right to care for their children guaranteed by the Texas State Constitutions. *Wiley v. Spratlan*, 543 S.W.2d 349, 352 (Tex. 1976). The Texas legislature has codified its acknowledgement that parents possess fundamental, constitutional rights beyond those expressly provided for by statute. Tex. Fam. Code § 151.001(a)(11) (concluding enumerated list of parental rights and obligations by stating that a parent has "any other right or duty existing between a parent and child by virtue of law").

129. DFPS's purported interest in preventing transgender children from receiving life-saving and medically recommended treatment for gender dysphoria is far outweighed by parents' rights to determine what medical care is necessary and in the best interests of their child, in consultation with doctors and evidence-based standards of care. A parent's right to control the care of their child is one of the most ancient and natural of all fundamental rights. *See Holick v. Smith*, 685 S.W.2d 18, 20 (Tex. 1985) ("This natural parental right has been characterized as essential, a basic civil right of man, and far more precious than property rights." (citation and quotations omitted)).

130. By, in effect, cutting off the ability of parents to treat their minor adolescent children in accordance with doctor-recommended and clinically appropriate care, the agency's new rule infringes on the Does' parental rights. The agency's new rule substitutes parents' judgment as to what medical care is in the best interests of their children for the judgment of the

government. There is no justification sufficiently compelling to warrant such a gross invasion of parental rights. The DFPS Statement creates a presumption that following clinical guidelines for treating gender dysphoria is incompatible with the best interests of transgender youth, forecloses determinative issues of competence and care, and "run[s] roughshod over the important interests of both parent and child." *Stanley v. Illinois*, 405 U.S. 645, 657 (1972).

131. As such, the DFPS Statement must be declared invalid because it conflicts with Plaintiffs' fundamental rights of parents under the Texas Constitution, as well as other equality and due process guarantees of the Texas Constitution.

B. Ultra Vires Claims – By All Plaintiffs Against Defendants Governor Abbott and Commissioner Masters

132. Plaintiffs incorporate the foregoing paragraphs in support of the following causes of action.

133. Plaintiffs request declaratory relief under the Uniform Declaratory Judgments Act ("UDJA").

134. The UDJA is remedial and intended to settle and afford relief from uncertainty and insecurity with respect to rights under state law and must be liberally construed to achieve that purpose. Tex. Civ. Prac. & Rem. Code. § 37.002. The UDJA waives the sovereign immunity of the State and its officials in actions that challenge the constitutionality of government actions and that seek only equitable relief.

135. Pursuant to the UDJA, Plaintiffs seek a declaratory judgment of the Court that Abbott's Letter and the DFPS Statement directing DFPS to investigate families for providing their children with medically necessary health care:

a. Is *ultra vires* and exceeds the Governor's and the Commissioner's authority under the Texas Family Code; and

b. Contravenes separation of powers established by Article II of the Texas Constitution.

136. In order to stop the Governor's and Commissioner's *ultra vires* and unconstitutional directives from being enforced, Plaintiffs also seek temporary and permanent injunctive relief pursuant to Texas Civil Practices & Remedies Code §§ 37.011 and 65.011.

137. A government official commits an *ultra vires* act when the officer "act[s] without legal authority or fail[s] to perform a purely ministerial act." *City of El Paso v. Heinrich*, 284 S.W.3d 366, 372 (Tex. 2009). An officer acts without legal authority "if he exceeds the bounds of his granted authority or if his acts conflict with the law itself." *Houston Belt & Terminal Ry. Co. v. City of Houston*, 487 S.W.3d 154, 158 (Tex. 2016).

138. In this case, both Governor Abbott and Commissioner Masters have acted without legal authority in directing DFPS to initiate investigations for any reported instances of the enumerated medical procedures in the Abbott Letter. For the reasons discussed below, there is a "probable right to relief" here on the *ultra vires* claims. *See Abbott v. Harris Cty.*, No. 03-21-00429-CV, 2022 WL 92027, at *10 (Tex. App. Jan. 6, 2022) (finding that plaintiffs had established "a probable right to relief on their claim that the Governor's issuance of [an executive order] constitutes an ultra vires act" in granting injunctive relief).

Governor Abbott Has Exceeded His Authority.

139. Governor Abbott has exceeded his authority by unilaterally redefining child abuse and then ordering "prompt and thorough investigation[s]" based on his redefinition.[31]

[31] Greg Abbott, Letter to Hon. Jaime Masters, Commissioner, Tex. Dep't of Fam. & Protective Servs. (Feb. 22, 2022), https://gov.texas.gov/uploads/files/press/O-MastersJaime202202221358.pdf.

140. In contrast to the Governor's past executive orders, *see, e.g.*, Executive Order GA-38 (citing Tex. Gov't Code. § 418.016), Governor Abbott issued this directive without citing any gubernatorial authority.

141. Instead, the Abbott Letter cites only to the Texas Family Code. The Texas Family Code, however, does not give Governor Abbott any authority to define the contours of "child abuse" or to "direct the agency to "conduct . . . investigation[s]," as he attempted to do in his letter.[32] The Texas Family Code itself defines child abuse and outlines DFPS's investigatory authority. *See* Tex. Fam. Code §§ 261.001, 261.301. These laws also specifically task the DFPS Commissioner with establishing procedures for investigating abuse and neglect, based on the definitions of abuse and neglect under Texas law and in accordance with the APA. Thus, the Governor has no authority to define the contours of what constitutes child abuse under Texas law or to unilaterally change any DFPS procedures. Indeed, even the Paxton Opinion merely identified what *could* be considered "child abuse". Governor Abbott then took that non-binding analysis and directed DFPS to presume, in all cases, that a minor adolescent with gender dysphoria with medical treatment consistent with well-established medical guidelines amounted to abuse.

142. Furthermore, the Texas Constitution makes clear that the Governor only administers the law pursuant to the general grant to "cause the laws to be faithfully executed." Tex. Const. art. 4, § 10. The Governor neither makes the law nor possesses the authority to suspend laws under the Texas Constitution. *See* Tex. Const. art. 1, § 28 ("No power of suspending laws in this State shall be exercised except by the Legislature.").

143. Even where a state agency like DFPS has been delegated the power to make rules, the Governor cannot lawfully order the Commissioner to adopt a particular rule, much less order

[32] *Id.*

her to do so without following the proper rulemaking process. *See* Tex. Hum. Res. Code § 40.027(c)(3) (tasking the Commissioner, not the Governor, with "oversee[ing] the development of rules relating to the matters within the department's jurisdiction").

Commissioner Masters Has Exceeded Her Authority.

144. Commissioner Masters has also exceeded her authority and acted *ultra vires* by implementing Governor Abbott's unlawful redefinition of child abuse. In accordance with the DFPS Statement issued soon after the Abbott Letter, Commissioner Masters has already directed her department to investigate any reports of minors who have undergone the medical procedures outlined in the Abbott Letter.

145. These actions contravene Commissioner Masters' limited statutory authority to "adopt rules and policies for the operation of and the provision of services by the department." Tex. Hum. Res. Code § 40.027(e). As set forth in Count A, Commissioner Masters has completely ignored the APA's mandatory rulemaking process. Therefore, the issuance and implementation of the DFPS Statement is *ultra vires* of the Commissioner's statutory rulemaking authority. *See City of El Paso v. Public Util. Comm'n*, 839 S.W.2d 895, 910 (Tex. App.—Austin 1992) ("[I]f there is no specific express authority for a challenged [agency] action, and if the action is inconsistent with a statutory provision or ascertainable legislative intent, we must conclude that, by performing the act, the agency has exceeded its grant of statutory authority."), *aff'd in part & rev'd in part*, 883 S.W.2d 179 (Tex. 1994). Furthermore, the Commissioner lacked authority to issue the DFPS Statement as new law or policy because it is the legislature's constitutional mandate to "provide for revising, digesting and publishing the laws." Tex. Const. art. 3, § 43.

146. Moreover, the DFPS Statement contradicts DFPS's enabling statute, which requires the department to "provide protective services for children" and "provide family support and family preservation services that respect the fundamental right of parents to control the education

and upbringing of their children." Tex. Hum. Res. Code § 40.002(b). Rather than support children and respect the right of parents to raise their children and the rights of transgender minors to receive medically necessary treatment available to similarly situated non-transgender minors, Commissioner Masters' action has already directly caused harm to loving families across Texas. This harm will become even more irreparable as investigations turn into family separations and medically necessary treatments are terminated.

147. Finally, this sequence of events, in which a Commissioner agrees to follow a Governor's unlawful directive—issued not as an executive order but as a letter—has never before been recognized by a court as a proper execution of government authority, further supporting the *ultra vires* nature of both officials' actions here.

C. Separation of Powers Claims – By All Plaintiffs Against Defendants Governor Abbott and Commissioner Masters

148. Plaintiffs incorporate the foregoing paragraphs in support of the following causes of action.

149. Defendants' actions violate the separation of powers established by Article II of the Texas Constitution. Defendants' actions run afoul of Article II in two ways:

a. *First*, the Governor's directive, which criminalizes conduct by adding a new definition of "child abuse" under Section 261.001 of the Texas Family Code, unduly interferes with the functions of the state legislature, which possesses *sole* authority to establish criminal offenses and designate applicable penalties. *See Martinez v. State*, 323 S.W.3d 493, 501 (Tex. Crim. App. 2010).

b. *Second*, all Defendants seek to adopt and enforce an overbroad interpretation of "child abuse." They do this in contravention of the plain

meaning of the statute, and despite the state legislature's recent decision not to adopt such a definition. This too represents an overreach by the executive branch into the legislative function.

150. The Texas Constitution prohibits one branch of state government from exercising power inherently belonging to another branch. Tex. Const. art. II, § 1; *see also Gen Servs. Comm'n v. Little-Tex. Insulation Co.*, 39 S.W.3d 591, 600 (Tex. 2001) (superseded by statute on other grounds).

151. A separation of powers constitutional violation occurs when: (1) one branch of government has assumed or has been delegated a power more "properly attached" to another branch, or (2) one branch has unduly interfered with another branch so that the other branch cannot effectively exercise its constitutionally assigned powers. *Jones v. State*, 803 S.W.2d 712, 715 (Tex. Crim. App. 1991) (citing *Rose v. State*, 752 S.W.2d 529, 535 (Tex. Crim. App. 1987)).

152. The "power to make, alter, and repeal laws" lies with the state legislature, and such power is plenary, "limited only by the express or clearly implied restrictions thereon contained in or necessarily arising from the Constitution." *Diaz v. State*, 68 S.W.3d 680, 685 (Tex. App.—El Paso 2000, pet. denied).

153. In particular, the legislature possesses the *sole* authority to establish criminal offenses and designate applicable penalties. *See Martinez*, 323 S.W.3d at 501; *see also Matchett v. State*, 941 S.W.2d 922, 932 (Tex. Crim. App. 1996) (the authority to define crimes and prescribe penalties for those crimes is vested exclusively with the legislature).

154. Governor Abbott's directive unduly interferes with the state legislature's sole authority to establish criminal offenses and penalties. First, the Abbott Letter outright claims that

"a number of so-called 'sex change' procedures constitute child abuse under existing Texas law," despite the fact that the legislature has failed to pass nearly identical legislation.

155. The Abbott Letter also violates separation of powers by inventing a separate crime when it directs, under the threat of *criminal prosecution*, "all licensed professionals who have direct contact with children" as well as "members of the general public" to report instances of minors who have undergone the medical procedures outlined in the Letter and the Paxton Opinion. This, too, is without legislative approval and represents an overreach by the executive into the core legislative function of establishing crimes and criminal penalties.

156. Second, separate and apart from the criminalization of conduct that has heretofore been legal, all Defendants violate separation of powers by seeking to adopt and enforce an overbroad interpretation of "child abuse" under the Family Code.

157. Courts have repeatedly held that the executive branch and the courts must, in construing statutes, take them as they find them. *See Tex. Highway Comm'n v. El Paso Bldg. & Const. Trades Council*, 234 S.W.2d 857, 863 (Tex. 1950); *Simmons v. Arnim*, 220 S.W. 66, 70 (Tex. 1920); *City of Port Arthur v. Tillman*, 398 S.W.2d 750, 752(Tex. 1965). In particular, the other branches are not empowered to "substitute what [they] believe is right or fair for what the legislature has written," *Vandyke v. State*, 538 S.W.3d 561, 569 (Tex. Crim. App. 2017) (citations omitted), or to give meanings to statutory language that contravene their plain meaning or clear legislative intent. *See Burton v. Rogers*, 492 S.W.2d 695 (Tex. Civ. App.—Beaumont 1973), writ granted, (July 11, 1973) and *judgment rev'd on other grounds*, 504 S.W.2d 404 (Tex. 1973) (finding that words employed by the legislature must be taken in their ordinary and popular acceptation). To do otherwise would once again violate the core legislative power to make, alter, and repeal laws.

158. Defendants violate separation of powers when they attempt to create new and novel definitions for "child abuse" under the Family Code. Defendants endeavored to redefine "child abuse" in spite of the state legislature's recent refusal to adopt Senate Bill 1646, which would have included certain treatments for gender dysphoria in adolescents under the definition of child abuse, and bills like it, such as House Bills 68 and 1339. In expanding the definition of child abuse beyond the limits permitted by the plain meaning of the Family Code, and in clear defiance of legislative intent, the Defendants impermissibly invade the legislative field. *See Brazos River Auth. v. City of Graham*, 354 S.W.2d 99, 109 (Tex. 1961).

159. Finally, there has been no delegation of powers from the state legislature to the executive that would in any way cure the separation of powers violation. While the legislature may not generally delegate its law-making power to another branch, it may designate some agency to carry out legislation for the purposes of practicality or efficiency. *See Tex Boll Weevil Eradication Found., Inc. v. Lewellen*, 952 S.W.2d 454, 466 (Tex. 1997). Separation of powers requires that in statutes delegating such power, the legislature provide definite guidelines and prescribe sufficient standards to guide the discretion conferred. *See State v. Rhine*, 255 S.W.3d 745, 749 (Tex. App.—Fort Worth 2008, pet. granted). Such standards must be reasonably clear and acceptable as standards of measurement. Tex. Const. art. II § 1.

160. In the instant case, the Texas Family Code provides no such delegation in any way from the state legislature to the executive of the power to expand—unilaterally and without legislative approval—the definition of "child abuse." Recent decisions by the state legislature in fact signal that the legislature does not intend and has explicitly declined to expand the definition of child abuse at this time to include certain gender-affirming care for minors.

161. For the foregoing reasons, Defendants' actions violate state constitutional separation of powers.

D. Due Process Vagueness Claims – By All Plaintiffs Against Defendants Governor Abbott and Commissioner Masters

162. Article 1, Section 19 of the Texas Constitution states: "No citizen of this State shall be deprived of life, liberty, property, privileges or immunities, or in any manner disfranchised, except by the due course of the law of the land." Under this guarantee, a governmental enactment is unconstitutionally vague if it fails to provide a person of ordinary intelligence fair notice of what is prohibited or is so standardless that it authorizes or encourages seriously discriminatory enforcement. *See Ex parte Jarreau*, 623 S.W.3d 468, 472 (Tex. App.--San Antonio 2020) (quoting *Sessions v. Dimaya*, 138 S. Ct. 1204, 1212 (2018)). Differently stated, governmental enactments are unconstitutionally void for vagueness when their prohibitions are not clearly defined.

163. Criminal enactments are subject to an even stricter vagueness standard because "the consequences of imprecision are... severe." *Hoffman Estates v. Flipside, Hoffman Estates, Ic.*, 455 U. S. 489, 498–499 (1982). Each ground—a lack of fair notice and a lack of standards for enforcement—provides an independent basis for a facial vagueness challenge. *Ex parte Jarreau*, 623 S.W.3d at 472.

164. The Abbott letter and DFPS's attempt to adopt and enforce an overbroad interpretation of "child abuse" under the Family Code create precisely this type of unconstitutional vagueness. These vague prohibitions leave parents like Plaintiffs Jane and John Doe uncertain how to act in order to avoid criminal penalty in their efforts to provide for the medical needs of the children they love. Under the text of the Family Code itself, a parent is liable for neglect for "failing to seek, obtain, or follow through with medical care for a child, with the failure resulting in or presenting an immediate danger of death, disfigurement, or bodily injury or with the failure

resulting in an observable and material impairment to the growth, development, or functioning of the child." Tex. Fam. Code § 261.001(4)(A)(ii)(b). Failing to seek medically necessary treatment for an adolescent's gender dysphoria could fall within this statutory definition. But if parents pursue the medical care necessary to their transgender minor adolescent's growth, development, or functioning, Defendants' recent actions make them liable for abuse. These parents are left without fair notice of how their actions will be assessed and what standard DFPS will employ.

165. The same is true for mandatory reporters like Plaintiff Dr. Mooney, who are left in a similarly untenable position. Under Defendants' actions, failing to report her clients who receive gender-affirming care will subject her to civil and criminal penalties, the loss of her license, and other severe consequences. If she does report her clients solely because they have sought essential and necessary medical care, however, she will be subject to penalty for violating professional standards of ethics and false reporting of child abuse under the plain terms of the statute, let alone having inflicted serious harm and trauma on her clients. Mandated reporters are left without fair notice of how their actions will be assessed and what standards will apply to them.

E. Deprivation of Parental Rights Due Process Claims – By Plaintiffs Jane and John Doe Against Defendants Governor Abbott and Commissioner Masters

166. Plaintiffs incorporate the foregoing paragraphs in support of the following causes of action.

167. Plaintiffs' right to care for their children is a fundamental liberty interest protected by the Texas Constitution and acknowledged by the legislature. *See Wiley v. Spratlan*, 543 S.W.2d 349, 352 (Tex. 1976); *see also* Tex. Fam. Code § 151.001(a)(11).

168. Under substantive due process, the government may not infringe parental rights unless there exist exceptional circumstances capable of withstanding strict scrutiny. *See Wiley v. Spratlan*, 543 S.W.2d 349, 352 (Tex. 1976). The state must have a compelling state interest, and

the state action in question "*must* be narrowly drawn to express *only* the legitimate state interests at stake." *Gibson v. J.W.T.*, 815 S.W.2d 863, 868 (Tex. App. – Beaumont 1991, writ granted), *aff'd and remanded In re J.W.T.*, 872 S.W.2d 189 (Tex. 1994) (citations omitted).

169. In the present case, there are no exceptional circumstances that would justify Defendants' complete negation of Plaintiffs' fundamental liberty interests in parental autonomy. There is perhaps no right more fundamental than the right of parents to care for their children. *See Holick v. Smith*, 685 S.W.2d 18, 20 (Tex. 1985). Defendants have trampled Plaintiffs' right to care for their children by effectively criminalizing the act of providing medically necessary care to their children in consultation with medical professionals in accordance with applicable standards of care. Defendants' actions cause immeasurable harm to both parents and young people, threaten family separation, and lack any legitimate justification at all, let alone a constitutionally adequate one. This is not a "narrowly drawn" policy that respects Plaintiffs' fundamental due process rights to parent their children.

F. Violation of the Guarantee of Equal Rights and Equality Under the Law – By Plaintiff Mary Doe Against Defendants Governor Abbott and Commissioner Masters

170. The Abbott Letter, DFPS's statement, and DFPS's implementation of these violates the Texas Constitution by denying transgender youth equal protection under law. Under the Texas Constitution, all persons "have equal rights," Tex. Const. art. I, § 3, and "[e]quality under the law shall not be denied or abridged because of sex." Tex. Const. art. I, § 3a.

171. The Abbott letter, incorporated into DFPS's statement, specifically designates "*gender*-transitioning procedures" to be abusive and refers to the Paxton Opinion by noting that it deems "'*sex* change' procedures [to] constitute child abuse." The Abbott letter, incorporated into DFPS's statement, explicitly uses sex-based terms, making plain that the discrimination at issue here is based on sex. Moreover, it discriminates against transgender youth, like Mary, because

they are transgender and they fail to conform to the stereotypes associated with the sex they were designated at birth.

172. As the United States Supreme Court has explained, however, "discrimination based on … transgender status necessarily entails discrimination based on sex." *Bostock v. Clayton Cty., Georgia*, 140 S. Ct. 1731, 1747 (2020); *cf. Tarrant Cty. Coll. Dist. v. Sims*, 621 S.W.3d 323, 329 (Tex. App. 2021) ("[W]e conclude we must follow Bostock and read the TCHRA's prohibition on discrimination 'because of ... sex' as prohibiting discrimination based on an individual's status as a … transgender person."). Likewise, discrimination based on transgender status is independently unconstitutional. *See Brandt v. Rutledge*, No. 4:21CV00450 JM, 2021 WL 3292057, at *2 (E.D. Ark. Aug. 2, 2021) ("The Court concludes that heightened scrutiny applies to Plaintiffs' Equal Protection claims because Act 626 rests on sex-based classifications and because 'transgender people constitute at least a quasi-suspect class.'" (quoting *Grimm v. Gloucester Cty. Sch. Bd.*, 972 F.3d 586, 607 (4th Cir. 2020)).

173. The Abbott letter, DFPS's statement, and DFPS's implementation of these directives therefore unlawfully discriminate against transgender youth by deeming the medically necessary care for the treatment of their gender dysphoria as presumptively abuse because they are transgender when the same treatment is permitted for non-transgender youth. By doing so, the Abbott letter, DFPS's statement, and DFPS's implementation of these directives place a stigma and scarlet letter upon transgender youth and subject them to additional harms. For example, the Abbott letter, DFPS's statement, and DFPS's implementation of these directives do nothing to protect transgender youth, yet subject them to abuse investigations simply because of who they are and force the denial of their medically necessary care unless they are separated from their families or their parents are penalized.

VIII. APPLICATION FOR EMERGENCY TEMPORARY RESTRAINING ORDER, TEMPORARY INJUNCTION, AND PERMANENT INJUNCTION

174. In addition to the above-requested relief, Plaintiffs seek a temporary restraining order, temporary injunction, and permanent injunction to stop this *ultra vires*, unlawful, and unconstitutional Order from being enforced by Defendants.

175. A temporary restraining order's purpose is to maintain the status quo pending trial. "The status quo is the last actual, peaceable, non-contested status which preceded the pending controversy." *In re Newton*, 146 S.W.3d 648, 651 (Tex. 2004) (citing *Janus Films, Inc. v. City of Fort Worth*, 358 S.W.2d 589, 589 (Tex. 1962) (per curiam)). Until a permanent injunction can be decided on the merits, Plaintiffs are entitled to a temporary restraining order pursuant to Texas Civil Practice & Remedies Code sections 37.011 and 65.011 and Texas Rules of Civil Procedure 680 *et seq.* to preserve the status quo before the unconstitutional enactment of Abbott's Letter and the DFPS Statement, which incorporate and reference the Paxton Opinion.

176. Plaintiffs meet all the elements necessary for immediate injunctive relief with respect to their APA, *ultra vires*, and separation of powers claims described above. Plaintiffs state a valid cause of action against each Defendant and have a probable right to the relief sought. For the reasons detailed above, there is a substantial likelihood that Plaintiffs will prevail after a trial on the merits because the Governor's directive is *ultra vires*, beyond the scope of his authority, and unconstitutional, and the improper rulemaking and implementation by Commissioner Masters and DFPS are similarly unlawful and void. Further, the Governor's and Commissioner's actions violate the separation of powers by impermissibly encroaching into the legislature's domain. Plaintiffs have already been injured by these actions and will continue to experience imminent and irreparable harm without injunctive relief.

177. Plaintiffs in this suit will face imminent and irreparable harms absent intervention by the Court. Specifically, Jane Doe has already been placed on administrative leave at work and is at risk of losing her job, her livelihood, and the means of caring for her family. Jane, John and Mary Doe face the imminent and ongoing deprivation of their constitutional rights. Mary faces the potential loss of her medically necessary care, which if abruptly discontinued can cause severe physical and emotional harms, including anxiety, depression, and suicidality. If placed on the Child Abuse Registry, Jane could lose the ability to practice her profession, and Jane and John Doe would be barred from ever working with children, including as volunteers in their community. Absent intervention by this court, Dr. Mooney could face civil suit by patients for failing to treat them in accordance with professional standards and loss of licensure for failing to follow her professional ethics, if she complies with Defendants' orders and actions. If she does not comply with Defendants' orders, Dr. Mooney could face immediate criminal prosecution.

178. For the same reasons above, Plaintiffs request the Court issue a temporary restraining order now and a temporary injunction following a hearing within 14 days and a permanent injunction after a trial on the merits. Since there is no adequate remedy at law that is complete, practical, and efficient to the prompt administration of justice in this case, equitable relief is necessary to enjoin the enforcement of enforcement of Defendants' illegal policy, preserve the status quo, and ensure justice.

179. In balancing the equities between Plaintiffs and Defendants, Plaintiffs will suffer imminent, irreparable, and ongoing harm including the deprivation of their vocations, their medical

treatment, and their constitutional rights, whereas the injury to Defendants is nominal pending the outcome of this suit. In fact, enjoining the Order will free an already overburdened DFPS.[33]

180. Plaintiffs are willing to post a bond if ordered to do so by the Court, but request that the bond be minimal because Defendants are acting in a governmental capacity, have no pecuniary interest in the suit, and no monetary damages can be shown. Tex. R. Civ. P. 684.

IX. CONDITIONS PRECEDENT

181. All conditions precedent have been performed or have occurred.

X. RELIEF REQUESTED

182. For the foregoing reasons, Plaintiffs request the Court grant the following relief:

a. A temporary restraining order to preserve the *status quo* and restrain Defendants from improperly relying on Abbott's Letter and the Paxton Opinion to investigate and report families based on the fact that their adolescent children are transgender; are transitioning; or have been prescribed or are being provided with medical treatment for their gender dysphoria, while the validity of Abbott's Letter and the Paxton Opinion are determined at a hearing to be held within 14 days;

b. Upon hearing, a temporary injunction prohibiting Defendants from enforcing Abbott's Letter, the Paxton Opinion, or the DFPS Statement, including by: requiring mandatory reporters or the general public to report families with minor children who are transgender or who have a diagnosis of gender dysphoria and are receiving medically recommended treatment for that condition, and investigating families for possible child abuse based

[33] Reese Oxner & Neelam Bohra, *Texas foster care crisis worsens, with fast-growing numbers of children sleeping in offices, hotels, churches*, Tex. Trib. (July 19, 2021), https://www.texastribune.org/2021/07/19/texas-foster-care-crisis/.

on allegations that they have a child that is transgender or that they have a minor child with gender dysphoria who is being treated with medically prescribed treatment for that condition;

c. After trial, a permanent injunction prohibiting Defendants from enforcing Abbott's Letter or the DFPS Statement, including by: requiring mandatory reporters or the general public to report families with minor children who are transgender or who have a diagnosis of gender dysphoria and are receiving medically recommended treatment for that condition, and investigating families for possible child abuse based on allegations that they have a child that is transgender or that they have a minor child with gender dysphoria who is being treated with medically prescribed treatment for that condition;

d. Declaratory judgment that the DFPS Statement violates the Texas Administrative Procedure Act;

e. Declaratory judgment that Abbott's Letter and the DFPS Statement are *ultra vires* and unconstitutional;

f. Reasonable and necessary attorneys' fees and costs as are equitable and just under Tex. Civ. Prac. & Rem. Code § 37.009; and

g. All other relief, general and special, at law and in equity, as the Court may deem necessary and proper.

[Signature Page Follows]

Dated: March 1, 2022

Respectfully submitted:

By: __*/s/ Paul D. Castillo* _____

Paul D. Castillo
Texas State Bar No. 24049461
Shelly L. Skeen
Texas State Bar No. 24010511
Nicholas "Guilly" Guillory
Texas State Bar No. 24122392
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
3500 Oak Lawn Ave, Unit 500
Dallas, Texas 75219
Phone: (214) 219-8585
Fax: (214) 219-4455
pcastillo@lambdalegal.org
sskeen@lambdalegal.org
nguillory@lambdalegal.org

Omar Gonzalez-Pagan*
M. Currey Cook*
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
120 Wall Street, 19th Floor
New York, New York 10005-3919
Phone: (212) 809-8585
ogonzalez-pagan@lambdalegal.org
ccook@lambdalegal.org

Karen L. Loewy*
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
1776 K Street, N.W., 8th Floor
Washington, DC 20006-2304
Phone: 202-804-6245
kloewy@lambdalegal.org

Camilla B. Taylor*
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
65 E. Wacker Place, Suite 2000
Chicago, IL 60601-7245
Phone: (312) 663-4413
ctaylor@lambdalegal.org

Brian Klosterboer
Texas State Bar No. 24107833
Andre Segura
Texas State Bar No. 24107112
AMERICAN CIVIL LIBERTIES UNION FOUNDATION OF TEXAS
5225 Katy Fwy., Suite 350
Houston, Texas 77007
Phone: (713) 942-8146
Fax: (346) 998-1577
bklosterboer@aclutx.org
asegura@aclutx.org

Chase Strangio*
James Esseks*
Anjana Samant*
Kath Xu*
AMERICAN CIVIL LIBERTIES UNION FOUNDATION
125 Broad Street, 18th Floor
New York, New York 10004
Phone: (917) 345-1742
cstrangio@aclu.org
jesseks@aclu.org
asamant@aclu.org
kxu@aclu.org

Derek R. McDonald
Texas State Bar No. 00786101
Maddy R. Dwertman
Texas State Bar No. 24092371
BAKER BOTTS L.L.P.
98 San Jacinto Boulevard, Suite 1500
Austin, Texas 78701-4078
Phone: (512) 322-2500
Fax: (512) 322-2501
derek.mcdonald@bakerbotts.com
maddy.dwertman@bakerbotts.com

Brandt Thomas Roessler
Texas State Bar No. 24127923
BAKER BOTTS L.L.P.

30 Rockefeller Plaza
New York, New York 10112-4498 **Pro hac vice* forthcoming
Phone: (212) 408-2500
brandt.roessler@bakerbotts.com

Attorneys for Plaintiffs

CERTIFICATE OF CONFERENCE

I certify that Plaintiffs have notified Defendants pursuant to the Local Rules of the District Courts of Travis County and will file the certification for requested temporary restraining order hearing.

/s/ Paul D. Castillo
Paul D. Castillo

Exhibit 1

CAUSE NO. _____

JANE DOE, *et al.*,	§	**IN THE DISTRICT COURT OF**
Plaintiffs,	§	
v.	§	**TRAVIS COUNTY, TEXAS**
	§	**_____ JUDICIAL DISTRICT**
GREG ABBOTT, *et. al*,	§	
Defendants.	§	

DECLARATION OF JANE DOE

I, Jane Doe,[1] hereby declare and state as follows:

1. I am over 18 years of age, of sound mind, and in all respects competent to testify. I have personal knowledge of the facts set forth in this Declaration and would testify competently to those facts if called to do so.

2. Along with my husband John Doe, I am a Plaintiff in this action. We are bringing claims on behalf of ourselves and as the parents and next friends of our daughter, Mary Doe.

3. We are residents of Texas.

4. Our daughter, Mary Doe, is 16 years old. We love and support her and only want what is best for her.

5. Mary is transgender. When she was born, she was designated as "male" on her birth certificate, even though she is a girl.

[1] Jane Doe, John Doe, and Mary Doe are pseudonyms. My husband, daughter (who is a minor), and I are proceeding under pseudonyms to protect our right to privacy and ourselves from discrimination, harassment, and violence, as well as retaliation for seeking to protect our rights.

6. From a very young age, Mary has expressed herself and behaved in manner that does not conform with the stereotypes associated with the sex she was designated at birth.

7. We have always permitted Mary to express herself and explore who she is.

8. In 2021, Mary informed us that she was transgender.

9. Mary has been under the care of the same pediatrician her entire life. Her pediatrician diagnosed her with gender dysphoria and referred our family to other medical professionals for further evaluation and treatment. These other medical professionals confirmed that Mary suffers from gender dysphoria.

10. We also did research as a family and connected Mary with youth support groups that would permit us to have discussions as a family.

11. Following Mary's diagnosis of gender dysphoria, Mary's doctors recommended that Mary be provided with medical care to treat and alleviate her gender dysphoria. This care has included the prescription of puberty-delaying medications and hormone therapy.

12. In consultation with these doctors and after extensive discussions about the benefits and potential side effects of this treatment, John, Mary, and I jointly decided to initiate treatment for Mary's gender dysphoria. This treatment has been prescribed by Mary's doctors in accordance with what they believe are best medical practices and what we understand will be the best course of action to protect Mary's physical and mental health.

13. Mary was worried about having to undergo a puberty that would result in permanent physical characteristics not in alignment with her female gender. We observed how the prospect of beginning this puberty caused Mary significant distress and exacerbated her dysphoria.

14. Being able to be affirmed as who she is, including through the course of treatment prescribed by her doctors, has brought Mary significant relief and allowed her to thrive.

15. My topmost commitment as a parent is to ensure to the health, safety, and wellbeing of my daughter, whom John and I love and support.

16. I have worked in the field of child protective services at various times throughout my career. At present, I am an employee for the Texas Department of Family and Protective Services (DFPS), where I work on the review of reports of abuse and neglect. My supervisors have recognized and commended my performance, which has been recognized through career advancement and merit compensation.

17. The issuance of Attorney General Paxton's opinion dated February 18, 2022 and Governor Abbott's letter on February 22, 2022, followed by DFPS's implementation of these to investigate the provision of medically necessary gender-affirming health care as abuse, has wreaked havoc on our lives.

18. We are terrified for Mary's health and wellbeing, and for our family. I feel betrayed by my state and the agency for whom I work.

19. On February 23, 2022, following the issuance of Attorney General Paxton's opinion and Governor Abbott's letter, I contacted my direct supervisor at DFPS to inquire how these would affect DFPS policy. The answer to my inquiry was important for my family as well as to my ability to perform my job at DFPS.

20. That same day, just mere hours later, I was placed on paid leave from my employment because I was the parent of a transgender adolescent who requires necessary medical care for the treatment of gender dysphoria.

21. On February 24, 2022, I was contacted by a DFPS Child Protective Services (CPS) Investigator, who was unknown to me, and informed that my family would be investigated in accordance with Governor Abbott's letter to determine if John and I had committed abuse by

affirming our transgender daughter's identity and following the advice of medical professionals to initiate treatment for her gender dysphoria.

22. On February 25, 2022, the CPS investigator visited our family home to interview Mary, John, and me. The CPS investigator interviewed John and me together, in the presence of our attorney, but he interviewed Mary, who was also accompanied by different attorney, apart from us. Aside from interviewing us, the CPS investigator asked us to sign releases to obtain Mary's medical records; we refused.

23. During his visit, the CPS investigator disclosed that the sole allegation against our family is that John and I have a transgender daughter and that our daughter may have been provided with medically necessary gender-affirming health care and is "currently transitioning from male to female."

24. The issuance of the Attorney General's opinion and Governor's letter, along with DFPS's implementation of these, has caused a significant amount of stress, anxiety, and fear for our family. For example, Mary has been traumatized by the prospect that she could be separated from her parents and could lose access to the medical treatment that has enabled her to thrive. The stress has taken a noticeable toll on her, and our daughter who is typically joyful and happy, is now moodier, stressed, and overwhelmed. Similarly, John and I are now filled anxiety and worry. I have been unable to sleep, worrying about what we can do and how we can keep our family intact and our daughter safe and healthy. We are living in constant fear about what will happen to our family due to the actions by DFPS, the Governor, and the Attorney General.

25. As a result of DFPS's implementation of the Attorney General's opinion and Governor's letter, I have not only been placed on leave from my employment, but may face termination, which would result not only in the loss of income for our family and a job I genuinely

care about.

26. John and I worry about the potential physical and mental health consequences of depriving Mary of the medical treatment her doctors have prescribed and that she needs. Not providing Mary with the medically necessary health care that she needs is not an option for us. Our primary goal and duty are to ensure Mary's health and wellbeing.

27. We do not believe it is a choice to deprive Mary of the medically necessary and essential health care that she requires and risk her health and wellbeing in order to avoid a finding that there is reason to believe that John and I have committed "abuse" and the consequences that would follow such a finding based on DFPS's implementation of the Attorney General's opinion and Governor's letter.

28. John and I have called Texas our home for nearly 20 years and Texas is the only home Mary has ever known. Even if feasible, moving out of state is not a desirable option, as among other things, it could mean the physical separation of our family, the loss of my employment, and separating Mary from her lifelong health care providers.

29. Texas is our home. We are part of a community that has known Mary all her life and been supportive and affirming. We worry not only about the multitude of harms caused by DFPS's implementation of the Attorney General's opinion and Governor's letter that I have described herein, but also about the effect that the actions by DFPS, the Governor, and the Attorney General will have on other transgender youth, like Mary, and their families. Our family is just as much a part of Texas as any other family, and Mary has the right to be provided with the same affirmation, love, and ability to thrive as any other youth in our state.

30. The actions by DFPS, the Governor, and the Attorney General threaten the health and wellbeing of transgender youth like Mary and the integrity of families like ours. We deserve

better from our state and government.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 28th day of February 2022 in Texas.

Jane Doe

Jane Doe

Exhibit 2

CAUSE NO. _____

	§	
JANE DOE, *et. al.*,	§	
	§	
Plaintiffs,	§	**IN THE DISTRICT COURT OF**
	§	**TRAVIS COUNTY, TEXAS**
v.	§	**_____ JUDICIAL DISTRICT**
	§	
	§	
GREG ABBOTT, *et. al*,	§	
	§	
Defendants.	§	

DECLARATION OF MEGAN A. MOONEY, PH.D.

I, Megan A. Mooney, declare and state as follows:

1. I am over 18 years of age, of sound mind, and in all respects competent to testify. I have personal knowledge of the facts set forth in this Declaration and would testify competently to those facts if called to do so. I am a Plaintiff in this action and I am bringing claims on behalf of myself.

2. I am a licensed psychologist in Texas. For approximately the past 19 years, I have worked with children and families to respond to and mitigate trauma and harm. I am bound by professional codes of ethics to do no harm to my patients.

3. I run a private psychology practice in Houston that serves children, adolescents, and families. Many of my patients are transgender or non-binary young people under the age of 18, including youth with gender dysphoria. According to the American Psychiatric Association's Diagnostic & Statistical Manual of Mental Disorders ("DSM-V"), gender dysphoria is the diagnostic term for the condition experienced by some transgender people of clinically significant distress resulting from the lack of congruence between their gender identity and the sex assigned

to them at birth. In order to be diagnosed with gender dysphoria, the incongruence must have persisted for at least six months and be accompanied by clinically significant distress or impairment in social, occupational, or other important areas of functioning.

4. Part of my job includes providing mental health evaluations for youth with gender dysphoria, referring youth with gender dysphoria for medical treatment, and continuing to treat young people who receive medical treatment for gender dysphoria.

5. I am a mandatory reporter obligated to report child abuse and neglect to the Texas Department of Family Protective Services (DFPS). I have received and conducted trainings on mandatory reporting requirements and am familiar with Texas law on child abuse and neglect. I have reported cases of child abuse to DFPS where appropriate and have testified in court cases involving child abuse and neglect.

6. From a clinical perspective, I have observed the tremendous health benefits that my patients experience as a result of medical treatment for gender dysphoria. My clinical observations are also supported by data and scientific studies. Gender-affirming medical treatment does not harm minors but rather greatly improves their health, wellbeing, and quality of life.

7. The latest actions purporting to require me to report gender-affirming care as child abuse put me in an untenable situation. If I fail to report my clients who receive this medical treatment, I face the prospect of civil and criminal penalties, the loss of my license, and other severe consequences. But if I report any of my clients for receiving critical and medically necessary care, I would be violating professional standards of ethics, inflict serious harm and trauma on my clients, irreparably damage the bonds of trust that I have built with my clients, face the possible closure of my practice if clients know that I cannot maintain their trust, and confront harsh penalties for false reporting of child abuse.

Background

8. I have a bachelor's degree in psychology from Vanderbilt University and completed both a master's degree and doctorate in clinical psychology at the University of Arkansas. During my doctoral program, which I completed in 2005, I was a child and family specialist and a clinical psychology intern at Baylor College of Medicine.

9. Since 2008, I have been a licensed psychologist with the Texas State Board of Examiners of Psychologists (TX License #33819, expires July 31, 2023). I have met all of the requirements for licensing and renewal for psychologists established under Texas Occupations Code, Section 501.2525.

10. As a licensed psychologist, I am required to follow the ethical principles of psychologists and code of conduct from the American Psychological Association ("APA"). The code of conduct requires me to strive to benefit my patients and do no harm, and I must respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination.[1]

11. I have spent nearly two decades working as a psychologist in Texas with children, adolescents, adults, and families. My focus is on helping young people and families respond to trauma. For over twelve years, I worked at DePelchin Children's Center in Houston, where I supervised a trauma program and provided therapy to children, adolescents, adults, and families. Because DePelchin is a licensed foster care agency, I became intimately familiar with DFPS and cases of abuse and neglect, received training regarding child welfare and mandatory reporting requirements, and I advised other mental health professionals, psychology trainees, and other

[1] Ethical Principles of Psychologists and Code of Conduct (Am. Psych. Ass'n 2017), https://www.apa.org/ethics/code.

employees about mandatory reporting requirements and how to respond to trauma, abuse, and neglect.

12. I am a member of the APA, the Texas Psychological Association ("TPA"), and the Houston Psychological Association. I was president of the TPA in 2020 and served on the board for over seven years. I remain an ex officio member of the TPA board.

13. I teach and train students in psychology at Baylor College of Medicine and the University of Texas Health Sciences Center at Houston. I have also published research and scholarship on trauma faced by LGBTQ+ youth in the Journal of Family Strengths.

14. I am an affiliate member of the National Child Traumatic Stress Network, where I serve on the Sexual Orientation and Gender Identity/Expression (SOGIE) workgroup and helped create resources on LGBTQ+ youth and trauma. I am also part of a working group striving to improve services and treatment for LGBTQ+ youth in foster care in Texas.

15. As someone who works closely with LGBTQ+ young people, I have seen first-hand the trauma and harm they face and the bullying and harassment they experience, especially in schools.[2]

16. In April 2021, I testified against Senate Bill 1646 (Perry), which sought to change the definition of child abuse in Section 261.001 of the Texas Family Code to encompass gender-affirming care, including providing puberty blockers and hormone therapy to transgender youth. This bill was opposed by the TPA, the APA, the Texas Medical Association, the Texas Pediatric

[2] The GLSEN 2019 National School Climate Survey found that 98.8% of LGBTQ+ students had heard negative remarks about gender expression and 87.4% heard negative remarks specifically about transgender people. Joseph G. Kosciw et al., The 2019 National School Climate Survey: The Experiences of Lesbian, Gay, Bisexual, Transgender, and Queer Youth in Our Nation's Schools xviii-xix, GLSEN (2020), https://www.glsen.org/sites/default/files/2021-04/NSCS19-FullReport-032421-Web_0.pdf. In Texas, the vast majority of LGBTQ+ students also regularly heard negative remarks about gender expression and transgender people. School Climate for LGBTQ Students in Texas (State Snapshot), GLSEN (2021), https://www.glsen.org/sites/default/files/2021-01/Texas-Snapshot-2019.pdf.

Society, and the Texas Academy of Family Physicians, among other professional associations. This bill did not become law.

Current Practice and Professional Responsibilities

17. I founded a private psychological practice in 2018 to serve young people and families in Houston and its surrounding areas. Most of my clients live in Houston, but I also see clients who live outside of Houston and Harris County, including by video conference. My practice focuses on providing therapeutic services to children and adolescents and I specialize in assisting clients with trauma and grief. Many of my clients identify as LGBTQ+ and the majority are transgender or non-binary.

18. As a psychologist, I often evaluate and diagnose gender dysphoria in my patients. I sometimes refer patients for medical treatment for gender dysphoria and oversee their ongoing mental health care during the course of such treatment. This care is only provided after careful mental health evaluation and with the informed consent of parents and the assent of minor patients.

19. Medical interventions to treat gender dysphoria in adolescence are effective, safe, and often lifesaving. I have personally witnessed time and time again, young people who were depressed and feeling hopeless and scared for their future begin to feel happy and optimistic just by starting medications to suppress puberty or to develop the secondary sex characteristics that align with their gender identity. Given the exceptionally high rates of suicidality in this population, medical interventions are a critical part of treatment and often save lives. At least 44% of transgender youth attempt suicide during their lifetime as compared to the national average of about 4% for teens.[3] This treatment does not harm patients but helps them; it is not abuse.

---

[3] *See* Brian S. Mustanski et al., *Mental Health Disorders, Psychological Distress, and Suicidality in a Diverse Sample of Lesbian, Gay, Bisexual, and Transgender Youths*, 100 Am. J. Pub. Health 2426 (2010), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2978194/; Matthew K. Nock et al., *Prevalence, correlates, and treatment of lifetime suicidal behavior among adolescents: results from the National Comorbidity Survey Replication*

20. As part of my ongoing professional obligations, I stay up to date on the latest data on mental health and medical interventions to treat patients with gender dysphoria. I have read numerous studies that document how being able to access gender-affirming care improves the mental health of transgender and non-binary youth and reduces suicidal ideation.[4]

21. As a licensed psychologist, I am required to follow the guidance of the APA and TPA, which recognize the scientific research and medical consensus that gender-affirming care is medically necessary for certain youth with gender dysphoria. The APA has published detailed protocols for providing culturally competent and developmentally appropriate psychological care for transgender and gender non-conforming people.[5] The APA recognizes that "diversity in gender identity and expression is part of the human experience and transgender and gender nonbinary

---

Adolescent Supplement, 70 JAMA Psychiatry 300 (2013), https://pubmed.ncbi.nlm.nih.gov/23303463/; Michelle M. Johns et al., *Trends in Violence Victimization and Suicide Risk by Sexual Identity Among High School Students - Youth Risk Behavior Survey, United States, 2015-2019*, 69 Morbidity & Mortality Weekly Rep. Supp. 19 (2020), https://pubmed.ncbi.nlm.nih.gov/32817596/; Michelle M. Johns et al., *Transgender Identity and Experiences of Violence Victimization, Substance Use, Suicide Risk, and Sexual Risk Behaviors Among High School Students - 19 States and Large Urban School Districts, 2017*, 68 Morbidity & Mortality Weekly Rep. 67 (2019), https://pubmed.ncbi.nlm.nih.gov/30677012/.

[4] *See, e.g.*, Amy E. Green et al., *Association of Gender-Affirming Hormone Therapy With Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth*, J. Adolescent Health (2021), https://www.jahonline.org/article/S1054-139X(21)00568-1/fulltext (finding lower rates of depression and suicide among transgender and non-binary youth who receive gender-affirming hormone therapy); Diana M. Turdof et al., *Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care*, 5 JAMA Network Open (2022), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2789423 (finding that gender-affirming medical interventions were associated with lower odds of depression and suicidality in transgender and non-binary youth); Laura E. Kuper et al., *Body Dissatisfaction and Mental Health Outcomes of Youth on Gender-Affirming Hormone Therapy*, 145 Pediatrics (2020), https://pubmed.ncbi.nlm.nih.gov/32220906/ (reviewing longitudinal studies and finding hormone therapy to improve mental health outcomes for transgender adolescents); Stephen M. Rosenthal, *Challenges in the care of transgender and gender- diverse youth: an endocrinologist's view*, 17 Nature Reviews Endocrinology 581 (2021), https://www.nature.com/articles/s41574-021-00535-9 (reviewing empirical studies identifying mental health benefits of gender-affirming care); Connor Grannis et al., *Testosterone Treatment, Internalizing Symptoms, and Body Image Dissatisfaction in Transgender Boys*, 132 Psychoneuroendocrinology (2021), https://pubmed.ncbi.nlm.nih.gov/34333318/; Jack L. Turban et al., *Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation*, 145 Pediatrics (2020), https://pubmed.ncbi.nlm.nih.gov/31974216/.

[5] Guidelines for Psychological Practice With Transgender and Gender Nonconforming People (Am. Psych. Ass'n 2015), https://www.apa.org/practice/guidelines/transgender.pdf.

identities and expressions are healthy, incongruence between one's sex and gender is neither pathological nor a mental health disorder."[6]

22. The APA also recognizes that "[s]ome transgender and gender nonbinary individuals seek gender-affirming medical care (e.g., hormone therapy, surgery) while others do not" and has established that "invalidation and rejection of transgender and gender nonbinary identities and diverse gender expressions by others (e.g., families, therapists, school personnel) are forms of discrimination, stigma, and victimization, which result in psychological distress."[7]

23. In 2019, after a review of the research as well as professional guidelines, TPA crafted a formal statement in which it concluded that "transgender children fare best when caregivers and treatment providers establish an affirming and supportive environment within which they can understand their emerging gender identity."

24. Pursuant to these guidelines, it is my job to support all patients in an exploration of their identity and appropriately diagnose and evaluate them. Many clients that I work with have already experienced trauma, and reporting them to DFPS simply for receiving gender-affirming care from a licensed medical provider would cause immense and irreversible harm.

The Governor's Directive and DFPS Implementation

25. Forcing me to report a client and their parents to DFPS for receiving the health care that they need would be catastrophic. Instead of benefiting my patients' mental health and helping them thrive, I would subject them to trauma and stress. My clients and their families could be investigated for child abuse, and families could be split apart simply for providing young people with the medical care that they need.

---

[6] APA Resolution on Gender Identity Change Efforts 2 (Am. Psych. Ass'n 2021), https://www.apa.org/about/policy/resolution-gender-identity-change-efforts.pdf.
[7] *Id.* at 1-2.

26. Under the Governor's directive and DFPS's implementation of its redefinition of gender-affirming health care as child abuse, my clients could be separated from their parents and guardians and removed for their homes. My clients' parents could also face catastrophic consequences. And having their families be subject to an investigation will dramatically worsen the mental health outcomes of my clients, and could worsen the already tragic rate of suicide among transgender youth.

27. The recent actions taken by Governor Abbott threaten me with criminal sanctions and put me in an impossible position. If I follow my ethical duties and Texas law by not reporting any of my clients for the health care described in the Governor's letter, I could be subject to prosecution for failure to report child abuse or neglect, which is a Class A misdemeanor and punishable by up to a year in prison and/or a fine of up to $4,000. I could also be subject to an investigation by the Texas Board of Examiners of Psychologists and lose my license, which would end my livelihood and private practice.

28. If I am compelled to follow the Governor's letter and DFPS's erroneous reliance on it, the personal and professional consequences that I face are even more devastating. Under Section 261.107 of the Texas Family Code, I could be charged with false reporting of child abuse if I make a report to DFPS when I know that child abuse is not happening. It is a state jail felony punishable by up to two years in prison and/or a $10,000 fine to falsely report child abuse. I also could be subject to an investigation by the Texas Board of Examiners of Psychologists and lose my license for failing to follow the ethical code of conduct promulgated by the APA. And I could be subject to malpractice lawsuits from my clients for failing to adhere to ethical guidelines and harming my clients. Even worse, it would be a betrayal of the bonds of trust between me and my clients and the oath that I swore as a psychologist to do no harm to my patients.

I declared under the penalty of perjury that the foregoing is true and correct.

Signed on this the 1st day of March, 2022.

Megan A. Mooney, PhD.

Appendix B

3/2/2022 9:51 AM
Velva L. Price
District Clerk
Travis County
D-1-GN-22-000977
Daniel Smith

CAUSE NO. D-1-GN-22-000977

JANE DOE, *et al.*,	§	IN THE DISTRICT COURT
Plaintiffs,	§	
	§	
v.	§	201st JUDICIAL DISTRICT
	§	
GOVERNOR ABBOTT, *et al.*,	§	
	§	
Defendants.	§	TRAVIS COUNTY, TEXAS

DEFENDANTS' PLEA TO THE JURISDICTION

Defendants Greg Abbott in his official capacity as Governor of the State of Texas ("Governor Abbott"), Jaime Masters in her official capacity of Commissioner of the Department of Family and Protective Services ("Commissioner Masters"), and the Texas Department of Family and Protective Services ("DFPS") (collectively, "Defendants") respectfully submit this Plea to the Jurisdiction and would show the Court as follows:

I. INTRODUCTION

With little notice and no opportunity to fully assess the petition and prepare a defense, Plaintiffs request that the Court abrogate Defendants' immunities and enter injunctive relief on unsupported claims. But even a cursory review of Plaintiffs' petition reveals insurmountable jurisdictional hurdles that deprive the Court of any authority to enter the relief that Plaintiffs seek. The Court lacks jurisdiction to enjoin executive agencies from following the law or impose obligations on them to disregard child abuse. Plaintiffs have not demonstrated that they have standing to pursue their claims or that their claims are ripe; they must proceed as every other litigant and are not entitled to pre-enforcement exceptions to Texas law. Moreover, Plaintiffs' claims lack substantive merit. Defendants do not consent to the jurisdiction of this Court and reserve the right to supplement and amend this plea to the jurisdiction, and to raise any and all jurisdictional arguments at any stage of the proceedings.

The Court lacks jurisdiction over Plaintiffs' claims, which should be dismissed.

II. BACKGROUND

The Petition alleges causes of action based upon the following sequence of events: (1) the Office of the Attorney General opined that in certain circumstances, it is possible that several gender-affirming treatments or therapies might be used as implements of child abuse; (2) Governor Abbott wrote a letter to Commissioner Masters instructing DFPS to duly investigate allegations of the use of such treatments as abuse; and (3) Commissioner Masters acknowledged that DFPS would follow the law.

None of these three incidents conclusively determined that each and every incident of treatment using these gender-affirming therapies for young people constitutes child abuse, and none of these three incidents constituted, or purported to be, a change in existing law.

Despite the clear wording of both the Attorney General Opinion and of Governor Abbott's letter, media coverage widely—and incorrectly—proclaimed that State officials sought to outlaw transgender youth. Plaintiff Jane Doe is the mother of a transgender daughter, and a DFPS employee. Following the breathless media coverage of these events, Ms. Doe reported concerns to her supervisor that her daughter's gender-affirming treatment may run afoul of some new State investigatory policy. Reporting such a concern constitutes a "self-report" under DFPS procedures, and the reporting employee is temporarily placed on paid administrative leave while the report is investigated. Mrs. Doe and her husband, Plaintiff John Doe, have filed suit to stop the DFPS investigation, and to prevent any investigations of allegations of child abuse involving gender-affirming treatments.

Plaintiff Mooney is a licensed psychologist who treats transgender youths. She has filed suit out of concern she would have to report all of her transgender youth clients seeking or engaging in gender-affirming therapies. She cites concerns that such a report would injure her clients, sever her professional relationship with her clients, and result in legal and administrative catch-22s inasmuch as

she believes she would be required to report abuse when she believed none had occurred.

III. ARGUMENT AND AUTHORITY

A. Standard of Review

A plea to the jurisdiction challenges the court's authority to determine the subject matter of the controversy.[1] Subject-matter jurisdiction is "never presumed and cannot be waived."[2] "Subject-matter jurisdiction is a multiple choice question with only two answers: yes or no."[3] A defendant may challenge the jurisdiction of the court by challenging the sufficiency of the plaintiff's pleadings, the existence of jurisdictional facts, or both.[4] "When a plea to the jurisdiction challenges the pleadings, [the court] determine[s] if the pleader has alleged facts that affirmatively demonstrate the court's jurisdiction to hear the cause."[5] "If the pleadings affirmatively negate the existence of jurisdiction, then a plea to the jurisdiction may be granted without allowing the plaintiffs an opportunity to amend."[6]

B. Sovereign Immunity Bars Plaintiffs' Claims.

"Sovereign immunity implicates a court's subject matter jurisdiction."[7] It is Plaintiffs' burden to establish a viable waiver of Defendants' sovereign immunity.[8] They have not met that burden here. The *ultra vires* exception applies to claims that a government official acted without lawful authority or failed to perform a purely ministerial act.[9] But to establish the Court's subject-matter jurisdiction, the plaintiff must do more than invoke the exception. "[M]erely asserting legal conclusions or labeling a

---

[1] *Bland Indep. Sch. Dist. v. Blue*, 34 S.W.3d 547, 553–54 (Tex. 2000).
[2] *Tex. Ass'n of Bus. v. Tex. Air Ctr. Bd.*, 852 S.W.2d 440, 443–44 (Tex. 1993).
[3] *City of Anson v. Harper*, 216 S.W.3d 384, 390 (Tex. App.—Eastland 2006, no pet.).
[4] *Tex. Dep't of Parks & Wildlife v. Miranda*, 133 S.W.3d 217, 225–28 (Tex. 2004).
[5] *Id.* at 226.
[6] *Id.* at 227.
[7] *EBS Sols., Inc. v. Hegar*, 601 S.W.3d 744, 749 (Tex. 2020).
[8] *See Town of Shady Shores v. Swanson*, 590 S.W.3d 544, 550 (Tex. 2019).
[9] *Hous. Belt & Terminal Ry. Co. v. City of Houston*, 487 S.W.3d 154, 161 (Tex. 2016).

defendant's actions as 'ultra vires,' 'illegal,' or 'unconstitutional' does not suffice to plead an ultra vires claim—what matters is whether the *facts* alleged constitute actions beyond the governmental actor's statutory authority, properly construed."[10] "[I]f the plaintiff alleges only facts demonstrating acts within the officer's legal authority and discretion, the claim seeks to control state action, and is barred by sovereign immunity."[11]

Defendants seek only to follow the law. The Court has no jurisdiction to enjoin DFPS from undertaking child abuse investigations and ignoring entirely the information from mandatory reporters who bring allegations of child abuse to investigators' attention. If any action is initiated against Plaintiffs, they will be able to defend those allegations or findings in that suit—none of their rights have been stripped or impugned simply by the opening of an investigation of child abuse in accordance with the law. Likewise, Dr. Mooney would have the same protections in any investigation regarding her conduct, including any actions regarding her medical licensure. But if parents could sue and obtain a temporary restraining order simply based on the initiation of a DFPS investigation, DFPS would be seriously hampered in identifying and preventing *all* child abuse—not just the alleged child abuse at issue in this case. All of Defendants' actions and any future proceedings are squarely within the bounds of their legal authority.

Furthermore, even if the merits of Plaintiffs' arguments regarding the proper construction of the child abuse provisions of the Texas Family Code were appropriate for the Court to consider on

---

[10] *Texas Dept. of Transp. v. Sunset Transp., Inc.*, 357 S.W.3d 691, 702 (Tex. App.—Austin 2011, no pet.) (emphasis in original); *see also Creedmoor-Maha Water Supply Corp.*, 307 S.W.3d 505, 515–16 (Tex. App.—Austin 2010, no pet.) (noting that "if the claimant is attempting to restrain a state officer's conduct on the grounds that it is unconstitutional, it must allege facts that actually constitute a constitutional violation" to fall within the *ultra vires* exception); *see also Klumb v. Houston Mun. Employees Pension Sys.*, 458 S.W.3d 1, 13 (Tex. 2015).

[11] *Creedmoor-Maha Water Supply Corp.*, 307 S.W.3d at 415–16; *see also Chambers-Liberty Ctys. Navigation Dist. v. State*, 575 S.W.3d 339, 345 (Tex. 2019) ("[T]he jurisdictional inquiry may unavoidably implicate the underlying substantive merits of the case when, as often happens in *ultra vires* claims, the jurisdictional inquiry and the merits inquiry are intertwined.").

these claims—and the Court need not and should not opine on those arguments—Plaintiffs' position is simply unsupportable. Attorney General Opinion No. KP-0401, though nonbinding, thoroughly explains why it is possible under Texas law that particular "'sex change' procedures and treatments . . . when performed on children, can legally constitute child abuse under several provisions of chapter 261 of the Texas Family Code." To the extent that Plaintiffs claim some constitutional defect with this interpretation, none of the Plaintiffs fall within any protected category, and this interpretation of the Texas Family Code readily satisfies rational basis review.[12] Accordingly, even on the merits of this question—which the Court need not reach—Plaintiffs have failed to establish any unlawful acts or legal interpretations, and they have failed to establish a waiver of Defendants' sovereign immunity.

Plaintiffs' APA claims do not alter this conclusion. There has been no agency action subject to APA review by either Defendant—Plaintiffs simply gesture to two letters, one of which they do not even provide to the Court, and they have no colorable claim that this is reviewable under the APA. More importantly, the APA does *not* waive sovereign immunity from claims for injunctive relief.[13]

Simply put, Plaintiffs seek to take away Defendants' lawful authority to protect the children of Texas. The Court has no authority to grant Plaintiffs an exception to these laws simply because Plaintiffs have a particular view on what constitutes child abuse. To hold otherwise would put all children in Texas at grave risk.

C. Plaintiffs lack standing.

"Subject matter jurisdiction requires that the party bringing the suit have standing, that there be a live controversy between the parties, and that the case be justiciable."[14] "A court has no

[12] *See, e.g.*, *Richards v. Tex. A&M Univ. Sys.*, 131 S.W.3d 550, 557 (Tex. App.—Waco Feb. 11, 2004) ("'[L]egislation survives an equal-protection challenge so long as the legislation is 'rationally related to a legitimate state interest.'").
[13] *See* Tex. Gov't Code § 2001.038(a).
[14] *State Bar of Texas v. Gomez*, 891 S.W.2d 243, 245 (Tex. 1994).

jurisdiction over a claim made by a plaintiff who lacks standing to assert it."[15] And claims "to correct an alleged violation of the separation of powers" must receive an "especially rigorous" standing inquiry.[16] This limit preserves the proper role of courts in our judicial system, which is "[to protect] the rights and liberties of individual citizens and minority groups," as opposed to being "some amorphous general supervis[or] of the operations of government."[17]

The Does have not been injured merely by the existence and operation of Texas law prohibiting child abuse. Plaintiffs simply allege that an investigator spoke to the Does. Pet. ¶ 83. However, Plaintiffs do not allege they were required to submit to interviews, subpoenaed, or otherwise coerced. Indeed, Plaintiffs allege that they refused to sign a release for Mary Doe's medical records. *Id.* Dr. Mooney's alleged injury is that the challenged letters create a duty to report. But the letters do no such thing—Dr. Mooney's duties flow from the Texas Family Code and Texas law, and Defendants have not altered those obligations in any way.

The bare possibility of investigation is not actionable under the APA.[18] Likewise, noncoercive investigation is not an injury in fact.[19] Child abuse should be investigated in Texas, and whether child abuse has occurred under Texas law is a fact-intensive determination that should be assessed after investigation pursuant to normal processes and, if necessary, adjudication by a court in a child abuse prosecution. Plaintiffs are not injured merely because they, like every other Texan, are potentially subject to child abuse investigation.

---

[15] *Heckman v. Williamson Cnty.*, 369 S.W.3d 137, 150 (Tex. 2012).
[16] *In re Abbott*, 601 S.W.3d 802, 809 (Tex. 2020) (cleaned up).
[17] *Id.* at 829 (quoting *United States v. Richardson*, 418 U.S. 166, 192 (1974) (Powell, J. concurring)); *see also Raines v. Byrd*, 521 U.S. 811, 819 (1997); *In re Abbott*, 601 S.W.3d at 809.
[18] *See Rea v. State*, 297 S.W.3d 379, 383-84 (Tex. App.—Austin 2009); *cf. LHR Enterprises, Inc. v. Geeslin*, No. 03-05-00176-CV, 2007 WL 3306492, at *5 (Tex. App.—Austin Nov. 7, 2007, pet. denied).
[19] *See, e.g.*, *Laird v. Tatum*, 408 U.S. 1 (1972) (finding no First Amendment injury from "the mere existence, without more, of a governmental investigative and data-gathering activity that is alleged to be broader in scope than is reasonably necessary for the accomplishment of a valid governmental purpose").

D. Plaintiffs' claims are not ripe

Each of Plaintiffs' complaints are wholly premature and unripe for adjudication. "Claims based on an allegedly improper investigation typically are not ripe because 'after reviewing information submitted by appellant, the agency might agree with [its] assertion[s].'"[20] Even issuance of an administrative complaint finding reason to believe there has been a violation is not final agency action subject to judicial review.[21] Dr. Mooney does not allege DFPS is investigating her or has taken any action against her, and the mere existence of investigative power is not an actionable injury. *See Laird*, *supra*. Even if the government could take some action against her, an administrative action is not ripe for judicial review until it is final. *See Rea v. State*, *supra*. And the Does do not allege that any investigative findings have been made or that any actions have been taken against them. When any investigations are concluded, and if any subsequent actions are taken, Plaintiffs will have every opportunity to defend against any prosecution or raise any other challenge. But Plaintiffs' claims are simply premature at this juncture.

E. This Court Cannot Enjoin the Governor

Only the Texas Supreme Court, not a district court, has jurisdiction to enjoin executive officers, including the Governor.

> Section 22.002(c) of the Tex. Gov't Code provides:
> (c) Only the supreme court has the authority to issue a writ of mandamus or injunction, or any other mandatory or compulsory writ or process, against any of the officers of the executive departments of the government of this state to order or compel the performance of a judicial, ministerial, or discretionary act or duty that, by state law, the officer or officers are authorized to perform.

Various courts have held that, under this statute, a district court does not have jurisdiction to enjoin an executive officer.[22]

---

[20] *Winter v. Cal. Med. Rev., Inc.*, 900 F.2d 1322, 1325 (9th Cir. 1989); *see also Rhode Island v. Narragansett Indian Tribe*, 19 F.3d 685, 692 (1st Cir. 1994).
[21] *F.T.C. v. Standard Oil Co. of California*, 449 U.S. 232, 241 (1980).
[22] *See, e.g.*, *In re B.N.A.*, 278 S.W.3d 530, 533 (Tex. App.—Dallas 2009, no pet.); *In re Office of Attorney General of Texas*, No. 05-18-00086-CV, 2018 WL 1725069, at *6 (Tex. App.—Dallas Apr. 10, 2018,

For example, in *In re B.N.A.*, the trial court issued an order that required the Office of the Attorney General ("OAG") to remit child-support payments to a private entity and enjoined the Attorney General from taking any additional action in the case.[23] The Fifth Court of Appeals concluded that the order was void under section 22.002(c) because "[t]he trial court lacked jurisdiction [to] compel the OAG to remit child support payments to [the private entity] and to enjoin the Attorney General from taking action in the case."[24] The Court therefore vacated those portions of the trial court's order.[25] The Fifth Court of Appeals reached the same conclusion in *In re Office of Attorney General of Texas*, holding that the trial court's injunction prohibiting OAG from distributing child-support payments was void under section 22.002(c).[26]

As the Texas Supreme Court explained: "[D]istrict courts generally have no jurisdiction over executive officer respondents."[27] And Governor Abbott is an "officer[] of the executive departments of the government of this state."[28] As such, this court lacks jurisdiction to enjoin him.

IV. CONCLUSION

For the foregoing reasons, Defendants request the Court dismiss the instant cause for lack of jurisdiction.

Respectfully submitted,

KEN PAXTON
Attorney General of Texas

BRENT WEBSTER

---

orig. proceeding) (mem. Op.); *In re C.H.*, No. 13-17-00544-CV, 2019 WL 5251145, at *3–4 (Tex. App.—Corpus Christi Oct. 17, 2019, no pet.) (mem. op.); *In re C.D.E.*, 533 S.W.3d 367, 372 (Tex. App.—Houston [14th Dist.] 2015, no pet.)

[23] 278 S.W.3d at 533.

[24] *Id.*

[25] *Id.*

[26] No. 05-18-00086-CV, 2018 WL 1725069, at *6 (Tex. App.—Dallas Apr. 10, 2018, orig. proceeding) (mem. op.).

[27] *A & T Consultants, Inc. v. Sharp*, 904 S.W.2d 668, 672 (Tex. 1995).

[28] Tex. Gov't Code § 22.002(c); Tex. Const. art. IV, § 1.

First Assistant Attorney General

GRANT DORFMAN
Deputy First Assistant Attorney General

SHAWN COWLES
Deputy Attorney General for Civil Litigation

THOMAS A. ALBRIGHT
Chief for General Litigation Division

/s/ Ryan G. Kercher
RYAN G. KERCHER
Texas Bar No. 24060998
Assistant Attorney General
Office of the Attorney General
P.O. Box 12548, Capitol Station
Austin, Texas 78711-2548
Phone: 512-463-2120
Fax: 512-320-0667
Ryan.Kercher@oag.texas.gov

Counsel for Defendants

CERTIFICATE OF SERVICE

I certify that a true and correct copy of the foregoing document has been served electronically through the electronic-filing manager in compliance with TRCP 21a on March 2, 2022 to:

Brian Klosterboer
Andre Segura
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF TEXAS
5225 Katy Fwy., Ste 350
Houston, TX 77007
Phone: 713-942-8146
bklosterboer@aclutx.org
asegura@aclutx.org

Chase Strangio
James Esseks
Anjana Samant
Kath Xu
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF TEXAS
125 Broad St, 18th Floor
New York, New York 10004
Phone: 917-345-1742

Brandt T. Roessler
BAKER BOTTS L.L.P.
30 Rockerfeller Plaza
New York, New York 10112-4498
Phone: 212-408-2500
Brandy.roessler@bakerbotts.com
Pro hac vice forthcoming

Paul D. Castillo
Shelly L. Skeen
Nicholas "Guilly" Guillory
LAMDA LEGAL DEFENSE AND
EDUCATION FUND, INC.
3500 Oak Lawn Ave., Unit 500
Dallas, Texas 75219
Phone: 214-219-8585
pcastillo@lambdalegal.org
sskeen@lambdalegal.org
nguillory@lamdalegal.org

cstrangio@aclu.org
jesseks@aclu.org
asamant@acclu.org
kxu@aclu.org

Derek R. McDonald
Maddy R. Dwertman
BAKER BOTTS L.L.P.
98 San Jacinto Blvd, Ste 1500
Austin, Texas 78701-4078
Phone: 512-322-2500
Derek.mcdonald@bakerbotts.com
Maddy.dwertman@bakerbotts.com

Omar Gonzalez-Pagan
M. Curry Cook
LAMDA LEGAL DEFENSE AND EDUCATION FUND, INC.
120 Wall Street, 19th Floor
New York, New York 10005-3919
Phone: 212-809-8585
Ogonzalez-pagan@lambdalegal.org
ccook@lambdalegal.org

Karen L. Loewy
LAMDA LEGAL DEFENSE AND EDUCATION FUND, INC.
1776 K Street, N.W., 8th Floor
Washington, DC 20006-2304
Phone: 202-804-6245
kloewy@lamdalegal.org

Camilla B. Taylor
LAMDA LEGAL DEFENSE AND EDUCATION FUND, INC.
65 E. Wacker Place, Ste 2000
Chicago, IL 60601-7245
Phone: 312-663-4413
ctaylor@lamdalegal.org

Counsel for Plaintiffs

/s/ Ryan G. Kercher
RYAN G. KERCHER

Automated Certificate of eService

This automated certificate of service was created by the efiling system. The filer served this document via email generated by the efiling system on the date and to the persons listed below. The rules governing certificates of service have not changed. Filers must still provide a certificate of service that complies with all applicable rules.

Caroline Taylor on behalf of Ryan Kercher
Bar No. 24060998
caroline.taylor@oag.texas.gov
Envelope ID: 62212890
Status as of 3/2/2022 5:19 PM CST

Case Contacts

Name	BarNumber	Email	TimestampSubmitted	Status
Katrina Shanks		katrina.shanks@oag.texas.gov	3/2/2022 9:51:04 AM	SENT

Associated Case Party: JANE DOE

Name	BarNumber	Email	TimestampSubmitted	Status
Andre Segura	24107112	asegura@aclutx.org	3/2/2022 9:51:04 AM	SENT
Brian Klosterboer		bklosterboer@aclutx.org	3/2/2022 9:51:04 AM	SENT
Chase Strangio		cstrangio@aclu.org	3/2/2022 9:51:04 AM	SENT
James Esseks		jesseks@aclu.org	3/2/2022 9:51:04 AM	SENT
Anjana Samant		asamant@acclu.org	3/2/2022 9:51:04 AM	SENT
Kath Xu		kxu@aclu.org	3/2/2022 9:51:04 AM	SENT
Shelly Skeen		sskeen@lamdalegal.org	3/2/2022 9:51:04 AM	SENT
Nicholas Guillory		nguillory@lamdalegal.org	3/2/2022 9:51:04 AM	SENT
Karen L.Loewy		kloewy@lamdalegal.org	3/2/2022 9:51:04 AM	SENT

Associated Case Party: GREG ABBOTT GOVERNOR OF TEXAS

Name	BarNumber	Email	TimestampSubmitted	Status
Ryan Kercher		ryan.kercher@oag.texas.gov	3/2/2022 9:51:04 AM	SENT

Associated Case Party: JOHN DOE

Name
Omar Gonzalez-Pagan
Derek McDonald

Automated Certificate of eService

This automated certificate of service was created by the efiling system. The filer served this document via email generated by the efiling system on the date and to the persons listed below. The rules governing certificates of service have not changed. Filers must still provide a certificate of service that complies with all applicable rules.

Caroline Taylor on behalf of Ryan Kercher
Bar No. 24060998
caroline.taylor@oag.texas.gov
Envelope ID: 62212890
Status as of 3/2/2022 5:19 PM CST

Associated Case Party: JOHN DOE

Maddy Dwertman		Maddy.dwertman@bakerbotts.com	3/2/2022 9:51:04 AM	SENT
Paul Castillo		pcastillo@lamdalegal.org	3/2/2022 9:51:04 AM	SENT
Camilla Taylor		ctaylor@lamdalegal.org	3/2/2022 9:51:04 AM	SENT
M. curry Cook		ccook@lamdalegal.org	3/2/2022 9:51:04 AM	SENT

Appendix C

Filed in the District Court
Of Travis County, Texas
At March 2, 2022; 5:15 PM
Velva L. Price, District Clerk

CAUSE NO. D-1-GN-22-000977

JANE DOE, individually and as parent and next friend of MARY DOE, a minor; JOHN DOE, individually and as parent and next friend of MARY DOE, a minor; and DR. MEGAN MOONEY	§	
Plaintiffs	§	
	§	IN THE DISTRICT COURT OF TRAVIS COUNTY, TEXAS 353RD JUDICIAL DISTRICT
v.	§	
GREG ABBOTT, sued in his official capacity as Governor of the State of Texas; JAIME MASTERS, sued in her official capacity as Commissioner of the Texas Department of Family and Protective Services; and the TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES,	§	
Defendants.	§	

ORDER GRANTING PLAINTIFFS' APPLICATION FOR TEMPORARY RESTRAINING ORDER

On this day the Court considered the Application by Plaintiffs John and Jane Doe, individually and as parents and next friends of Plaintiff Mary Doe, a minor, and Dr. Megan Mooney (collectively, "Plaintiffs") for a Temporary Restraining Order, as found in Plaintiffs' Petition and Application for Temporary Restraining Order, Temporary Injunction, and Permanent Injunction, and Request for Declaratory Relief ("Petition") filed against Defendants Greg Abbott, in his official capacity as Governor of the State of Texas, Jaime Masters, in her official capacity as Commissioner of the Texas Department of Family and Protective Services, and the Texas Department of Family and Protective Services (collectively, "Defendants").

From the facts set forth in Plaintiffs' Petition, and the declarations attached thereto, the Court finds Plaintiffs will suffer irreparable injury unless Defendants are immediately restrained from enforcing the Governor's letter and the DFPS statement, both issued February 22, 2022 and which make reference to and incorporate Attorney General Paxton's Opinion No. KP-0401. The Court finds Jane Doe has been placed on administrative leave at work and is at risk of losing her job and that Jane, John and Mary Doe face the imminent and ongoing deprivation of their constitutional rights, the potential loss of necessary medical care, and the stigma attached to being the subject of an unfounded child abuse investigation. The Court further finds that if placed on the Child Abuse Registry, Jane Doe could lose the ability to practice her profession and both Jane and John Doe could lose their ability to work with minors and volunteer in their community.

The Court further finds that Plaintiff Mooney could face civil suit by patients for failing to treat them in accordance with professional standards and loss of licensure for failing to follow her professional ethics if she complies with Defendants' orders and actions. If she does not comply with Defendants' orders, Dr. Mooney could face immediate criminal prosecution, as set forth in the Governor's letter.

The Court finds Defendants' wrongful actions cannot be remedied by any award of damages or other adequate remedy at law.

IT IS THEREFORE ORDERED that Defendants are immediately enjoined and restrained from taking any actions against Plaintiffs based solely on the Governor's letter and DFPS statement, both issued February 22, 2022, as well as Attorney General Paxton's Opinion No. KP-0401 which they reference and incorporate. IT IS FURTHER ORDERED that Defendants are enjoined from taking any employment action or investigating reports against these Plaintiffs based solely on facilitating or providing gender-affirming care to transgender minors based on the fact that

the minors are transgender, gender transitioning, or receiving or being prescribed gender-affirming medical treatment.

IT IS FURTHER ORDERED that Plaintiffs' Application for Temporary Injunction be heard before the Honorable Judge Amy Clark Meachum of the 201st Judicial District Court of Travis County, Texas on Friday, March 11, 2022, at 10:00 a.m. o'clock. The hearing will be conducted using Zoom videoconference technology and a link will be provided by the Court in advance of the hearing.

The purpose of the hearing is to determine why a temporary injunction should not be issued as requested by Plaintiffs. The Clerk of the Court is hereby directed to issue a show cause notice to Defendants to appear at the temporary injunction hearing.

At issue for the Temporary Injunction hearing will be the Validity of and Enforcement of the Governor's letter and the DFPS statement, both issued February 22, 2022, as well as Attorney General Paxton's Opinion No. KP-0401, which they reference and incorporate, and whether they violate the constitutional rights of the Plaintiffs and other persons, the Texas Administrative Procedure Act, Texas Gov't Code § 2001.038, or any other applicable laws. The Temporary Injunction hearing will decide whether a statewide Temporary Injunction should be issued to enjoin Defendants from the following: (1) investigating reports of any persons facilitating or providing gender-affirming care to transgender minors solely based on the fact that the minors are transgender, gender transitioning, or receiving or being prescribed gender-affirming medical treatment; (2) prosecuting or referring for prosecution such reports; and (3) imposing reporting requirements on persons who are aware of others who facilitate or provide gender-affirming care to transgender minors solely based on the fact that the minors are transgender, gender transitioning, or receiving or being prescribed gender-affirming medical treatment.

The Clerk of the Court shall forthwith, on filing by Plaintiffs of the Bond hereinafter required, and on proving of the same according to law, issue a temporary restraining order in conformity with the laws and terms of this Order.

This Order shall not be affected unless and until Plaintiffs execute and file with the Clerk a bond in conformity with the law, in the amount of $100.00 dollars.

Signed this 2nd day of March 2022, at 4:55 p.m. in Travis County, Texas.

AMY CLARK MEACHUM
JUDGE PRESIDING

Appendix D

ACCEPTED
03-22-00107-CV
62282300
THIRD COURT OF APPEALS
AUSTIN, TEXAS
3/3/2022 2:58 PM
JEFFREY D. KYLE
CLERK

3/2/2022 6:40 PM
Velva L. Price
District Clerk
Travis County
D-1-GN-22-000977
Selina Hamilton

CAUSE NO. D-1-GN-22-000977

JANE DOE, *et al.*, *Plaintiffs,*	§	IN THE DISTRICT COURT
v.	§	201st JUDICIAL DISTRICT
GOVERNOR ABBOTT, *et al.*, *Defendants.*	§	TRAVIS COUNTY, TEXAS

DEFENDANTS' NOTICE OF ACCELERATED INTERLOCUTORY APPEAL

Defendants Greg Abbott in his official capacity as Governor of the State of Texas ("Governor Abbott"), Jaime Masters in her official capacity of Commissioner of the Department of Family and Protective Services ("Commissioner Masters"), and the Texas Department of Family and Protective Services ("DFPS") (collectively, "Defendants") respectfully appeal the Court's interlocutory order of March 2, 2022. Said Order implicitly denied Defendants' plea to the jurisdiction and granted Plaintiffs' request for a temporary restraining order. The Order enjoins Defendants from taking any actions against Plaintiffs based solely on the Governor's February 22, 2022 letter and DFPS statement of the same date, as well as Attorney General Opinion No. KP-0401; the Order further enjoins Defendants from taking any employment action or investigating reports against Plaintiffs based solely on facilitating or providing gender-affirming care to transgender minors based on the fact that the minors are transgender, gender transitioning, or receiving or being prescribed gender-affirming medical treatment.

Defendants are entitled to an interlocutory appeal pursuant to Civil Practice and Remedies Code section 51.014(a)(8), which allows for an immediate appeal from an order that denies a plea to the jurisdiction. Defendants appeal to the Third Court of Appeals. This is an accelerated appeal as provided by Texas Rule of Appellate Procedure 28.1. This is not a parental termination or child

protection case, as defined in Rule 28.4.

Pursuant to Texas Civil Practice and Remedies Code § 51.014(b), all further proceedings in this court are stayed pending resolution of Defendants' appeal. Upon filing of this instrument, the March 2, 2022 Order is superseded pursuant to Texas Civil Practice and Remedies Code section 6.001(b) and Texas Rule of Appellate Procedure 29.1(b). Pursuant to section 6.001, as governmental officers/entities, Defendants are not required to file a supersedeas bond for court costs. Defendants' appeal is therefore perfected upon the filing of the notice of appeal.

Respectfully submitted,

KEN PAXTON
Attorney General of Texas

BRENT WEBSTER
First Assistant Attorney General

GRANT DORFMAN
Deputy First Assistant Attorney General

SHAWN COWLES
Deputy Attorney General for Civil Litigation

THOMAS A. ALBRIGHT
Chief for General Litigation Division

/s/ Ryan G. Kercher
RYAN G. KERCHER
Texas Bar No. 24060998
Assistant Attorney General
Office of the Attorney General
P.O. Box 12548, Capitol Station
Austin, Texas 78711-2548
Phone: 512-463-2120
Fax: 512-320-0667
Ryan.Kercher@oag.texas.gov

Counsel for Defendants

CERTIFICATE OF SERVICE

I certify that a true and correct copy of the foregoing document has been served electronically through the electronic-filing manager in compliance with TRCP 21a on March 2, 2022 to:

Brian Klosterboer
Andre Segura
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF TEXAS
5225 Katy Fwy., Ste 350
Houston, TX 77007
Phone: 713-942-8146
bklosterboer@aclutx.org
asegura@aclutx.org

Chase Strangio
James Esseks
Anjana Samant
Kath Xu
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF TEXAS
125 Broad St, 18th Floor
New York, New York 10004
Phone: 917-345-1742
cstrangio@aclu.org
jesseks@aclu.org
asamant@aclu.org
kxu@aclu.org

Derek R. McDonald
Maddy R. Dwertman
BAKER BOTTS L.L.P.
98 San Jacinto Blvd, Ste 1500
Austin, Texas 78701-4078
Phone: 512-322-2500
Derek.mcdonald@bakerbotts.com
Maddy.dwertman@bakerbotts.com

Brandt T. Roessler
BAKER BOTTS L.L.P.
30 Rockerfeller Plaza
New York, New York 10112-4498
Phone: 212-408-2500
Brandt.roessler@bakerbotts.com
Pro hac vice forthcoming

Paul D. Castillo
Shelly L. Skeen
Nicholas "Guilly" Guillory
LAMBDA LEGAL DEFENSE AND
EDUCATION FUND, INC.
3500 Oak Lawn Ave., Unit 500
Dallas, Texas 75219
Phone: 214-219-8585
pcastillo@lambdalegal.org
sskeen@lambdalegal.org
nguillory@lamdalegal.org

Omar Gonzalez-Pagan
M. Curry Cook
LAMBDA LEGAL DEFENSE AND
EDUCATION FUND, INC.
120 Wall Street, 19th Floor
New York, New York 10005-3919
Phone: 212-809-8585
Ogonzalez-pagan@lambdalegal.org
ccook@lambdalegal.org

Camilla B. Taylor
LAMBDA LEGAL DEFENSE AND
EDUCATION FUND, INC.
65 E. Wacker Place, Ste 2000
Chicago, IL 60601-7245
Phone: 312-663-4413
ctaylor@lamdalegal.org

Karen L. Loewy
LAMBDA LEGAL DEFENSE AND
EDUCATION FUND, INC.
1776 K Street, N.W., 8th Floor
Washington, DC 20006-2304
Phone: 202-804-6245
kloewy@lamdalegal.org

Counsel for Plaintiffs

/s/ *Ryan G. Kercher*
RYAN G. KERCHER

Automated Certificate of eService

This automated certificate of service was created by the efiling system. The filer served this document via email generated by the efiling system on the date and to the persons listed below. The rules governing certificates of service have not changed. Filers must still provide a certificate of service that complies with all applicable rules.

Katrina Shanks on behalf of Ryan Kercher
Bar No. 24060998
katrina.shanks@oag.texas.gov
Envelope ID: 62246361
Status as of 3/3/2022 2:05 PM CST

Case Contacts

Name	BarNumber	Email	TimestampSubmitted	Status
Katrina Shanks		katrina.shanks@oag.texas.gov	3/2/2022 6:40:19 PM	SENT

Associated Case Party: JANE DOE

Name	BarNumber	Email	TimestampSubmitted	Status
Andre Segura	24107112	asegura@aclutx.org	3/2/2022 6:40:19 PM	SENT
Brian Klosterboer		bklosterboer@aclutx.org	3/2/2022 6:40:19 PM	SENT
Chase Strangio		cstrangio@aclu.org	3/2/2022 6:40:19 PM	SENT
James Esseks		jesseks@aclu.org	3/2/2022 6:40:19 PM	SENT
Anjana Samant		asamant@acclu.org	3/2/2022 6:40:19 PM	SENT
Kath Xu		kxu@aclu.org	3/2/2022 6:40:19 PM	SENT
Shelly Skeen		sskeen@lamdalegal.org	3/2/2022 6:40:19 PM	SENT
Nicholas Guillory		nguillory@lamdalegal.org	3/2/2022 6:40:19 PM	SENT
Nicholas Guillory		nguillory@lambdalegal.org	3/2/2022 6:40:19 PM	SENT
Karen Loewy		kloewy@lambdalegal.org	3/2/2022 6:40:19 PM	SENT
Omar Gonzalez-Pagan		ogonzalez-pagan@lambdalegal.org	3/2/2022 6:40:19 PM	SENT
Camilla Taylor		ctaylor@lambdalegal.org	3/2/2022 6:40:19 PM	SENT
M. Currey Cook		ccook@lambdalegal.org	3/2/2022 6:40:19 PM	SENT
Paul Castillo		pcastillo@lambdalegal.org	3/2/2022 6:40:19 PM	SENT
Shelly Skeen		sskeen@lambdalegal.org	3/2/2022 6:40:19 PM	SENT
Karen L.Loewy		kloewy@lamdalegal.org	3/2/2022 6:40:19 PM	SENT

Associated Case Party: GREG ABBOTT GOVERNOR OF TEXAS

Name

Automated Certificate of eService

This automated certificate of service was created by the efiling system. The filer served this document via email generated by the efiling system on the date and to the persons listed below. The rules governing certificates of service have not changed. Filers must still provide a certificate of service that complies with all applicable rules.

Katrina Shanks on behalf of Ryan Kercher
Bar No. 24060998
katrina.shanks@oag.texas.gov
Envelope ID: 62246361
Status as of 3/3/2022 2:05 PM CST

Associated Case Party: GREG ABBOTT GOVERNOR OF TEXAS

Ryan Kercher		ryan.kercher@oag.texas.gov	3/2/2022 6:40:19 PM	SENT

Associated Case Party: JOHN DOE

Name	BarNumber	Email	TimestampSubmitted	Status
Omar Gonzalez-Pagan		Ogonzalez-pagan@lamdalegal.org	3/2/2022 6:40:19 PM	SENT
Derek McDonald		Derek.mcdonald@bakerbotts.com	3/2/2022 6:40:19 PM	SENT
Maddy Dwertman		Maddy.dwertman@bakerbotts.com	3/2/2022 6:40:19 PM	SENT
Paul Castillo		pcastillo@lamdalegal.org	3/2/2022 6:40:19 PM	SENT
Camilla Taylor		ctaylor@lamdalegal.org	3/2/2022 6:40:19 PM	SENT
M. curry Cook		ccook@lamdalegal.org	3/2/2022 6:40:19 PM	SENT

Automated Certificate of eService

This automated certificate of service was created by the efiling system. The filer served this document via email generated by the efiling system on the date and to the persons listed below. The rules governing certificates of service have not changed. Filers must still provide a certificate of service that complies with all applicable rules.

Katrina Shanks on behalf of Ryan Kercher
Bar No. 24060998
katrina.shanks@oag.texas.gov
Envelope ID: 62282300
Status as of 3/3/2022 4:17 PM CST

Case Contacts

Name	BarNumber	Email	TimestampSubmitted	Status
Ryan Kercher		ryan.kercher@oag.texas.gov	3/3/2022 3:58:43 PM	SENT
Brian Klosterboer	24107833	bklosterboer@aclutx.org	3/3/2022 3:58:43 PM	SENT
Andre Segura	24107112	asegura@aclutx.org	3/3/2022 3:58:43 PM	SENT
Chase Strangio		cstrangio@aclu.org	3/3/2022 3:58:43 PM	SENT
Derek Raymond McDonald	786101	derek.mcdonald@bakerbotts.com	3/3/2022 3:58:43 PM	SENT
Paul Castillo	24049461	pcastillo@lambdalegal.org	3/3/2022 3:58:43 PM	SENT
Shelly L. Skeen	24010511	slskeen@gmail.com	3/3/2022 3:58:43 PM	SENT
Nicholas GuillyGuillory		nguillory@lambdalegal.org	3/3/2022 3:58:43 PM	SENT
James Esseks		jesseks@aclu.org	3/3/2022 3:58:43 PM	SENT
Anjana Samant		asamant@acclu.org	3/3/2022 3:58:43 PM	SENT
Kath Xu		kxu@aclu.org	3/3/2022 3:58:43 PM	SENT
Karen L.Loewy		kloewy@lamdalegal.org	3/3/2022 3:58:43 PM	SENT
Omar Gonzalez-Pagan		Ogonzalez-pagan@lamdalegal.org	3/3/2022 3:58:43 PM	SENT
Camilla Taylor		ctaylor@lamdalegal.org	3/3/2022 3:58:43 PM	SENT
Maddy Dwertman		Maddy.dwertman@bakerbotts.com	3/3/2022 3:58:43 PM	SENT
M. curry Cook		ccook@lamdalegal.org	3/3/2022 3:58:43 PM	SENT

Appendix E

Filed in The District Court
of Travis County, Texas
MAR 11 2022
At 5:24 P.M.
Velva L. Price, District Clerk

CAUSE NO. D-1-GN-22-000977

JANE DOE, individually and as parent and next friend of MARY DOE, a minor; JOHN DOE, individually and as parent and next friend of MARY DOE, a minor; and DR. MEGAN MOONEY	§	
Plaintiffs	§	
	§	IN THE DISTRICT COURT OF TRAVIS COUNTY, TEXAS 353RD JUDICIAL DISTRICT
v.	§	
GREG ABBOTT, sued in his official capacity as Governor of the State of Texas; JAIME MASTERS, sued in her official capacity as Commissioner of the Texas Department of Family and Protective Services; and the TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES,	§	
Defendants.	§	

ORDER GRANTING PLAINTIFFS' APPLICATION FOR TEMPORARY INJUNCTION

On this day the Court considered the application by Plaintiffs John and Jane Doe, individually and as parents and next friends of Plaintiff Mary Doe, a minor, and Dr. Megan Mooney (collectively, "Plaintiffs") for a Temporary Injunction (the "Application"), as found in Plaintiffs' Petition and Application for Temporary Restraining Order, Temporary Injunction, and Permanent Injunction, and Request for Declaratory Relief ("Petition") filed against Defendants Greg Abbott, in his official capacity as Governor of the State of Texas, Jaime Masters, in her official capacity as Commissioner of the Texas Department of Family and Protective Services, and the Texas Department of Family and Protective Services ("DFPS") (collectively, "Defendants").

Based on the facts set forth in Plaintiffs' Application, the supporting declarations, the testimony, the evidence, and the arguments of counsel presented during the March 11, 2022, hearing on Plaintiffs' Application, this Court finds sufficient cause to enter a Temporary Injunction. Plaintiffs state a valid cause of action against each Defendant and have a probable right to the declaratory and permanent injunctive relief they seek. For the reasons detailed in Plaintiffs' Application and accompanying evidence, there is a substantial likelihood that Plaintiffs will prevail after a trial on the merits because the Governor's directive is *ultra vires*, beyond the scope of his authority, and unconstitutional. The improper rulemaking and implementation by Commissioner Masters and DFPS are similarly void.

The Court further finds that gender-affirming care was not investigated as child abuse by DFPS until after February 22, 2022. The series of directives and decisions by the Governor, the Executive Director, and other decision-makers at DFPS, changed the *status quo* for transgender children and their families, as well as professionals who offer treatment, throughout the State of Texas. The Governor's Directive was given the effect of a new law or new agency rule, despite no new legislation, regulation or even stated agency policy. Governor Abbott and Commissioner Masters' actions violate separation of powers by impermissibly encroaching into the legislative domain.

It clearly appears to the Court that unless Defendants are immediately enjoined from enforcing the Governor's directive and the DFPS rule enforcing that directive, both issued February 22, 2022, and which make reference to and incorporate Attorney General Paxton's Opinion No. KP-0401, Plaintiffs will suffer imminent and irreparable injury. For example, Jane Doe has already been placed on administrative leave at work and is at risk of losing her job, her livelihood, and the means of caring for her family. Jane, John and Mary Doe face the imminent

and ongoing deprivation of their constitutional rights and the stigma attached to being the subject of a child abuse investigation. Mary faces the potential loss of medically necessary care, which if abruptly discontinued can cause severe and irreparable physical and emotional harms, including anxiety, depression, and suicidality. If placed on the Child Abuse Registry, Jane Doe would lose the ability to practice her profession, and both Jane and John Doe would lose their ability to work with minors and volunteer in their community. Absent intervention by this court, Dr. Mooney could face civil suit by patients for failing to treat them in accordance with professional standards and loss of licensure for failing to follow her professional ethics if Defendants' directives are enforced. If Defendants' directives remain in effect, Dr. Mooney will be required to report her patients who are receiving medically necessary gender-affirming care, in contravention of the code of ethics governing her profession and the medical needs of her patients. If Dr. Mooney does not report her patients, she could face immediate criminal prosecution, as set forth in the Governor's letter. Defendants' wrongful actions cannot be remedied by any award of damages or other adequate remedy at law.

The Temporary Injunction being entered by the Court today maintains the status quo prior to February 22, 2022, and should remain in effect while this Court, and potentially the Court of Appeals, and the Supreme Court of Texas, examine the parties' merits and jurisdictional arguments.

IT IS THEREFORE ORDERED that, until all issues in this lawsuit are finally and fully determined, Defendants are immediately enjoined and restrained from enforcing the Governor's directive and DFPS rule, both issued February 22, 2022, as well as Attorney General Paxton's Opinion No. KP-0401 which they reference and incorporate. This Temporary Injunction Restrains ~~retrains~~ the following actions by the Defendants: (1) taking any actions against Plaintiffs based on

the Governor's directive and DFPS rule, both issued February 22, 2022, as well as Attorney General Paxton's Opinion No. KP-0401 which they reference and incorporate; (2) investigating reports in the State of Texas against any and all persons based solely on alleged child abuse by persons, providers or organizations in facilitating or providing gender-affirming care to transgender minors where the only grounds for the purported abuse or neglect are either the facilitation or provision of gender-affirming medical treatment or the fact that the minors are transgender, gender transitioning, or receiving or being prescribed gender-affirming medical treatment; (3) prosecuting or referring for prosecution such reports; and (4) imposing reporting requirements on persons in the State of Texas who are aware of others who facilitate or provide gender-affirming care to transgender minors solely based on the fact that the minors are transgender, gender transitioning, or receiving or being prescribed gender-affirming medical treatment.

IT IS FURTHER ORDERED that a trial on the merits of this case is July 11, 2022. The Clerk of the Court is hereby directed to issue a show cause notice to Defendants to appear at the trial.

The Clerk of the Court shall forthwith, on filing by Plaintiffs of the Bond hereinafter required, and on proving of the same according to law, issue a temporary injunction in conformity with the laws and terms of this Order.

Plaintiffs have previously executed and filed with the Clerk a bond in conformity with the law in the amount of $100 dollars, and that bond amount will remain adequate and effective for this Temporary Injunction.

It is further ORDERED that this Order shall not expire until judgment in this case is entered or this Case is otherwise dismissed by the Court.

Signed this 11th day of March 2022, at 5:22 P.M o'clock in Travis County, Texas.

JUDGE AMY CLARK MEACHUM

Appendix F

Filed In The District Court
of Travis County, Texas
MAR 11 2022
At 5:24 P.M.
Velva L. Price, District Clerk

NO. D-1-GN-22-000977

JANE DOE, ET AL., *Plaintiff*,	IN THE DISTRICT COURT OF
v.	TRAVIS COUNTY, TEXAS
GOVERNOR ABBOTT, ET AL., *Defendants*.	201st JUDICIAL DISTRICT

ORDER ~~GRANTING~~ DENYING PLEA TO THE JURISDICTION

On this day, the Court considered Defendants' Plea to the Jurisdiction. After due consideration, the Court finds said plea ~~meritorious.~~ Not FOUNDED AND without merit. DENIED.

IT IS THEREFORE ORDERED that Defendants' Plea to the Jurisdiction is ~~GRANTED~~.

~~IT IS FURTHER ORDERED that all of Plaintiffs' claims against Defendants are hereby~~ DISMISSED WITHOUT PREJUDICE in their entirety.

~~This is a FINAL JUDGMENT, and all relief not specifically granted is denied.~~

SIGNED this 11th day of MARCH, 2022.

HON. AMY CLARK MEACHUM
201st DISTRICT COURT JUDGE

Appendix G

3/11/2022 5:59 PM
Velva L. Price
District Clerk
Travis County
D-1-GN-22-000977
Selina Hamilton

No. D-1-GN-22-000977

Jane Doe, et al., *Plaintiff*, **v.** **Governor Abbott, et al.,** *Defendants*.	**In the District Court of** **Travis County, Texas** **201st Judicial District**

DEFENDANTS' NOTICE OF ACCELERATED INTERLOCUTORY APPEAL

Defendants Greg Abbott in his official capacity as Governor of the State of Texas ("Governor Abbott"), Jaime Masters in her official capacity of Commissioner of the Department of Family and Protective Services ("Commissioner Masters"), and the Texas Department of Family and Protective Services ("DFPS") (collectively, "Defendants") appeal the Court's interlocutory orders of March 11, 2022. Said Orders (1) denied Defendants' plea to the jurisdiction; and (2) granted Plaintiffs' request for a temporary injunction.

Defendants are entitled to an interlocutory appeal pursuant to Civil Practice and Remedies Code section 51.014(a)(4),(8), which allows for an immediate appeal from an order that denies a plea to the jurisdiction or grants a temporary injunction. Defendants appeal to the Third Court of Appeals. This is an accelerated appeal as provided by Texas Rule of Appellate Procedure 28.1. This is not a parental termination or child protection case, as defined in Rule 28.4.

Pursuant to Texas Civil Practice and Remedies Code § 51.014(b), all further proceedings in this court are stayed pending resolution of Defendants' appeal. Upon filing of this instrument, the March 11, 2022 Orders are superseded pursuant to Texas Civil Practice and Remedies Code section 6.001(b) and Texas Rule of Appellate Procedure 29.1(b). Pursuant to section 6.001, as governmental officers/entities, Defendants are not required to file a supersedeas bond for court

costs. Defendants' appeal is therefore perfected upon the filing of the notice of appeal.

Respectfully Submitted.

KEN PAXTON
Attorney General of Texas

BRENT WEBSTER
First Assistant Attorney General

GRANT DORFMAN
Deputy First Assistant Attorney General

SHAWN COWLES
Deputy Attorney General for Civil Litigation

CHRISTOPHER HILTON
Division Chief
General Litigation Division

/s/ Courtney Corbello
COURTNEY CORBELLO
Attorney-in-Charge
Assistant Attorney General
Texas State Bar No. 24097533
courtney.corbello@oag.texas.gov

General Litigation Division
Office of the Attorney General
P.O. Box 12548
Austin, Texas 78711-2548
(512) 463-2120 / Fax (512) 320-0667

ATTORNEYS FOR DEFENDANTS

CERTIFICATE OF SERVICE

I, **COURTNEY CORBELLO**, Assistant Attorney General of Texas, hereby certify that a true and correct copy of the foregoing document has been served electronically through the electronic-filing manager in compliance with TRCP 21a on March 11, 2022 to:

Brian Klosterboer

Brandt T. Roessler

Andre Segura
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF TEXAS
5225 Katy Fwy., Ste 350
Houston, TX 77007
Phone: 713-942-8146
bklosterboer@aclutx.org
asegura@aclutx.org

Chase Strangio
James Esseks
Anjana Samant
Kath Xu
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF TEXAS
125 Broad St, 18th Floor
New York, New York 10004
Phone: 917-345-1742
cstrangio@aclu.org
jesseks@aclu.org
asamant@aclu.org
kxu@aclu.org

Derek R. McDonald
Maddy R. Dwertman
BAKER BOTTS L.L.P.
98 San Jacinto Blvd, Ste 1500
Austin, Texas 78701-4078
Phone: 512-322-2500
Derek.mcdonald@bakerbotts.com
Maddy.dwertman@bakerbotts.com

Karen L. Loewy
LAMBDA LEGAL DEFENSE AND
EDUCATION FUND, INC.
1776 K Street, N.W., 8th Floor
Washington, DC 20006-2304
Phone: 202-804-6245
kloewy@lamdalegal.org

BAKER BOTTS L.L.P.
30 Rockerfeller Plaza
New York, New York 10112-4498
Phone: 212-408-2500
Brandt.roessler@bakerbotts.com
Pro hac vice forthcoming

Paul D. Castillo
Shelly L. Skeen
Nicholas "Guilly" Guillory
LAMBDA LEGAL DEFENSE AND
EDUCATION FUND, INC.
3500 Oak Lawn Ave., Unit 500
Dallas, Texas 75219
Phone: 214-219-8585
pcastillo@lambdalegal.org
sskeen@lambdalegal.org
nguillory@lamdalegal.org

Omar Gonzalez-Pagan
M. Curry Cook
LAMBDA LEGAL DEFENSE AND
EDUCATION FUND, INC.
120 Wall Street, 19th Floor
New York, New York 10005-3919
Phone: 212-809-8585
Ogonzalez-pagan@lambdalegal.org
ccook@lambdalegal.org

Camilla B. Taylor
LAMBDA LEGAL DEFENSE AND
EDUCATION FUND, INC.
65 E. Wacker Place, Ste 2000
Chicago, IL 60601-7245
Phone: 312-663-4413
ctaylor@lamdalegal.org

Counsel for Plaintiffs

/s/ Courtney Corbello
COURTNEY CORBELLO
Assistant Attorney General

Automated Certificate of eService

This automated certificate of service was created by the efiling system. The filer served this document via email generated by the efiling system on the date and to the persons listed below. The rules governing certificates of service have not changed. Filers must still provide a certificate of service that complies with all applicable rules.

Thomas Ray on behalf of Courtney Corbello
Bar No. 24097533
thomas.ray@oag.texas.gov
Envelope ID: 62554631
Status as of 3/14/2022 9:50 AM CST

Case Contacts

Name	BarNumber	Email	TimestampSubmitted	Status
Cynthia L.Saiter		csaiter@scottdoug.com	3/11/2022 5:59:10 PM	SENT
Kennon L.Wooten		kwooten@scottdoug.com	3/11/2022 5:59:10 PM	SENT
Ruth Adams		radams@scottdoug.com	3/11/2022 5:59:10 PM	SENT
Michelle Joyner		mjoyner@scottdoug.com	3/11/2022 5:59:10 PM	SENT
Katrina Shanks		katrina.shanks@oag.texas.gov	3/11/2022 5:59:10 PM	SENT

Associated Case Party: JANE DOE

Name
Raylynn Howell
Andre Segura
Chase Strangio
James Esseks
Brian Klosterboer
Anjana Samant
Kath Xu
Shelly Skeen
Nicholas Guillory
Karen L.Loewy
Nicholas Guillory
Karen Loewy
Omar Gonzalez-Pagan
Camilla Taylor
M. Currey Cook

Automated Certificate of eService

This automated certificate of service was created by the efiling system. The filer served this document via email generated by the efiling system on the date and to the persons listed below. The rules governing certificates of service have not changed. Filers must still provide a certificate of service that complies with all applicable rules.

Thomas Ray on behalf of Courtney Corbello
Bar No. 24097533
thomas.ray@oag.texas.gov
Envelope ID: 62554631
Status as of 3/14/2022 9:50 AM CST

Associated Case Party: JANE DOE

Paul Castillo		pcastillo@lambdalegal.org	3/11/2022 5:59:10 PM	SENT
Shelly Skeen		sskeen@lambdalegal.org	3/11/2022 5:59:10 PM	SENT
David Goode		david.goode@bakerbotts.com	3/11/2022 5:59:10 PM	SENT
Brandt Roessler		brandt.roessler@bakerbotts.com	3/11/2022 5:59:10 PM	SENT

Associated Case Party: GREG ABBOTT GOVERNOR OF TEXAS

Name	BarNumber	Email	TimestampSubmitted	Status
Judd Stone	24076720	judd.stone@oag.texas.gov	3/11/2022 5:59:10 PM	SENT
Thomas Ray		thomas.ray@oag.texas.gov	3/11/2022 5:59:10 PM	SENT
Ryan Kercher		ryan.kercher@oag.texas.gov	3/11/2022 5:59:10 PM	SENT
Courtney Corbello		courtney.corbello@oag.texas.gov	3/11/2022 5:59:10 PM	SENT
Ryan Kercher		Ryan.Kercher@oag.texas.gov	3/11/2022 5:59:10 PM	SENT

Associated Case Party: American Professional Society on the Abuse of Children

Name	BarNumber	Email	TimestampSubmitted	Status
Greg R.Wehrer		greg.wehrer@squirepb.com	3/11/2022 5:59:10 PM	SENT
Greg R.Wehrer		greg.wehrer@squirepb.com	3/11/2022 5:59:10 PM	SENT

Associated Case Party: JOHN DOE

Name
Camilla Taylor
Omar Gonzalez-Pagan
M. curry Cook

Automated Certificate of eService

This automated certificate of service was created by the efiling system. The filer served this document via email generated by the efiling system on the date and to the persons listed below. The rules governing certificates of service have not changed. Filers must still provide a certificate of service that complies with all applicable rules.

Thomas Ray on behalf of Courtney Corbello
Bar No. 24097533
thomas.ray@oag.texas.gov
Envelope ID: 62554631
Status as of 3/14/2022 9:50 AM CST

Associated Case Party: JOHN DOE

Derek McDonald		Derek.mcdonald@bakerbotts.com	3/11/2022 5:59:10 PM	SENT
Maddy Dwertman		Maddy.dwertman@bakerbotts.com	3/11/2022 5:59:10 PM	SENT
Paul Castillo		pcastillo@lamdalegal.org	3/11/2022 5:59:10 PM	SENT

Associated Case Party: TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES

Name	BarNumber	Email	TimestampSubmitted	Status
Ryan Kercher		Ryan.Kercher@oag.texas.gov	3/11/2022 5:59:10 PM	SENT

Appendix H

REPORTER'S RECORD
VOLUME 1 OF 3 VOLUMES
TRIAL COURT CAUSE NO. D-1-GN-22-000977

JANE DOE, ET AL., Plaintiffs,	)	IN THE DISTRICT COURT
VS.	)	TRAVIS COUNTY, TEXAS
GREG ABBOTT, ET EL., Defendants.	)	353RD JUDICIAL DISTRICT

HEARING ON MOTION FOR TEMPORARY INJUNCTION

AND PLEA TO THE JURISDICTION

MORNING SESSION

On the 11th day of March, 2022, the following proceedings came on to be heard in the above-entitled and numbered cause before the Honorable Amy Clark Meachum, Judge Presiding, held in Austin, Travis County, Texas:

Proceedings reported by machine shorthand.

1 **APPEARANCES**

2

3 **FOR THE PLAINTIFFS:**

4 **PAUL D. CASTILLO**
SBOT NO. 24049461
5 **SHELLY L. SKEEN**
SBOT NO. 24010511
6 LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
3500 Oak Lawn Avenue, Unit 500
7 Dallas, Texas 75219
Phone: (214) 219-8585
8
- AND -
9
BRIAN KLOSTERBOER
10 SBOT NO. 24107833
ANDRE SEGURA
11 SBOT NO. 24107112
AMERICAN CIVIL LIBERTIES UNION FOUNDATION OF TEXAS
12 5225 Katy Freeway, Suite 350
Houston, Texas 77007
13 Phone: (713) 942-8146

14 - AND -

15 **OMAR GONZALEZ-PAGAN**
PRO HAC VICE
16 LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
120 Wall Street, 19th Floor
17 New York, New York 10005
Phone: (212) 809-8585
18
- AND -
19
MADDY R. DWERTMAN
20 SBOT NO. 24092371
BAKER BOTTS L.L.P.
21 98 San Jacinto Boulevard, Suite 1500
Austin, Texas 78701
22 Phone: (512) 322-2500

23

24

25

1 **APPEARANCES CONTINUED**

2

3 **FOR THE DEFENDANTS:**

4 **COURTNEY CORBELLO**
SBOT NO. 24097533
5 TEXAS ATTORNEY GENERAL
P.O. Box 12548
6 Austin, Texas 78711
Phone: (512) 463-2120
7

8

9 ALSO PRESENT: HOLT LACKEY, ATTORNEY FOR RANDA MULANAX

10 IAN PITTMAN, ATTORNEY FOR JANE DOE

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

INDEX

VOLUME 1

HEARING ON MOTION FOR TEMPORARY INJUNCTION AND PLEA TO THE JURISDICTION

MORNING SESSION

MARCH 11, 2022

	Page	Vol.
Announcements.....	7	1
Opening Statement by Mr. Castillo.....	11	1
Opening Statement by Ms. Corbello.....	12	1

PLAINTIFFS' WITNESSES

	Direct	Cross	Vol.
RANDA MULANAX			
By Mr. Castillo	17		1
By Ms. Corbello		59	1
JANE DOE			
By Mr. Gonzalez-Pagan	82		1
By Ms. Corbello		99	1

	Page	Vol.
Lunch Recess.....	143	1
Court Reporter's Certificate.....	144	1

1 **ALPHABETICAL WITNESS INDEX**

2

	Direct	Cross	Vol.
3			
4 **DOE, JANE**			
By Mr. Gonzalez-Pagan	82		1
5 By Ms. Corbello		99	1
6 **RANDA MULANAX**			
By Mr. Castillo	17		1
7 By Ms. Corbello		59	1

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

1 **EXHIBIT INDEX**

2

3 **PLAINTIFFS'**

NO.	DESCRIPTION	OFFER	ADMIT	VOL.
1	Texas Attorney General Opinion No. KP-0401	28	28	1
2	Governor Abbott Letter to Commissioner Jaime Masters	29	29	1
3	Commissioner Masters Statement to Governor's Letter/AG Opinion	31	31	1
11	Dallas Morning News Article	56	58	1
15	CPS Handbook Sections 1200-1245	21	21	1
16	CPS Handbook Sections 2140-2157	22	22	1
17	Agenda for Leadership Meeting 02-24-2022	41	41	1
18	Mulanax Resignation Letter	55	55	1

1 THE COURT: This is GN-22-977, Jane Doe,
2 et al. vs. Greg Abbott, et al. This is Judge Amy Clark
3 Meachum presiding. It is March 11th, 2022, and we are
4 here today for the temporary injunction set by last
5 week's TRO. From the outset, let's go ahead and go
6 through who's here, who are the lawyers, and who you're
7 representing.
8 MR. CASTILLO: Good morning, Your Honor,
9 Paul Castillo with Lamda Legal representing the
10 plaintiffs.
11 MX. DWERTMAN: Good morning, Your Honor.
12 THE COURT: Oh, up.
13 MX. DWERTMAN: Good morning, Your Honor.
14 Maddy Dwertman, Baker Botts, also representing
15 plaintiffs.
16 THE COURT: Thank you.
17 MR. KLOSTERBOER: Good morning, Your
18 Honor. Brian Klosterboer with the ACLU of Texas for
19 the plaintiffs.
20 THE COURT: And if -- those are the
21 speaking parts. But if we have other people who might
22 be speaking, we need to go ahead and take their
23 announcements as well.
24 MR. SEGURA: Good morning, Your Honor.
25 Andre Segura for the plaintiffs.

1 MS. SKEEN: Good morning, Your Honor.
2 Shelly Skeen for the plaintiffs.
3 MR. GONZALEZ-PAGAN: Good morning, Your
4 Honor. Omar Gonzalez-Pagan --
5 THE REPORTER: I'm sorry. I can't hear.
6 THE COURT: We cannot hear that. That's
7 what I'm -- yes. If you want to either speak up or
8 come to the microphone and speak.
9 MR. GONZALEZ-PAGAN: Good morning, Your
10 Honor. I'm Omar Gonzalez-Pagan for the plaintiffs.
11 I'm an out-of-state attorney; however, we will need to
12 act on my *pro hac* before.
13 THE COURT: Thank you. All right. Then
14 the first bit of business we will do are *pro hac vice*
15 motions. Any *pro hac vice* motions pending before the
16 Court and proposed orders that you want to handle --
17 hand to the Court to sign off on?
18 MR. CASTILLO: Yes, Your Honor, if I may
19 approach?
20 THE COURT: Yes. This is
21 Mr. Gonzalez-Pagan's motion for admission *pro hac vice*,
22 correct?
23 MR. CASTILLO: That is correct.
24 THE COURT: His -- his fee has been paid?
25 MR. CASTILLO: It has, Your Honor.

1 statement from DFPS, what was your reaction?
2 A. Personally, I was upset. I felt like this was
3 an overreach, and it was placing us in a situation the
4 Department should not be in, in being private, medical
5 decisions between parents, a child, and doctors, and we
6 are not qualified to say that, you know, statements
7 from a doctor and psychiatrist and other medical
8 professionals is not correct.
9 Q. What is -- the last sentence of this statement
10 reads, If any such allegations are reported to us, they
11 will be investigated under existing policies of child
12 protective investigations? What does that mean to you?
13 A. To me, that means that they would be treated
14 the same way that any other intakes or reports would be
15 treated.
16 Q. Did this policy -- or did this statement
17 change anything for DFPS?
18 A. In a way, yes.
19 Q. And in what way is that?
20 A. My perception is that these intakes are not
21 being treated the same as every other case that we
22 receive.
23 MS. CORBELLO: Your Honor, I'm going to
24 object. Again, she's not qualified, nor does she have
25 foundation to testify how the Department is handling

1 these investigations as a whole, only as to herself.
2 MR. KLOSTERBOER: We can still lay more
3 foundation.
4 THE COURT: No. I -- what is your
5 intention in calling this witness? Are you calling her
6 as a Department representative, or are you calling her
7 as -- in her individual capacity? What is the
8 plaintiffs' position on their calling of this witness?
9 MR. KLOSTERBOER: She's testifying in her
10 individual capacity.
11 THE COURT: Then that's overruled.
12 MS. CORBELLO: Thank you, Your Honor.
13 Q. (BY MR. KLOSTERBOER) What happened -- so the
14 letter and statement came out February 22nd. What
15 happened in the days following that?
16 A. To my knowledge, reports started to come in
17 within Region 7.
18 Q. Did you all have any meetings --
19 THE COURT: What is Region 7?
20 THE WITNESS: Region 7 is the central
21 area of the Department of Family and Protective
22 Services. It encompasses a lot of counties. I don't
23 remember all of them, but it's -- I'm -- most of them
24 are Travis, Williamson, Hays, Bell.
25 THE COURT: Thank you. I just...

1 messages, we were to use the term "speci-" -- "specific
2 cases" and not discuss them through anything, other
3 than Teams or phone calls.
4 Q. Were there any parts of that meeting that you
5 did hear any directives or information about the
6 statement, this directive?
7 A. That we had to be investigating these cases.
8 Q. And what does that mean to you, that you had
9 to be investigating these cases?
10 A. We cannot Priority None these cases or PN
11 these cases, which was where I feel the unequal
12 treatment is coming in. If they are supposed to be
13 treated like every other investigation, we should be
14 able to make calls, assess if any child abuse or
15 neglect is likely to be occurring, and close them out.
16 MS. CORBELLO: Your Honor, I'm going to
17 object. This is now speculation based on a hearsay
18 statement, not what was said to her. Counsel asked
19 what was meant.
20 THE COURT: No. Sustained. I think you
21 need to break up the question.
22 Q. (BY MR. KLOSTERBOER) What were you told
23 specifically about the prioritization of these cases?
24 A. So I have been told about that directly
25 outside of that meeting, that we cannot Priority None

1 danger, and that the Department needs to respond
2 immediately to ensure child safety.
3 THE COURT: And -- and Priority 2 is
4 what?
5 THE WITNESS: Priority 2 could be that
6 while, you know, there may have been an incident, that
7 there is no immediate danger, but that the Department
8 needs to look to assess ongoing safety.
9 THE COURT: And then Priority None is
10 what?
11 THE WITNESS: Priority None means that it
12 is either, like, not likely that a child is being
13 abused or neglected or will be abused or neglected in
14 the foreseeable future, that it is not within the
15 authority of the Department to investigate, or that --
16 I'm sorry. I'm blanking -- or that it has already been
17 investigated. Sorry, Your Honor.
18 THE COURT: Continue.
19 MR. KLOSTERBOER: Thank you.
20 Q. (BY MR. KLOSTERBOER) When you said that
21 someone told you that you were not allowed to Priority
22 None these cases, what -- what else did -- did they
23 say?
24 A. That they also -- sorry. We cannot Priority
25 None these cases, and they are also not eligible for

1 alternative response. Alternative response is another
2 area of investigations that operates a little bit
3 differently. It's a little less -- well, a little less
4 invasive. They hold meetings with the families, and no
5 dispositions are assigned at the end of the case.
6 Q. So going back to the meeting that you said
7 happened on February 24th, you said that you came in a
8 little bit late or joined the -- the -- the meeting
9 late. But were there any notes or emails after the
10 meeting?
11 A. Yes, there were.
12 Q. And did you bring a copy of any of those
13 today?
14 A. My attorney did.
15 MR. KLOSTERBOER: Your Honor, we --
16 plaintiffs have not seen this either until this
17 morning, and it was provided to defense counsel, as
18 well, the document that --
19 THE COURT: And I believe Mr. Lackey has
20 provided it to me as well. I think I have these small
21 number, or is there more than this?
22 MR. LACKEY: Correct, Your Honor. There
23 are two documents, and I have 17 additional copies of
24 each, if they need to be published more widely.
25 THE COURT: So you need to mark these?

A. If I were to receive any of these cases, I was to not discuss them through email, text, or anything. I was not to use anything specific in email that could be pulled by media if requested.

Q. And -- and you're almost six years working at CPS. Had you ever been explicitly told not to put information about cases in writing?

A. No.

Q. And even when cases of abuse and neglect involved very serious and sensitive allegations, would you all still use email and texts to talk about those cases?

A. Yes, we do.

Q. What did you make of the instructions to not put anything in writing?

A. Seemed very unethical.

Q. And you mentioned that you were also told that you have to keep these cases open. What -- what -- what exactly were you told upfront?

A. Just that we cannot Priority None them, so we had to initiate an investigation.

Q. And can you tell if they were -- when they're talking about this type of case in this meeting, what type of case were they talking about?

A. The cases of gender-affirming care.

1 with me, us coming together with the families to see
2 what solutions we could come up with, or if there's any
3 reason for safety interventions, and then kind of go
4 about the case.
5 Q. You testified that before February 22nd, you
6 weren't personally aware of any cases involving the --
7 the medical -- specific allegations of the medical care
8 of transgender youth. About how many cases are you
9 aware of now?
10 A. I know of three within our region. The last
11 update I think that I saw was maybe seven cases across
12 the state.
13 Q. And how many regions are there in Texas?
14 A. Technically 12, but one of them -- the 12th
15 one is just state office, so that's located within
16 Region 7, so 11.
17 Q. Now, you said that you've heard that there
18 might be up to seven cases statewide?
19 A. I believe so. I believe that's what I saw in
20 a news article.
21 Q. We actually have a copy of a news article.
22 That's Exhibit 11. We'll come back to that.
23 When you were told that you had to
24 consult with some of the senior leadership of DFPS, did
25 that also include consulting with any attorneys?

A. Yes. I believe that they wanted us to staff -- I'm sorry. I believe they wanted us to staff with our general counsel on ongoing -- these cases as well to see how we needed to proceed, just based on the current state of everything.

Q. Were you -- so you've been -- were you told that you have to consult with a general counsel on these types of cases?

A. Yes.

Q. Had that been a requirement for your other cases?

A. No.

Q. Are these -- are these cases -- has CPS changed -- or let me -- you talked a little bit about the alternative response. Would that often be used for -- in a more therapeutic or less harmful way for families?

A. Yes.

Q. And what would that look like again?

A. So those cases, they typically contact the parents ahead of time, arrange a meeting with the family, and typically do not do interviews separately, like I said, unless something were to come up later in the case where they felt that there were significant concerns where interviews would need to be done

1 not be one to make any changes to anything.
2 Q. (BY MR. KLOSTERBOER) And do you consider
3 being told that you are not allowed to Priority None
4 these cases, you can't -- they can't go to alternative
5 response, they can't be closed, you can't put anything
6 in writing, do you consider that to be a change in DFPS
7 policy?
8 A. Yes.
9 Q. What could happen to the families that are
10 currently being investigated by DFPS?
11 MS. CORBELLO: Objection; speculation,
12 lack of foundation. She hasn't testified that she
13 knows anything about these investigations.
14 THE COURT: As the question was asked, I
15 will sustain that objection.
16 MR. KLOSTERBOER: Withdrawn, Your Honor.
17 Q. (BY MR. KLOSTERBOER) What's going to come
18 next for you personally?
19 A. I have resigned from the Department. My last
20 day will be the 31st of this month.
21 Q. What led you to resign?
22 A. This is a very stressful job overall, but I've
23 been with the Department for, like I said, almost six
24 years, so I've been here through a lot of highs and
25 lows. And through all of the stresses and challenges

1 that you face with this job, I have always felt that at
2 the end of the day, the Department has children's best
3 interest at heart and family's best interest at heart,
4 and I no longer feel that way with this order.
5 Even though overall investigations is
6 there to ensure child safety, this has -- it's -- it's
7 just -- it -- it feels unethical. It feels like we are
8 stepping into a dangerous territory of interfering with
9 parents and medical providers on care for their
10 children. I see this leading down a slippery slope of
11 what would be next, what other medical decisions or
12 private decisions would the government now try to
13 interfere with.
14 And I see no end -- I see no really end
15 goal for these cases. Investigations is to ensure a
16 child is being cared for, loved, and safe in their
17 home. If they're not, then we either see if we could
18 offer the family services, or we remove a child from
19 their home.
20 And I don't see -- if it were -- you
21 know, we would refer to medical providers for their
22 opinions. We would refer to psychiatrists, doctors,
23 pediatricians -- like pediatricians, professionals who
24 are experienced in these fields. If they've already
25 recommended these treatments, it is not our position to

1 step in and say that they are incorrect.
2 Q. And you also brought with you to the Court
3 today the resignation letter that you submitted on
4 March 9th to DFPS?
5 A. My attorney did, yes.
6 MR. KLOSTERBOER: Your Honor, may I
7 approach?
8 THE COURT: Yes.
9 Q. (BY MR. KLOSTERBOER) Is this a -- a true and
10 correct copy of the letter that you sent to your
11 supervisors?
12 A. Yes.
13 MR. KLOSTERBOER: Your Honor, plaintiffs
14 move to admit this letter as Exhibit 18.
15 MS. CORBELLO: Your Honor, we object to
16 the admission of this exhibit based on hearsay.
17 THE COURT: Overruled. 18's admitted.
18 *(Plaintiffs' Exhibit 18 admitted.)*
19 Q. (BY MR. KLOSTERBOER) And one final thing.
20 You also testified that -- that you have personal
21 knowledge of at least three investigations going on in
22 your region involving transgender young people and the
23 medical care they receive?
24 A. Yes.
25 Q. And you said you've read news articles about

1 MS. CORBELLO: Correct, Your Honor.
2 MR. GONZALEZ-PAGAN: Your Honor --
3 THE COURT: Then understood.
4 MR. GONZALEZ-PAGAN: -- if I may, I'll
5 just quickly note for the record, there's an agreed
6 upon protective order not to disclose in any way the
7 identities of the Doe plaintiffs.
8 THE COURT: Thank you. I -- I didn't
9 hear an objection as to today's proceedings. She was
10 just making a statement on the record as to some sort
11 of future possibility.
12 MR. GONZALEZ-PAGAN: Thank you, Your
13 Honor.
14 THE COURT: So you may proceed.
15 Q. (BY MR. GONZALEZ-PAGAN) Ms. Doe, do you live
16 in Texas?
17 A. Yes.
18 Q. Are you over 18 years of age?
19 A. Yes.
20 Q. Do you know any of the other plaintiffs in
21 this case?
22 A. My family.
23 Q. Who is your family?
24 A. John Doe is my husband, and Mary Doe is my
25 daughter.

1 you were being placed on administrative leave?
2 A. I was contacted by my boss' boss.
3 Q. What did your -- and -- and your boss' boss,
4 you mean somebody in an administrative capacity at
5 DFPS; is that right?
6 A. Correct. Uh-huh.
7 Q. What did your boss' boss state to you?
8 A. That she was very sorry, but that -- and she
9 didn't agree with the policy, but that -- you know,
10 that I would unfortunately have to be investigated.
11 And during my investigation, I would be on paid
12 administrative leave.
13 Q. You made reference to a policy. What policy
14 is that?
15 A. I mean, we don't have a policy, but -- but it
16 did -- the Paxton opinion and Abbott's letter.
17 Q. What do you understand the Governor's letter
18 to do?
19 A. To -- it's to investigate families who have
20 transgender children who may be receiving care.
21 Q. So February 23rd, you were informed that you
22 were being placed on leave and would be under
23 investigation; is that correct?
24 A. Correct.
25 Q. You referenced an opinion by Attorney General

1 Paxton and a letter by Governor Abbott. How did you
2 come to learn about these directives?
3 A. Just on my own reading the news.
4 Q. What were your impressions with regards to
5 this opinion and letter?
6 A. I was really concerned as a parent about
7 how -- what this would mean for my family and for my
8 daughter, as well as what it would mean for -- you
9 know, how I'd be able to do my job.
10 Q. You just noted that you were concerned about
11 how these would affect how you would go about your job.
12 Did you talk to anybody about what this would mean for
13 your job?
14 A. Yes.
15 Q. With whom did you speak?
16 A. My supervisor.
17 Q. When did you have contact with your -- your
18 supervisor?
19 A. On the 23rd.
20 Q. What were you informed at that point in time?
21 A. That she was unaware of any policy, and that
22 she would reach out to other people and let me know.
23 Q. Were you placed on leave thereafter?
24 A. Yes.
25 Q. How long thereafter?

1 A. A couple hours. Less than six hours.
2 Q. Had you previously spoken with your supervisor
3 about the Department's approach to gender-affirming
4 care?
5 A. What do you mean by that?
6 Q. Prior to February 23rd, had you spoken with
7 your supervisor about how the Department would
8 investigate reports of the provision of
9 gender-affirming care?
10 A. So yes, I had. I had spoken to her on the
11 22nd, you know, about the Paxton opinion prior to the
12 Abbott letter -- you know, prior to me knowing about
13 the Abbott letter. So I contacted her about the Paxton
14 opinion, and she had heard absolutely nothing. She had
15 had a supervisor meeting the prior week. It was not
16 discussed.
17 Q. Did you learn anything else from your
18 supervisor when you contacted her on February 22nd
19 about the Paxton opinion?
20 A. Yes. She said, Oh, that's very weird. We got
21 a -- you know, there was a report that had been, you
22 know, made about gender-affirming care, and it was
23 deemed a CNR, so clearly not reportable.
24 Q. And that was affirmed to you on February 22nd
25 prior to the issuance of the Abbott letter?

1 A. Correct.
2 THE COURT: Can you refresh me on what a
3 CNR is?
4 THE WITNESS: That means "clearly not
5 reportable," which means that it does not go out for
6 investigation.
7 Q. (BY MR. GONZALEZ-PAGAN) Prior to
8 February 22nd, had you spoken to your supervisor or
9 anybody else at DFPS regarding it -- the Department's
10 approach to investigations of gender-affirming care?
11 A. No.
12 Q. And are you currently on leave pending the
13 outcome of the Agency's investigation?
14 A. Yes.
15 Q. What happened after you were placed under
16 investigation?
17 A. After I was told that this would happen?
18 Q. Yes.
19 A. I was completely shocked. Like, I had no idea
20 this was going to happen. I had just been asking about
21 policy. I was -- I was contacted -- I was contacted
22 the fol- -- the following day by an investigator, who
23 said that he was very sorry, and that I would have to
24 be investigated, and that they'd be coming to my home.
25 And then the following day, which was

1 the -- on -- on that Friday, whether -- I think that
2 was the 25th, the investigator came to my home.
3 Q. What happened when the investigator came into
4 your home on February 25th?
5 A. John and I had gotten counsel, so we had an
6 attorney there for us, and then we also had an attorney
7 for Mary. So we gave information; you know, we
8 answered just basic information to the investigator and
9 then referred him to our attorneys for any other
10 information.
11 Q. Did the investigator tell you why you were
12 being placed under investigation?
13 A. Yes.
14 Q. What is your understanding of the allegations
15 against you?
16 A. The allegations were two sentences. I don't
17 remember what -- exactly what they said, but it was
18 that -- you know, that we have a daughter who was born
19 male and is, quote, transitioning to female, and that
20 she may be receiving gender-affirming care, and that
21 was it.
22 Q. Is Mary Doe transgender?
23 A. Yes.
24 Q. Prior to being placed on inves- -- on
25 investigation on February 23rd, did anybody at DFPS

1 know that your daughter is transgender?
2 A. Just a couple of people. My supervisor and
3 just a couple of close friends. I wasn't hiding. It
4 just wasn't, you know -- just didn't talk about it.
5 Just wasn't relevant.
6 Q. How long ago prior to February 23rd did your
7 supervisor and a handful of other folks know that your
8 daughter was transgender?
9 A. I would say shortly -- I guess always. I
10 mean, I've been open, like -- maybe a year or so, I
11 guess, I should say.
12 Q. As a DFPS employee, based on your own
13 experience, are DFPS employees mandatory reporters?
14 A. Yes.
15 Q. Prior to February 23rd, had you ever been
16 reported or investigated for child abuse?
17 A. No.
18 Q. The allegations said that your daughter may be
19 receiving care. Has your daughter been prescribed
20 gender-affirming care?
21 A. Yes.
22 Q. And this has been by medical professionals?
23 A. Correct.
24 Q. Was this known to your supervisor?
25 A. Yes.

1 Q. Since you were placed on leave and had an
2 investigation started against you, your family, what
3 has been your reaction to this chain of events?
4 A. Like complete disbelief. It's just like --
5 it -- it -- it doesn't seem real. Just terrified
6 for -- just want to protect my child and -- I don't
7 know. I'm sorry. I just -- like, I don't have words
8 for -- for how unbelievably awful this situation has
9 been, like to not -- like, I don't have -- I don't have
10 my job. I don't have, you know, the sense of security
11 and privacy; like living in a constant state of fear
12 basically. It's been absolutely awful.
13 Q. Is Mary Doe aware of this investigation?
14 A. Yes.
15 Q. Is she aware of Governor Abbott's letter?
16 A. Yes.
17 Q. As a parent, what has been your observation of
18 how this has affected Mary Doe?
19 A. So she found out about the letter on her own
20 at school, and she just -- she read a news article and
21 was very upset. She didn't know anything about us
22 or -- or my situation or what was going to happen to
23 us, but she just -- upon, like, hearing about this
24 letter, she had a lot of questions, and she was very
25 scared. John and I reassured her, like, you know, we

1 will figure it out. Don't worry about it; like you're
2 fine.
3 And then -- so the day progressed, and I
4 was put on leave, and told about this investigation.
5 And by the time she got home from her after-school
6 activities, you know, life looked very different. You
7 know, we have never -- we have raised her, you know, to
8 be confident and secure in, like, our love for her,
9 that we will never let anything happen to her. We
10 trust her. We affirm her. We believe her. She's very
11 secure and loved.
12 That said, she didn't have, you know, a
13 reaction that some kids might have of complete panic,
14 but it -- she's definitely had issues. And I hate that
15 I'm having to talk about this, because it's nobody's
16 business. But she thought that she was going to be
17 taken away from us. She thought that she would have to
18 go live with -- you know, with her grandparents.
19 She is, you know, an honor roll student.
20 She started just, like, not wanting to go to school.
21 She's doing more counseling. She's never had, you
22 know, severe anxiety like a lot of trans kids have.
23 She's -- you know, but she's -- she's definitely, like,
24 anxious and moody, and I don't blame her.
25 Q. As a parent, what is your reaction to

observing that change in mood and behavior from Mary?

A. It's heartbreaking, and I'm so -- I feel powerless to -- it's like -- it's just so unbelievable that we're even here, that this is happening, like -- I'm sorry. You know, we just -- she thinks this is her fault, and it's not. She didn't do anything wrong. We didn't do anything wrong. But I think it's hard to convince a 16-year old, that, you know, this -- that this stress and this pain that -- that everyone's going through, you know, she -- she really does, I think, feel like she's done something wrong.

Q. What effect has this investigation and being placed on leave, as a result, caused to you and your husband?

A. We're just in constant fear. I mean, this is -- you know, Texas is the only home that Mary's ever known. You know, we've lived here a long time. We have a wonderful community here, loving, supportive friends and family, and, you know, I don't want to leave. We don't -- we don't want to leave, but that is something that we have talked about, that we might have to leave.

Q. As parents, what is it that you and John want for Mary?

A. To be happy and healthy and just live her life

1 the way -- the way that she wants to. We've raised her
2 to, you know, just look out for others and to be, you
3 know -- I'm sorry. I...
4 Q. What was your goal in seeking medical advice
5 about whether Mary necessitated gender-affirming care?
6 A. What was our goal?
7 Q. Yes.
8 A. Was to affirm her so -- you know, and follow
9 medical directives, we believe her, and -- you know,
10 it's not something that we took lightly or into our own
11 hands. It's like in consultation with professionals
12 and people who have known her a long time. It wasn't,
13 you know, a decision made lightly, but it's, you
14 know...
15 Q. What do you all want to achieve with this
16 case?
17 A. Again, I hate that I'm here. I'm not here for
18 any reason other than I don't know what else to do.
19 The way I understand it is that even if this particular
20 investigation that we are currently, you know, facing,
21 even if that's closed, that doesn't stop more and more
22 and more and more reports from coming in. Like, this
23 is not going to end. This will be a continuance
24 disruption of my family's life. We will be living in
25 fear until we decide to leave. Right? So that's the

1 know, life sustaining, then -- then that would go out
2 for investigation, right, as -- as someone who is --
3 you know, that the parents are not providing that
4 needed care. And in terms of just a -- a child taking
5 medication? No, I don't know of any cases of a
6 child -- like, you know, it's not something that's
7 asked, you know -- no, I don't -- I don't know of any.
8 Q. You referred that the investigator on
9 February 25th showed up at your home and investigated
10 and interviewed you and John. Was Mary also
11 interviewed?
12 A. Oh, yes, yes. Separately from us with her own
13 attorney.
14 Q. As a parent, what is your perception of what
15 having to undergo that interview had on Mary?
16 A. She was really scared. She, you know -- she
17 was really -- she's a very, like, sarcastic and funny
18 kid, and she was terrified of, like, saying anything
19 that could be misinterpreted, so she just felt, like,
20 very much -- she was not at ease at all. You know, the
21 whole thing was just -- was just surreal. It was just
22 so weird. I don't know. It was very upsetting.
23 And she -- she thought that she was going
24 to be taken away from us that night. We're saying, No,
25 no, no, Honey, like that's -- that's not happening.

1 A. Correct.
2 Q. And her pediatrician is the one who diagnosed
3 her with gender dysphoria?
4 A. Yes.
5 Q. And then that pediatrician provided referrals
6 to other doctors; is that right?
7 A. Yes.
8 Q. And were those doctors specialists in gender
9 dysphoria treatment?
10 A. Among other things, yes.
11 Q. What other doctors was she referred to?
12 A. I don't remember.
13 Q. Was she referred to a therapist or
14 psychiatrist?
15 A. She already has one.
16 Q. So it wasn't necessary at that time?
17 A. Correct.
18 Q. Was she being treated by that therapist or
19 psychiatrist for gender dysphoria at the time that she
20 saw this pediatrician?
21 MR. GONZALEZ-PAGAN: Objection, Your
22 Honor; I think it skirts into the -- what the question
23 on what care is being provided again.
24 THE COURT: Overruled.
25 A. I'm sorry.

1 it needs to be admitted. So can we work on redacting
2 this?
3 MR. GONZALEZ-PAGAN: Understood, Your
4 Honor.
5 THE COURT: All right. Thank you. And
6 you go ahead and leave, and then everybody else will
7 leave after that. Ms. Corbello, I'm displeased.
8 MS. CORBELLO: I -- I'm -- I'm displeased
9 with myself, Your Honor. I -- I promise you, it's not
10 my intent to disclose her identity. I don't want her
11 harassed more than she needs to in the media. I
12 promise you, it's -- it was simply a result of I use a
13 Samsung, I wasn't thinking clearly, and I was up all
14 night preparing for this with my children screaming,
15 and it was --
16 THE COURT: All right. I want to make
17 clear --
18 MS. CORBELLO: I so promise.
19 THE COURT: -- for the purpose of the
20 record, we're striking the use of the name, and
21 Ms. Racanelli will strike it from her record. Thank
22 you.
23 MS. CORBELLO: Thank you, Your Honor.
24 THE COURT: See everybody in an hour.
25 *(Lunch recess.)*

1 **REPORTER'S CERTIFICATE**

2

3 STATE OF TEXAS)
)
4 COUNTY OF TRAVIS)

5 I, Alicia Racanelli, Official Court Reporter in and
6 for the 201st District Court of Travis County, State of
7 Texas, do hereby certify that the above and foregoing
8 contains a true and correct transcription of all
9 portions of evidence and other proceedings requested in
10 writing by counsel for the parties to be included in
11 this volume of the Reporter's Record, in the
12 above-styled and numbered cause, all of which occurred
13 in open court or in chambers and were reported by me.

14 I further certify that this Reporter's Record of
15 the proceedings truly and correctly reflects the
16 exhibits, if any, offered in evidence by the respective
17 parties.

18 WITNESS MY OFFICIAL HAND this the 16th day of
19 March, 2022.

20

21

22 /s/ Alicia Racanelli
Alicia Racanelli, Texas CSR No. 3591
23 Expiration Date: April 30, 2023
Official Court Reporter, 201st District Court
24 Travis County, Texas
P.O. Box 1748, Austin, Texas 78767
25 Telephone (512) 854-4028

REPORTER'S RECORD
VOLUME 2 OF 3 VOLUMES
TRIAL COURT CAUSE NO. D-1-GN-22-000977

JANE DOE, ET AL., Plaintiffs,	)	IN THE DISTRICT COURT
VS.	)	TRAVIS COUNTY, TEXAS
GREG ABBOTT, ET AL., Defendants.	)	353RD JUDICIAL DISTRICT

HEARING ON MOTION FOR TEMPORARY INJUNCTION

AND PLEA TO THE JURISDICTION

AFTERNOON SESSION

On the 11th day of March, 2022, the following proceedings came on to be heard in the above-entitled and numbered cause before the Honorable Amy Clark Meachum, Judge Presiding, held in Austin, Travis County, Texas:

Proceedings reported by machine shorthand.

1 **APPEARANCES**

2

3 **FOR THE PLAINTIFFS:**

4 **PAUL D. CASTILLO**
SBOT NO. 24049461
5 **SHELLY L. SKEEN**
SBOT NO. 24010511
6 LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
3500 Oak Lawn Avenue, Unit 350
7 Dallas, Texas 75219
Phone: (214) 219-8585
8
- AND -
9
BRIAN KLOSTERBOER
10 SBOT NO. 24107833
ANDRE SEGURA
11 SBOT NO. 24107112
AMERICAN CIVIL LIBERTIES UNION FOUNDATION OF TEXAS
12 5225 Katy Freeway, Suite 350
Houston, Texas 77007
13 Phone: (713) 942-8146

14 - AND -

15 **OMAR GONZALEZ-PAGAN**
PRO HAC VICE
16 LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
120 Wall Street, 19th Floor
17 New York, New York 10005
Phone: (212) 809-8585
18
- AND -
19
MADDY R. DWERTMAN
20 SBOT NO. 24092371
BAKER BOTTS L.L.P.
21 98 San Jacinto, Suite 1500
Austin, Texas 78701
22 Phone: (512) 322-2500

23

24

25

1 **APPEARANCES CONTINUED**

2

3 **FOR THE DEFENDANTS:**

4 **COURTNEY CORBELLO**
SBOT NO. 24097533
5 TEXAS ATTORNEY GENERAL
P.O. Box 12548
6 Austin, Texas 78711
Phone: (512) 463-2120
7

8
ALSO PRESENT: HOLT LACKEY, ATTORNEY FOR RANDA MULANAX
9 IAN PITTMAN, ATTORNEY FOR JANE DOE

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

INDEX

VOLUME 2

HEARING ON MOTION FOR TEMPORARY INJUNCTION AND PLEA TO THE JURISDICTION

AFTERNOON SESSION

MARCH 11, 2022

	Page	Vol.
Proceedings.....	8	2

PLAINTIFFS' WITNESSES

	Direct	Cross	Vol.
JANE DOE			
By Ms. Corbello		10	2
By Mr. Gonzalez-Pagan	15		2
MEGAN MOONEY, PH.D.			
By Mr. Klosterboer	17		2
By Ms. Corbello		31	2
By Mr. Klosterboer	72		2
ARMAND ANTOMMARIA, M.D.			
By Mr. Segura	75		2
By Ms. Corbello		92	2
By Mr. Segura		111	2
CASSANDRA BRADY, M.D.,			
By Mr. Gonzalez-Pagan	113		2
By Ms. Corbello		127	2

1 **INDEX CONTINUED**

	Page	Vol.
Closing Argument by Mr. Castillo.....	131	2
Closing Argument by Ms. Corbello.....	136	2
Closing Argument by Mx. Dwertman.....	141	2
Closing Argument by Mr. Castillo.....	143	2
Ruling of the Court.....	144	2
Proceedings Concluded.....	149	2
Reporter's Certificate.....	150	2

1 **ALPHABETICAL WITNESS INDEX**

2

	Direct	Cross	Vol.
3			
4 **ANTOMMARIA, ARMAND, M.D.**			
By Mr. Segura	75		2
5 By Ms. Corbello		92	2
By Mr. Segura		111	2
6			
BRADY, CASSANDRA, M.D.,			
7 By Mr. Gonzalez-Pagan	113		2
By Ms. Corbello		127	2
8			
DOE, JANE			
9 By Ms. Corbello		10	2
By Mr. Gonzalez-Pagan	15		2
10			
MOONEY, MEGAN, PH.D.			
11 By Mr. Klosterboer	17		2
By Ms. Corbello		31	2
12 By Mr. Klosterboer	72		2

13

14

15

16

17

18

19

20

21

22

23

24

25

EXHIBIT INDEX

PLAINTIFFS'

NO.	DESCRIPTION	OFFER	ADMIT	VOL.
4	Expert Declaration of Armand Antommaria, M.D.	83	--	2
5	Curriculum Vitae of Armand Antommaria, M.D.	77	78	2
7	Curriculum Vitae of Cassandra Brady, M.D.	118	118	2
8	Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline	121	121	2
19	Bibliography from Expert Declaration of Cassandra Brady, M.D.	126	126	2

DEFENDANTS'

NO.	DESCRIPTION	OFFER	ADMIT	VOL.
1	WPATH Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7	41	41	2

1 THE COURT: We can go back on the record
2 at this time.
3 MR. GONZALEZ-PAGAN: Your Honor, if I may
4 before proceeding with the line of questioning, I would
5 like to make a detailed objection on the record.
6 THE COURT: Yes.
7 MR. GONZALEZ-PAGAN: Your Honor, it's
8 clear to plaintiffs that today's actions are, at best,
9 with callous disregard for the rules and the agreement
10 that was entered into by the parties. I would note that
11 the exhibit provided included the name of a minor,
12 already also in violation of Texas Rules of Civil
13 Procedures. I would note that that was an exhibit that
14 defendants obviously had and came to Court without it
15 having been redacted even for that very specific
16 purpose. I think that that callous disregard sheds
17 light into their repeated reservation as to when they
18 would use the names. It seems at least apparent based
19 on the course of conduct to plaintiffs, that the
20 defendants intended to make public Jane Doe's identity.
21 At this point in time, the plaintiffs
22 would like to reserve the opportunity to provide the
23 Court with further course of action, including
24 possibility of sanctions.
25 THE COURT: Well, you can reserve that,

1 calling?
2 MR. KLOSTERBOER: Your Honor, the
3 plaintiffs call Dr. Megan Mooney.
4 THE COURT: Okay. Dr. Mooney will be
5 next, and we will go back up on YouTube.
6 (Witness sworn)
7 THE COURT: And while it can be
8 difficult, I'll just remind you, like I have everybody
9 else. I know it's difficult to be on the witness stand,
10 and sometimes we try to speak lower, but try to project
11 if you can.
12 THE WITNESS: Yes, Your Honor.
13 MEGAN MOONEY, Ph.D.,
14 having been first duly sworn, testified as follows:
15 DIRECT EXAMINATION
16 BY MR. KLOSTERBOER:
17 Q. Dr. Mooney, would you please state your full
18 name?
19 A. Dr. Megan Mooney.
20 Q. And where do you reside?
21 A. In Houston.
22 Q. Are you a plaintiff in this case?
23 A. I am.
24 Q. What is your occupation?
25 A. I'm a licensed psychologist.

1 DePelchin Children's Center in Houston, followed by
2 working at a trauma and grief center for children, and
3 then my private practice.
4 Q. About how many years now have you been working
5 with children and families?
6 A. If you include the years spent in graduate
7 school, probably about 25.
8 Q. Where is your current practice located?
9 A. It's in Houston.
10 Q. Do you also have clients who live outside of
11 Houston and Harris County?
12 A. I do.
13 Q. What services do you provide your clients in
14 general?
15 A. In general, individual and family therapy.
16 I'll supervise some assessments.
17 Q. Are some of your clients, in general,
18 transgender?
19 A. Yes.
20 Q. As a part of your practice, do you sometimes
21 diagnose clients with gender dysphoria?
22 A. Yes.
23 Q. And even though you're not testifying as an
24 expert, just what is your understanding of what gender
25 dysphoria means?

1 But I understand what you're saying, and we'll just have
2 to take that question by question.
3 MS. CORBELLO: Thank you, Your Honor.
4 THE COURT: Thank you.
5 MR. KLOSTERBOER: Thank you, Your Honor.
6 Q. (By Mr. Klosterboer) As a matter of fact, in
7 your practice, do you diagnose, sometimes client --
8 sorry.
9 In your practice, do you sometimes make
10 medical referrals for transgender clients who you see
11 who are experiencing gender dysphoria?
12 A. Yes.
13 Q. And based on your clinical experience, how are
14 the decisions made with adolescents and their families
15 about whether to seek medical treatment?
16 A. It is a thoughtful process, a careful process
17 that involves both the assent of the child and the
18 consent of the parent, in consultation with me and, as
19 needed, medical providers.
20 Q. In your clinical practice and your personal
21 experiences, what are some of the results that you have
22 seen from transgender young people who are able to
23 access medical care to treat gender dysphoria?
24 A. I have seen and it's well substantiated in
25 research that there are significant positive mental

1 health benefits of children and adolescents who undergo
2 gender-affirming treatments.
3 Q. Are you a member of any professional
4 associations?
5 A. I'm a member of the Houston Psychological
6 Association, the Texas Psychological Association, and
7 the American Psychological Association.
8 Q. Have those associations taken any stances on
9 medical care and access to it for transgender young
10 people?
11 A. Both the Texas and American Psychological
12 Associations have supported publicly gender-affirming
13 medical care.
14 Q. As a licensed psychologist, are you a
15 mandatory reporter under Texas law?
16 A. I am.
17 Q. To your knowledge, is everyone in the state of
18 Texas a mandatory reporter?
19 A. Yes.
20 Q. What are --
21 A. Adults specifically. Excuse me.
22 Q. What are your obligations as a mandatory
23 reporter?
24 A. If I have a reasonable suspicion of abuse or
25 neglect of a child or a vulnerable adult, to make a

1 report to statewide intake for DFPS.
2 Q. And in your career working with young people
3 and families, have you reported child abuse and neglect
4 to DFPS before?
5 A. Yes.
6 Q. On February 22nd, when the Governor's letter
7 and DFPS statement came out, what was your reaction?
8 A. I was very upset, very concerned for both
9 myself as a mandated reporter, and for the children and
10 families across the state of Texas that this would
11 impact.
12 Q. Why were you upset?
13 A. It goes against medically necessary research
14 about what gender-affirming care is. It goes against my
15 ethical standards and the guidelines and practice set
16 forth for me by my national association. It concerned
17 me for my practice and what that meant, as well, for the
18 families that I serve.
19 Q. What did you do after learning about the
20 Governor's letter and DFPS statement after February
21 22nd -- on or after February 22nd?
22 A. Once I had also seen information put forth by
23 ACLU Texas about this not being legally binding, I made
24 sure to get that information out as widely as I could to
25 other professionals, both in mental health circles and

1 educational circles.
2 Q. As you were sharing that information, did you
3 tell people that you would not be complying with the
4 Governor's order and DFPS's implementation?
5 MS. CORBELLO: Objection; hearsay.
6 MR. KLOSTERBOER: Your Honor, it's a
7 statement of the witness herself. I asked if she told
8 anyone.
9 MS. CORBELLO: That's hearsay, Your
10 Honor.
11 THE COURT: It also is coming in for
12 other purposes, not for the truth of the matter
13 asserted, but as to -- for motive. So I'm going to
14 overrule that objection.
15 A. So the question was did I --
16 Q. (By Mr. Klosterboer) I'll repeat the
17 question.
18 A. Thank you.
19 Q. Before filing this lawsuit, did you tell
20 people that you would not comply with the Governor's
21 directive and DFPS implementation?
22 A. Yes.
23 Q. And you made that publicly known?
24 A. Yes.
25 Q. What are some of the consequences for you as a

1 mandatory reporter if you do not report what is
2 eventually -- what could be found to be abuse or neglect
3 under Texas law?
4 A. I mean, there's legal ramifications, as I
5 understand it, and civilly and criminally, as well as a
6 threat to my license and my professional well-being.
7 Q. Would there be any harms to your practice or
8 professional reputation?
9 A. By reporting gender-affirming care
10 specifically?
11 Q. No. The consequences of if you -- if you were
12 not going to comply and the Court found that this type
13 of medical care is abuse or neglect?
14 A. Oh, yes. Well, I would expect so given that I
15 expected the loss of my license is one of the possible
16 ramifications.
17 Q. In Governor Abbott's directive on
18 February 22nd, he sent this letter not only -- or who
19 all did he send his letter to?
20 A. He, I believe, sent it to the executive
21 directors of a number of state agencies, including the
22 one that oversees my license.
23 Q. And when he sent it -- well, I can refer to
24 it.
25 MR. KLOSTERBOER: It's now in evidence,

1 Your Honor. It's Exhibit 2.
2 Q. (By Mr. Klosterboer) And what's the name of
3 the agency that oversees psychologists in Texas?
4 A. It's the Behavioral Health Executive Council.
5 Q. And this letter was sent to the director of
6 that council?
7 A. Yes, Mr. Darrell Spinks.
8 Q. What did you make of that when the Governor
9 sent the letter to that executive director?
10 A. Again, it concerned me. I take it as a
11 directive to mental health providers that we were
12 expected to report this as potential abuse.
13 Q. And does the Texas Behavioral Health Executive
14 Council, to your knowledge, have authority --
15 enforcement authority over psychologists in Texas?
16 A. Yes.
17 Q. Since filing this lawsuit, have you had any
18 threats about your license?
19 A. Yes. I received an email that threatened my
20 license directly and accused me of being a child abuser.
21 Q. When someone makes a threat against your
22 license, are you able to always find out about it?
23 A. No.
24 Q. Why is that?
25 A. My understanding is that there is internal

1 processes within my licensing board by which they review
2 it for a period of time first and determine whether
3 there's merit to it, and so that process would occur
4 without my knowledge.
5 Q. We talked about some of the possible penalties
6 if you don't comply with the Governor's directive and
7 DFPS implementation, but what would the harms be to you
8 personally if you were required to report your clients
9 and their families for abuse and neglect for receiving
10 medical care for gender dysphoria?
11 A. The foundation of the therapeutic relationship
12 is our confidentiality and privacy, and by nature, the
13 families that I might see and that other mental health
14 providers might see are charged with trust with our
15 clients. And having to disclose what I consider
16 medically necessary and professionally upheld standards
17 of care as potential abuse would be devastating to my
18 clients. It would ruin my opportunity to tell them what
19 I hold confidential and true in sessions. I would
20 expect it would have a direct impact on my business.
21 Q. Would being required to report your clients
22 for receiving this type of medical care violate your
23 ethical obligations?
24 A. I believe it would.
25 Q. Could it potentially result in you losing your

1 license?
2 A. I believe it could.
3 Q. Could you be prosecuted for false reporting of
4 child abuse if you know that you're reporting families,
5 but it does not meet the definitions of abuse and
6 neglect?
7 MS. CORBELLO: Objection; lacks
8 foundation, speculation.
9 THE COURT: Overruled.
10 A. My understanding of the law is that a false
11 report of abuse is something that would be legally
12 problematic for me.
13 Q. (By Mr. Klosterboer) Based on your role as a
14 mandatory reporter, do you face harsh consequences
15 either way, whether the DFPS implementation and Governor
16 Abbott's letter is requiring you to report patients or
17 even if it doesn't -- actually, let me withdraw that
18 question.
19 Is there uncertainty right now in your
20 life about whether you're required to report or not?
21 A. I would say that the legal guidance that I
22 have heard is that I am not currently in violation of
23 Texas law. That said, this makes me incredibly anxious,
24 the opinion from the Attorney General and the letter
25 from the Governor, and I've heard widespread confusion

1 from other mental health professionals, as well as
2 families, about the implication of both of these.
3 Q. And what other reactions have you seen in the
4 community to this directive?
5 A. I would say generally speaking outright panic.
6 Parents are terrified that CPS is going to come and
7 question their children or take them away. Mental
8 health professionals are scared that we are either
9 violating our standards of the professional codes of
10 conduct or in violation of the law, and it puts medical
11 professionals that I work with all the time in a
12 horrible position of not being able to provide care to
13 children and families.
14 Q. And from being a member of the community and
15 your personal knowledge, what effects of this have you
16 seen among LGBTQ youth?
17 A. I would say that what I've seen has also held
18 up again by research in reaction to similar moves,
19 policy and legislatively, that we see direct concern and
20 impacts on the mental health and well-being of young
21 people. We see increased risk of suicidality, increased
22 depression, increased anxiety. That is a common
23 reaction I'm hearing currently, and it is what I've seen
24 in similar situations.
25 Q. Have you also seen any reaction, personally,

1 A. They're updating. The last guidelines were
2 published quite a while ago, I believe in 2015, and so
3 we've got a lot more research and information now to
4 guide that care.
5 Q. Is it fair to say the APA knows more now about
6 the treatment of gender dysphoria than they did prior to
7 today?
8 A. I would assume so; although, I don't speak for
9 the American Psychological Association.
10 Q. So the best way to treat gender dysphoria, is
11 it fair to say that's evolving currently?
12 MR. KLOSTERBOER: Objection, Your Honor.
13 Once again, this witness is not here to testify as an
14 expert or globally on what's happening with the
15 treatment protocols with gender dysphoria.
16 THE COURT: So, at this point, I think
17 it's up to the witness if she has knowledge of this or
18 if she does not know about it, to testify one way or the
19 other.
20 A. Can you repeat that question?
21 Q. (By Ms. Corbello) Of course. Are you aware
22 of whether the best treatment modalities for gender
23 dysphoria are currently evolving?
24 A. I don't think I am aware. I know what our
25 current research suggests, and that's what I would be

1 Q. (By Mr. Segura) Doctor, what current
2 positions do you hold?
3 A. I'm currently the director of the Ethics
4 Center at Cincinnati Children's Hospital Medical Center,
5 the Lee Ault Carter Chair in Pediatric Ethics, an
6 attending physician in the division of hospital medicine
7 at Cincinnati Children's Hospital Medical Center, and
8 professor of pediatrics and surgery at the University of
9 Cincinnati College of Medicine.
10 Q. Great. And as part of your duties, do you
11 consult with medical providers on the treatment of
12 adolescent patients for -- or with gender dysphoria?
13 A. I do. I'm engaged in the monthly
14 multidisciplinary reviews and policies at Cincinnati
15 Children's Transgender Clinic and consult on an
16 as-needed basis in the care of individual patients when
17 ethical issues arise.
18 Q. And in this role, do you keep up with research
19 for treatment for gender dysphoria?
20 A. I do.
21 Q. And for how long have you been involved in
22 this practice?
23 A. Since 2012.
24 MR. SEGURA: Your Honor, I'd like to move
25 for the admission of Exhibit 5.

1 dysphoria, and we'd ask that the Court limit,
2 appropriately, if it's inclined to grant him as an
3 expert.
4 THE COURT: Those objections are
5 overruled, and you may proceed. He is qualified as an
6 expert and can testify at this time.
7 MR. SEGURA: Thank you, Your Honor.
8 Q. (By Mr. Segura) Dr. Antommaria, what were you
9 asked to do in this case?
10 A. I was asked to provide my opinion regarding
11 the Attorney General and the Governor's directive.
12 Q. Doctor, did you report -- did you prepare a
13 report in this case?
14 A. Yes, I did.
15 Q. Okay. I'd like to pull -- for you to pull up
16 what you should have as Exhibit 4. Do you have that?
17 A. I do.
18 Q. And what is this document?
19 A. That's a copy of my expert declaration.
20 Q. And have you signed and sworn to the
21 contents -- to the truth of the contents in this report
22 under penalty of perjury?
23 A. I have.
24 MR. SEGURA: Your Honor, I move for the
25 admission of Exhibit 4 as Dr. Antommaria's expert report

1 for this case.
2 MS. CORBELLO: Your Honor, we would
3 object to the admission of an expert report. It's
4 clearly hearsay. It's not admissible under the Texas
5 Rules; and, furthermore, it was a report that I only
6 received at 9:00 a.m. this morning. It's prejudicial
7 and provides an undue burden on defendants.
8 THE COURT: It is hearsay at this point.
9 Generally, I don't admit expert reports unless both
10 sides ask for the Court to, and so I'm going to sustain
11 that objection.
12 He can testify about his opinions, but he
13 just can't shortchange it by putting in a report.
14 MR. SEGURA: Absolutely, Your Honor.
15 Q. (By Mr. Segura) Doctor, can you tell us what
16 is gender dysphoria?
17 A. Gender dysphoria is the psychological distress
18 caused by incongruence between one's gender identity and
19 one's sex assigned at birth.
20 Q. Doctor, is gender dysphoria in adolescents a
21 serious medical condition?
22 A. Yes, it is.
23 Q. Is there treatment to alleviate the symptoms
24 caused by gender dysphoria?
25 A. So, yes, there is a treatment.

1 Q. And is there a treatment that's specific to
2 adolescents?
3 A. The treatment that would be specific to
4 adolescents would be the use of puberty blocking
5 medication at the onset of puberty.
6 Q. Great. Thank you. And when you have that mic
7 right next to you, we can hear you really great.
8 A. Okay.
9 Q. And are the standards for treatment of gender
10 dysphoria documented anywhere?
11 A. Yes. Both the Endocrine Society has the
12 clinical practice guideline, and WPATH has a standard of
13 care.
14 Q. Taking the Endocrine Society guideline first,
15 how was that guideline developed?
16 A. The Endocrine Society uses well-established
17 procedures to establish their guidelines through a
18 robust mechanism of screening which goes to the
19 authoring committee. They then undergo a systematic
20 review of the literature on relevant topics, and then
21 they make recommendations that they both grade the
22 strength of the recommendation and the quality of the
23 evidence supporting the recommendations that they make.
24 Q. And is that guideline comparable to other
25 guidelines used in pediatric medicine?

1 A. Yes, those guidelines that the Endocrine
2 Society produces on other topics, as well as guidelines
3 produced by other medical professional associations.
4 Q. And is that guideline generally accepted in
5 the medical community?
6 A. Yes.
7 Q. Okay. You also mentioned the WPATH standards
8 of care. How were those developed?
9 A. The Version 7 standards of care was also based
10 on review of the literature that was published in
11 peer-reviewed articles and the establishment, then, of a
12 writing committee that engaged in an iterative process
13 to revise the existing Version 6 of the standards of
14 care.
15 Q. And are those standards of care also generally
16 accepted in the medical community?
17 A. Yes, they are.
18 Q. Doctor, based on your knowledge of the
19 research, would you say that pubertal suppression used
20 to treat gender dysphoria in adolescents is safe?
21 A. Yes.
22 Q. Would you say it's effective?
23 A. Yes.
24 Q. How is it effective?
25 A. There are prospective observational studies

1 that show that pubertal suppression decreases depression
2 among individuals with gender dysphoria and improves
3 general functioning in those individuals.
4 Q. And would you say that hormone therapy used to
5 treat gender dysphoria in adolescents is safe?
6 A. Yes.
7 Q. Would you say it is effective?
8 A. Yes.
9 Q. And how is it effective?
10 A. There are similar prospective observational
11 studies that show improvements in mental health outcomes
12 through use of gender-affirming hormone therapy.
13 Q. Now, based on your experience as a pediatric
14 bioethicist, is there anything about the risks and
15 benefits of this sort of treatment that would require
16 any unique oversight?
17 A. No.
18 Q. And are there risks of not providing treatment
19 if it is deemed medically indicated for an adolescent
20 with gender dysphoria?
21 A. Yes. Individuals with gender dysphoria are at
22 high risk for depression, anxiety, self-harm,
23 suicidality, and eating disorders.
24 Q. Doctor, what is the goal of treatment for
25 gender dysphoria in adolescents?

1 treatment a form of medical abuse?
2 MS. CORBELLO: Objection; outside the
3 scope of this expert's testimony.
4 THE COURT: That one I think is fine, so
5 I'm going to overrule that objection.
6 MR. SEGURA: Thank you.
7 Q. (By Mr. Segura) Doctor, what does it mean for
8 a medication or a procedure to be prescribed as off
9 label?
10 A. It means to be used for an indication other
11 than the indication approved by the label to the Food
12 and Drug Administration.
13 Q. Is off-label use of medication a common
14 practice in pediatrics?
15 A. Yes, it's a common practice in pediatrics.
16 Q. Does prescribing medication as off label --
17 off-label medication mean that it is unsafe?
18 A. It does not mean --
19 MS. CORBELLO: Your Honor, I'm going
20 to --
21 A. -- it is unsafe.
22 MS. CORBELLO: -- object that that's
23 outside the scope of the expert testimony. He's not
24 been offered to testify as to prescriptions.
25 THE COURT: Overruled.

1 Q. (By Mr. Segura) Does it mean that it is
2 experimental if it is off label?
3 MS. CORBELLO: Same objection.
4 THE COURT: Overruled.
5 A. No, it does not mean that it is experimental.
6 Q. (By Mr. Segura) And do you, yourself,
7 prescribe medication that is off label?
8 A. Yes, as a pediatric hospitalist, I routinely
9 prescribe medication off label.
10 Q. Doctor, can you quickly provide a summary of
11 your conclusions in your report?
12 MS. CORBELLO: I'm going to object to the
13 extent he's testifying to the contents of the report
14 that have been deemed hearsay.
15 THE COURT: Well, that's overruled.
16 Q. (By Mr. Segura) You can go ahead and provide
17 your summary.
18 A. My conclusions are that gender-affirming
19 hormone therapy and puberty blockers are medically
20 necessary for the treatment of gender dysphoria, and
21 they are not sterilizing procedures; therefore, they do
22 not constitute child abuse, and characterizing them as
23 such puts healthcare providers in an untenable position
24 of either violating their professional obligations or
25 the law and causes serious harm to patients and their

1 families.
2 MR. SEGURA: Thank you, Doctor. No
3 further questions at this moment.
4 CROSS-EXAMINATION
5 BY MS. CORBELLO:
6 Q. Good afternoon, Doctor.
7 A. Good afternoon.
8 Q. It's nice to meet you over Zoom. Let me know
9 if at any time you can't hear me. My name is Courtney
10 Corbello. I represent the defendants in this case.
11 Just going back to a few things you
12 testified to with your counsel, you stated earlier that
13 gender dysphoria is a serious medical condition. Right?
14 A. Correct.
15 Q. That's a term that means something to you as a
16 doctor. Right?
17 A. Yes.
18 Q. What does a serious medical condition mean?
19 A. A serious -- so a medical condition would be
20 a -- an entity that is a medical diagnosis that has
21 significant negative consequences to the individual who
22 is experiencing that diagnosis.
23 Q. The treatment of gender dysphoria, would you
24 say that this is a specialty practice in the area of
25 medicine?

1 residency from Vanderbilt University School of Medicine
2 at Vanderbilt Medical Center and a pediatric
3 endocrinology fellowship at Cincinnati Children's
4 Hospital.
5 Q. And are you board certified?
6 A. I am in general pediatrics, as well as
7 pediatric endocrinology.
8 Q. What current positions do you hold?
9 A. I am an assistant professor of general
10 pediatrics in the division of endocrinology at the
11 Vanderbilt Children's Hospital.
12 Q. Do you also practice medicine?
13 A. I do practice medicine.
14 Q. Do you have any positions related to your
15 practice of medicine?
16 A. Yes. I am a clinic director for two specialty
17 clinics at the hospital. The clinics are the
18 Differences of Sex Development Clinic and the Gender
19 Diverse Clinic for Transgender Adolescents with Gender
20 Dysphoria.
21 Q. Can you please describe the care that you
22 provide at each of these clinics?
23 A. Yes. At the Differences of Sex Development
24 Clinic, these individuals may present with atypical
25 development of their genetics being chromosomal,

1 presented to you as proposed Plaintiffs' Exhibit No. 7?
2 A. Yes.
3 MR. GONZALEZ-PAGAN: Your Honor, at this
4 time, we would move for admission of the CV of Dr. Brady
5 into evidence.
6 MS. CORBELLO: I'm going to object again
7 as hearsay, Your Honor.
8 THE COURT: Overruled. What number is
9 it?
10 MR. GONZALEZ-PAGAN: Plaintiffs' Exhibit
11 No. 7.
12 THE COURT: 7 is hereby admitted.
13 (Plaintiffs Exhibit 7 admitted)
14 MR. GONZALEZ-PAGAN: Your Honor, also at
15 this time -- actually, I will set some more foundation.
16 Q. (By Mr. Gonzalez-Pagan) Dr. Brady, you
17 discussed that you provide care consistent with clinical
18 guidelines. What are the clinical guidelines that you
19 follow?
20 A. So for the care of transgender and gender
21 dysphoric youth, I follow the Endocrine Society and the
22 WPATH guidelines that are evidence-based guidelines.
23 Q. Are the Endocrine Society guidelines widely
24 accepted within the medical community?
25 A. Yes, they're widely accepted by a large number

1 of medical organizations across the country.
2 Q. And you mentioned they were evidence based.
3 What do you mean by that?
4 A. So evidence based means that they utilize data
5 and research that's available to confirm their
6 guidelines and support the recommendations.
7 Q. Okay. Are the WPATH standards of care, are
8 these widely accepted within the medical community?
9 A. They are, as well similar to the Endocrine
10 Society guidelines, accepted by a number of medical
11 organizations across the country and world.
12 Q. And are these also based on scientific study
13 and research?
14 A. Yes.
15 Q. And are both of these guidelines that you
16 routinely employ in your career and in your practice?
17 A. Yes. I use them every day.
18 MR. GONZALEZ-PAGAN: Your Honor, at this
19 time, I would move to qualify Dr. Brady as an expert on
20 the provision, protocols, and treatment of care
21 regarding gender dysphoria.
22 MS. CORBELLO: I'd object on the basis of
23 Rule 702. There's been no testimony as to how this is
24 helping the trier of fact, the Court, understand the
25 evidence or determine a fact at issue.

1 THE COURT: Objection overruled. She is
2 qualified as an expert and may continue testifying at
3 this time.
4 MR. GONZALEZ-PAGAN: Thank you.
5 Q. (By Mr. Gonzalez-Pagan) Dr. Brady, will you
6 pull what's been premarked as proposed Plaintiffs'
7 Exhibit No. 8? Do you recognize this document?
8 A. I do.
9 Q. What is it?
10 A. This is the Endocrine Society clinical
11 practice guidelines for the treatment of gender
12 dysphoria.
13 Q. Are these the guidelines to which you referred
14 that you follow in your practice?
15 A. Yes.
16 Q. And these are the guidelines that provide the
17 recommendations for the course of treatment for gender
18 dysphoria in adolescents when it comes to
19 endocrinologists. Is that right?
20 A. That is correct.
21 Q. Who publishes these guidelines?
22 A. This is published by the Endocrine Society.
23 Q. And --
24 A. The Journal of Clinical Endocrinology &
25 Metabolism.

1 A. I have.
2 Q. Could you please summarize your expert
3 opinions with regards to this case and information of
4 gender dysphoria -- of treatment for gender dysphoria?
5 A. Absolutely. So, on a day-to-day basis, I am
6 treating gender dysphoria, utilizing evidence-based
7 guidelines and standards of care that are accepted by a
8 number of reputable medical associations across the
9 country. These are medically necessary treatments for
10 gender dysphoria youth.
11 My concern with the directives from the
12 Attorney General and the Governor is that these
13 medically necessary treatments that are safe and
14 effective, if they are withheld, would lead to
15 significant harm and mental health comorbidities and
16 potentially death in these gender dysphoric adolescents.
17 Q. Dr. Brady, what are the types of treatment
18 that you provide for adolescents that suffer from gender
19 dysphoria?
20 A. The -- the treatments I provide include
21 pubertal blocking agents, as well as gender-affirming
22 hormones such as testosterone and estrogen for gender
23 dysphoric adolescents.
24 Q. Are puberty blockers reversible?
25 A. They are.

1 Q. Are they safe?
2 A. They are safe.
3 Q. Are they effective for the treatment of gender
4 dysphoria?
5 A. They are.
6 Q. Do you rely on research -- what's the basis
7 for your opinion that these treatments are safe and
8 effective?
9 A. Sure. So there is data to show that not only
10 the use of these pubertal blockers in gender dysphoric
11 adolescents, but also in conditions that I treat such as
12 central precocious puberty, that these are reversible,
13 safe, and effective treatments. And this data has been
14 around for many years, especially in the population of
15 central precocious puberty individuals that we treat.
16 Q. So these are treatments that you provide for
17 other conditions distinct from gender dysphoria?
18 A. Yes.
19 Q. And are the risks and effects similar?
20 A. Yes. The risks --
21 MS. CORBELLO: Object as outside the
22 scope of this expert's testimony.
23 MR. GONZALEZ-PAGAN: Your Honor, the
24 expert has testified that she --
25 THE COURT: Overruled.

1 MR. GONZALEZ-PAGAN: Thank you.
2 A. Yes, the risks associated with pubertal
3 blocking agents are very similar across the treatment of
4 central precocious puberty, as well as in gender
5 dysphoric adolescents.
6 Q. (By Mr. Gonzalez-Pagan) Doctor, is a
7 provision of hormones as a treatment for gender
8 dysphoria safe?
9 A. Yes. The treatment of gender-affirming
10 hormones is safe, similar to the use of these
11 gender-affirming hormones across the medical practice.
12 I use these in -- such as in individuals who may need
13 these for hypogonadism.
14 Q. And are their risks distinct or unique because
15 they're being used to treat gender dysphoria?
16 A. No, they are not distinct or unique. They're
17 very similar across the board for any condition in which
18 I'm using them.
19 Q. And what is the basis for your opinion?
20 A. I am a clinician that sees these patients on a
21 day-to-day basis, as well as utilizes these standards of
22 care and other research to support my medical practice.
23 Q. You mentioned research. Did you prepare a
24 bibliography in conjunction with your expert report for
25 this case?

1 MR. GONZALEZ-PAGAN: Your Honor, if I
2 may, we would like to propose the bibliography of
3 Dr. Brady's report as Plaintiffs' proposed Exhibit 19.
4 THE COURT: So let's mark that as 19.
5 Ms. Corbello?
6 MS. CORBELLO: We object. This
7 bibliography was prepared by the expert. It's hearsay.
8 It's irrelevant and outside the scope.
9 THE COURT: Overruled. 19 is admitted.
10 (Plaintiffs Exhibit 19 admitted)
11 MR. GONZALEZ-PAGAN: Thank you, Your
12 Honor.
13 Q. (By Mr. Gonzalez-Pagan) Dr. Brady, just
14 briefly. What are the harms that can come from the
15 withholding or pausing of the provision of
16 gender-affirming care for transgender youth with gender
17 dysphoria?
18 A. The harms that can be associated with
19 withholding or pausing care are significant mental
20 health distress associated with increased anxiety,
21 depression, and suicide, so that equates to the
22 increased risk for death.
23 MR. GONZALEZ-PAGAN: Thank you. No more
24 questions at this time, Your Honor.
25 THE COURT: Thank you.

1 jurisdiction requested by the State.
2 We can go off the record at this time.
3 (Proceedings concluded at 5:22 p.m.)
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

1 **REPORTER'S CERTIFICATE**

2

3 STATE OF TEXAS)

4 COUNTY OF TRAVIS)

5 I, STEVEN STOGEL, Substitute Court Reporter

6 for the 201st District Court of Travis County, State of

7 Texas, do hereby certify that the above and foregoing

8 contains a true and correct transcription of all

9 portions of evidence and other proceedings requested in

10 writing by counsel for the parties to be included in

11 this volume of the Reporter's Record in the above-styled

12 and numbered cause, all of which occurred in open court

13 or in chambers and were reported by me.

14 I further certify that the Reporter's Record

15 of the proceedings truly and correctly reflects the

16 exhibits, if any, offered in evidence by the respective

17 parties.

18 WITNESS MY HAND on this the 16th day of March,

19 2022.

20 /s/ Steven Stogel

21 Steven Stogel, Texas CSR #6174
Expiration Date: 4/30/2023
Roving Court Reporter for

22 Travis County Civil Courts
Austin, Texas 78701

23 (512) 854-6263
Steven.Stogel@traviscountytx.gov

24

25

REPORTER'S RECORD
VOLUME 3 OF 3 VOLUMES
TRIAL COURT CAUSE NO. D-1-GN-22-000977

JANE DOE, ET AL., Plaintiffs,	)	IN THE DISTRICT COURT
VS.	)	TRAVIS COUNTY, TEXAS
GREG ABBOTT, ET AL., Defendants.	)	353RD JUDICIAL DISTRICT

EXHIBIT VOLUME

On the 11th day of March, 2022, the following proceedings came on to be heard in the above-entitled and numbered cause before the Honorable Amy Clark Meachum, Judge Presiding, held in Austin, Travis County, Texas:

Proceedings reported by machine shorthand.

1 **APPEARANCES**

2

3 **FOR THE PLAINTIFFS:**

4 **PAUL D. CASTILLO**
SBOT NO. 24049461
5 **SHELLY L. SKEEN**
SBOT NO. 24010511
6 LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
3500 Oak Lawn Avenue, Unit 500
7 Dallas, Texas 75219
Phone: (214) 219-8585
8
- AND -
9
BRIAN KLOSTERBOER
10 SBOT NO. 24107833
ANDRE SEGURA
11 SBOT NO. 24107112
AMERICAN CIVIL LIBERTIES UNION FOUNDATION OF TEXAS
12 5225 Katy Freeway, Suite 350
Houston, Texas 77007
13 Phone: (713) 942-8146

14 - AND -

15 **OMAR GONZALEZ-PAGAN**
PRO HAC VICE
16 LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
120 Wall Street, 19th Floor
17 New York, New York 10005
Phone: (212) 809-8585
18
- AND -
19
MADDY R. DWERTMAN
20 SBOT NO. 24092371
BAKER BOTTS L.L.P.
21 98 San Jacinto, Suite 1500
Austin, Texas 78701
22 Phone: (512) 322-2500

23

24

25

1 **APPEARANCES CONTINUED**

2

3 **FOR THE DEFENDANTS:**

4 **COURTNEY CORBELLO**
SBOT NO. 24097533
5 TEXAS ATTORNEY GENERAL
P.O. Box 12548
6 Austin, Texas 78711
Phone: (512) 463-2120
7

8

9 ALSO PRESENT: HOLT LACKEY, ATTORNEY FOR RANDA MULANAX

10 IAN PITTMAN, ATTORNEY FOR JANE DOE

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

EXHIBIT INDEX

PLAINTIFFS'

NO.	DESCRIPTION	OFFER	ADMIT	VOL.
1	Texas Attorney General Opinion NO. KP-0401	28	28	1
2	Governor Abbott Letter to Commissioner Jaime Masters	29	29	1
3	Commissioner Masters Statement to Governor's Letter/AG Opinion	31	31	1
4	Expert Declaration of Armand Antommaria, M.D.	81	--	2
5	Curriculum Vitae of Armand Antommaria, M.D.	76	76	2
7	Curriculum Vitae of Cassandra Brady, M.D.	116	116	2
8	Endocrine Treatment of Gender-Disphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline	119	119	2
11	Dallas Morning News Article	56	58	1
15	CPS Handbook Sections 1200-1245	21	21	1
16	CPS Handbook Sections 2140-2157	22	22	1
17	Agenda for Leadership Meeting 02-24-2022	41	41	1
18	Mulanax Resignation Letter	55	55	1

EXHIBIT INDEX CONTINUED

PLAINTIFFS'

NO.	DESCRIPTION	OFFER	ADMIT	VOL.
19	Bibliography from Expert Declaration of Cassandra Brady, M.D.	124	124	2

DEFENDANTS'

NO.	DESCRIPTION	OFFER	ADMIT	VOL.
1	WPATH Standards of Care for the Health of Transsexual, Transgender, and Gender/Nonconforming People, Version 7	40	40	2

STATE OF TEXAS)
)
COUNTY OF TRAVIS)

I, Alicia Racanelli, Official Court Reporter in and for the 201st District Court of Travis County, State of Texas, do hereby certify that the following exhibits constitute true and complete duplicates of the original exhibits, excluding physical evidence, offered into evidence during the court hearing in the above-entitled and numbered cause as set out herein before the Honorable Amy Clark Meachum, Judge of the 201st District Court of Travis County, State of Texas.

WITNESS MY OFFICIAL HAND on this the 16th day of March, 2022.

/s/ Alicia Racanelli

Alicia Racanelli, Texas CSR No. 3591
Expiration Date: April 30, 2023
Official Court Reporter, 201st District Court
Travis County, Texas
P.O. Box 1748, Austin, Texas 78767
Telephone (512) 854-4028

KEN PAXTON
ATTORNEY GENERAL OF TEXAS

February 18, 2022

The Honorable Matt Krause
Chair, House Committee on General
Investigating
Texas House of Representatives
Post Office Box 2910
Austin, Texas 78768-2910

Opinion No. KP-0401

Re: Whether certain medical procedures performed on children constitute child abuse (RQ-0426-KP)

Dear Representative Krause:

You ask whether the performance of certain medical and chemical procedures on children—several of which have the effect of sterilization—constitute child abuse.[1] You specifically ask about procedures falling under the broader category of "gender reassignment surgeries." Request Letter at 1. You state that such procedures typically are performed to "transition individuals with gender dysphoria to their desired gender," and you identify the following specific "sex-change procedures":

> (1) sterilization through castration, vasectomy, hysterectomy, oophorectomy, metoidioplasty, orchiectomy, penectomy, phalloplasty, and vaginoplasty; (2) mastectomies; and (3) removing from children otherwise healthy or non-diseased body part or tissue.

Id. at 1 (footnotes omitted). Additionally, you ask whether "providing, administering, prescribing, or dispensing drugs to children that induce transient or permanent infertility" constitutes child abuse. *See id.* at 1–2. You include the following categories of drugs: (1) puberty-suppression or puberty-blocking drugs; (2) supraphysiologic doses of testosterone to females; and (3) supraphysiologic doses of estrogen to males. *See id.*

---

[1]*See* Letter from Honorable Matt Krause, Chair, House Comm. on Gen. Investigating, to Honorable Ken Paxton, Tex. Att'y Gen. at 1 (Aug. 23, 2021), https://www2.texasattorneygeneral.gov/opinions/opinions/51paxton/rq/2021/pdf/RQ0426KP.pdf ("Request Letter"); *see also* Letter from Honorable Jaime Masters, Comm'r, Tex. Dept. of Family & Protective Servs., to Honorable Greg Abbott, Governor, State of Tex. at 1 (Aug. 11, 2021), https://gov.texas.gov/uploads/files/press/Response_to_August_6_2021_OOG_Letter_08.11.2021.pdf (on file with the Op. Comm.) (hereinafter "Commissioner's Letter").

ALL-STATE LEGAL
EXHIBIT
PX 01

You qualify your question with the following statement: "Some children have a medically verifiable genetic disorder of sex development or do not have the normal sex chromosome structure for male or female as determined by a physician through genetic testing that require procedures similar to those described in this request." *Id.* at 2. In other words, in rare circumstances, some of the procedures you list are borne out of medical necessity. For example, a minor male with testicular cancer may need an orchiectomy. This opinion does not address or apply to medically necessary procedures.

I. Executive Summary

Based on the analysis herein, each of the "sex change" procedures and treatments enumerated above, when performed on children, can legally constitute child abuse under several provisions of chapter 261 of the Texas Family Code.

- These procedures and treatments can cause "mental or emotional injury to a child that results in an observable and material impairment in the child's growth, development, or psychological functioning." TEX. FAM. CODE § 261.001(1)(A).

- These procedures and treatments can "caus[e] or permit[] the child to be in a situation in which the child sustains a mental or emotional injury that results in an observable and material impairment in the child's growth, development, or psychological functioning." *Id.* § 261.001(1)(B).

- These procedures and treatments can cause a "physical injury that results in substantial harm to the child." *Id.* § 261.001(1)(C).

- These procedures and treatments often involve a "failure to make a reasonable effort to prevent an action by another person that results in physical injury that results in substantial harm to the child[,]" particularly by parents, counselors, and physicians. *Id.* § 261.001(1)(D).

In addition to analysis under the Family Code, we discuss below the fundamental right to procreation, issues of physical and emotional harm associated with these procedures and treatments, consent laws in Texas and throughout the country, and existing child abuse standards. Each of the procedures and treatments you ask about can constitute child abuse when performed on minor children.

II. Nature and context of the question presented

Forming the basis for your request, you contend that the "sex change" procedures and treatments you ask about are typically performed to transition individuals with gender dysphoria to their desired gender. *See* Request Letter at 1. The novel trend of providing these elective sex changes to minors often has the effect of permanently sterilizing those minor children. While you refer to these procedures as "sex changes," it is important to note that it remains medically impossible to truly change the sex of an individual because this is determined biologically at

conception. No doctor can replace a fully functioning male sex organ with a fully functioning female sex organ (or vice versa). In reality, these "sex change" procedures seek to destroy a fully functioning sex organ in order to cosmetically create the illusion of a sex change.

Beyond the obvious harm of permanently sterilizing a child, these procedures and treatments can cause side effects and harms beyond permanent infertility, including serious mental health effects, venous thrombosis/thromboembolism, increased risk of cardiovascular disease, weight gain, decreased libido, hypertriglyceridemia, elevated blood pressure, decreased glucose tolerance, gallbladder disease, benign pituitary prolactinoma, lowered and elevated triglycerides, increased homocysteine levels, hepatotoxicity, polycythemia, sleep apnea, insulin resistance, chronic pelvic pain, and increased cancer and stroke risk.[2]

While the spike in these procedures is a relatively recent development,[3] sterilization of minors and other vulnerable populations without clear consent is not a new phenomenon and has an unsettling history. Historically weaponized against minorities, sterilization procedures have harmed many vulnerable populations, such as African Americans, female minors, the disabled, and others.[4] These violations have been found to infringe upon the fundamental human right to procreate. Any discussion of sterilization procedures in the context of minor children must, accordingly, consider the fundamental right that is at stake: the right to procreate. Given the uniquely vulnerable nature of children, and the clear dangers of sterilization demonstrated throughout history, it is important to emphasize the crux of the question you present today—*whether facilitating (parents/counselors) or conducting (doctors) medical procedures and treatments that could permanently deprive minor children of their constitutional right to procreate, or impair their ability to procreate, before those children have the legal capacity to consent to those procedures and treatments, constitutes child abuse.*

The medical evidence does not demonstrate that children and adolescents benefit from engaging in these irreversible sterilization procedures. The prevalence of gender dysphoria in children and adolescents has never been estimated, and there is no scientific consensus that these sterilizing procedures and treatments even serve to benefit minor children dealing with gender dysphoria. As stated by the Centers for Medicare and Medicaid Services, "There is not enough high-quality evidence to determine whether gender reassignment surgery improves health outcomes for Medicare beneficiaries with gender dysphoria and whether patients most likely to benefit from these types of surgical intervention can be identified prospectively."[5] Also, "several studies show a higher rate of regret at being sterilized among younger women than among those

---

[2]*See* Timothy Cavanaugh, M.D., *Cross-Sex Hormone Therapy*, FENWAY HEALTH (2015), https://www.lgbtqiahealtheducation.org/wp-content/uploads/Cross-Sex-Hormone-Therapy1.pdf.

[3]SOCIETY FOR EVIDENCE BASED GENDER MEDICINE, https://segm.org/ (demonstrating a spike in referrals to Gender Identify Development Services around the mid-2010s).

[4]Alexandra Stern, Ph.D., *Forced sterilization policies in the US targeted minorities and those with disabilities – and lasted into the 21st Century*, (Sept. 23, 2020), https://ihpi.umich.edu/news/forced-sterilization-policies-us-targeted-minorities-and-those-disabilities-and-lasted-21st.

[5]Centers for Medicare and Medicaid Services, Decision Memo for Gender Dysphoria and Gender Reassignment Surgery (CAG-00446N) (Aug. 30, 2016), http://www.lb7.uscourts.gov/documents/17-264URL1DecisionMemo.pdf.

who were sterilized at a later age." 43 FED. REG. at 52,151, 52,152. This further indicates that minor children are not sufficiently mature to make informed decisions in this context.

There is no evidence that long-term mental health outcomes are improved or that rates of suicide are reduced by hormonal or surgical intervention. "Childhood-onset gender dysphoria has been shown to have a high rate of natural resolution, with 61-98% of children reidentifying with their biological sex during puberty. No studies to date have evaluated the natural course and rate of gender dysphoria resolution among the novel cohort presenting with adolescent-onset gender dysphoria."[6] One of the few relevant studies monitored transitioned individuals for 30 years. It found high rates of post-transition suicide and significantly elevated all-cause mortality, including increased death rates from cardiovascular disease and cancer, although causality could not be established.[7] The lack of evidence in this field is why the Centers for Medicare & Medicaid Services rejected a nationwide coverage mandate for adult gender transition surgeries during the Obama Administration. Similarly, the World Professional Association for Transgender Health states that with respect to irreversible procedures, genital surgery should not be carried out until patients reach the legal age of majority to give consent for medical procedures in a given country.[8]

Generally, the age of majority is eighteen in Texas. TEX. CIV. PRAC. & REM. CODE § 129.001. With respect to consent to sterilization procedures, Medicaid sets the age threshold even higher, at twenty-one years old. Children and adolescents are promised relief and asked to "consent" to life-altering, irreversible treatment—and to do so in the midst of reported psychological distress, when they cannot weigh long-term risks the way adults do, and when they are considered by the State in most regards to be without legal capacity to consent, contract, vote, or otherwise. Legal and ethics scholars have suggested that it is particularly unethical to radically intervene in the normal physical development of a child to "affirm" a "gender identity" that is at odds with bodily sex.[9]

State and federal governments have "wide discretion to pass legislation in areas where there is medical and scientific uncertainty." *Gonzales v. Carhart*, 550 U.S. 124, 163 (2007). Thus, states routinely regulate the medical profession and routinely update their regulations as new trends arise and new evidence becomes available. In the opioid context, for instance, states responded to an epidemic caused largely by pharmaceutical companies and medical professionals. Dismissing as "opioidphobic" any concern that "raising pain treatment to a 'patients' rights' issue could lead to overreliance on opioids," these experts created new pain standards and assured doctors that

---

[6]SOCIETY FOR EVIDENCE BASED GENDER MEDICINE, https://segm.org/.

[7]*See* Cecilia Dhejne, et al., *Long-term Follow-up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, 6 PLOS ONE, Issue 2, 5 (Feb. 22, 2011) (19 times the expected norm overall (Table 2), and 40 times the norm for biological females (Table s1)), https://journals.plos.org/plosone /article?id=10.1371/journal.pone.0016885.

[8]WORLD PROFESSIONAL ASS'N FOR TRANSGENDER HEALTH, *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People* at 59 (7th ed. 2012), available at https://www. wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English2012.pdf?_t=1613669341.

[9]Ryan T. Anderson & Robert P. George, Physical Interventions on the Bodies of Children to "Affirm" their "Gender Identity" Violate Sound Medical Ethics and Should Be Prohibited, PUBLIC DISCOURSE: THE JOURNAL OF THE WITHERSPOON INSTITUTE (Dec. 8, 2019), https://www.thepublicdiscourse.com/2019/12/58839/.

prescribing more opioids was largely risk free.[10] *Id.* As we know now, the results were—indeed, *are*—nothing short of tragic.[11] There is always the potential for novel medical determinations to promote purported remedies that may not improve patient outcomes and can even result in tragic harms. The same potential for harm exists for minors who have engaged in the type of procedures or treatments above.

The State's power is arguably at its zenith when it comes to protecting children. In the Supreme Court's words, that is due to "the peculiar vulnerability of children." *Bellotti v. Baird*, 443 U.S. 622, 634 (1979); *see also Ginsberg v. New York*, 390 U.S. 629, 640 (1968) ("The State also has an independent interest in the well-being of its youth."). The Supreme Court has explained that children's "inability to make critical decisions in an informed, mature manner" makes legislation to protect them particularly appropriate. *Bellotti*, 443 U.S. at 634. The procedures that you ask about impose significant and irreversible effects on children, and we therefore address them with extreme caution, mindful of the State's duty to protect its children. *See generally T.L. v. Cook Children's Med. Ctr.*, 607 S.W.3d 9, 42 (Tex. App.—Fort Worth 2020), *cert. denied*, 141 S. Ct. 1069 (2021) ("Children, by definition, are not assumed to have the capacity to take care of themselves. They are assumed to be subject to the control of their parents, and if parental control falters, the State must play its part as *parens patriae.* In this respect, the [child]'s liberty interest may, in appropriate circumstances, be subordinated to the State's *parens patriae* interest in preserving and promoting the welfare of the child.") (citation omitted).

III. To the extent that these procedures and treatments could result in sterilization, they would deprive the child of the fundamental right to procreate, which supports a finding of child abuse under the Family Code.

A. The procedures you describe can and do cause sterilization.

The surgical and chemical procedures you ask about can and do cause sterilization.[12] Similarly, the treatments you ask about often involve puberty-blocking medications. Such medications suppress the body's production of estrogen or testosterone to prevent puberty and are being used in this context to pause the sexual development of a person that occurs during puberty. The use of these chemical procedures for this purpose is not approved by the federal Food and Drug Administration and is considered an "off-label" use of the medications. These chemical procedures prevent a person's body from developing the capability to procreate. There is insufficient medical evidence available to demonstrate that discontinuing the medication resumes a normal puberty process. *See generally Hennessy-Waller v. Snyder*, 529 F. Supp. 3d 1031, 1042 (D. Ariz. 2021), citing *Bell v. Tavistock and Portman NHS Foundation Trust*, 2020 EWHC 3274,

---

[10] *See* David W. Baker, *The Joint Commission's Pain Standards: Origins and Evolution* 4 (May 5, 2017) (footnotes omitted), https://perma.cc/RZ42-YNRC ("[N]o large national studies were conducted to examine whether the standards improved pain assessment or control.").

[11] *See generally* U.S. HEALTH & HUMAN SERVS., WHAT IS THE U.S. OPIOID EPIDEMIC?, https://www.hhs.gov/opioids/about-the-epidemic/index html.

[12] *See* Philip J. Cheng, *Fertility Concerns of the Transgender Patient*, TRANSL ANDROL UROL. 2019;9(3):209-218 (explaining that hysterectomy, oophorectomy, and orchiectomy "results in permanent sterility"), https://www ncbi nlm nih.gov/pmc/articles/PMC6626312/.

¶ 134 (Dec. 1, 2020) (referring to *Bell's* conclusion that a clinic's practice of prescribing puberty-suppressing medication to individuals under age 18 with gender dysphoria and determining such treatment was experimental). Thus, because the procedures you inquire about can and do result in sterilization, they implicate a minor child's constitutional right to procreate.

B. The United States Constitution protects a fundamental right to procreation.

The United States Supreme Court recognizes that the right to procreate is a fundamental right under the Fourteenth Amendment. *See Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942). Almost a century ago, the Court explained the unique concerns sterilization poses respecting this fundamental right:

> The power to sterilize, if exercised, may have subtle, far reaching and devastating effects. In evil or reckless hands it can cause races or types which are inimical to the dominant group to wither and disappear. There is no redemption for the individual whom the law touches. Any experiment which the State conducts is to his irreparable injury. He is forever deprived of a basic liberty.

Id. To the extent the procedures you describe cause permanent damage to reproductive organs and functions of a child before that child has the legal capacity to consent, they unlawfully violate the child's constitutional right to procreate. *See generally* 43 FED. REG. at 52,146–52,152 (discussing ripeness for coercion and regret rates among minor children).

C. Because children are legally incompetent to consent to sterilization, procedures and treatments that result in a child's sterilization are unauthorized and infringe on the child's fundamental right to procreate.

Under Texas law, a minor is a person under eighteen years of age that has never been married and never declared an adult by a court. *See* TEX. CIV. PRAC. & REM. CODE § 129.001; TEX. FAM. CODE §§ 1.104, 101.003 (including a minor on active duty in the military, one who does not live with a parent or guardian and who manages their own financial affairs, among others). State law recognizes seven instances in which a minor can consent to certain types of medical treatment on their own. *See id.* § 32.003. None of the express provisions relating to a minor's ability to consent to medical treatment addresses consent to the procedures used for "gender-affirming" treatment. *See generally id.*

The lack of authority of a minor to consent to an irreversible sterilization procedure is consistent with other law. The federal Medicaid program does not allow for parental consent, has established a minimum age of 21 for consent to sterilization procedures, and imposes detailed requirements for obtaining that consent. 42 C.F.R. §§ 441.253(a); 441.258 ("Consent form requirements"). Federal Medicaid funds may not be used for any sterilization without complying with the consent requirements, meaning a doctor may not be reimbursed for sterilization procedures performed on minors. *Id.* § 441.256(a).

The higher age limit for sterilization procedures was implemented due to a number of special concerns, including historical instances of forced sterilization. *See* 43 FED. REG. 52146, 52148. "[M]inors and other incompetents have been sterilized with federal funds and . . . an indefinite number of poor people have been improperly coerced into accepting a sterilization operation under the threat that various federally supported welfare benefits would be withdrawn unless they submitted to irreversible sterilization." *Relf v. Weinberger*, 372 F. Supp. 1196, 1199 (D.D.C. 1974), *vacated*, 565 F.2d 722 (D.C. Cir. 1977). In addition, the 21-year minimum age-of-consent rule accounted for concerns that minors were more susceptible to coercion than those over 21 and that younger women had higher rates of regret for sterilization than those who were sterilized at a later age. 43 FED. REG. at 52,151 (pointing to comments suggesting that "persons under 21 are more susceptible to coercion than those over 21 and are more likely to lack the maturity to make an informed decision" and acknowledging "these considerations favor protecting such individuals by limiting their access to the procedure"); *see id.* at 52,151–52,152 (pointing to "several studies [that] show a higher rate of regret at being sterilized among younger women than among those who were sterilized at a later age").

Regarding parental consent, Texas law generally recognizes a parent's right to consent to a child's medical care. TEX. FAM. CODE § 151.001(a)(6) ("A parent of a child has the following rights and duties: . . . (6) the right to consent to the child's . . . medical and dental care, and psychiatric, psychological, and surgical treatment . . .".). But this general right to consent to certain medically necessary procedures does not extend to elective (not medically necessary) procedures and treatments that infringe upon a minor child's constitutional right to procreate. Indeed, courts have analyzed the imposition of unnecessary medical procedures upon children in similar circumstances in the past to determine whether doing so constitutes child abuse.

One such situation that the law has addressed is often referred to as "Munchausen by proxy" or "factitious disorder imposed on another":

> [A] psychological disorder that is characterized by the intentional feigning, exaggeration, or induction of the symptoms of a disease or injury in oneself or another and that is accompanied by the seeking of excessive medical care from various doctors and medical facilities typically resulting in multiple diagnostic tests, treatments, procedures, and hospitalizations. Unlike the malingerer, who consciously induces symptoms to obtain something of value, the patient with a factitious disorder consciously produces symptoms for unconscious reasons, without identifiable gain.[13]

In situations such as this, an individual intentionally seeks to procure—often by deceptive means, such as exaggeration—unnecessary medical procedures or treatments either for themselves or others, usually their children. In Texas, courts have found that these "Munchausen by proxy" situations can constitute child abuse. *See generally Williamson v. State*, 356 S.W.3d 1, 19–21 (Tex. App.—Houston [1st Dist.] 2010, pet. ref'd) (recognizing that an unnecessary medical procedure

---

[13] *Factitious disorder*, MERRIAM-WEBSTER.COM DICTIONARY, https://www merriam-webster.com/dictionary/factitious%20disorder.

may cause serious bodily injury, supporting a charge of injury to a child under section 22.04 of the Penal Code).[14]

In the context of elective sex change procedures for minors, the Legislature has not provided any avenue for parental consent, and no judicial avenue exists for the child to proceed with these procedures and treatments without parental consent. By comparison, Texas law respecting abortion requires parental consent and, in extenuating circumstances, permits non-parental consent for a minor to obtain an abortion. TEX. OCC. CODE § 164.052(19) (requiring written consent of a child's parent before a physician may perform an abortion on an unemancipated minor); TEX. FAM. CODE § 33.003 (authorizing judicial approval of a minor's abortion without parental consent in limited circumstances). But the Texas Legislature has not decided to make those same allowances for consent to sterilization, and thus a parent cannot consent to sterilization procedures or treatments that result in the permanent deprivation of a minor child's constitutional right to procreate.[15] Thus, no avenue exists for a child to consent to or obtain consent for an elective procedure or treatment that causes sterilization.

IV. The procedures and treatments you describe can constitute child abuse under the Family Code.

Having established the legal and cultural context of this opinion request, we now consider whether these procedures and treatments qualify as child abuse under the Family Code. *See* Request Letter at 1. Where, as a factual matter, one of these procedures or treatments cannot result in sterilization, a court would have to go through the process of evaluating, on a case-by-case basis, whether that procedure violates any of the provisions of the Family Code—and whether the procedure or treatment poses a similar threat or likelihood of substantial physical and emotional harm. Thus, where a factual scenario involving non-medically necessary, gender-based procedures or treatments on a minor causes or threatens to cause harm or irreparable harm[16] to the child—comparable to instances of Munchausen syndrome by proxy or criminal injury to a child—or demonstrates a lack of consent, etc., a court could find such procedures to constitute child abuse under section 261.001.

A. The Texas Legislature defines child abuse broadly.

Family Code chapter 261 provides for the reporting and investigation of abuse or neglect of a child. *See* TEX. FAM. CODE §§ 261.001–.505; *see also* TEX. PENAL CODE § 22.04 (providing for the offense of injury to a child). Section 261.001 defines abuse through a broad and nonexclusive list of acts and omissions. TEX. FAM. CODE § 261.001(1); *see also In re Interest of*

---

[14]*See also* Tex. Dep't of Fam. & Protective Servs., Tex. Practice Guide for Child Protective Servs. Att'ys, § 7, at 15 (2018), https://www.dfps.state.tx.us/Child_Protection/Attorneys_Guide/default.asp.

[15]Federal Medicaid programs will not reimburse for these types of procedures on minors, regardless of whether the child or parent consents, because of the numerous concerns outlined in the Federal Register provisions discussed above. *See* 43 FED. REG. at 52,146–52,159.

[16] For example, a non-medically necessary procedure or treatment that seeks to alter a minor female's breasts in such a way that would or could prevent that minor female from having the ability to breastfeed her eventual children likely causes irreparable harm and could form the basis for a finding of child abuse.

S.M.R., 434 S.W.3d 576, 583 (Tex. 2014). Of course, this broad definition of abuse would apply to and include criminal acts against children, such as "female genital mutilation"[17] or "injury to a child."[18]

Your questions implicate several components of section 261.001(1). Subsection 261.001(1)(A) identifies "mental or emotional injury to a child that results in an observable and material impairment in the child's growth, development, or psychological functioning." Subsection 261.001(1)(B) provides that "causing or permitting the child to be in a situation in which the child sustains a mental or emotional injury that results in an observable and material impairment in the child's growth, development, or psychological functioning" is abuse. Subsection 261.001(1)(C) includes as abuse a "physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child." And subsection 261.001(1)(D) includes "failure to make a reasonable effort to prevent an action by another person that results in physical injury that results in substantial harm to the child."

Offering some clarity to the scope of "abuse" under subsection 261.001(1), the Texas Department of Family and Protective Services ("Department") adopted rules giving meaning to the key terms and phrases used in the definition. The Department acknowledges that emotional abuse is a subset of abuse that includes "[m]ental or emotional injury to a child that results in an observable and material impairment in the child's growth, development, or psychological functioning." 40 TEX. ADMIN. CODE § 707.453(a) (Tex. Dept. of Fam. & Protective Servs., What is Emotional Abuse?). The Department's rules provide that "[m]ental or emotional injury" means

> [t]hat a child of any age experiences significant or serious negative effects on intellectual or psychological development or functioning. . . . and exhibits behaviors indicative of observable and material impairment . . . . mean[ing] discernable and substantial damage or deterioration to a child's emotional, social, and cognitive development.

Id. § 707.453(b)(1)–(2).

With respect to physical injuries, the Department further clarified the meaning of the phrase "[p]hysical injury that results in substantial harm to the child," explaining that it means in relevant part a

---

[17]A person commits an offense if the person: (1) knowingly circumcises, excises, or infibulates any part of the labia majora or labia minora or clitoris of another person who is younger than 18 years of age; (2) is a parent or legal guardian of another person who is younger than 18 years of age and knowingly consents to or permits an act described by Subdivision (1) to be performed on that person; or (3) knowingly transports or facilitates the transportation of another person who is younger than 18 years of age within this state or from this state for the purpose of having an act described by Subdivision (1) performed on that person. TEX. HEALTH & SAFETY CODE § 167.001.

[18]A person commits an offense if he intentionally, knowingly, recklessly, or with criminal negligence, by act or intentionally, knowingly, or recklessly by omission, causes to a child, elderly individual, or disabled individual: (1) serious bodily injury; (2) serious mental deficiency, impairment, or injury; or (3) bodily injury. TEX. PENAL CODE § 22.04.

> real and significant physical injury or damage to a child that includes but is not limited to . . . [a]ny of the following, if caused by an action of the alleged perpetrator directed toward the alleged victim: . . . *impairment of or injury to any bodily organ or function*; . . . .

Id. § 707.455(b)(2)(A) (emphasis added). The Department's rules also define a "[g]enuine threat of substantial harm from physical injury" to include the

> *declaring or exhibiting the intent or determination to inflict real and significant physical injury or damage to a child.* The declaration or exhibition does not require actual physical contact or injury.

Id. § 707.455(b)(1) (emphasis added).

Subsection 261.001(1) and these rules define "abuse" broadly to include mental or emotional injury in addition to a physical injury. To the extent the specific procedures about which you ask may cause mental or emotional injury or physical injury within these provisions, they constitute abuse.

Further, the Legislature has explicitly defined "female genital mutilation" and made such act a state jail felony. *See* TEX. HEALTH & SAFETY CODE § 167.001(a)–(b). While the Legislature has not elsewhere defined the phrase "genital mutilation", nor specifically for males of any age,[19] the Legislature's criminalization of a particular type of genital mutilation supports an argument that analogous procedures that include genital mutilation—potentially including gender reassignment surgeries—could constitute "abuse" under the Family Code's broad and non-exhaustive examples of child abuse or neglect.[20] *See* TEX. FAM. CODE § 261.001(1)(A)–(M); *see generally* Commissioner's Letter at 1 (concluding that genital "mutilation may cause a genuine threat of substantial harm from physical injury to the child"). Thus, many of the procedures and treatments you ask about can constitute "female genital mutilation," a standalone criminal act. But even where these procedures and treatments may not constitute "female genital mutilation" under Texas law, a court could still find that these procedures and treatments constitute child abuse under section 261.001 of the Family Code.

B. Each of these procedures and treatments can constitute abuse under Texas Family Code § 261.001(1)(A), (B), (C), or (D).

The Texas Family Code is clear—causing or permitting substantial harm to the child or the child's growth and development is child abuse. Courts have held that an unnecessary surgical

---

[19]Your letter does not mention nor request an analysis under federal law. However, under federal law, there are at least two definitions of female genital mutilation, 8 U.S.C § 1374 and 18 U.S.C. § 116. For purposes of this opinion, we have not considered federal statutes, nor have we undertaken any analysis under state or federal constitutions beyond that included here.

[20]The Eighty-seventh Legislature considered multiple bills that would have amended Family Code subsection 261.001(1) to expressly include in the definition of abuse the performing of surgery or other medical procedures on a child for the purpose of gender transitioning or gender reassignment. Those bills did not pass. *See, e.g.*, Tex. H.B. 22, 87th Leg., 3d C.S. (2021).

procedure that removes a healthy body part from a child can constitute a real and significant injury or damage to the child. *See generally Williamson v. State*, 356 S.W.3d 1, 19–21 (Tex. App.—Houston [1st Dist.] 2010, pet. ref'd) (recognizing that an unnecessary medical procedure may cause serious bodily injury, supporting a charge of injury to a child under section 22.04 of the Penal Code). The *Williamson* case involved a "victim of medical child abuse, sometimes referred to as Munchausen Syndrome by Proxy." *Id.* at 5. Munchausen syndrome by proxy is "where an alleged perpetrator . . . attempts to gain medical procedures and issues for [their] child for secondary gain for themselves . . . . [A]s a result, the children are subjected to multiple diagnostic tests, therapeutic procedures, sometimes operative procedures, in order to treat things that aren't really there." *Williamson*, 356 S.W.3d at 11. In the *Williamson* case, the abuse was perpetrated on the child when he was five and six years old by his mother. *Id.* The evidence showed that two surgeries performed on the child "were not medically necessary and that [his mother] knowingly and intentionally caused the unnecessary procedures to be performed by fabricating, exaggerating, and inducing the symptoms leading to the surgeries." *Id.*

Similarly, in *Austin v. State*, a court of appeals upheld the conviction for felony injury of a child of a mother suffering from Munchausen syndrome by proxy who injected her son with insulin. *See* 222 S.W.3d 801, 804 (Tex. App.—Austin 2007, pet. ref'd); *see also In re McCabe*, 580 S.E.2d 69, 73 (N.C. Ct. App. 2003) (concluding that abuse through Munchausen syndrome by proxy was abuse under state statute defining abuse in a similar manner as chapter 261); *Matter of Aaron S.*, 625 N.Y.S.2d 786, 793 (Fam. Ct. 1993), *aff'd sub nom. Matter of Suffolk Cnty. Dep't of Soc. Servs on Behalf of Aaron S.*, 626 N.Y.S.2d 227 (App. Div. 1995) (finding that a mother neglected her son by subjecting him to a continuous course of medical treatment for condition which he did not have and that he was a neglected child under state statute governing abuse of a child). In guidance documents published for its child protective services attorneys, the Texas Department of Family and Protective Services explains that "Munchausen by proxy syndrome is relatively rare, but when it occurs, it is frequently a basis for a finding of child abuse."[21] Whether motivated by Munchausen syndrome by proxy or otherwise, it is clear that unnecessary medical treatment inflicted on a child by a parent can constitute child abuse under the Family Code.

By definition, procedures and treatments resulting in sterilization cause "physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child" by surgically altering key physical body parts of the child in ways that render entire body parts, organs, and the entire reproductive system of the child physically incapable of functioning. Thus, such procedures and treatments can constitute child abuse under section 261.001(1)(C). Even where the procedure or treatment does not involve the physical removal or alteration of a child's reproductive organs (*i.e.* puberty blockers), these procedures and treatments can cause "mental or emotional injury to a child that results in an observable and material impairment in the child's growth, development, or psychological functioning" by subjecting a child to the mental and emotional injury associated with lifelong sterilization—an impairment to

[21]TEX. DEP'T OF FAM. & PROTECTIVE SERVS., TEX. PRACTICE GUIDE FOR CHILD PROTECTIVE SERVS. ATT'YS, § 7, at 15 (2018), https://www.dfps.state.tx.us/Child_Protection/Attorneys_Guide/default.asp (citing *Reid v. State*, 964 S.W.2d 723 (Tex. App.—Amarillo 1998, pet. ref'd) (mem. op.) (expert testimony admitted regarding general acceptance of Munchausen diagnosis as a form of child abuse)).

one's growth and development. Therefore, a court could find these procedures and treatments to be child abuse under section 261.001(1)(A). Further, attempts by a parent to consent to these procedures and treatments on behalf of their child may, if successful, "cause or permit the child to be in a situation in which the child sustains a mental or emotional injury that results in an observable and material impairment in the child's growth, development, or psychological functioning[,]" and could be child abuse under section 261.001(1)(B). Additionally, the failure to stop a doctor or another parent from conducting these treatments and procedures on a minor child can constitute a "failure to make a reasonable effort to prevent an action by another person that results in physical injury that results in substantial harm to the child[,]" and this "failure to make a reasonable effort to prevent" can also constitute child abuse under section 261.001(1)(D). Any person that conducts or facilitates these procedures or treatments could be engaged in child abuse, whether that be parents, doctors, counselors, etc.

It is important to note that anyone who has "a reasonable cause to believe that a child's physical or mental health or welfare has been adversely affected by abuse or neglect by any person shall immediately make a report" as described in the Family Code. TEX. FAM. CODE § 261.101(a). Further, "[i]f a professional has reasonable cause to believe that a child has been abused or neglected or may be abused or neglected, or that a child is a victim of an offense under Section 21.11, Penal Code, and the professional has reasonable cause to believe that the child has been abused as defined by Section 261.001, the professional shall make a report not later than the 48th hour after the hour the professional first has reasonable cause to believe that the child has been or may be abused or neglected or is a victim of an offense under Section 21.11, Penal Code." TEX. FAM. CODE § 261.101(b). The term includes teachers, nurses, doctors, day-care employees, employees of a clinic or health care facility that provides reproductive services, juvenile probation officers, and juvenile detention or correctional officers. *Id.* A failure to report under these circumstances is a criminal offense. TEX. FAM. CODE § 261.109(a).

SUMMARY

Each of the "sex change" procedures and treatments enumerated above, when performed on children, can legally constitute child abuse under several provisions of chapter 261 of the Texas Family Code.

When considering questions of child abuse, a court would likely consider the fundamental right to procreation, issues of physical and emotional harm associated with these procedures and treatments, consent laws in Texas and throughout the country, and existing child abuse standards.

Very truly yours,

KEN PAXTON
Attorney General of Texas

BRENT E. WEBSTER
First Assistant Attorney General

LESLEY FRENCH
Chief of Staff

MURTAZA F. SUTARWALLA
Deputy Attorney General for Legal Counsel

AARON REITZ
Deputy Attorney General for Legal Strategy

RALPH M. MOLINA
Special Counsel to the First Assistant Attorney General

VIRGINIA K. HOELSCHER
Chair, Opinion Committee

CHARLOTTE M. HARPER
Assistant Attorney General, Opinion Committee

GOVERNOR GREG ABBOTT

February 22, 2022

The Honorable Jaime Masters
Commissioner
Texas Department of Family and Protective Services
701 West 51st Street
Austin, Texas 78751

Dear Commissioner Masters:

Consistent with our correspondence in August 2021, the Office of the Attorney General (OAG) has now confirmed in the enclosed opinion that a number of so-called "sex change" procedures constitute child abuse under existing Texas law. Because the Texas Department of Family and Protective Services (DFPS) is responsible for protecting children from abuse, I hereby direct your agency to conduct a prompt and thorough investigation of any reported instances of these abusive procedures in the State of Texas.

As OAG Opinion No. KP-0401 makes clear, it is already against the law to subject Texas children to a wide variety of elective procedures for gender transitioning, including reassignment surgeries that can cause sterilization, mastectomies, removals of otherwise healthy body parts, and administration of puberty-blocking drugs or supraphysiologic doses of testosterone or estrogen. *See* TEX. FAM. CODE § 261.001(1)(A)–(D) (defining "abuse"). Texas law imposes reporting requirements upon all licensed professionals who have direct contact with children who may be subject to such abuse, including doctors, nurses, and teachers, and provides criminal penalties for failure to report such child abuse. *See id.* §§ 261.101(b), 261.109(a-1). There are similar reporting requirements and criminal penalties for members of the general public. *See id.* §§ 261.101(a), 261.109(a).

Texas law also imposes a duty on DFPS to investigate the parents of a child who is subjected to these abusive gender-transitioning procedures, and on other state agencies to investigate licensed facilities where such procedures may occur. *See* TEX. FAM. CODE § 261.301(a)–(b). To protect Texas children from abuse, DFPS and all other state agencies must follow the law as explained in OAG Opinion No. KP-0401.

Sincerely,

Greg Abbott

Greg Abbott
Governor

EXHIBIT
ALL-STATE LEGAL
PX 02

GA:jsd

Enclosure

cc: Ms. Cecile Young, Executive Commissioner, Health and Human Services Commission
Mr. Stephen B. Carlton, Executive Director, Texas Medical Board
Ms. Katherine A. Thomas, Executive Director, Texas Board of Nursing
Dr. Tim Tucker, Executive Director, Texas State Board of Pharmacy
Mr. Darrell Spinks, Executive Director, Texas Behavioral Health Executive Council
Mr. Mike Morath, Commissioner, Texas Education Association
Ms. Cristina Galindo, Chair, Texas State Board of Educator Certification
Ms. Camille Cain, Executive Director, Texas Juvenile Justice Department

1:40

AG Opinion Statement

DOCX - 13 KB

Statement on Governor's Letter/AG Opinion

In accordance with Governor Abbott's directive today to Commissioner Masters, we will follow Texas law as explained in Attorney General opinion KP-0401.

At this time, there are no pending investigations of child abuse involving the procedures described in that opinion. If any such allegations are reported to us, they will be investigated under existing policies of Child Protective Investigations.

Open Office

ALL-STATE LEGAL®

EXHIBIT

PX 03

Curriculum Vitae

Last Updated: March 9, 2022

PERSONAL DATA

Armand H. Matheny Antommaria, MD, PhD, FAAP, HEC-C
Birth Place: Pittsburgh, Pennsylvania
Citizenship: United States of America

CONTACT INFORMATION

Address: 3333 Burnet Ave, ML 15006, Cincinnati, OH 45229
Telephone Number: (513) 636-4939
Electronic Mail Address: armand.antommaria@cchmc.org

EDUCATION

1983-1987	BSEE	Valparaiso University, with High Distinction Valparaiso, IN
1983-1987	BS	Valparaiso University (Chemistry), with High Distinction Valparaiso, IN
1987-1989 1998-2000	MD	Washington University School of Medicine Saint Louis, MO
1989-2000	PhD	The University of Chicago Divinity School (Religious Ethics) Chicago, IL
2000-2003	Resident	University of Utah (Pediatrics) Salt Lake City, UT
2005-2006	Certificate	Conflict Resolution Certificate Program, University of Utah Salt Lake City, UT

BOARD CERTIFICATION

2019 Pediatric Hospital Medicine, American Board of Pediatrics
2019 Healthcare Ethics Consultant-Certified, Healthcare Ethics Consultation Certification Commission
2004 General Pediatrics, American Board of Pediatrics

PROFESSIONAL LICENSES

2012-Present	Doctor of Medicine, Ohio
2006-2010	Alternative Dispute Resolution Provider—Mediator, Utah
2001-2014	Physician and Surgeon, Utah
2001-2014	Physician and Surgeon Controlled Substance, Utah

PROFESSIONAL EXPERIENCE

Full Time Positions

2019-Present	*Professor* Cincinnati Children's Hospital Medical Center, Cincinnati, OH Department of Surgery
2019-Present	*Professor of Clinical-Affiliated* University of Cincinnati, Cincinnati, OH Department of Surgery
2017-Present	*Professor* Cincinnati Children's Hospital Medical Center, Cincinnati, OH Division of Pediatric Hospital Medicine

ALL-STATE LEGAL®
EXHIBIT
PX 05

2017-Present *Professor of Clinical-Affiliated*
University of Cincinnati, Cincinnati, OH
Department of Pediatrics

2016-2017 *Associate Professor of Clinical-Affiliated*
University of Cincinnati, Cincinnati, OH
Department of Pediatrics

2012-2017 *Associate Professor*
Cincinnati Children's Hospital Medical Center, Cincinnati, OH
Division of Pediatric Hospital Medicine

2012-Present *Lee Ault Carter Chair in Pediatric Ethics*
Cincinnati Children's Hospital Medical Center

2012-2016 *Associate Professor-Affiliated*
University of Cincinnati, Cincinnati, OH
Department of Pediatrics

2010-2012 *Associate Professor of Pediatrics* (with Tenure)
University of Utah School of Medicine, Salt Lake City, UT
Divisions of Inpatient Medicine and Medical Ethics

2010-2012 *Adjunct Associate Professor of Medicine*
University of Utah School of Medicine, Salt Lake City, UT
Division of Medical Ethics and Humanities

2004-2010 *Assistant Professor of Pediatrics* (Tenure Track)
University of Utah School of Medicine, Salt Lake City, UT
Divisions of Inpatient Medicine and Medical Ethics

2004-2010 *Adjunct Assistant Professor of Medicine*
University of Utah School of Medicine, Salt Lake City, UT
Division of Medical Ethics and Humanities

2003-2004 *Instructor of Pediatrics* (Clinical Track)
University of Utah School of Medicine, Salt Lake City, UT
Divisions of Inpatient Medicine and Medical Ethics

2003-2004 *Adjunct Instructor of Medicine*
University of Utah School of Medicine, Salt Lake City, UT
Division of Medical Ethics

Part Time Positions

2021 *Consultant*
Proctor & Gamble, Cincinnati, OH

2019 *Consultant*
Sanofi Genzyme, Cambridge, MA

2018-Present *Consultant*
Center for Conflict Resolution in Healthcare, Memphis, TN

2017-2020 *Consultant*
Amicus Therapeutics, Cranbury, NJ

2017 *Expert Witness*
Robert J. Klickovich, MD, PLLC v. Tristate Arthritis & Rheumatology, PSC, *et al.,*
Commonwealth of Kentucky, Boone Circuit Court, Division III, Civil Action No. 16-CI-01690

2017 *Consultant*
Sarepta Therapeutics, Cambridge, MA

2014 *Consultant*
Genzyme, A Sanofi Company, Cambridge, MA

Editorial Experience

Editorial Board

2020-Present *Pediatrics,* Associate Editor for Ethics Rounds and Member of the Executive Editorial Board

2015-2020 *Journal of Clinical Ethics*

2009-2020 *Journal of Medical Humanities*

Guest Academic Editor

2017 *PLOS|ONE*

Ad Hoc Reviewer: *Academic Medicine, Academic Pediatrics, AJOB Primary Research, American Journal of Bioethics, American Journal of Law & Medicine, American Journal of Medical Genetics, American Journal of Transplantation, BMC Medical Ethics, BMJ Open, Canadian Journal of Bioethics, CHEST, Clinical Transplantation, European Journal of Human Genetics, Frontiers in Genetics, Hospital Medicine, International Journal of Health Policy and Management, International Journal of Nursing Studies, Journal of Adolescent and Young Adult Oncology, Journal of Clinical Ethics, Journal of Empirical Research on Human Research Ethics, Journal of General Internal Medicine, Journal of Healthcare Leadership, Journal of Hospital Medicine, Journal of the Kennedy Institute of Ethics, Journal of Law, Medicine & Ethics, Journal of Medical Ethics, Journal of Medical Humanities, Journal of Medicine and Life, Journal of Palliative Care, Journal of Pediatrics, Journal of Pediatric Surgery, Mayo Clinic Proceedings, Medicine, Healthcare and Philosophy, Molecular Diagnosis & Therapy, New England Journal of Medicine, Patient Preference and Adherence, Pediatrics, Pediatrics in Review, Personalized Medicine, PLOS|ONE, Risk Management and Healthcare Policy, Saudi Medical Journal, SSM - Qualitative Research in Health,* and *Theoretical Medicine and Bioethics*

SCHOLASTIC AND PROFESSIONAL HONORS

2021 *Hidden Gem Award,* Cincinnati Children's Hospital Medical Center, Cincinnati, OH

2019-2021 *Presidential Citation,* American Society for Bioethics and Humanities, Chicago, IL

2016 *Laura Mirkinson, MD, FAAP Lecturer,* Section on Hospital Medicine, American Academy of Pediatrics, Elk Grove Village, IL

2016, 2018 *Certificate of Excellence*, American Society for Bioethics and Humanities, Glenview, IL

2013, 2016 *Senior Resident Division Teaching Award,* Cincinnati Children's Hospital Medical Center, Cincinnati, OH

2012 *Role Model*, Quality Review Committee, Primary Children's Medical Center, Salt Lake City, UT

2011 *Member*, Society for Pediatric Research, The Woodlands, TX

2011 *Presidential Citation*, American Society for Bioethics and Humanities, Glenview, IL

2009 *Role Model*, Quality Review Committee, Primary Children's Medical Center, Salt Lake City, UT

2008 *Nominee,* Physician of the Year, Primary Children's Medical Center, Salt Lake City, UT

2005-2006 *Fellow,* Medical Scholars Program, University of Utah School of Medicine, Salt Lake City, UT

1995-1997 *Doctoral Scholar*, Crossroads, A Program of Evangelicals for Social Action, Philadelphia PA

1989-1992 *Fellow*, The Pew Program in Medicine, Arts, and the Social Sciences, University of Chicago, Chicago, IL

ADMINISTRATIVE EXPERIENCE

Administrative Duties

2019-Present *Chair,* Oversight Committee, Cincinnati Fetal Center, Cincinnati, OH

2014-Present *Chair*, Ethics Committee, Cincinnati Children's Hospital Medical Center, Cincinnati, OH

2012-Present *Director*, Ethics Center, Cincinnati Children's Hospital Medical Center, Cincinnati, OH
2012-Present *Chair,* Ethics Consultation Subcommittee, Cincinnati Children's Hospital Medical Center, Cincinnati, OH
2010 *Co-Chair,* Ethics Subcommittee, Work Group for Emergency Mass Critical Care in Pediatrics, Centers for Disease Control and Prevention, Atlanta, GA
2009 *Chair*, Ethics Working Group, H1N1 and Winter Surge, Primary Children's Medical Center, Salt Lake City, UT
2005-2012 *Chair*, Ethics Committee, Primary Children's Medical Center, Salt Lake City, UT
2005-2012 *Chair*, Ethics Consultation Subcommittee, Primary Children's Medical Center, Salt Lake City, UT
2003-4 *Chair*, Clinical Pertinence Committee, Primary Children's Medical Center, Salt Lake City, UT

Professional & Scientific Committees

Committees

2021 *Member*, EMCO Capacity Collaboration, Ohio Hospital Association, Columbus, OH
2020-2021 *Member*, Allocation of Scarce Resources Work Group, Ohio Hospital Association, Columbus, OH
2020-Present *Member,* Literature Selection Technical Review Committee, National Library of Medicine, Bethesda, MD
2020 *Member*, Crisis Standards of Care Workgroup, The Health Collaborative, Cincinnati, OH
2019-Present *Member,* Healthcare Ethics Consultant Certification Commission, Oak Park, IL
2019 *Member,* Expert Panel, Pediatric Oncology End-of-Life Care Quality Markers, Institute for Cancer Outcomes & Survivorship, University of Alabama at Birmingham, Birmingham, AL
2018 *Member,* Resource Planning and Allocation Team Implementation Task Force, Ohio Department of Health, Columbus, OH
2012-Present *Member*, Gaucher Initiative Medical Expert Committee, Project HOPE, Millwood, VA
2009-2014 *Member,* Clinical Ethics Consultation Affairs Committee, American Society for Bioethics and Humanities, Glenview, IL
2005-2011 *Member,* Committee on Bioethics, American Academy of Pediatrics, Oak Park, IL

Data Safety and Monitoring Boards

2019-Present *Member,* Data and Safety Monitoring Board, Sickle Cell Domestic Trials, National Heart, Lung, and Blood Institute, Bethesda, MD
2018-Present *Member,* Standing Safety Committee for P-188-NF (Carmeseal-MD™) in Duchenne Muscular Dystrophy, Phrixus Pharmaceuticals, Inc., Ann Arbor, MI
2017-Present *Member*, Observational Study Monitoring Board, Sickle Cell Disease Observational Monitoring Board, National Heart, Lung, and Blood Institute, Bethesda, MD
2016-2018 *Member,* Observational Study Monitoring Board, Long Term Effects of Hydroxyurea in Children with Sickle Cell Anemia, National Heart, Lung, and Blood Institute, Bethesda, MD

Reviewer

2020-Present *Abstract Reviewer*, American Society for Bioethics and Humanities Annual Meeting
2020 *Grant Reviewer,* The Croatian Science Foundation, Hvatska zaklada za znanost (HRZZ)
2018 *Book Proposal Reviewer*, Elsevier
2018-2019 *Category Leader,* Religion, Culture, and Social Sciences, American Society for Bioethics and Humanities Annual Meeting
2017 *Timekeeper,* American Society for Bioethics and Humanities Annual Meeting
2017-Present *Abstract Reviewer,* Pediatric Academic Societies Annual Meeting

2016-Present	*Workshop Reviewer*, Pediatric Academic Societies Annual Meeting
2016	*Grant Reviewer*, Innovation Research Incentives Scheme, The Netherlands Organisation for Health Research and Development
2016-2017	*Abstract Reviewer*, American Society for Bioethics and Humanities Annual Meeting
2014, 2016	*External Peer Reviewer*, PSI Foundation, Toronto, Ontario, Canada
2014	*Member,* Scientific Committee, International Conference on Clinical Ethics and Consultation
2013	*Abstract Reviewer*, American Society for Bioethics and Humanities Annual Meeting
2013	*Reviewer*, Open Research Area Plus, Agence Nationale de la Research, Deutsche Forschungsgemeinschaft, Economic and Social Research Council, National Science Foundation, and Organization for Scientific Research
2011-2012	*Abstract Reviewer,* Pediatric Academic Societies Annual Meeting
2011-2013	*Workshop Reviewer*, Pediatric Academic Societies Annual Meeting
2011-Present	*Abstract Reviewer*, Pediatric Hospital Medicine Annual Meeting
2011-2012	*Religious Studies Subcommittee Leader,* Program Committee, American Society for Bioethics and Humanities Annual Meeting
2010	*Abstract Reviewer*, American Society for Bioethics and Humanities Annual Meeting

Other

2021	*Timekeeper,* American Society for Bioethics and Humanities Annual Meeting
2021	*Mentor,* Early Career Advisor Professional Development Track, American Society for Bioethics and Humanities.
2021	*Mentor,* Early Career Advisor Paper or Project Track, American Society for Bioethics and Humanities.
2109	*Mentor*, Early Career Advising Program, American Society for Bioethics and Humanities
2018	*Passing Point Determination*, Healthcare Ethics Consultant-Certified Examination, Healthcare Ethics Consultant Certification Commission
2018	*Member*, Examination Committee, Healthcare Ethics Consultant-Certified Examination, Healthcare Ethics Consultant Certification Commission
2018	*Item Writer*, Healthcare Ethics Consultant-Certified Examination, Healthcare Ethics Consultant Certification Commission

UNIVERSITY COMMUNITY ACTIVITIES

Cincinnati Children's Hospital Medical Center

2020-Present	*Member*, Faculty Diversity and Inclusion Steering Committee
2020-Present	*Member*, Medical Management of COVID-19 Committee
2020-2021	*Member,* Caregiver Refusal Team
2020-2021	*Member,* COVID-19 Vaccine Allocation Committee
2020	*Member*, Personal Protective Equipment Subcommittee of the COVID-19 Steering. Committee
2018-2019	*Member,* Planning Committee, Center for Clinical & Translational Science & Training Research Ethics Conference
2017-Present	*Member*, Donor Selection Committee
2017-2020	*Member,* Employee Emergency Fund Review Committee
2017	*Member,* Root Cause Analysis Team
2016-2017	*Member,* Planning Committee, Center for Clinical & Translational Science & Training Research Ethics Conference
2015-2019	*Member,* Destination Excellence Medical Advisory Committee
2015-Present	*Member,* Disorders of Sexual Development Case Review Committee
2015-2019	*Member,* Destination Excellence Case Review Committee
2014-2018	*Member,* Genomics Review Group, Institutional Review Board

2014-2017 *Member,* Center for Pediatric Genomics Leadership Committee
2013-2017 *Member,* Genetic Testing Subcommittee, Health Network
2013-2016 *Member,* Schwartz Center Rounds Planning Committee
2013-2014 *Member*, Genomics Ad Hoc Subcommittee, Board of Directors
2012-Present *Member,* Cincinnati Fetal Center Oversight Committee
2012-Present *Member,* Ethics Committee
2012-Present *Member,* G-23
2012-2016 *Member,* Integrated Solid Organ Transplant Steering Committee

University of Utah
2009-2012 *Member,* Consolidated Hearing Committee

University of Utah School of Medicine
2010-2012 *Member,* Medical Ethics, Humanities, and Cultural Competence Thread Committee
2008-2010 *Member,* Fourth Year Curriculum Committee

University of Utah Department of Pediatrics
2010-2011 *Member,* Planning Committee, 25th Annual Biological Basis of Children's Health Conference, "Sex, Gender, and Sexuality"
2009-2012 *Member,* Medical Executive Committee
2005-2012 *Member,* Retention, Promotion, and Tenure Committee
2004-2012 *Interviewer,* Residency Program
2003-2012 *Member,* Education Committee

Intermountain Healthcare
2009-2012 *Member,* System-Wide Bioethics Resource Service
2009-2012 *Member,* Pediatric Guidance Council

Primary Children's Medical Center
2012-2012 *Member,* Shared Accountability Organization Steering Committee
2009 *Member*, H1N1 and Winter Surge Executive Planning Team
2005-2010 *Member,* Continuing Medical Education Committee
2005-2010 *Member*, Grand Rounds Planning Committee
2003-2012 *Member*, Ethics Committee

ACTIVE MEMBERSHIPS IN PROFESSIONAL SOCIETIES
2012-Present Association of Bioethics Program Directors
2011-Present Society for Pediatric Research
2000-Present American Academy of Pediatrics
1999-Present American Society of Bioethics and Humanities

FUNDING
Past Grants
2015-2019 "Better Outcomes for Children: Promoting Excellence in Healthcare Genomics to Inform Policy."
Percent Effort: 9%
National Human Genome Research Institute
Grant Number: 1U01 HG008666-01
Role: Investigator

2015-2016 "Ethics of Informed Consent for Youth in Foster Care"
Direct Costs: $10,000
Ethics Grant, Center for Clinical and Translational Science and Training
University of Cincinnati Academic Health Center
Role: Co-Investigator

2014-2015 "Extreme Personal Exposure Biomarker Levels: Engaging Community Physicians and Ethicists for Guidance"
Direct Costs: $11,640
Center for Environmental Genetics
University of Cincinnati College of Medicine
Role: Investigator

2014-2015 "Child, Adolescent, and Parent Opinions on Disclosure Policies for Incidental Findings in Clinical Whole Exome Sequencing"
Direct Costs: $4,434
Ethics Grant, Center for Clinical and Translational Science and Training, University of Cincinnati Academic Health Center
Role: Principal Investigator

2013-2014 "Better Outcomes for Children: GWAS & PheWAS in eMERGEII
Percent Effort: 5%
National Human Genome Research Institute
Grant Number: 3U01HG006828-0251
Role: Investigator

2004-2005 "Potential Patients' Knowledge, Attitudes, and Beliefs Regarding Participating in Medical Education: Can They be Interpreted in Terms of Presumed Consent?"
Direct Costs: $8,000
Interdisciplinary Research in Applied Ethics and Human Values, University Research Committee, University of Utah
Role: Principal Investigator

TEACHING RESPONSIBILITIES/ASSIGNMENTS

Course and Curriculum Development

2003-2012 Medical Ethics, Internal Medicine 7560, University of Utah School of Medicine, Taught 1 time per year, Taken by medical students, Enrollment 100

Course Lectures

2018, 2021 Introduction to Biotechnology, "Ethics and Biotechnology" and "Clinical Ethics," BIOL 3027, University of Cincinnati, Taught 1 time per year, Taken by undergraduate students, Enrollment 25.

2018-Present Biomedical Ethics, "Conscientious Objection in Healthcare" and "Ethical Issues in the Care of Transgender Adolescents," MEDS 4035 & MEDS 4036, University of Cincinnati College of Medicine, Taught 1 time per year, Taken by senior undergraduate students, Enrollment 52.

2016 Foundations of Healthcare Ethics and Law, "Clinical Ethics," HESA 390, Xavier University.

2014-Present Physicians and Society, "Transfusion and the Jehovah's Witness Faith," "Obesity Management: Ethics, Policy, and Physician Implicit Bias," "Embryos and Ethics: The Ethics of Designer Babies," "Ethics and Genetic Testing," and "Ethics and Direct to

Consumer Genetic Testing," 26950112 and 26950116, University of Cincinnati School of Medicine, Taken by first and second year medical students, Enrollment 100.

2014-Present Ethical Issues in Health Care, "Ethical Issues in Managing Drug Shortages: The Macro, Meso, and Micro Levels," HESA 583, College of Social Sciences, Health, and Education Health Services Administration, Xavier University, Taken by health services administration students, Enrollment 25.

2009 Physical Diagnosis II, Internal Medicine 7160, University of Utah School of Medicine, Taught 1 time per year, Taken by medical students, Enrollment 100

2003-2012 Medical Ethics, Internal Medicine 7560, University of Utah School of Medicine, Taught 1 time per year, Taken by fourth year medical students, Enrollment 100

Small Group Teaching

2018-Present Ethics in Research, GNTD 7003-001, University of Cincinnati School of Medicine, Taught 1 time per year, Taken by fellows, MS, and PhD students, Enrollment 110.

2007 Physical Diagnosis I, Internal Medicine 7150, University of Utah School of Medicine, Taught 1 time per year, Taken by medical students, Enrollment 100

2003-2012 Medical Ethics, Internal Medicine 7560, University of Utah School of Medicine, Taught 1 time per year, Taken by fourth medical students, Enrollment 100

2003 Pediatric Organ System, Pediatrics 7020, University of Utah School of Medicine, Taught 1 time per year, Taken by medical students, Enrollment 100

Graduate Student Committees

2018-Present *Chair,* Scholarship Oversight Committee, William Sveen, Pediatric Critical Care Fellowship, Cincinnati Children's Hospital Medical Center, Cincinnati, OH

2018-2020 *Member*, Scholarship Oversight Committee, Anne Heueman, Genetic Counseling, University of Cincinnati, Cincinnati, OH

2017-2019 *Chair*, Scholarship Oversight Committee, Bryana Rivers, Genetic Counseling, University of Cincinnati, Cincinnati, OH

2013-2015 *Mentor*, Sophia Hufnagel, Combined Pediatrics/Genetics Residency, Cincinnati Children's Hospital Medical Center, Cincinnati, OH

2013-2015 *Co-Chair,* Scholarship Oversight Committee, Andrea Murad, Genetic Counseling, University of Cincinnati, Cincinnati, OH

2013-2014 *Member*, Scholarship Oversight Committee, Grace Tran, Genetic Counseling, University of Cincinnati, Cincinnati, OH

2011-2012 *Chair,* Scholarship Oversight Committee, Kevin E. Nelson, MD, PhD, Pediatric Inpatient Medicine Fellowship, University of Utah, Salt Lake City, UT

Continuing Education Lectures

2008 Choosing Healthplans All Together (CHAT) Exercise Facilitator, 18th Annual Intermountain Medical Ethics Conference, "Setting Priorities for Healthcare in Utah: What Choices are We Ready to Make?," Salt Lake City, Utah, October 3.

2007 *Speaker*, Infant Medical Surgical Unit, Primary Children's Medical Center, "Withholding and Withdrawing Artificial Nutrition and Hydration: Can It Be Consistent With Care?," Salt Lake City, Utah, September 6.

2007 *Faculty Scholar-in Residence,* Summer Seminar, "The Role of Religion in Bioethics," Utah Valley State College, Orem, Utah, May 1.

2006 *Workshop Leader,* Faculty Education Retreat, "Publications and Publishing in Medical Education," University of Utah School of Medicine, Salt Lake City, Utah, September 15.

2006 *Breakout Session,* 16th Annual Intermountain Medical Ethics Conference, "Donation after Cardiac Death: Evolution of a Policy," Salt Lake City, Utah, March 28.

Other Educational Activities

2008 *Instructor*, Contemporary Ethical Issues in Medicine and Medical Research, Osher Lifelong Learning Institute, University of Utah, "Religion and Bioethics: Religiously Based Demands for and Refusals of Treatment," Salt Lake City, Utah, February 7.

2007 *Speaker*, Biology Seminar, Utah Valley State College, "Is He Dead?: Criteria of the Determination of Death and Their Implications for Withdrawing Treatment and Recovering Organs for Transplant," Orem, Utah, September 21.

PEER-REVIEWED JOURNAL ARTICLES

1. Anne C Heuerman, Danielle Bessett, Armand H. Matheny Antommaria, Leandra. K. Tolusso, Nicki Smith, Alison H. Norris and Michelle L. McGowan (2021). "Experiences of reproductive genetic counselors with abortion regulations in Ohio." *Journal of Genetic Counseling*. Online ahead of print. PMID: 34755409.
2. Armand H. Matheny Antommaria and Ndidi I. Unaka. (2021) "Counterpoint: Prioritizing Health Care Workers for Scarce Critical Care Resources is Impractical and Unjust. *Journal of Hospital Medicine.* 16: 182-3. PMID 33617445.
3. Gregory A. Grabowski, Armand H. Matheny Antommaria, Edwin H. Kolodny, and Pramod K. Mistry. (2021) "Gaucher Disease: Basic and Translational Science Needs for More Complete Therapy and Management." *Molecular Genetics and Metabolism*. 132: 59-75. PMID: 33419694.
4. Armand H. Matheny Antommaria, Laura Monhollen, and Joshua K. Schaffzin. (2021) "An Ethical Analysis of Hospital Visitor Restrictions and Masking Requirements During the COVID-19." *Journal of Clinical Ethics.* 32(1): 35-44. PMID 33416516.
5. Armand H. Matheny Antommaria (2020) "The Pediatric Hospital Medicine Core Competencies: 4.05 Ethics." *Journal of Hospital Medicine.* 15(S1): 120-121.
6. Armand H. Matheny Antommaria, Tyler S. Gibb, Amy L. McGuire, Paul Root Wolpe, Matthew K. Wynia, Megan K. Applewhite, Arthur Caplan, Douglas S. Diekema, D. Micah Hester, Lisa Soleymani Lehmann, Renee McLeod-Sordjan, Tamar Schiff, Holly K. Tabor, Sarah E. Wieten, and Jason T. Eberl for a Task Force of the Association of Bioethics Program Directors (2020) "Ventilator Triage Policies During the COVID-19 Pandemic at U.S. Hospitals Associated With Members of the Association of Bioethics Program Directors." *Annals of Internal Medicine.* 173(3): 188-194. PMID: 32330224.
7. Armand H. Matheny Antommaria (2020) "Conflicting Duties and Reciprocal Obligations During a Pandemic." *Journal of Hospital Medicine.* 5:284-286. PMID: 32379030.
8. Mary V. Greiner, Sarah J. Beal, and Armand H. Matheny Antommaria (2020) "Perspectives on Informed Consent Practices for Minimal-Risk Research Involving Foster Youth." *Pediatrics*. 45:e20192845. PMID: 32156772.
9. Jennifer deSante-Bertkau, Michelle McGowan, and Armand H. Matheny Antommaria (2018) "Systematic Review of Typologies Used to Characterize Clinical Ethics Consultations." *Journal of Clinical Ethics.* 29:291-304. PMID: 30605439.
10. Andrew J. Redmann, Melissa Schopper, Armand H. Matheny Antommaria, Judith Ragsdale, Alessandro de Alarcon, Michael J. Jutter, Catherine K. Hart, and Charles M. Myer. (2018) "To Transfuse or Not to Transfuse? Jehovah's Witnesses and PostOperative Hemorrhage in Pediatric Otolaryngology." *International Journal of Pediatric Otorhinolaryngology*. 115:188-192. PMID: 30368384.
11. Armand H. Matheny Antommaria, Kyle B. Brothers, John A. Myers, Yana B Feygin, Sharon A. Aufox, Murray H. Brilliant, Pat Conway, Stephanie M. Fullerton, Nanibaa' A. Garrison, Carol R. Horowitz, Gail P. Jarvik, Rongling Li, Evette J. Ludman, Catherine A. McCarty, Jennifer B. McCormick, Nathaniel D. Mercaldo, Melanie F. Myers, Saskia C. Sanderson, Martha J. Shrubsole, Jonathan S. Schildcrout, Janet L. Williams, Maureen E. Smith, Ellen Wright Clayton, Ingrid A. Holm. (2018) "Parents' Attitudes toward Consent and Data Sharing in Biobanks: A Multi-Site Experimental Survey." *AJOB Empirical Research.* 21:1-15. PMID: 30240342.

12. Armand H. Matheny Antommaria and Cynthia A. Prows. (2018) "Content Analysis of Requests for Religious Exemptions from a Mandatory Influenza Vaccination Program for Healthcare Personnel" *Journal of Medical Ethics.* 44: 389-391. PMID: 29463693.
13. Armand H. Matheny Antommaria (2017) "May Medical Centers Give Nonresident Patients Priority in Scheduling Outpatient Follow-Up Appointments?" *Journal of Clinical Ethics.* 28: 217-221. PMID: 28930708.
14. Andrea M. Murad, Melanie F. Myers, Susan D. Thompson, Rachel Fisher, and Armand H. Matheny Antommaria (2017) "A Qualitative Study of Adolescents' Understanding of Biobanks and Their Attitudes Toward Participation, Re-contact, and Data Sharing." *American Journal of Medical Genetics: Part A.* 173: 930-937. PMID: 28328120.
15. Saskia Sanderson, Kyle Borthers, Nathaniel Mercaldo, Ellen Wright Clayton, Armand Antommaria, Sharon Aufox, Murray Brillant, Diego Campos, David Carrell, John Connolly, Pat Conway, Stephanie Fullerton, Nanibaa Garrison, Carol Horowitz, Gail Jarvik, David Kaufman, Terrie Kitchner, Rongling Li, Evette Ludman, Cahterine McCarty, Jennifer McCormick, Valerie McManus, Melanie Myers, Aaron Scrol, Janet Williams, Martha Shrubsole, Jonathan Schildcrout, Maureen Smith, and Ingrid Holm (2017) "Public Attitudes Towards Consent and Data Sharing in Biobank Research: A Large Multisite Experimental Survey in the US." *The American Journal of Human Genetics*. 100: 414-427. PMID: 28190457.
16. Maureen E. Smith, Saskia C Sanderson, Kyle B Brothers, Melanie F Myers, Jennifer McCormick, Sharon A Aufox, Martha J Shrubsole, Nanibaa' A Garrison, Nathaniel D Mercaldo, Jonathan S Schildcrout, Ellen Wright Clayton, Armand H. Matheny Antommaria, Melissa Basford, Murray Brilliant, John J Connolly, Stephanie M Fullerton, Carol R Horowitz, Gail P Jarvik, Dave Kaufman, Terrie Kitchner, Rongling Li, Evette J Ludman, Catherine McCarty, Valerie McManus, Sarah C Stallings, Janet L Williams, and Ingrid A Holm (2016) "Conducting a Large, Multi-Site Survey about Patients' Views on Broad Consent: Challenges and Solutions." *BMC Medical Research Methodology.* 16: 162. PMID: 27881091.
17. Angela Lorts, Thomas D. Ryan, Armand H. Matheny Antommaria, Michael Lake, and John Bucuvalas (2016) "Obtaining Consensus Regarding International Transplantation Continues to be Difficult for Pediatric Centers in the United States." *Pediatric Transplant.* 20: 774-777. PMID: 27477950.
18. Sophia B. Hufnagel, Lisa J. Martin, Amy Cassedy, Robert J. Hopkin, and Armand H. Matheny Antommaria (2016) "Adolescents' Preferences Regarding Disclosure of Incidental Findings in Genomic Sequencing That Are Not Medically Actionable in Childhood." *American Journal of Medical Genetics Part A*. 170: 2083-2088. PMID: 27149544.
19. Nanibaa' A. Garrison, Nila A. Sathe, Armand H. Matheny Antommaria, Ingrid A. Holm, Saskia Sanderson, Maureen E. Smith, Melissa McPheeters, and Ellen Wright Clayton (2016) "A Systematic Literature Review of Individuals' Perspectives on Broad Consent and Data Sharing in the United States." *Genetics in Medicine.* 18: 663-71. PMID: 26583683.
20. Kyle B. Brothers, Ingrid A. Holm Janet E. Childerhose, Armand H. Matheny Antommaria, Barbara A. Bernhardt, Ellen Wright Clayton, Bruce D. Gelb, Steven Joffe, John A. Lynch, Jennifer B. McCormick, Laurence B. McCullough, D. William Parsons, Agnes S. Sundaresan, Wendy A. Wolf, Joon-Ho Yu, and Benjamin S. Wilfond (2016) "When Genomic Research Participants Grow Up: Contact and Consent at the Age of Majority." *The Journal of Pediatrics* 168: 226-31. PMID: 26477867.
21. Erin E. Bennett, Jill Sweney, Cecile Aguayo, Criag Myrick, Armand H. Matheny Antommaria, and Susan L. Bratton (2015) "Pediatric Organ Donation Potential at a Children's Hospital." *Pediatric Critical Care Medicine.* 16: 814-820. PMID: 26237656.
22. Anita J. Tarzian, Lucia D. Wocial, and the ASBH Clinical Ethics Consultation Affairs Committee (2015) "A Code of Ethics for Health Care Ethics Consultants: Journey to the Present and Implications for the Field." *American Journal of Bioethics*. 15: 38-51. PMID: 25970392.

23. Armand H. Matheny Antommaria, Christopher A. Collura, Ryan M. Antiel, and John D. Lantos (2015) "Two Infants, Same Prognosis, Different Parental Preferences." *Pediatrics*, 135: 918-923. PMID: 25847802.
24. Stefanie Benoit, Armand H. Matheny Antommaria, Norbert Weidner, and Angela Lorts (2015) "Difficult Decision: What should we do when a VAD supported child experiences a severe stroke?" *Pediatric Transplantation* 19: 139-43. PMID: 25557132.
25. Kyle B. Brothers, John A. Lynch, Sharon A. Aufox, John J. Connolly, Bruce D. Gelb, Ingrid A. Holm, Saskia C. Sanderson, Jennifer B. McCormick, Janet L. Williams, Wendy A. Wolf, Armand H. Matheny Antommaria, and Ellen W. Clayton (2014) "Practical Guidance on Informed Consent for Pediatric Participants in a Biorepository." *Mayo Clinic Proceedings,* 89: 1471-80. PMID: 25264176.
26. Sophia M. Bous Hufnagel and Armand H. Matheny Antommaria (2014) "Laboratory Policies on Reporting Secondary Findings in Clinical Whole Exome Sequencing: Initial Uptake of the ACMG's Recommendations." *American Journal of Medical Genetics Part A*, 164: 1328-31. PMID: 24458369.
27. Wylie Burke, Armand H. Matheny Antommaria, Robin Bennett, Jeffrey Botkin, Ellen Wright Clayton, Gail E. Henderson, Ingrid A. Holm, Gail P. Jarvik, Muin J. Khoury, Bartha Maria Knoppers, Nancy A. Press, Lainie Friedman Ross, Mark A. Rothstein, Howard Saal, Wendy R. Uhlmann, Benjamin Wilfond, Susan M. Wold, and Ron Zimmern (2013) "Recommendations for Returning Genomic Incidental Findings? We Need to Talk!" *Genetics in Medicine*, 15: 854-859. PMID: 23907645.
28. Armand H. Matheny Antommaria (2013) "An Ethical Analysis of Mandatory Influenza Vaccination of Health Care Personnel: Implementing Fairly and Balancing Benefits and Burdens," *American Journal of Bioethics*, 13: 30-37. PMID: 23952830.
29. Joseph A. Carrese and the Members of the American Society for Bioethics and Humanities Clinical Ethics Consultation Affairs Standing Committee (2012) "HCEC Pearls and Pitfalls: Suggested Do's and Don't's for Healthcare Ethics Consultants," *Journal of Clinical Ethics*, 23: 234-240. PMID: 23256404.
30. Christopher G Maloney, Armand H Matheny Antommaria, James F Bale Jr., Jian Ying, Tom Greene and Rajendu Srivastiva (2012) "Factors Associated with Intern Noncompliance with the 2003 Accreditation Council for Graduate Medical Education's 30-hour Duty Period Requirement," *BMC Medical Education* 12: 33. PMID: 22621439.
31. Armand H. Matheny Antommaria, Jill Sweney, and W. Bradley Poss (2010) "Critical Appraisal of: Triaging Pediatric Critical Care Resources During a Pandemic: Ethical and Medical Considerations," *Pediatric Critical Care Medicine,* 11:396-400. PMID: 20453611.
32. Armand H. Matheny Antommaria, Karen Trotochaud, Kathy Kinlaw, Paul N. Hopkins, and Joel Frader (2009) "Policies on Donation After Cardiac Death at Children's Hospitals: A Mixed-Methods Analysis of Variation," *Journal of the American Medical Association,* 301: 1902-8. PMID: 19436017.
33. Kristine M. Pleacher, Elizabeth S. Roach, Willem Van der Werf, Armand H. Matheny Antommaria, and Susan L. Bratton (2009) "Impact of a Pediatric Donation after Cardiac Death Program," *Pediatric Critical Care Medicine,* 10: 166-70. PMID: 19188881.
34. Flory L. Nkoy, Sarah Petersen, Armand H Matheny Antommaria, and Christopher G. Maloney (2008) "Validation of an Electronic System for Recording Medical Student Patient Encounters," *AMIA [American Medical Informatics Association] Annual Symposium Proceedings*, 6: 510-14. PMID: 18999155. Nominated for the Distinguished Paper Award
35. Armand H. Matheny Antommaria, Sean D. Firth, and Christopher G. Maloney (2007) "The Evaluation of an Innovative Pediatric Clerkship Structure Using Multiple Outcome Variables including Career Choice" *Journal of Hospital Medicine*, 2: 401-408. PMID: 18081170.
36. Armand H. Matheny Antommaria (2006) "'Who Should Survive?: One of the Choices on Our Conscience:' Mental Retardation and the History of Contemporary Bioethics." *Kennedy Institute of Ethics Journal*, 16: 205-224. PMID: 17091558.
37. Armand H. Matheny Antommaria (2004) "Do as I Say Not as I Do: Why Bioethicists Should Seek Informed Consent for Some Case Studies." *Hastings Center Report,* 34 (3): 28-34. PMID: 15281724.

38. Armand H. Matheny Antommaria (2004) "A Gower Maneuver: The American Society for Bioethics and Humanities' Resolution of the 'Taking Stands' Debate." *American Journal of Bioethics,* 4 (Winter): W24-27. PMID: 15035934.

NON PEER-REVIEWED JOURNAL ARTICLES

1. Katherine Wade and Armand H. Matheny Antommaria (2016) "Inducing HIV Remission in Neonates: Children's Rights and Research Ethics." *Journal of Medicine and Biology*, 58(3): 348-54. PMID 27157354.
2. Armand H. Matheny Antommaria (2014) "Response to Open Peer Commentaries on 'An Ethical Analysis of Mandatory Influenza." *American Journal of Bioethics,* 14(7): W1-4. PMID: 24978422.
3. Armand H. Matheny Antommaria and Brent D. Kaziny (2012) "Ethical Issues in Pediatric Emergency Medicine's Preparation for and Response to Disasters." *Virtual* Mentor, 14: 801-4. PMID: 23351860.
4. Armand H. Matheny Antommaria, Tia Powell, Jennifer E. Miller, and Michael D. Christian (2011) "Ethical Issues in Pediatric Emergency Mass Critical Care," *Pediatric Critical Care Medicine*, 12(6 Suppl): S163-8. PMID: 22067926.
5. Armand H. Matheny Antommaria and Emily A. Thorell (2011) "Non-Pharmaceutical Interventions to Limit Transmission of a Pandemic Virus: The Need for Complementary Programs to Address Children's Diverse Needs." *Journal of Clinical Ethics,* 22: 25-32. PMID: 21595352.
6. Armand H. Matheny Antommaria (2010) "Conscientious Objection in Clinical Practice: Notice, Informed Consent, Referral, and Emergency Treatment." *Ave Maria Law Review*, 9: 81-99.
7. Armand H. Matheny Antommaria (2008) "Defending Positions or Identifying Interests: The Uses of Ethical Argumentation in the Debate over Conscience in Clinical Practice," *Theoretical Medicine and Bioethics,* 29: 201-12. PMID: 18821078.
8. Armand H. Matheny Antommaria (2008) "How can I give her IV antibiotics at home when I have three other children to care for?: Using Dispute System Design to Address Patient-Provider Conflicts in Health Care." *Hamline Journal of Public Law & Policy*, 29: 273-86.
9. Armand H. Matheny Antommaria (2007) "Alternative Dispute Resolution and Pediatric Clinical Ethics Consultation: Why the Limits of Ethical Expertise and the Indeterminacy of the Best Interests Standard Favor Mediation." *Ohio State Journal on Dispute Resolution,* 23: 17-59.
10. Armand H. Matheny Antommaria (2006) "Jehovah's Witnesses, Roman Catholicism, and Calvinism: Religion and State Intervention in Parental, Medical Decision-Making," *Journal of Law and Family Studies,* 8: 293-316.
11. Armand H. Matheny Antommaria and James F. Bale, Jr. (2002) "Ethical Issues in Clinical Practice: Cases and Analyses," *Seminars in Pediatric Neurology* 9: 67-76. PMID: 11931129.

REVIEW ARTICLES

Armand H. Matheny Antommaria (2010) "Conceptual and Ethical Issues in the Declaration of Death: Current Consensus and Controversies." *Pediatrics in Review* 31: 427-430. PMID: 20889737.

BOOKS

Armand H. Matheny Antommaria (1998) *A Retrospective, Political and Ethical Analysis of State Intervention into Parental Healthcare Decisions for Infants with Disabilities*. Wynnewood, Pennsylvania: Evangelicals for Social Action.

BOOK CHAPTERS

1. Armand H. Matheny Antommaria (2018) "Against Medical Advice Discharges: Pediatric Considerations." In *Against-Medical-Advice Discharges from the Hospital: Optimizing Prevention and Management to Promote High-Quality, Patient-Centered Care.* David Alfandre. New York, Springer: 143-157.

2. Armand H. Matheny Antommaria (2016) "Conscientious Objection in Reproductive Medicine." In *The Oxford Handbook of Reproductive Ethics.* Leslie Francis. Oxford, Oxford University Press: 209-225.
3. Armand H. Matheny Antommaria (2011) "Patient Participation in Medical Education." In *Clinical Ethics in Pediatrics: A Case-based Approach.* Douglas Diekema, Mark Mercurio, and Mary Beth Adam. Cambridge, Cambridge University Press: 221-225.
4. Armand H. Matheny Antommaria (2011) "State Intervention in Parental Decision Making: *Gone Baby Gone*." In *The Picture of Health: Medical Ethics and the Movies.* Henri Colt, Silvia Quadrelli, and Lester Friedman. Oxford, Oxford University Press: 308-12.
5. Armand H. Matheny Antommaria (2009) "Managing Conflicts of Interest: A Perspective from a Pediatrician." In *Professionalism in Medicine: The Case-Based Guide for Medical Students*. John Spandorfer, Charles Pohl, Thomas Nasca and Susan Lee Rattner. Cambridge, Cambridge University Press: 376-7.
6. Armand H. Matheny Antommaria (2007) "Do-Not-Resuscitate Orders." In *Comprehensive Pediatric Hospital Medicine*. L. B. Zaoutis and V. W. Chiang. Philadelphia, Mosby Elsevier**:** 1200-4.

OTHER

Policy Statements and Technical Reports

1. American Academy of Pediatrics Committee on Bioethics. Armand H. Matheny Antommaria Lead Author. (2013) "Conflicts between Religious or Spiritual Beliefs and Pediatric Care: Informed Refusal, Exemptions, and Public Funding." *Pediatrics.* 132: 962-965. PMID: 24167167.
2. American Academy of Pediatrics Committee on Bioethics. Armand H. Matheny Antommaria Lead Author. (2013) "Ethical Controversies in Organ Donation After Circulatory Death." *Pediatrics.* 131: 1021-1026. PMID: 23629612.
3. American Academy of Pediatrics Committee on Bioethics and Committee on Genetics and the American College of Medical Genetics and Genomics Social, Ethical, and Legal Issues Committee (2013) "Policy Statement: Ethical and Policy Issues in Genetic Testing and Screening of Children." *Pediatrics.* 131: 620-622. PMID: 23428972.
4. Lainie Friedman Ross, Howard M. Saal, Karen L. David, Rebecca R. Anderson and the American Academy of Pediatrics Committee on Bioethics and Committee on Genetics and the American College of Medical Genetics and Genomics Social, Ethical, and Legal Issues Committee (2013) "Technical Report: Ethical and Policy Issues in Genetic Testing and Screening of Children." *Genetics in Medicine.* 15: 234-245. PMID: 23429433.
5. American Academy of Pediatrics Committee for Pediatric Research and Committee on Bioethics (2012) "Human Embryonic Stem Cell (hESC) and Human Embryo Research." *Pediatrics* 130: 972-977. PMID: 23109685.
6. American College of Obstetricians and Gynecologists, Committee on Ethics and American Academy of Pediatrics, Committee on Bioethics (2011) "Maternal-Fetal Intervention and Fetal Care Centers," *Pediatrics* 128; e473-e478. PMID: 21788223.
7. American Academy of Pediatrics Committee on Pediatric Emergency Medicine and Committee on Bioethics (2011) "Consent for Emergency Medical Services for Children and Adolescents." *Pediatrics* 128: 427-433. PMID: 21788221.
8. Council on School Health and Committee on Bioethics. Robert Murray and Armand H. Matheny Antommaria Lead Authors. (2010) "Honoring –Do-Not-Attempt Resuscitation Requests in Schools." *Pediatrics* 125; 1073-1077. PMID: 20421255.
9. Committee on Bioethics (2010) "Ritual Genital Cutting of Female Minors." *Pediatrics* 125; 1088-1093. PMID: 20421257.
10. Committee on Bioethics. (2010) "Children as Hematopoietic Stem Cell Donors," *Pediatrics* 125; 392-40. PMID: 20100753.

11. Committee on Bioethics. Armand H. Matheny Antommaria Lead Author. (2009) "Physician Refusal to Provide Information or Treatment Based on Claims of Conscience." *Pediatrics.* 124; 1689-93. PMID: 19948636.
12. Committee on Bioethics (2009) "Pediatrician-Family-Patient Relationships: Managing the Boundaries." *Pediatrics* 124; 1685-8. PMID: 19948635.
13. Douglas S. Diekema, Jeffrey R. Botkin, and Committee on Bioethics (2009) "Forgoing Medically Provided Nutrition and Hydration in Children." *Pediatrics* 124; 813-22. PMID: 19651596.
14. Lainie Friedman Ross, J. Richard Thistlethwaite, Jr., and the Committee on Bioethics (2008) "Minors as Living Solid-Organ Donors." *Pediatrics* 122: 454-61. PMID: 18676567.
15. Mary E. Fallat, John Hutter, and Section on Hematology Oncology and Section on Surgery the Committee on Bioethics (2008) "Preservation of Fertility in Pediatric and Adolescent Patients with Cancer." *Pediatrics* 121: 1461-9. PMID: 18450888.
16. Marcia Levetown and Bioethics and the Committee on Bioethics (2008) "Communicating With Children and Families: From Everyday Interactions to Skill in Conveying Distressing Information." *Pediatrics* 121: 1441-60. PMID: 18450887.
17. American Academy of Pediatrics. Committee on Bioethics (2007) "Professionalism in Pediatrics: Statement of Principles." *Pediatrics* 120:895-7. PMID: 17908776.

Ethics Rounds

1. Jennifer E. deSante-Bertkau, Timothy K. Knilans, Govind Persad, Patricia J. Zettler, Holly Fernandez Lynch, and Armand H. Matheny Antommaria. (2021) "Off-Label Prescription of COVID-19 Vaccines in Children: Clinical, Ethical, and Legal Issues." *Pediatrics..*Oct 6: e2021054578. PMID: 34615694.
2. Jamilah M. Hackworth, Meera Kotagal, O. N. Ray Bignal, 2nd, Ndidi Unaka, and Armand H. Matheny Antommaria. (2021) "Microaggressions: Privileged Observers' Duty to Act and What They Can Do." *Pediatrics*. 148: e2021052758. PMID: 34417286.
3. Elizabeth Lanphier, Luke Mosley, and Armand H. Matheny Antommaria. (2021) "Assessing Visitor Policy Exemption Requests During the COVID-19 Pandemic." *Pediatrics.* 148: e2021051254. PMID: 33990461.
4. Natalie Lanocha, Tyler Tate, Erica Salter, Nanette Elster, and Armand H. Matheny Antommaria. (2021) "Can Parents Restrict Access to Their Adolescent's Voice?: Deciding About a Tracheostomy." *Pediatrics*. 147: e2021050358. PMID 33785636.
5. Timothy Crisci, Zeynep N. Inanc Salih, Ndidi Unaka, Jehanna Peerzada, and Armand H. Matheny Antommaria. (2021) "What Should an Intern Do When She Disagrees With the Attending?" *Pediatrics.* 147: e2020049646. PMID 33627371.
6. Liza-Marie Johnson, Erica C. Kaye, Kimberly Sawyer, Alex M. Brenner, Stefan J. Friedrichsdorf, Abby R. Rosenberg, Armand H. Mathey Antommaria. (2021) "Opioid Management in the Dying Child With Addiction." *Pediatrics* 147: e2020046219. PMID 33446508.

Continuing Medical Education

1. Armand H. Matheny Antommaria (2014) Authored 4 questions. NEJM Knowledge+ Family Medicine Board Review. NEJM Group.
2. Armand H. Matheny Antommaria (2009) "Hot Topics: Ethics and Donation After Cardiac Death [online course]. PediaLink. American Academy of Pediatrics. October 24. http://ethics.ht.courses.aap.org/. Accessed December 14. 2009.

Editorials

1. Armand H.Matheny Antommaria, Chris Feudtner, Mary Beth Benner, and Felicia Cohn on Behalf of the Healthcare Ethics Consultant-Certified Certification Commission (2020) "The Healthcare Ethics Consultant-Certified Program: Fair, Feasible, and Defensible, But Neither Definite Nor Finished," *American Journal of Bioethics* 20:1-5. PMID: 32105202.

2. Armand H. Matheny Antommaria and Pamela W. Popp (2020) "The Potential Roles of Surrogacy Ladders, Standby Guardians, and Medicolegal Partnerships, in Surrogate Decision Making for Parents of Minor Children," *Journal of Pediatrics* 220:11-13. PMID 31952849.

Commentaries

1. William Sveen and Armand H. Matheny Antommaria. (2020) "Why Healthcare Workers Should Not Be Prioritized in Ventilator Triage." *American Journal of Bioethics.* 20(7): 133-135. PMID: 32716811.
2. Armand H. Matheny Antommaria, William Sveen, and Erika L. Stalets (2020) "Informed Consent Should Not Be Required for Apnea Testing and Arguing It Should Misses the Point," *American Journal of Bioethics.* 20: 25-27. PMID: 32441602.
3. Armand H. Matheny Antommaria (2019) "Relational Potential versus the Parent-Child Relationship," *Hastings Center Report*. 49(3): 26-27. PMID: 31269255.
4. Armand H. Matheny Antommaria, Robert A. Shapiro, and Lee Ann E. Conard (2019) "Psychological Maltreatment and Medical Neglect of Transgender Adolescents: The Need for Recognition and Individualized Assessment." *American Journal of Bioethics.* 19: 72-74. PMID: 31543011.
5. Armand H. Matheny Antommaria (2018) "Accepting Things at Face Value: Insurance Coverage for Transgender Healthcare." *American Journal of Bioethics.* 18: 21-23. PMID: 31159689.
6. Armand H. Matheny Antommaria and Judith R. Ragsdale (2018) "Shaken, not Stirred: What are Ethicists Licensed to Do?" *American Journal of Bioethics* 18: 56-58. PMID: 29697345.
7. Armand H. Matheny Antommaria (2017) "Issues of Fidelity and Trust Are Intrinsic to Uncontrolled Donation after Circulatory Determination of Death and Arise Again with Each New Resuscitation Method," *American Journal of Bioethics* 17: 20-22. PMID: 28430053.
8. Armand H. Matheny Antommaria (2016) "Conscientious Objection: Widening the Temporal and Organizational Horizons," *The Journal of Clinical Ethics* 27: 248-250. PMID: 27658282.
9. Armand H. Matheny Antommaria and Ron King. (2016) "Moral Hazard and Transparency in Pediatrics: A Different Problem Requiring a Different Solution." *American Journal of Bioethics* 16: 39-40. PMID: 27292846.
10. Armand H. Matheny Antommaria and Richard F. Ittenabch (2016) "Quality Attestation's Portfolio Evaluation Is Feasible, But Is It Reliable and Valid?" *American Journal of Bioethics* 16: 35-38. PMID: 26913658.
11. Armand H. Matheny Antommaria and Kristin Stanley Bramlage (2015) "Enrolling Research Participants in Private Practice: Conflicts of Interest, Consistency, Therapeutic Misconception, and Informed Consent." *AMA Journal of Ethics*. 17:1122-1126. PMID: 26698585.
12. Armand H. Matheny Antommaria (2015) "Characterizing Clinical Ethics Consultations: The Need for a Standardized Typology of Cases." *American Journal of Bioethics* 15: 18-20. PMID: 25970383.
13. Armand H. Matheny Antommaria (2015) "Intensified Conflict Instead of Closure: Clinical Ethics Consultants' Recommendations' Potential to Exacerbate Ethical Conflicts." *American Journal of Bioethics* 15: 52-4. PMID: 25562231.
14. Lainie Friedman Ross and Armand H. Matheny Antommaria (2014) "The need to promote all pediatric stem cell donors' understanding and interests." *Pediatrics* 133: e1356-e1357. PMID: 24777208.
15. Armand H. Matheny Antommaria (2014) "Pubertal Suppression and Professional Obligations: May a Pediatric Endocrinologist Refuse to Treat an Adolescent with Gender Dysphoria." *American Journal of Bioethics* 13: 43-46. PMID: 24422933.
16. Armand H. Matheny Antommaria (2012) "Empowering, Teaching, and Occasionally Advocating: Clinical Ethics Consultants' Duties to All of the Participants in the Process." *American Journal of Bioethics* 12 11-3. PMID: 22852533.
17. Armand H. Matheny Antommaria (2010) "Dying but not Killing: Donation after Cardiac Death Donors and the Recovery of Organs." *Journal of Clinical Ethics* 21: 229-31. PMID: 21089993.

18. Armand H. Matheny Antommaria and Julie Melini (2010) "Is it Reasonable to Refuse to be Seen by a Nurse Practitioner in the Emergency Department?" *American Journal of Bioethics* 10: 15-17. PMID: 20694899.
19. William Meadow, Chris Feudtner, Armand H. Matheny Antommaria, Dane Sommer, John Lantos (2010) "A Premature Baby with Necrotizing Enterocolitis Whose Parents Are Jehovah's Witnesses." *Pediatrics.* 216: 151-155. PMID: 20566607.
20. C. C. Weitzman, S. Schlegel, Nancy Murphy, Armand H. Matheny Antommaria, J. P. Brosco, Martin T. Stein (2009) "When Clinicians and a Parent Disagree on the Extent of Medical Care." *Journal of Developmental and Behavioral Pediatrics.* 30: 242-3. PMID: 19525718. Reprinted as (2010) *Journal of Developmental and Behavioral Pediatrics.* 31: S92-5. PMID: 20414087
21. Armand H. Matheny Antommaria and Susan Bratton (2008) "Nurses' Attitudes toward Donation after Cardiac Death: Implications for Nurses' Roles and Moral Distress." *Pediatric Critical Care Medicine,* 9: 339-40. PMID: 18446100.
22. Armand H. Matheny Antommaria and Nannette C. Dudley (2007) "Should Families Be Present During CPR?" *AAP Grand Rounds,* 17: 4-5.
23. Armand H. Matheny Antommaria (2006) "The Proper Scope of Analysis of Conscientious Objection in Healthcare: Individual Rights or Professional Obligations" *Teaching Ethics*, 7: 127-31.
24. Armand H. Matheny Antommaria and Rajendu Srivastava (2006) "If Cardiologists Take Care of Patients with Heart Disease, What do Hospitalists Treat?: Hospitalists and the Doctor-Patient Relationship." *American Journal of Bioethics*, 6: 47-9. PMID: 16423793.
25. Armand H. Matheny Antommaria (2003) "I Paid Out-of-Pocket for My Son's Circumcision at Happy Valley Tattoo and Piercing: Alternative Framings of the Debate over Routine Neonatal Male Circumcision," *American Journal of Bioethics* 3: 51-3. PMID: 12859817.

Letters

1. Benjamin S. Wilfond, David Magnus, Armand H Matheny Antommaria, Paul Appelbaum, Judy Aschner, Keith J. Barrington, Tom Beauchamp, Renee D. Boss, Wylie Burke, Arthur L. Caplan, Alexander M. Capron, Mildred Cho, Ellen Wright Clayton, F. Sessions Cole, Brian A. Darlow, Douglas Diekema, Ruth R. Faden, Chris Feudtner, Joseph J. Fins, Norman C. Fost, Joel Frader, D. Micah Hester, Annie Janvier, Steven Joffe, Jeffrey Kahn, Nancy E. Kass, Eric Kodish, John D. Lantos, Laurence McCullough, Ross McKinney, Jr., William Deadow, P. Pearl O'Rourke, Kathleen E. Powderly, DeWayne M. Pursley, Lainie Friedman Ross, Sadath Sayeed, Richard R. Sharp, Jeremy Sugarman, William O. Tarnow-Mordi, Holly Taylor, Tom Tomlison, Robert D. Truog, Yoram T. Unguru, Kathryn L. Weise, David Woodrum, Stuart Youngner (2013) "The OHRP and SUPPORT," *New England Journal of Medicine,* 368: e36. PMID: 23738513.
2. Lainie Friedman Ross and Armand H. Matheny Antommaria (2011) "In Further Defense of the American Academy of Pediatrics Committee on Bioethics 'Children as Hematopoietic Stem Cell Donors' Statement." *Pediatric Blood & Cancer*. 57: 1088-9.
3. Armand H. Matheny Antommaria (2011) "Growth Attenuation: Health Outcomes and Social Services." *Hastings Center Report*, 41(5): 4. PMID: 21980886.
4. Susan Bratton and Armand H. Matheny Antommaria (2010) "Dead Donor Rule and Organ Procurement: The Authors Reply." *Pediatric Critical Care Medicine*, 11: 314-5.
5. Armand H. Matheny Antommaria and Joel Frader (2009) "Policies of Children's Hospitals on Donation After Cardiac Death—Reply." *Journal of the American Medical Association*, 302: 845.

Case Reports

Armand H. Matheny Antommaria (2002) "Case 4.9: Inappropriate Access to a Celebrity's Medical Records." In *Ethics and Information Technology: A Case-Based Approach to a Health Care System in Transition*, James G. Anderson and Kenneth W. Goodman, 79-80. New York: Springer-Verlag.

Book Reviews

1. Armand H. Matheny Antommaria (2021) Review of *When Harry Became Sally: Responding to the Transgender Moment,* by Ryan T. Anderson. *Journal of Medical Humanities* 42: 195-9. PMID 31808021.
2. Armand H. Matheny Antommaria (2012) Review of *The Ethics of Organ Transplantation*, by Steven J. Jensen, ed., *Journal of the American Medical Association* 308: 1482-3.
3. Armand H Matheny Antommaria (2012) Review of *The Soul of Medicine: Spiritual Perspectives and Clinical Practice*, by John R. Peteet and Michael N. D'Ambra, ed., *Journal of the American Medical Association* 308: 87.
4. Armand H. Matheny Antommaria (2009) Review of *Conflicts of Conscience in Health Care: An Institutional Compromise,* by Holly Fernandez Lynch. *American Journal of Bioethics* 9: 63-4.
5. Armand H. Matheny Antommaria (2008) Review of *A Practical Guide to Clinical Ethics Consulting: Expertise, Ethos, and Power*, by Christopher Meyers. *American Journal of Bioethics* 8: 72-3.
6. Armand H. Matheny Antommaria (2004) Review of *Children, Ethics, and Modern Medicine*, by Richard B. Miller. *American Journal of Bioethics* 4: 127-8.
7. Armand H. Matheny Antommaria (2002) Review of *Ward Ethics: Dilemmas for Medical Students and Doctors in Training*, by Thomasine Kushner and David Thomasma, ed. *American Journal of Bioethics* 2: 70-1. PMID: 22494193.
8. Armand H. Matheny Antommaria (1999) Review of *Human Cloning: Religious Responses*, by Ronald Cole-Turner, ed. *Prism* 6 (March/April): 21.
9. Armand H. Matheny Antommaria (1999) Review of *Christian Theology and Medical Ethics: Four Contemporary Approaches*, by James B. Tubbs, Jr. *Journal of Religion* 79 (April): 333-5.
10. Armand H. Matheny Antommaria (1997) Review of *Body, Soul, and Bioethics*, by Gilbert C. Meilaender. *Prism* 4 (May/June): 28.

Newspaper Articles

1. W. Bradley Poss and Armand H. Matheny Antommaria (2010) "Mass casualty planning must incorporate needs of children." *AAP News* 31 (July): 38.
2. Robert Murray and Armand H. Matheny Antommaria (2010) "Pediatricians should work with school nurses to develop action plans for children with DNAR orders." *AAP News* 31 (May): 30..
3. Armand H. Matheny Antommaria (2009) "Addressing physicians' conscientious objections in health care." *AAP News* 30 (December): 32.

UNPUBLISHED POSTER PRESENTATIONS

1. Armand H. Matheny Antommaria. (2018) "Ethical Issues in the Care of International Patients: A Case Study." International Conference on Clinical Ethics and Consultation, Oxford, United Kingdom.
1. Jill S Sweney, Brad Poss, Colin Grissom, Brent Wallace, and Armand H Matheny Antommaria, (2010) "Development of a Statewide Pediatric Pandemic Triage Plan in Utah." Pediatric Academic Societies Annual Meeting, Vancouver, Canada. E-PAS20103713.147.
2. Christopher G. Maloney, Armand H. Matheny Antommaria, James F. Bale, Thomas Greene, Jian Ying, Gena Fletcher, and Rajendu Srivastava (2010) "Why Do Pediatric Interns Violate the 30 Hour Work Rule?" Pediatric Academic Societies Annual Meeting, Vancouver, Canada. E-PAS20101500.596
3. Armand H. Matheny Antommaria and Edward B. Clark (2007) "Resolving Conflict through Bioethics Mediation." 3rd International Conference on Ethics Consultation and Clinical Ethics, Toronto, Canada.
4. Elizabeth Tyson, Tracy Hill, Armand Antommaria, Gena Fletcher, and Flory Nkoy (2007) "Physician Practice Patterns Regarding Nasogastric Feeding Supplementation and Intravenous Fluids in Bronchiolitis Patients." Pediatrics Academic Societies Annual Meeting, Toronto, Canada. E-PAS2007:61300.

ORAL PRESENTATIONS

Keynote/Plenary Lectures

International

1. 2021, *Panelist*, Partnership for Quality Medical Donations, Charitable Access Programming for Rare Diseases, "Ethical Issues," Webinar, April 6.
2. 2017, *Invited Speaker*, Spina Bifida Fetoscopic Repair Study Group and Consortium, "Ethics of Innovation and Research in Fetal Surgery," Cincinnati, Ohio, October 26.
3. 2014, *Invited Speaker,* CIC 2013 CCI: Canadian Immunization Conference, "Condition-of-Service Influenza Prevention in Health Care Settings," Ottawa, Canada, December 2.
4. 2014, *Invited Speaker*, National Conference of the Chinese Pediatric Society, "A Brief Introduction to Pediatric Research and Clinical Ethics," Chongqing, China, September 12.

National

1. 2020, *Panelist*, Children's Mercy Bioethics Center, "Ethical Issues in the COVID Pandemic at Children's Hospitals," Webinar, March 2.
2. 2019, *Invited Speaker*, North American Fetal Therapy Network (NAFTnet), "Ethics of Innovation," Chicago, Illinois, October 12.
3. 2019, *Panelist,* National Society of Genetic Counselors Prenatal Special Interest Group, "Fetal Intervention Ethics," Webinar, September 12.
4. 2017, *Invited Participant,* American College of Epidemiology Annual Meeting, Preconference Workshop, "Extreme Personal Exposure Biomarker Levels: Guidance for Study Investigators," New Orleans, Louisiana, September 24.
5. 2016, *Invited Speaker,* American Academy of Pediatrics National Conference & Exhibition, Joint Program: Section on Hospital Medicine and Section on Bioethics, "Resource Allocation: Do We Spend Money to Save One Patient with Ebola or Over a 1,000?" San Francisco, California, October 23.
6. 2016, *Invited Speaker*, 26th Annual Specialist Education in Extracorporeal Membrane Oxygenation (SEECHMO) Conference, "Ethical Issues in ECMO: The Bridge to Nowhere," Cincinnati, Ohio, June 5.
7. 2015, *Invited Speaker,* Extracorporeal Life Support Organization (ELSO) 26th Annual Conference, "ECMO-Supported Donation after Circulatory Death: An Ethical Analysis," Atlanta, Georgia, September 20.
8. 2014, *Invited Speaker*, Pediatric Evidence-Based Practice 2014 Conference: Evidence Implementation for Changing Models of Pediatric Health Care, "Ethical Issues in Evidence-Based Practice," Cincinnati, Ohio, September 19.
9. 2014, *Invited Speaker,* 6th Annual David Kline Symposium on Public Philosophy: Exploring the Synergy Between Pediatric Bioethics and Child Rights, "Does Predictive Genetic Testing for Adult Onset Conditions that Are Not Medically Actionable in Childhood Violate Children's Rights?" Jacksonville, Florida, March 6.
10. 2010, *Invited Speaker,* Quest for Research Excellence: The Intersection of Standards, Culture and Ethics in Childhood Obesity, "Research Integrity and Religious Issues in Childhood Obesity Research," Denver, Colorado, April 21.
11. 2010, *Invited Speaker*, Symposium on the Future of Rights of Conscience in Health Care: Legal and Ethical Perspectives, J. Reuben Clark Law School at Brigham Young University and the Ave Maria School of Law, "Conscientious Objection in Clinical Practice: Disclosure, Consent, Referral, and Emergency Treatment," Provo, Utah, February 26.
12. 2009, *Invited Speaker*, Pediatric Organ Donation Summit, "Research Findings Regarding Variations in Pediatric Hospital Donation after Cardiac Death Policies," Chicago, Illinois, August 18.

13. 2008, *Meet-the-Experts*, American Academy of Pediatrics National Conference & Exhibition, "Physician Refusal to Provide Treatment: What are the ethical issues?" Boston, Massachusetts, October 11.
14. 2008, *Invited Conference Faulty*, Conscience and Clinical Practice: Medical Ethics in the Face of Moral Controversy, The MacLean Center for Clinical Medical Ethics at the University of Chicago, "Defending Positions or Identifying Interests: The Uses of Ethical Argumentation in the Debate over Conscience in Clinical Practice," Chicago, IL, March 18.
15. 2007, *Symposium Speaker*, Alternative Dispute Resolution Strategies in End-of-Life Decisions, The Ohio State University Mortiz College of Law, "The Representation of Children in Disputes at the End-of-Life," Columbus, Ohio, January 18.
16. 2005, *Keynote Speaker*, Decisions and Families, *Journal of Law and Family Studies* and The University of Utah S.J. Quinney College of Law, "Jehovah's Witnesses, Roman Catholicism, and Calvinism: Religion and State Intervention in Parental, Medical Decision-Making," Salt Lake City, Utah, September 23.

<u>Regional/Local</u>

1. 2021, *Panelist*, Pediatric Residency Noon Conference, University of Tennessee Health Science Center, "Bioethics Rounds—Ethical Issues in the Care of Transgender Adolescents," Memphis, Tennessee, September 21.
2. 2020, *Keynote Speaker*, 53rd Annual Clinical Advances in Pediatrics, "Referral to a Fetal Care Center: How You Can Help Patients' Mothers Address the Ethical Issues," Kansas City, Kansas, September 16.
3. 2019, *Speaker,* Patient and Family Support Services, Primary Children's Hospital, "Ethical Issues in the Care of Trans Adolescents," Salt Lake City, Utah, December 5.
4. 2019, *Speaker,* Evening Ethics, Program in Medical Ethics and Humanities, University of Utah School of Medicine, "Patients, Parents, and Professionals: Ethical Issues in the Treatment of Trans Adolescents," Salt Lake City, Utah, December 4.
5. 2019, *Speaker,* Pediatric Hospital Medicine Board Review Course, "Ethics, Legal Issues, and Human Rights including Ethics in Research," Cincinnati, Ohio, September 8.
6. 2019, *Speaker,* Advances in Fetology, "Evolving Attitudes Toward the Treatment of Children with Trisomies," Cincinnati, Ohio, September 6.
7. 2019, *Speaker,* Half-Day Ethics Training: Ethics Consultation & Ethics Committees, "Navigating the Rapids of Clinical Ethics Consultation: Intake, Recommendations, and Documentation," Salt Lake City, Utah, June 1.
8. 2019, *Speaker*, Scientific and Ethical Underpinnings of Gene Transfer/Therapy in Vulnerable Populations: Considerations Supporting Novel Treatments, BioNJ, "What Next? An Ethical analysis of Prioritizing Conditions and Populations for Developing Novel Therapies," Cranbury, New Jersey, March 7.
9. 2018, *Panelist*, Periviability, 17th Annual Regional Perinatal Summit, Cincinnati, Ohio, October 12.
10. 2018, *Speaker,* Regional Advance Practice Registered Nurse (APRN) Conference, "Adults are Not Large Children: Ethical Issues in Caring for Adults in Children's Hospitals," Cincinnati, Ohio, April 26.
11. 2018, *Speaker*, Southern Ohio/Northern Kentucky Sigma Theta Tau International Annual Conference, "Between Hope and Hype: Ethical Issues in Precision Medicine," Sharonville, Ohio, March 2.
12. 2017, *Speaker*, Advances in Fetology 2017, "Ethics of Innovation and Research: Special Considerations in Fetal Therapy Centers," Cincinnati, Ohio, October 27.
13. 2016, *Speaker*, End-of-Life Pediatric Palliative Care Regional Conference, "Ethical/Legal Issues in Pediatric Palliative Care," Cincinnati, Ohio, September 15.
14. 2016, *Speaker*, 26th Annual Bioethics Network of Ohio (BENO) Conference, "When Does Parental Refusal of Medical Treatment for Religious Reasons Constitute Neglect?" Dublin, Ohio, May 29.

15. 2014, *Speaker,* Cincinnati Comprehensive Sickle Cell Center Symposium: Research Ethics of Hydroxyurea Therapy for Sickle Cell Disease During Pregnancy and Lactation, "Ethical Issues in Research with Pregnant and Lactating Women," Cincinnati, Ohio, October 30.
16. 2014, *Speaker,* Advances in Fetology 2014, "The 'Miracle Baby' and Other Cases for Discussion," Cincinnati, Ohio, September 26.
17. 2014, *Speaker,* Advances in Fetology 2014, "'Can you tell me …?': Achieving Informed Consent Given the Prevalence of Low Health Literacy," Cincinnati, Ohio, September 26.
18. 2014, *Panelist*, Center for Clinical & Translational Science & Training, Secrets of the Dead: The Ethics of Sharing their Data, Cincinnati, Ohio, August 28.
19. 2014, *Speaker,* Office for Human Research Protections Research Community Forum: Clinical Research … and All That Regulatory Jazz, "Research Results and Incidental Findings: Do Investigators Have a Duty to Return Results to Participants," Cincinnati, Ohio, May 21.
20. 2013, *Opening Presentation*, Empirical Bioethics: Emerging Trends for the 21st Century, University of Cincinnati Center for Clinical & Translational Science & Training, "Empirical vs. Normative Ethics: A Comparison of Methods," Cincinnati, Ohio, February 21.
21. 2012, *Videoconference,* New York State Task Force on Life and the Law, "Pediatric Critical Care Triage," New York, New York, March 1.
22. 2011, *Presenter,* Fall Faculty Development Workshop, College of Social Work, University of Utah, "Teaching Ethics to Students in the Professions, " Salt Lake City, Utah, November 14.
23. 2011, *Speaker,* 15th Annual Conference, Utah Chapter of the National Association of Pediatric Nurse Practitioners, "Ethical Issues in Pediatric Practice," Salt Lake City, Utah, September 22.
24. 2011, *Speaker*, Code Silver! Active Shooter in the Hospital, Utah Hospitals & Health Systems Association, Salt Lake City, Utah, March 21.
25. 2009, *Speaker,* Medical Staff Leadership Conference, Intermountain Healthcare, "The Ethics of Leadership," Park City, Utah, October 30.
26. 2008, *Speaker*, The Art and Medicine of Caring: Supporting Hope for Children and Families, Primary Children's Medical Center, "Medically Provided Hydration and Nutrition: Ethical Considerations," Salt Lake City, Utah, February 25.
27. 2005, *Speaker*, Utah NAPNAP (National Association of Pediatric Nurse Practitioners) Chapter Pharmacology and Pediatric Conference, "Immunization Update," Salt Lake City, Utah, August 18.
28. 2005, *Keynote Speaker,* 17th Annual Conference, Utah Society for Social Work Leadership in Health Care, "Brain Death: Accommodation and Consultation," Salt Lake City, March 18.
29. 2004, *Continuing Education Presentation*, Utah NAPNAP (National Association of Pediatric Nurse Practitioners), "Febrile Seizures," Salt Lake City, Utah, April 22.
30. 2004, *Speaker,* Advocacy Workshop for Primary Care Providers, "Ethics of Advocacy," Park City, Utah, April 3.
31. 2002, *Speaker,* 16th Annual Biologic Basis of Pediatric Practice Symposium, "Stem Cells: Religious Perspectives," Deer Valley, Utah, September 14.

Meeting Presentations

International

1. 2018, *Speaker*, International Conference on Clinical Ethics and Consultation, "A Systematic Review of Typologies Used to Characterize Clinical Ethics Consultations," Oxford, United Kingdom, June 21.

National

1. 2021, *Panelist,* Pediatric Endocrine Society Annual Meeting, Difference of Sex Development Special Interest Group, Virtual Conference, April 29.
2. 2020, *Speaker,* American Society for Bioethics and Humanities Annual Meeting, "Is This Child Dead? Controversies Regarding the Neurological Criteria for Death," Virtual Conference, October 17.

3. 2020, *Speaker,* American Society for Bioethics and Humanities Annual Meeting, "Contemporary Ethical Controversy in Fetal Therapy: Innovation, Research, Access, and Justice," Virtual Conference, October 15.
4. 2020, *Speaker,* American Society for Bioethics and Humanities Annual Meeting, "K-12 Schools and Mandatory Public Health Programs During the COVID-19 Pandemic," Virtual Conference, October 15.
5. 2019, *Speaker,* American Society for Bioethics and Humanities Annual Meeting, "Ethical Issues in Translating Gene Transfer Studies Involving Children with Neurodegenerative Disorders," Pittsburgh, Pennsylvania, October 26.
6. 2019, *Moderator,* Pediatric Academic Societies Annual Meeting, Clinical Bioethics, Baltimore, Maryland, April 28.
7. 2018, *Presenter,* American Society for Bioethics and Humanities Annual Meeting, "Looking to the Past, Understanding the Present, and Imaging the Future of Bioethics and Medical Humanities' Engagement with Transgender Health," Anaheim, California, October 19.
8. 2018, *Speaker,* American Society for Bioethics and Humanities Annual Meeting, "Should Vaccination Be a Prerequisite for Sold Organ Transplantation?" Anaheim, California, October 18.
9. 2018, Lindsey Douglas, Armand H. Matheny Antommaria, Derek Williams. *Workshop Presenter*, Pediatric Hospital Medicine Annual Meeting, "IRB Approved! Tips and Tricks to Smooth Sailing through the Institutional Review Board (IRB)." Atlanta, Georgia, July 20.
10. 2018, Alan Schroeder, Armand H. Matheny Antommaria, Hannah Bassett, Kevin Chi, Shawn Ralston, Rebecca Blankenburg. *Workshop Speaker,* Pediatric Hospital Medicine Annual Meeting, "When You Don't Agree with the Plan: Balancing Diplomacy, Value, and Moral Distress," Atlanta, Georgia, July 20.
11. 2018, Alan Schroeder, Hannah Bassett, Rebecca Blankenburg, Kevin Chi, Shawn Ralston, Armand H. Matheny Antommaria. *Workshop Speaker,* Pediatric Academic Societies Annual Meeting, "When You Don't Agree with the Plan: Balancing Diplomacy, Value, and Moral Distress," Toronto, Ontario, Canada, May 7.
12. 2017, *Speaker,* American Society for Bioethics and Humanities Annual Meeting, "Tensions in Informed Consent for Gender Affirming Hormone Therapy and Fertility Preservation in Transgender Adolescents," Kansas City, Missouri, October 19.
13. Lindsey Douglas, Armand H. Matheny Antommaria, and Derek Williams. 2017, *Workshop Leader,* PHM[Pediatric Hospital Medicine]2017, "IRB Approved! Tips and Tricks to Smooth Sailing through the Institutional Review Board (IRB) Process," Nashville, Tennessee, July 21.
14. 2016, *Speaker*, American Society for Bioethics and Humanities Annual Meeting, "Ethical Challenges in the Care of International Patients: Organization, Justice, and Cultural Considerations," Washington, DC, October 9.
15. 2015, *Coauthor,* The American Society of Human Genetics Annual Meeting, "Adolescents' Opinions on Disclosure of Non-Actionable Secondary Findings in Whole Exome Sequencing," Baltimore, Maryland, October 9.
16. 2012, *Speaker*, American Society for Bioethics and Humanities Annual Meeting, "A Public Health Ethics Analysis of the Mandatory Immunization of Healthcare Personnel: Minimizing Burdens and Increasing Fairness," Washington, DC, October 21.
17. Armand H. Matheny Antommaria, Valerie Gutmann Koch, Susie A. Han, Carrie S. Zoubul. 2012, *Moderator*, American Society for Bioethics and Humanities Annual Meeting, "Representing the Underrepresented in Allocating Scarce Resources in a Public Health Emergency: Ethical and Legal Considerations," Washington, DC, October 21.
18. 2012, *Platform Presentation,* Pediatric Academic Societies Annual Meeting, "Qualitative Analysis of International Variation in Donation after Circulatory Death Policies and Rates," Boston, Massachusetts, April 30. Publication 3150.4.

19. 2011, *Speaker*, American Society for Bioethics and Humanities Annual Meeting, "The Intersection of Policy, Medicine, and Ethics during a Public Health Disaster: Special Considerations for Children and Families," Minneapolis, Minnesota, October 13.
20. Armand H. Matheny Antommaria and Joel Frader. 2010, *Workshop Leader,* Pediatric Academic Societies Annual Meeting, "Conscientious Objection in Health Care: Respecting Conscience and Providing Access," Vancouver, British Columbia, Canada. May 1. Session 1710.
21. 2009, *Workshop Leader,* American Society for Bioethics and Humanities Annual Meeting, "Advanced Clinical Ethics Consultation Skills Workshop: Process and Interpersonal Skills," Washington, DC, October 15.
22. 2009, *Platform Presentation*, Pediatric Academic Societies Annual Meeting, "Qualitative Analysis of Donation after Cardiac Death Policies at Children's Hospitals," Baltimore, Maryland, May 2. Publication 2120.6.
23. 2008, *Speaker*, American Society for Bioethics and Humanities Annual Meeting, "Qualitative Analysis of Donation After Cardiac Death (DCD) Policies at Children's Hospitals," Cleveland, Ohio, October 26.
24. 2007, *Participant,* Hamline University School of Law Biennial Symposium on Advanced Issues in Dispute Resolution, "An Intentional Conversation About Conflict Resolution in Health Care," Saint Paul, Minnesota, November 8-10.
25. *2007*, *Speaker,* American Society of Bioethics and Humanities Annual Meeting, "Bioethics Consultation and Alternative Dispute Resolution: Opportunities for Collaboration," Washington, DC, October 21.
26. 2007, *Speaker,* American Society of Bioethics and Humanities Annual Meeting, "DNAR Orders in Schools: Collaborations Beyond the Hospital," Washington, DC, October 18.
27. Armand H. Matheny Antommaria and Jeannie DePaulis. 2007, *Speaker,* National Association of Children's Hospitals and Related Institutions Annual Meeting, "Using Mediation to Address Conflict and Form Stronger Therapeutic Alliances," San Antonio, Texas, October 9.
28. 2006, *Speaker,* American Society of Bioethics and Humanities Annual Meeting, "Bioethics Mediation: A Critique," Denver, Colorado, October 28.
29. 2005, *Panelist,* American Society of Bioethics and Humanities Annual Meeting, "How I See This Case: 'He Is Not His Brain,'" Washington, DC, October 20.
30. 2005, *Paper Presentation,* Pediatric Ethics: Setting an Agenda for the Future, The Cleveland Clinic, "'He Is Not His Brain:' Accommodating Objections to 'Brain Death,'" Cleveland, Ohio, September 9.
31. 2004, *Speaker,* American Society for Bioethics and Humanities Spring Meeting, "Verification and Balance: Reporting Within the Constraints of Patient Confidentiality," San Antonio, Texas, March 13.
32. 2002, *Panelist*, American Society for Bioethics and Humanities Annual Meeting, "'Who Should Survive?:' Mental Retardation and the History of Bioethics," Baltimore, Maryland, October 24.

Invited/Visiting Professor Presentations

1. 2013, Visiting Professor, "How to Listen, Speak and Think Ethically: A Multidisciplinary Approach," Norton Suburban Hospital and Kosair Children's Hospital, Louisville, Kentucky, May 22.
2. 2010, Visiting Professor, Program in Bioethics and Humanities and Department of Pediatrics, "What to Do When Parents Want Everything Done: 'Futility' and Ethics Facilitation," University of Iowa Carver College of Medicine, Iowa City, Iowa, September 10.

Grand Round Presentations

1. 2019, David Green Lectureship, "Establishing Goals of Care and Ethically Limiting Treatment," Primary Children's Hospital, Salt Lake City, Utah, December 5.
2. 2018, "The Ethics of Medical Intervention for Transgender Youth," El Rio Health, Tucson, Arizona, September 29.

3. 2018, Pediatrics, "Patient Selection, Justice, and Cultural Difference: Ethical Issues in the Care of International Patients," Cleveland Clinic, Cleveland, Ohio, April 10.
4. 2018, Bioethics, "Reversibility, Fertility, and Conflict: Ethical Issues in the Care of Transgender and Gender Nonconforming Children and Adolescents," Cleveland Clinic, Cleveland, Ohio, April 9.
5. 2017, Heart Institute, "'Have you ever thought about what you would want—if god forbid—you became sicker?': Talking with adult patients about advance directives," Cincinnati Children's Hospital Medical Center, Cincinnati, Ohio, October 16.
6. 2017, Pediatrics, "Respectful, Effective Treatment of Jehovah's Witnesses," with Judith R. Ragsdale, PhD, MDiv and David Morales, MD, Cincinnati Children's Hospital Medical Center, Cincinnati, Ohio, March 14.
7. 2017, Pediatrics, "Ethical Dilemmas about Discharging Patients When There Are Disagreements Concerning Safety," Seattle Children's Hospital, Seattle, Washington, January 19.
8. 2015, Pediatrics, "'Nonbeneficial' Treatment: What must providers offer and what can they withhold?," Greenville Health System, Greenville, South Carolina, May 10.
9. 2014, Advance Practice Providers, "Common Ethical Issues," Cincinnati Children's Hospital Medical Center, Cincinnati, Ohio, August 13.
10. 2014, Respiratory Therapy, "Do-Not-Resuscitate (DNR) Orders," Cincinnati Children's Hospital Medical Center, Cincinnati, Ohio, July 15.
11. 2013, Heart Institute, "No Not Months. Twenty-Two *Years*-Old: Transiting Patients to an Adult Model of Care." Cincinnati Children's Hospital Medical Center, Cincinnati, Ohio, October 21.
12. 2013, Division of Neonatology, "This Premature Infant Has a *BRCA1* Mutation!?: Ethical Issues in Clinical Whole Exome Sequencing for Neonatologists." Cincinnati Children's Hospital Medical Center, Cincinnati, Ohio, October 11.
13. 2013, Department of Pediatrics, "Adults are Not Large Children: Ethical Issues in Caring for Adults in Children's Hospitals," Cincinnati Children's Hospital Medical Center, Cincinnati, Ohio, February 26.
14. 2012, "Mandate or Moratorium?: Persisting Ethical Controversies in Donation after Circulatory Death," Cedars-Sinai Medical Center, Los Angeles, California, May 16.
15. 2011, Division of Pediatric Neurology Friday Lecture Series, "Inducing or Treating 'Seizures' with Placebos: Is It Ever Ethical?," University of Utah, Salt Lake City, Utah, October 7.
16. 2011, Department of Surgery, "DNR Orders in the OR and other Ethical Issues in Pediatric Surgery: Case Discussions," Primary Children's Medical Center, Salt Lake City, Utah, October 3.
17. 2009, Department of Pediatrics, "What to Do When Parents Want Everything Done: 'Futility' and Bioethical Mediation," Primary Children's Medical Center, Salt Lake City, Utah, September 17.
18. 2008, Division of Pulmonology and Critical Care, "Futility: May Clinicians Ever Unilaterally Withhold or Withdraw Medical Treatment?" Utah Valley Regional Medical Center, Provo, Utah, April 17.
19. 2007, Division of Otolaryngology-Head and Neck Surgery, "Advance Directives, Durable Powers of Attorney for Healthcare, and Do Not Attempt Resuscitation Orders: Oh My!," University of Utah School of Medicine, Salt Lake City, Utah, June 20.

Outreach Presentations

1. 2019, *Panelist*, Cincinnati Edition, WVXU, "The Ethics of Human Gene Editing," Cincinnati, Ohio, June 13.
2. 2019, *Speaker,* Adult Forum, Indian Hill Church, "Medical Ethics," Indian Hill, Ohio, March 24.
3. 2016, *Speaker,* Conversations in Bioethics: The Intersection of Biology, Technology, and Faith, Mt. Washington Presbyterian Church, "Genetic Testing," Cincinnati, Ohio, October 12.
4. 2008, *Speaker,* Science in Society, Co-sponsored by KCPW and the City Library, "Death—Choices," Salt Lake City, Utah, November 20.
5. 2003, *Panelist,* Utah Symposium in Science and Literature, "The Goodness Switch: What Happens to Ethics if Behavior is All in Our Brains?" Salt Lake City, Utah, October 10.

6. 2002, *Respondent*, H. Tristram Englehardt, Jr. "The Culture Wars in Bioethics," Salt Lake Community College, Salt Lake City, Utah, March 29.

Podcasts

1. 2021, "Ethics of COVID Vaccines in Kids," PHM from Pittsburgh, August 12.
2. 2020, COVID Quandaries: Episode 1, "Is Getting Sick Just Part of the Job?" Hard Call, October 6.

Version Date: 3/4/22

CURRICULUM VITAE

Cassandra C Brady, MD

Office Address: Village at Vanderbilt
Division of Pediatric Endocrinology and Diabetes
1500 21st Avenue South, Suite 1514
Nashville, TN, USA 37212

EDUCATION:

2001-2005	BS	Indiana University, Bloomington, IN
2005-2009	MD	Indiana University School of Medicine, Indianapolis, IN

POSTGRADUATE TRAINING:

2009-2012	Resident/General Pediatrics Monroe-Carell Jr. Children's Hospital at Vanderbilt Nashville, TN
2012-2015	Fellow/Pediatric Endocrinology Cincinnati Children's Hospital Medical Center Cincinnati, OH

MEDICAL LICENSURE:

2015	Tennessee Medical License, Number 52482

CERTIFICATIONS:

2012-present	American Board of Pediatrics Certified, General Pediatrics
2015-presnt	American Board of Pediatrics Certified, Pediatric Endocrinology

ACADEMIC APPOINTMENTS:

2015-present	Assistant Professor of Pediatrics, Vanderbilt University Medical Center

PROFESSIONAL ORGANIZATIONS:

2019-present	Endocrine Society

2017-present	Pediatric Endocrine Society, Transgender Special Interest Group and Differences of Sex Development (DSD) Special Interest Group
2019-Present	Pediatric Endocrine Society, Transgender Special Interest Group, Advocacy Subcommittee
2019-2020	Pediatric Endocrine Society, Lead Author and Team Lead, Policy Statement on Genital Surgery, DSD Special Interest Group, Advocacy Subgroup
2020-Present	Pediatric Endocrine Society, DSD Special Interest Group, Education Subcommittee
2021-present	Pediatric Endocrine Society, Public Policy Committee
2019-present	World Professional Association for Transgender Health (WPATH)
2019	World Professional Association of Transgender Health (WPATH), Global Education Initiative (GEI) Foundations Course
2020-present	American Academy of Pediatrics: Pediatric Endocrinology Subgroup
2020-present	American Academy of Pediatrics: TN AAP Member, LGBTQ Legislative Subcommittee Chair

OTHER PROFESSIONAL ACTIVITIES:

National Service

2016-present Manuscript Reviewer
Obesity
Pediatrics
Transgender Health

2019-present Consultant for media in support of advocacy:

"How to Support Positive Gender Identity Development in your Children." *My Southern Health* (2019)

"Warnings about Risk of Prepubertal Gynecomastia." Med-Page (2019)

Pediatric News Journal, Vol 54, No 4, 2019. Quoted regarding experience with transgender legislation in the state of TN

The New York Times interview with Sabrina Imbler, "For Transgender Youth, Stigma is Just One Barrier to Healthcare" (2021)

Modern Health interview with Lisa Gillespie, "The doctor at the statehouse: how medical associations fought against anti-transgender youth bills" (2021)

The New York Times interview with Azeen Ghorayshi, "Doctors Debate Whether Trans Teens Need Therapy Before Hormones." (2022)

Regional/Local Service

2018-present LGBTQ Legislative Subcommittee Chair
Advocacy meeting with Senator Haile (January 2020)
Advocacy call with Representative Terry (February 2020)
Advocacy meeting with Representative Clemmons (February 2021)
Advocacy meeting with Representative Love (February 2021)
Advocacy call with Senator Hensley (February 2021)
Senate Health Subcommittee, opposition to SB 126 (March 2021)
TN House Health Subcommittee, opposition to HB 1027 (April 2021)

2020-present Consultant for media in support of advocacy

Tennessean interview with Stella Yu, "Fighting Fears." (March 2021)

Tennessean, Morad A, Yaun J, Sinard D, Dentz B, Butler H, **Brady C**. "Transgender bills don't support well-being of all children. *(March 2021)*

Vanderbilt Hustler, interview with Charlotte Mauger, "Lambda and VSG work to address recent anti-transgender legislation in TN." (April 2021)

MiniVHAN Podcast , interview with Mallory Yoder discussing Gender Affirming Care. (May 2021)

2020-present Advocacy
TN Transgender Task Force
Established group of providers across the state that provide care to transgender youth, current focus legislation

Vanderbilt University Medical Center

Institutional

2009-2012 Residency Advisory Council, Vanderbilt Pediatric Residency
2010-2012 American Academy of Pediatrics Delegate
2016-2017 EpicLeap Clinical Design Pediatric Endocrinology Workflow Team

2017-2018	Clinical Practice Guideline Committee
2017	Epic Peer Trainer
2018	Transgender Policy Working Group, Vanderbilt University Medical Center, LGBTQ Program
2015-present	Pediatric Residency Interviewing
2019-present	Pediatric Residency Mentor
2020	SOGI working group
2021	Inaugural member, Academy of Excellence in Clinical Medicine, Vanderbilt University Medical Center

Clinical Program

2017-present	Clinic Director, Differences of Sex Development Clinic *This clinic includes pediatric endocrinology and urology. We provide inpatient consult services, prenatal consults, and outpatient consult services. Families travel from across the surrounding 5 states to our clinic.*
2016	Gender Clinic Planning Committee, Vanderbilt University Medical Center
2018-present	Clinic Director, Vanderbilt Pediatric and Adolescent Gender Clinic (VPATH) *This clinic includes a variety of pediatric subspecialists who provide clinical care for patients who are gender diverse. Patients travel from five surrounding states to this clinic.*

Awards

2017, 2019-2021	Excellence in Patient Experience Award (honors clinicians who have reached the 90th percentile nationally in patient experience)
2020	TN AAP Special Achievement Award
2021	Friends of Fashion, Healthcare Hero, Friends of Vanderbilt Children's Hospital, patient nominated
2021	Nashville Top Doctors, *Nashville Lifestyles,* peer chosen

TEACHING ACTIVITIES:

Graduate School

2016-present	"Care of the Transgender Individual." Vanderbilt University School of Nursing, Current Issues Course for FNP, Nashville, TN
October 2016	"Transgender Care - Open Discussion." Vanderbilt University, Peabody College, Care of the Hospitalized Child Course
2016-present	"Differences of Sex Development." Vanderbilt University School of Nursing, LGBTI Course, Module 3, Nashville, TN
2020	"Differences of Sex Development." Vanderbilt University, Master of Genetic Counseling Program, Nashville, TN

Medical School

2017-present	Lecturer, Vanderbilt University School of Medicine Sexual Medicine Immersion Course (2-3 sessions per year)
2019-present	Lecturer, Vanderbilt University School of Medicine, Endocrine, Digestion and Reproduction, First Year Course (1 session per year)
2015-present	Ward Attending, Pediatric Endocrinology and Diabetes (1 week per quarter)
2020	Mentorship, Kyle Gavulic

Pediatric House Officers

2015-present	Ward Attending, Pediatric Endocrinology and Diabetes (1 week per quarter)
2015-present	Faculty Preceptor, Pediatric Endocrinology and Diabetes Clinic(1 day per week)
2018-present	Lecturer, General Pediatrics Residency Noon Conference (2-3 presentations per year)
2020	Lecturer, General Pediatrics Residency Chief's Case, Monroe-Carell Junior Children's Hospital at Vanderbilt (Frasier Syndrome)
2020-present	Mentorship, Pediatric Residency Program, Dr. Julie Wittwer
2021-present	Mentorship, Pediatric Residency Program, Dr. Ally Metro
2021	General Pediatrics Residency Chalk Talk, Monroe-Carell Junior Children's Hospital at Vanderbilt (Congenital Adrenal Hyperplasia)

Pediatric Endocrinology and Diabetes Fellows

2012-2015	Fellows Conference, Cincinnati Children's Hospital Medical Center, Pediatric Endocrinology Fellowship – 8 presentations each year in Board Review, Case Conferences, Journal Club, Research topics)
2015-current	Ward Attending, Pediatric Endocrinology and Diabetes
2015-current	Faculty Preceptor, Pediatric Endocrinology and Diabetes Clinic
2016-2019	Mentorship, Dr. Kristin Favela, Pediatric Endocrinology Fellow

INVITED PRESENTATIONS:

National

July 2017	"The Hospitalized Child with Diabetes/Hyperglycemia: Don't Sugar Coat It." Pediatric Hospital Medicine Conference, Nashville, TN
September 2021	"Conversations about Fertility in the Pediatric Setting." Panel on Reproductive Endocrinology and Transgender Medicine. Endocrine Ethics Association Virtual Conference.

Regional

September 2014	"Disorders of Sex Development: Focus on Congenital Adrenal Hyperplasia." Public Health Nurse Education Day, Cincinnati, OH
November 2016	"Intro to Intersex." Vanderbilt University Lambda Association
September 2018	**Brady C**, Morgan T. "Combined DSD Evaluation: Endocrine-genetic testing for efficient genotype-phenotype determination." 97th Annual Meeting of the South-Central Section of the American Urologic Society (AUA), Nashville, TN
February 2019	"Introduction to the Clinical Care of Youth with Differences in Sexual Development and Gender Dysphoria." Tennessee Alliance for Sexual Health (TNASH), Nashville, TN
November 2020	"Panel Discussion: Gender Dysphoria." 2nd Annual Pediatric Advanced Practice Provider Conference, Memphis, TN (virtual)
July 2021	Romano M, Cyperski M, **Brady C**. "PATH to Affirmative Medical Care for Transgender/Gender Diverse Youth: A Guide for Mental Health Providers." Southeast AIDS Education and Training Center Webcast Wednesday. Nashville, TN
April 2021	**Brady C**, Panelist for "Marshalling, Mobilizing, and Messaging on Anti-Transgender health legislation." AAP Advocacy Conference (Virtual)
August 2021	Romano M, Cyperski M, **Brady C**. "Ways to Support and Advocate for Transgender and Gender Diverse Youth in a Non-Affirming Environment: Perspectives from a Team of Providers." Southern LGBTQ Health Symposium (Virtual)

Continuing Medical Education/Grand Rounds

2015-current	Lecturer, Pediatric Endocrinology Division Conference (2 presentations per year)
2018-2019	Pediatric Gender Medicine Case Conference, (multidisciplinary case conference), Monroe-Carell Junior Children's Hospital at Vanderbilt
December 2019	"Differences of Sexual Development: A Surgical Perspective from an Endocrinologist." Vanderbilt Children's Hospital, Pediatric General Surgery Grand Rounds, Nashville, TN, (Invited)

March 2019	**Brady C,** Romano M. "A PATH to Transgender Medical Care: A guide for primary care providers." Cumberland Pediatrics Foundation CME dinner (Invited)
May 2019	"Thyroid and Adrenal Disorders in Rheumatology." Division of Pediatric Rheumatology, Monroe Carell Junior Children's Hospital at Vanderbilt, Nashville, TN (Invited)
January 2020	"Care of the Transgender Child and Adolescent." Division of OB/GYN at VUMC, Resident Education, Nashville, TN (Invited)
2020, 2022	"Differences of Sex Development." Vanderbilt Children's Hospital, Pediatric Urology Division Conference, Nashville, TN (Invited)
October 2020	Cyperski M, **Brady C**, Romano M. "PATH to affirmative medical care for transgender/gender diverse (TGD) youth: A guide for mental health providers." Vanderbilt Psychiatry, Grand Rounds, Nashville, TN (Invited)
January 2021	**Brady C,** Gregory A. "The Transgender/Gender Diverse Athlete." Vanderbilt University Medical Center Division of Endocrinology and Diabetes, Grand Rounds.
January 2022	**Brady C**, Cox M. "We've Got Spirit: The Role of Spiritual Care in Transgender/Gender Diverse Healthcare." Vanderbilt University Medical Center Division of Endocrinology and Diabetes, Grand Rounds.
February 2022	"Differences of Sex Development: A Discussion for All Providers." Vanderbilt University Medical Center, LGBTQ+ Medical Certificate, Content Expert. (Invited)
March 2022	"The Gender Diverse Athlete." Cook Children's Pediatric Endocrinology, Grand Rounds. (Invited)

Other Teaching

2016	**Brady CC.** NEJM Knowledge+ Family Medicine Board Review. Wrote 4 endocrinology questions in pediatrics for a comprehensive lifelong learning product from NEJM Group (http://knowledgeplus.nejm.org/)
2017, 2019	"Care of the Transgender Individual." Edward Curd Lane Pediatric Nursing Inservice, Monroe-Carell Junior Children's Hospital at Vanderbilt, Franklin, TN
April 2017	"Disorders of Sex Development." Edward Curd Lane Pediatric Nursing Inservice, Monroe-Carell Junior Children's Hospital at Vanderbilt, Franklin, TN

May 2019	"Care of the Transgender Child and Adolescent." Nashville Child and Family Wellness Center, Nashville, TN
September 2021	Bennett J, **Brady C.** "Transgender Health and Its Nutrition Considerations". Nutrition and Dietitian September Inservice

OTHER SIGNIFICANT ACTIVITIES

2008	Camp John Warvel for Type I Diabetes, American Diabetes Association, Medical Staff, Cleveland, IN
2011	Tennessee Camp for Diabetic Children, Medical Staff, Soddy Daisy, TN
2012	Global Healing, Pediatric Resident, Roatan, Honduras
2012-2015	Camp Korelitz for Type 1 Diabetes, American Diabetes Association, Medical Staff and Planning Committee, Clarkesville, OH

RESEARCH PROGRAM

2020	Clinical consultant for Dr. Ellen Clayton's (PI) PRiSM Study

PUBLICATIONS AND PRESENTATIONS

Peer Reviewed Journals:

Po'e E, **Neureiter C,** Escarfuller J, Gesell S, Tempesti T, Widman P, Barkin S. Systemic Exposure to Recreation Centers Increases Use by Latino Families with Young Children. *Pediatric Obesity*. 8(2). 116-23, 2012.

Brady C, Palladino AA, Gutmark-Little I. A Novel Case of Compound Heterozygous Congenital Hyperinsulinism without High Insulin Levels. *International Journal of Pediatric Endocrinology*. (1):16. Open Access, 2015.

Brady CC, Vannest JJ, Dolan LM, Kadis DS, Lee GR, Holland SK, Khoury JC, Shah, AS. Obese Adolescents with Type 2 Diabetes Perform Worse than Controls on Cognitive and Behavioral Assessments. *Pediatric Diabetes*. (Epub ahead of print) 2016.

Lingren T, Thaker V, **Brady C,** Namjou B, Kennebeck S, Bickel J, Patibandia N, Ni Y, Van Driest SL, Chen L, Roach A, Cobb B, Kirby J, Denny J, Bailey-Davis L, Williams MS, Marsolo K, Solti I, Holm IA, Harley J, Kohane IS, Savova G, Crimmins N. Developing an Algorithm to Detect Early Childhood Obesity in Two Tertiary Pediatric Medical Centers. *Applied Clinical Informatics*. 7 (3): 693-706. 2016.

Brady CC, Thaker VV, Lingren T, Woo JG, Kennebeck SS, Namjou-Khales B, Roach A, Bickel JP, Patibandia N, Savova GK, Solti I, Holm IA, Harley JB, Kohane IS,

Crimmins NA. Suboptimal Clinical Documentation in Young Children with Severe Obesity at Tertiary Care Centers. *International Journal of Pediatrics*. (Epub) 2016.

Redel JM, DiFrancesco M, Vannest J, Altaye M, Beebe D, Khoury J, Dolan LM, Lee G, Brunner H, Holland S, **Brady C**, Shah AS. Brain Gray Matter Volume Differences in Obese Youth with Type 2 Diabetes: A Pilot Study. *Journal of Pediatric Endocrinology and Metabolism.* 31 (3): 261-268. 2018.

Nasomyont N, Lindsley AW, Assa'ad A, Neilson DE, **Brady CC**, Rutter MR. Central diabetes insipidus in a pediatric patient with *NFKB2* Mutation: Extending the endocrine phenotype in DAVID syndrome. *The Journal of Clinical Endocrinology and Metabolism*. 104 (9): 4051-4057. 2019.

Lawson C, Naseeruddin Ahmed S, **Brady C,** Shoemaker A. A Clinic-based Approach to Diagnosis and Management of Prediabetes in High-risk Children and Adolescents. *Journal of the Endocrine Society*. 4 (4): 1-8. 2020.

Cyperski MA, Romano ME, **Brady CC**. Supporting transgender/gender diverse (TGD) youth across settings and systems of care: Experiences from a pediatric interdisciplinary clinic. *the Behavior Therapist*, *43*(7), 242-247. 2020.

Redel JM, DiFrancesco M, Lee GR, Ziv A, Dolan LM, **Brady CC**, Shah AS. Cerebral Blood Flow is Lower in Youth with Type 2 Diabetes Compared to Obese Controls: A Pilot Study. *Pediatric Diabetes*. Epub ahead of print. 2022.

Abstracts/Presentations at Scientific Meetings:

Craig J, **Neureiter C**, O'Neil J, Steele G. "Assessing Maternal and Paternal Birth Weight as a Factor for Delivering Low Birth Weight Infants." October 10, 2008, American Academy of Pediatrics National Conference and Exhibition, Boston, MA. ("Poster" or "Poster Presentation"))

Neureiter C, Poe E, Escarfuller J, Widman P, Barkin S. "Recreation Center Exposure Increases Physical Activity Use by Latino Families with Young Children**."** April 30, 2011, Pediatric Academic Society, Denver, CO. (Platform Presentation)

Brady C, Lingren T, Kennebeck S, Solti I, Crimmins NA. "Pediatric Providers are Poor at Identifying Severe Obesity in Young Children." September 21, 2013, 9th Annual Joint Meeting of Paediatric Endocrinology, Milan, Italy. (Poster Presented)

Brady C, Palladino AA, Burrow TA, Gutmark-Little I. "The Inaccuracy of Insulin Levels in Congenital Hyperinsulinism and the Importance of Genetic Testing." June 22, 2014, 6th International Congress of Endocrinology, The Endocrine Society's 96th Annual Meeting and Expo, Chicago, IL. (Poster Presented)

Thaker V, Lingren T, Namjou B, Perry C, Crimmins N, **Brady C,** Solti I, Savova G, Kohane I, Harley J. "Comparative Analysis of Electronic Health Record (EHR)-driven and Conventional Cohort–driven Genomic Research." October, 2014, 64th Annual Meeting of the American Society of Human Genetics, San Diego, CA. (Poster)

Brady C, Vannest J, Lee GR, Dolan L, Holland S, Shah AS. "Youth with Early Onset Type 2 Diabetes have Worse Cognitive Performance Compared to Controls." April, 2015, Pediatric Endocrine Society Annual Meeting, San Diego, CA. (Poster Presented)

Brady C, Lee GR, Dolan LM, Vannest J, Holland S, Khoury J, Shah AS. "Subclinical Cardiovascular Disease is Inversely Associated with Cerebral Blood Flow in Adolescents with Type 2 Diabetes." June 2015, 75th Scientific Sessions American Diabetes Association, Boston, MA. (Poster and Guided Audio Tour Presented)

Redel JM, Vannest J, Altaye M, Dolan LM, Lee G, Brunner H, DiFrancesco M, Holland S, **Brady C,** Shah AS. "Brain Gray Matter Volume Changes in Youth with Type 2 Diabetes." June 2016. 76th Scientific Sessions American Diabetes Association, New Orleans, LA. (Oral Abstract Presentation-Presenter: Redel JM)

Redel JM, Lee G, DiFrancesco M, Vannest J, Dolan LM, **Brady C,** Khoury J, Shah AS. Adolescents with Type 2 Diabetes Demonstrate Reduced Microstructural Integrity in Brain White Matter. *Poster Presentation and Moderated Poster Discussion*. American Diabetes Association 77th Scientific Sessions. San Diego, CA, June 9-13, 2017. (Poster-Presenter: Redel JM)

Redel JM, Vannest J, Altaye M, Dolan LM, Lee G, Brunner H, DiFrancesco M, Holland, S, **Brady C,** Shah AS. Brain Gray Matter Volume Differences in Youth with Type 2 Diabetes. *Poster Presentation.* 10th International Meeting of Pediatric Endocrinology. Washington, D.C., September 15, 2017. (Poster-Presenter: Redel JM)

Nasomyont N, Lindsley AW, Assa'ad A, **Brady C**, Rutter MM. Central Diabetes Insipidus, ACTH Deficiency And Common Variable Immunodeficiency In A Pediatric Patient With NFKB2 Mutation: A Case Report. *Poster Presentation*. Endocrine Society Annual Meeting, Chicago, IL. March 17, 2018. (Poster-Presenter: Nasomyont N)

Wheeler F, **Brady C.** "Clinical and cytogenetic findings in a phenotypic female with a 46,XY karyotype and gonadal failure." American College of Medical Genetics, Poster, April 2021. (Poster-Presenter: Wheeler F)

Logel S, Whitehead J, Maru J, Walch A, **Brady C**, Lasarev M, Rehm J, Millington K. "Transgender and Gender-Diverse Youth have Higher Prevalence of Certain Autoimmune Diseases." Pediatric Endocrine Society Annual Meeting, Presidential Poster Session, Virtual, April 30, 2021. (Poster Presenter: Logel S)

Brady C, Cyperski M, Romano M. "Providing Affirmative Care and Advocating for Gender Diverse Youth in a Non-Affirming Political Landscape." Community Engagement Mini Symposium. USPATH Virtual Scientific Symposium, November 6, 2021.

Endocrine Treatment of Gender-Dysphoric/ Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline

Wylie C. Hembree,[1] Peggy T. Cohen-Kettenis,[2] Louis Gooren,[3] Sabine E. Hannema,[4] Walter J. Meyer,[5] M. Hassan Murad,[6] Stephen M. Rosenthal,[7] Joshua D. Safer,[8] Vin Tangpricha,[9] and Guy G. T'Sjoen[10]

[1]New York Presbyterian Hospital, Columbia University Medical Center, New York, New York 10032 (Retired); [2]VU University Medical Center, 1007 MB Amsterdam, Netherlands (Retired); [3]VU University Medical Center, 1007 MB Amsterdam, Netherlands (Retired); [4]Leiden University Medical Center, 2300 RC Leiden, Netherlands; [5]University of Texas Medical Branch, Galveston, Texas 77555; [6]Mayo Clinic Evidence-Based Practice Center, Rochester, Minnesota 55905; [7]University of California San Francisco, Benioff Children's Hospital, San Francisco, California 94143; [8]Boston University School of Medicine, Boston, Massachusetts 02118; [9]Emory University School of Medicine and the Atlanta VA Medical Center, Atlanta, Georgia 30322; and [10]Ghent University Hospital, 9000 Ghent, Belgium

***Cosponsoring Associations:** American Association of Clinical Endocrinologists, American Society of Andrology, European Society for Pediatric Endocrinology, European Society of Endocrinology, Pediatric Endocrine Society, and World Professional Association for Transgender Health.

Objective: To update the "Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline," published by the Endocrine Society in 2009.

Participants: The participants include an Endocrine Society–appointed task force of nine experts, a methodologist, and a medical writer.

Evidence: This evidence-based guideline was developed using the Grading of Recommendations, Assessment, Development, and Evaluation approach to describe the strength of recommendations and the quality of evidence. The task force commissioned two systematic reviews and used the best available evidence from other published systematic reviews and individual studies.

Consensus Process: Group meetings, conference calls, and e-mail communications enabled consensus. Endocrine Society committees, members and cosponsoring organizations reviewed and commented on preliminary drafts of the guidelines.

Conclusion: Gender affirmation is multidisciplinary treatment in which endocrinologists play an important role. Gender-dysphoric/gender-incongruent persons seek and/or are referred to endocrinologists to develop the physical characteristics of the affirmed gender. They require a safe and effective hormone regimen that will (1) suppress endogenous sex hormone secretion determined by the person's genetic/gonadal sex and (2) maintain sex hormone levels within the normal range for the person's affirmed gender. Hormone treatment is not recommended for prepubertal gender-dysphoric/gender-incongruent persons. Those clinicians who recommend gender-affirming endocrine treatments—appropriately trained diagnosing clinicians (required), a mental health provider for adolescents (required) and mental health

ALL-STATE LEGAL®
EXHIBIT
PX 08

ISSN Print 0021-972X ISSN Online 1945-7197
Printed in USA
Copyright © 2017 Endocrine Society
Received 24 July 2017. Accepted 24 August 2017.
First Published Online 13 September 2017

Abbreviations: BMD, bone mineral density; DSD, disorder/difference of sex development; DSM, Diagnostic and Statistical Manual of Mental Disorders; GD, gender dysphoria; GnRH, gonadotropin-releasing hormone; ICD, International Statistical Classification of Diseases and Related Health Problems; MHP, mental health professional; VTE, venous thromboembolism.

Downloaded from https://academic.oup.com/jcem/article/102/11/3869/4157558 by guest on 10 March 2022

professional for adults (recommended)—should be knowledgeable about the diagnostic criteria and criteria for gender-affirming treatment, have sufficient training and experience in assessing psychopathology, and be willing to participate in the ongoing care throughout the endocrine transition. We recommend treating gender-dysphoric/gender-incongruent adolescents who have entered puberty at Tanner Stage G2/B2 by suppression with gonadotropin-releasing hormone agonists. Clinicians may add gender-affirming hormones after a multidisciplinary team has confirmed the persistence of gender dysphoria/gender incongruence and sufficient mental capacity to give informed consent to this partially irreversible treatment. Most adolescents have this capacity by age 16 years old. We recognize that there may be compelling reasons to initiate sex hormone treatment prior to age 16 years, although there is minimal published experience treating prior to 13.5 to 14 years of age. For the care of peripubertal youths and older adolescents, we recommend that an expert multidisciplinary team comprised of medical professionals and mental health professionals manage this treatment. The treating physician must confirm the criteria for treatment used by the referring mental health practitioner and collaborate with them in decisions about gender-affirming surgery in older adolescents. For adult gender-dysphoric/gender-incongruent persons, the treating clinicians (collectively) should have expertise in transgender-specific diagnostic criteria, mental health, primary care, hormone treatment, and surgery, as needed by the patient. We suggest maintaining physiologic levels of gender-appropriate hormones and monitoring for known risks and complications. When high doses of sex steroids are required to suppress endogenous sex steroids and/or in advanced age, clinicians may consider surgically removing natal gonads along with reducing sex steroid treatment. Clinicians should monitor both transgender males (female to male) and transgender females (male to female) for reproductive organ cancer risk when surgical removal is incomplete. Additionally, clinicians should persistently monitor adverse effects of sex steroids. For gender-affirming surgeries in adults, the treating physician must collaborate with and confirm the criteria for treatment used by the referring physician. Clinicians should avoid harming individuals (via hormone treatment) who have conditions other than gender dysphoria/gender incongruence and who may not benefit from the physical changes associated with this treatment. **(*J Clin Endocrinol Metab* 102: 3869–3903, 2017)**

Summary of Recommendations

1.0 Evaluation of youth and adults

1.1. We advise that only trained mental health professionals (MHPs) who meet the following criteria should diagnose gender dysphoria (GD)/gender incongruence in adults: (1) competence in using the Diagnostic and Statistical Manual of Mental Disorders (DSM) and/or the International Statistical Classification of Diseases and Related Health Problems (ICD) for diagnostic purposes, (2) the ability to diagnose GD/gender incongruence and make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (3) training in diagnosing psychiatric conditions, (4) the ability to undertake or refer for appropriate treatment, (5) the ability to psychosocially assess the person's understanding, mental health, and social conditions that can impact gender-affirming hormone therapy, and (6) a practice of regularly attending relevant professional meetings. (Ungraded Good Practice Statement)

1.2. We advise that only MHPs who meet the following criteria should diagnose GD/gender incongruence in children and adolescents: (1) training in child and adolescent developmental psychology and psychopathology, (2) competence in using the DSM and/or the ICD for diagnostic purposes, (3) the ability to make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (4) training in diagnosing psychiatric conditions, (5) the ability to undertake or refer for appropriate treatment, (6) the ability to psychosocially assess the person's understanding and social conditions that can impact gender-affirming hormone therapy, (7) a practice of regularly attending relevant professional meetings, and (8) knowledge of the criteria for puberty blocking and gender-affirming hormone treatment in adolescents. (Ungraded Good Practice Statement)

1.3. We advise that decisions regarding the social transition of prepubertal youths with GD/gender incongruence are made with the assistance of an MHP or another experienced professional. (Ungraded Good Practice Statement).

Downloaded from https://academic.oup.com/jcem/article/102/11/3869/4157558 by guest on 10 March 2022

1.4. We recommend against puberty blocking and gender-affirming hormone treatment in prepubertal children with GD/gender incongruence. (1 |⊕⊕○○)
1.5. We recommend that clinicians inform and counsel all individuals seeking gender-affirming medical treatment regarding options for fertility preservation prior to initiating puberty suppression in adolescents and prior to treating with hormonal therapy of the affirmed gender in both adolescents and adults. (1 |⊕⊕⊕○)

2.0 Treatment of adolescents

2.1. We suggest that adolescents who meet diagnostic criteria for GD/gender incongruence, fulfill criteria for treatment, and are requesting treatment should initially undergo treatment to suppress pubertal development. (2 |⊕⊕○○)
2.2. We suggest that clinicians begin pubertal hormone suppression after girls and boys first exhibit physical changes of puberty. (2 |⊕⊕○○)
2.3. We recommend that, where indicated, GnRH analogues are used to suppress pubertal hormones. (1 |⊕⊕○○)
2.4. In adolescents who request sex hormone treatment (given this is a partly irreversible treatment), we recommend initiating treatment using a gradually increasing dose schedule after a multidisciplinary team of medical and MHPs has confirmed the persistence of GD/gender incongruence and sufficient mental capacity to give informed consent, which most adolescents have by age 16 years. (1 |⊕⊕○○).
2.5. We recognize that there may be compelling reasons to initiate sex hormone treatment prior to the age of 16 years in some adolescents with GD/gender incongruence, even though there are minimal published studies of gender-affirming hormone treatments administered before age 13.5 to 14 years. As with the care of adolescents ≥16 years of age, we recommend that an expert multidisciplinary team of medical and MHPs manage this treatment. (1 |⊕○○○)
2.6. We suggest monitoring clinical pubertal development every 3 to 6 months and laboratory parameters every 6 to 12 months during sex hormone treatment. (2 |⊕⊕○○)

3.0 Hormonal therapy for transgender adults

3.1. We recommend that clinicians confirm the diagnostic criteria of GD/gender incongruence and the criteria for the endocrine phase of gender transition before beginning treatment. (1 |⊕⊕⊕○)
3.2. We recommend that clinicians evaluate and address medical conditions that can be exacerbated by hormone depletion and treatment with sex hormones of the affirmed gender before beginning treatment. (1 |⊕⊕⊕○)
3.3. We suggest that clinicians measure hormone levels during treatment to ensure that endogenous sex steroids are suppressed and administered sex steroids are maintained in the normal physiologic range for the affirmed gender. (2 |⊕⊕○○)
3.4. We suggest that endocrinologists provide education to transgender individuals undergoing treatment about the onset and time course of physical changes induced by sex hormone treatment. (2 |⊕○○○)

4.0 Adverse outcome prevention and long-term care

4.1. We suggest regular clinical evaluation for physical changes and potential adverse changes in response to sex steroid hormones and laboratory monitoring of sex steroid hormone levels every 3 months during the first year of hormone therapy for transgender males and females and then once or twice yearly. (2 |⊕⊕○○)
4.2. We suggest periodically monitoring prolactin levels in transgender females treated with estrogens. (2 |⊕⊕○○)
4.3. We suggest that clinicians evaluate transgender persons treated with hormones for cardiovascular risk factors using fasting lipid profiles, diabetes screening, and/or other diagnostic tools. (2 |⊕⊕○○)
4.4. We recommend that clinicians obtain bone mineral density (BMD) measurements when risk factors for osteoporosis exist, specifically in those who stop sex hormone therapy after gonadectomy. (1 |⊕⊕○○)
4.5. We suggest that transgender females with no known increased risk of breast cancer follow breast-screening guidelines recommended for non-transgender females. (2 |⊕⊕○○)
4.6. We suggest that transgender females treated with estrogens follow individualized screening according to personal risk for prostatic disease and prostate cancer. (2 |⊕○○○)
4.7. We advise that clinicians determine the medical necessity of including a total hysterectomy and oophorectomy as part of gender-affirming surgery. (Ungraded Good Practice Statement)

Downloaded from https://academic.oup.com/jcem/article/102/11/3869/4157558 by guest on 10 March 2022

5.0 Surgery for sex reassignment and gender confirmation

5.1. We recommend that a patient pursue genital gender-affirming surgery only after the MHP and the clinician responsible for endocrine transition therapy both agree that surgery is medically necessary and would benefit the patient's overall health and/or well-being. (1 |⊕⊕○○)

5.2. We advise that clinicians approve genital gender-affirming surgery only after completion of at least 1 year of consistent and compliant hormone treatment, unless hormone therapy is not desired or medically contraindicated. (Ungraded Good Practice Statement)

5.3. We advise that the clinician responsible for endocrine treatment and the primary care provider ensure appropriate medical clearance of transgender individuals for genital gender-affirming surgery and collaborate with the surgeon regarding hormone use during and after surgery. (Ungraded Good Practice Statement)

5.4. We recommend that clinicians refer hormone-treated transgender individuals for genital surgery when: (1) the individual has had a satisfactory social role change, (2) the individual is satisfied about the hormonal effects, and (3) the individual desires definitive surgical changes. (1 |⊕○○○)

5.5. We suggest that clinicians delay gender-affirming genital surgery involving gonadectomy and/or hysterectomy until the patient is at least 18 years old or legal age of majority in his or her country. (2 |⊕⊕○○).

5.6. We suggest that clinicians determine the timing of breast surgery for transgender males based upon the physical and mental health status of the individual. There is insufficient evidence to recommend a specific age requirement. (2 |⊕○○○)

Changes Since the Previous Guideline

Both the current guideline and the one published in 2009 contain similar sections. Listed here are the sections contained in the current guideline and the corresponding number of recommendations: Introduction, Evaluation of Youth and Adults (5), Treatment of Adolescents (6), Hormonal Therapy for Transgender Adults (4), Adverse Outcomes Prevention and Long-term Care (7), and Surgery for Sex Reassignment and Gender Confirmation (6). The current introduction updates the diagnostic classification of "gender dysphoria/gender incongruence." It also reviews the development of "gender identity" and summarizes its natural development. The section on clinical evaluation of both youth and adults, defines in detail the professional qualifications required of those who diagnose and treat both adolescents and adults. We advise that decisions regarding the social transition of prepubertal youth are made with the assistance of a mental health professional or similarly experienced professional. We recommend against puberty blocking followed by gender-affirming hormone treatment of prepubertal children. Clinicians should inform pubertal children, adolescents, and adults seeking gender-confirming treatment of their options for fertility preservation. Prior to treatment, clinicians should evaluate the presence of medical conditions that may be worsened by hormone depletion and/or treatment. A multidisciplinary team, preferably composed of medical and mental health professionals, should monitor treatments. Clinicians evaluating transgender adults for endocrine treatment should confirm the diagnosis of persistent gender dysphoria/gender incongruence. Physicians should educate transgender persons regarding the time course of steroid-induced physical changes. Treatment should include periodic monitoring of hormone levels and metabolic parameters, as well as assessments of bone density and the impact upon prostate, gonads, and uterus. We also make recommendations for transgender persons who plan genital gender-affirming surgery.

Method of Development of Evidence-Based Clinical Practice Guidelines

The Clinical Guidelines Subcommittee (CGS) of the Endocrine Society deemed the diagnosis and treatment of individuals with GD/gender incongruence a priority area for revision and appointed a task force to formulate evidence-based recommendations. The task force followed the approach recommended by the Grading of Recommendations, Assessment, Development, and Evaluation group, an international group with expertise in the development and implementation of evidence-based guidelines (1). A detailed description of the grading scheme has been published elsewhere (2). The task force used the best available research evidence to develop the recommendations. The task force also used consistent language and graphical descriptions of both the strength of a recommendation and the quality of evidence. In terms of the strength of the recommendation, strong recommendations use the phrase "we recommend" and the number 1, and weak recommendations use the phrase "we suggest" and the number 2. Cross-filled circles indicate the quality of the evidence, such that ⊕○○○ denotes very low–quality evidence; ⊕⊕○○, low quality; ⊕⊕⊕○, moderate quality; and ⊕⊕⊕⊕, high quality. The task force has confidence that persons who receive care according to the strong recommendations will derive, on average, more benefit than harm. Weak recommendations require more careful consideration of the person's circumstances, values, and preferences to determine the best course of action. Linked to each recommendation is a description of the evidence and the

Downloaded from https://academic.oup.com/jcem/article/102/11/3869/4157558 by guest on 10 March 2022

values that the task force considered in making the recommendation. In some instances, there are remarks in which the task force offers technical suggestions for testing conditions, dosing, and monitoring. These technical comments reflect the best available evidence applied to a typical person being treated. Often this evidence comes from the unsystematic observations of the task force and their preferences; therefore, one should consider these remarks as suggestions.

In this guideline, the task force made several statements to emphasize the importance of shared decision-making, general preventive care measures, and basic principles of the treatment of transgender persons. They labeled these "Ungraded Good Practice Statement." Direct evidence for these statements was either unavailable or not systematically appraised and considered out of the scope of this guideline. The intention of these statements is to draw attention to these principles.

The Endocrine Society maintains a rigorous conflict-of-interest review process for developing clinical practice guidelines. All task force members must declare any potential conflicts of interest by completing a conflict-of-interest form. The CGS reviews all conflicts of interest before the Society's Council approves the members to participate on the task force and periodically during the development of the guideline. All others participating in the guideline's development must also disclose any conflicts of interest in the matter under study, and most of these participants must be without any conflicts of interest. The CGS and the task force have reviewed all disclosures for this guideline and resolved or managed all identified conflicts of interest.

Conflicts of interest are defined as remuneration in any amount from commercial interests; grants; research support; consulting fees; salary; ownership interests [*e.g.*, stocks and stock options (excluding diversified mutual funds)]; honoraria and other payments for participation in speakers' bureaus, advisory boards, or boards of directors; and all other financial benefits. Completed forms are available through the Endocrine Society office.

The Endocrine Society provided the funding for this guideline; the task force received no funding or remuneration from commercial or other entities.

Commissioned Systematic Review

The task force commissioned two systematic reviews to support this guideline. The first one aimed to summarize the available evidence on the effect of sex steroid use in transgender individuals on lipids and cardiovascular outcomes. The review identified 29 eligible studies at moderate risk of bias. In transgender males (female to male), sex steroid therapy was associated with a statistically significant increase in serum triglycerides and low-density lipoprotein cholesterol levels. High-density lipoprotein cholesterol levels decreased significantly across all follow-up time periods. In transgender females (male to female), serum triglycerides were significantly higher without any changes in other parameters. Few myocardial infarction, stroke, venous thromboembolism (VTE), and death events were reported. These events were more frequent in transgender females. However, the quality of the evidence was low. The second review summarized the available evidence regarding the effect of sex steroids on bone health in transgender individuals and identified 13 studies. In transgender males, there was no statistically significant difference in the lumbar spine, femoral neck, or total hip BMD at 12 and 24 months compared with baseline values before initiating masculinizing hormone therapy. In transgender females, there was a statistically significant increase in lumbar spine BMD at 12 months and 24 months compared with baseline values before initiation of feminizing hormone therapy. There was minimal information on fracture rates. The quality of evidence was also low.

Introduction

Throughout recorded history (in the absence of an endocrine disorder) some men and women have experienced confusion and anguish resulting from rigid, forced conformity to sexual dimorphism. In modern history, there have been numerous ongoing biological, psychological, cultural, political, and sociological debates over various aspects of gender variance. The 20th century marked the emergence of a social awakening for men and women with the belief that they are "trapped" in the wrong body (3). Magnus Hirschfeld and Harry Benjamin, among others, pioneered the medical responses to those who sought relief from and a resolution to their profound discomfort. Although the term transsexual became widely known after Benjamin wrote "The Transsexual Phenomenon" (4), it was Hirschfeld who coined the term "transsexual" in 1923 to describe people who want to live a life that corresponds with their experienced gender vs their designated gender (5). Magnus Hirschfeld (6) and others (4, 7) have described other types of trans phenomena besides transsexualism. These early researchers proposed that the gender identity of these people was located somewhere along a unidimensional continuum. This continuum ranged from all male through "something in between" to all female. Yet such a classification does not take into account that people may have gender identities outside this continuum. For instance, some experience themselves as having both a male and female gender identity, whereas others completely renounce any gender classification (8, 9). There are also reports of individuals experiencing a continuous and rapid involuntary alternation between a male and female identity (10) or men who do not experience themselves as men but do not want to live as women (11, 12). In some countries, (*e.g.*, Nepal, Bangladesh, and Australia), these nonmale or nonfemale genders are officially recognized (13). Specific treatment protocols, however, have not yet been developed for these groups.

Downloaded from https://academic.oup.com/jcem/article/102/11/3869/4157558 by guest on 10 March 2022

Instead of the term transsexualism, the current classification system of the American Psychiatric Association uses the term gender dysphoria in its diagnosis of persons who are not satisfied with their designated gender (14). The current version of the World Health Organization's ICD-10 still uses the term transsexualism when diagnosing adolescents and adults. However, for the ICD-11, the World Health Organization has proposed using the term "gender incongruence" (15).

Treating persons with GD/gender incongruence (15) was previously limited to relatively ineffective elixirs or creams. However, more effective endocrinology-based treatments became possible with the availability of testosterone in 1935 and diethylstilbestrol in 1938. Reports of individuals with GD/gender incongruence who were treated with hormones and gender-affirming surgery appeared in the press during the second half of the 20th century. The Harry Benjamin International Gender Dysphoria Association was founded in September 1979 and is now called the World Professional Association for Transgender Health (WPATH). WPATH published its first Standards of Care in 1979. These standards have since been regularly updated, providing guidance for treating persons with GD/gender incongruence (16).

Prior to 1975, few peer-reviewed articles were published concerning endocrine treatment of transgender persons. Since then, more than two thousand articles about various aspects of transgender care have appeared.

It is the purpose of this guideline to make detailed recommendations and suggestions, based on existing medical literature and clinical experience, that will enable treating physicians to maximize benefit and minimize risk when caring for individuals diagnosed with GD/gender incongruence.

In the future, we need more rigorous evaluations of the effectiveness and safety of endocrine and surgical protocols. Specifically, endocrine treatment protocols for GD/gender incongruence should include the careful assessment of the following: (1) the effects of prolonged delay of puberty in adolescents on bone health, gonadal function, and the brain (including effects on cognitive, emotional, social, and sexual development); (2) the effects of treatment in adults on sex hormone levels; (3) the requirement for and the effects of progestins and other agents used to suppress endogenous sex steroids during treatment; and (4) the risks and benefits of gender-affirming hormone treatment in older transgender people.

To successfully establish and enact these protocols, a commitment of mental health and endocrine investigators is required to collaborate in long-term, large-scale studies across countries that use the same diagnostic and inclusion criteria, medications, assay methods, and response assessment tools (*e.g.*, the European Network for the Investigation of Gender Incongruence) (17, 18).

Terminology and its use vary and continue to evolve. Table 1 contains the definitions of terms as they are used throughout this guideline.

Biological Determinants of Gender Identity Development

One's self-awareness as male or female changes gradually during infant life and childhood. This process of cognitive and affective learning evolves with interactions with parents, peers, and environment. A fairly accurate timetable exists outlining the steps in this process (19). Normative psychological literature, however, does not address if and when gender identity becomes crystallized and what factors contribute to the development of a gender identity that is not congruent with the gender of rearing. Results of studies from a variety of biomedical disciplines—genetic, endocrine, and neuroanatomic—support the concept that gender identity and/or gender expression (20) likely reflect a complex interplay of biological, environmental, and cultural factors (21, 22).

With respect to endocrine considerations, studies have failed to find differences in circulating levels of sex steroids between transgender and nontransgender individuals (23). However, studies in individuals with a disorder/difference of sex development (DSD) have informed our understanding of the role that hormones may play in gender identity outcome, even though most persons with GD/gender incongruence do not have a DSD. For example, although most 46,XX adult individuals with virilizing congenital adrenal hyperplasia caused by mutations in *CYP21A2* reported a female gender identity, the prevalence of GD/gender incongruence was much greater in this group than in the general population without a DSD. This supports the concept that there is a role for prenatal/postnatal androgens in gender development (24–26), although some studies indicate that prenatal androgens are more likely to affect gender behavior and sexual orientation rather than gender identity *per se* (27, 28).

Researchers have made similar observations regarding the potential role of androgens in the development of gender identity in other individuals with DSD. For example, a review of two groups of 46,XY persons, each with androgen synthesis deficiencies and female raised, reported transgender male (female-to-male) gender role changes in 56% to 63% and 39% to 64% of patients, respectively (29). Also, in 46,XY female-raised individuals with cloacal

Downloaded from https://academic.oup.com/jcem/article/102/11/3869/4157558 by guest on 10 March 2022

Table 1. Definitions of Terms Used in This Guideline

Biological sex, biological male or female: These terms refer to physical aspects of maleness and femaleness. As these may not be in line with each other (*e.g.*, a person with XY chromosomes may have female-appearing genitalia), the terms biological sex and biological male or female are imprecise and should be avoided.

Cisgender: This means not transgender. An alternative way to describe individuals who are not transgender is "non-transgender people."

Gender-affirming (hormone) treatment: See "gender reassignment"

Gender dysphoria: This is the distress and unease experienced if gender identity and designated gender are not completely congruent (see Table 2). In 2013, the American Psychiatric Association released the fifth edition of the DSM-5, which replaced "gender identity disorder" with "gender dysphoria" and changed the criteria for diagnosis.

Gender expression: This refers to external manifestations of gender, expressed through one's name, pronouns, clothing, haircut, behavior, voice, or body characteristics. Typically, transgender people seek to make their gender expression align with their gender identity, rather than their designated gender.

Gender identity/experienced gender: This refers to one's internal, deeply held sense of gender. For transgender people, their gender identity does not match their sex designated at birth. Most people have a gender identity of man or woman (or boy or girl). For some people, their gender identity does not fit neatly into one of those two choices. Unlike gender expression (see below), gender identity is not visible to others.

Gender identity disorder: This is the term used for GD/gender incongruence in previous versions of DSM (see "gender dysphoria"). The ICD-10 still uses the term for diagnosing child diagnoses, but the upcoming ICD-11 has proposed using "gender incongruence of childhood."

Gender incongruence: This is an umbrella term used when the gender identity and/or gender expression differs from what is typically associated with the designated gender. Gender incongruence is also the proposed name of the gender identity–related diagnoses in ICD-11. Not all individuals with gender incongruence have gender dysphoria or seek treatment.

Gender variance: See "gender incongruence"

Gender reassignment: This refers to the treatment procedure for those who want to adapt their bodies to the experienced gender by means of hormones and/or surgery. This is also called gender-confirming or gender-affirming treatment.

Gender-reassignment surgery (gender-confirming/gender-affirming surgery): These terms refer only to the surgical part of gender-confirming/gender-affirming treatment.

Gender role: This refers to behaviors, attitudes, and personality traits that a society (in a given culture and historical period) designates as masculine or feminine and/or that society associates with or considers typical of the social role of men or women.

Sex designated at birth: This refers to sex assigned at birth, usually based on genital anatomy.

Sex: This refers to attributes that characterize biological maleness or femaleness. The best known attributes include the sex-determining genes, the sex chromosomes, the H-Y antigen, the gonads, sex hormones, internal and external genitalia, and secondary sex characteristics.

Sexual orientation: This term describes an individual's enduring physical and emotional attraction to another person. Gender identity and sexual orientation are not the same. Irrespective of their gender identity, transgender people may be attracted to women (gynephilic), attracted to men (androphilic), bisexual, asexual, or queer.

Transgender: This is an umbrella term for people whose gender identity and/or gender expression differs from what is typically associated with their sex designated at birth. Not all transgender individuals seek treatment.

Transgender male (also: trans man, female-to-male, transgender male): This refers to individuals assigned female at birth but who identify and live as men.

Transgender woman (also: trans woman, male-to female, transgender female): This refers to individuals assigned male at birth but who identify and live as women.

Transition: This refers to the process during which transgender persons change their physical, social, and/or legal characteristics consistent with the affirmed gender identity. Prepubertal children may choose to transition socially.

Transsexual: This is an older term that originated in the medical and psychological communities to refer to individuals who have permanently transitioned through medical interventions or desired to do so.

exstrophy and penile agenesis, the occurrence of transgender male changes was significantly more prevalent than in the general population (30, 31). However, the fact that a high percentage of individuals with the same conditions did not change gender suggests that cultural factors may play a role as well.

With respect to genetics and gender identity, several studies have suggested heritability of GD/gender incongruence (32, 33). In particular, a study by Heylens *et al.* (33) demonstrated a 39.1% concordance rate for gender identity disorder (based on the DSM-IV criteria) in 23 monozygotic twin pairs but no concordance in 21 same-sex dizygotic or seven opposite-sex twin pairs. Although numerous investigators have sought to identify specific genes associated with GD/gender incongruence, such studies have been inconsistent and without strong statistical significance (34–38).

Studies focusing on brain structure suggest that the brain phenotypes of people with GD/gender incongruence differ in various ways from control males and females, but that there is not a complete sex reversal in brain structures (39).

In summary, although there is much that is still unknown with respect to gender identity and its expression, compelling studies support the concept that biologic factors, in addition to environmental factors, contribute to this fundamental aspect of human development.

Downloaded from https://academic.oup.com/jcem/article/102/11/3869/4157558 by guest on 10 March 2022

Natural History of Children With GD/Gender Incongruence

With current knowledge, we cannot predict the psychosexual outcome for any specific child. Prospective follow-up studies show that childhood GD/gender incongruence does not invariably persist into adolescence and adulthood (so-called "desisters"). Combining all outcome studies to date, the GD/gender incongruence of a minority of prepubertal children appears to persist in adolescence (20, 40). In adolescence, a significant number of these desisters identify as homosexual or bisexual. It may be that children who only showed some gender nonconforming characteristics have been included in the follow-up studies, because the DSM-IV text revision criteria for a diagnosis were rather broad. However, the persistence of GD/gender incongruence into adolescence is more likely if it had been extreme in childhood (41, 42). With the newer, stricter criteria of the DSM-5 (Table 2), persistence rates may well be different in future studies.

1.0 Evaluation of Youth and Adults

Gender-affirming treatment is a multidisciplinary effort. After evaluation, education, and diagnosis, treatment may include mental health care, hormone therapy, and/or surgical therapy. Together with an MHP, hormone-prescribing clinicians should examine the psychosocial impact of the potential changes on people's lives, including mental health, friends, family, jobs, and their role in society. Transgender individuals should be encouraged to experience living in the new gender role and assess whether this improves their quality of life. Although the focus of this guideline is gender-affirming hormone therapy, collaboration with appropriate professionals responsible for each aspect of treatment maximizes a successful outcome.

Diagnostic assessment and mental health care

GD/gender incongruence may be accompanied with psychological or psychiatric problems (43–51). It is therefore necessary that clinicians who prescribe hormones and are involved in diagnosis and psychosocial assessment meet the following criteria: (1) are competent in using the DSM and/or the ICD for diagnostic purposes, (2) are able to diagnose GD/gender incongruence and make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (3) are trained in diagnosing psychiatric conditions, (4) undertake or refer for appropriate treatment, (5) are able to do a psychosocial assessment of the patient's understanding, mental health, and social conditions that can impact gender-affirming hormone therapy, and (6) regularly attend relevant professional meetings.

Because of the psychological vulnerability of many individuals with GD/gender incongruence, it is important that mental health care is available before, during, and sometimes also after transitioning. For children and adolescents, an MHP who has training/experience in child and adolescent gender development (as well as child and adolescent psychopathology) should make the diagnosis, because assessing GD/gender incongruence in children and adolescents is often extremely complex.

During assessment, the clinician obtains information from the individual seeking gender-affirming treatment. In the case

Table 2. DSM-5 Criteria for Gender Dysphoria in Adolescents and Adults

A. A marked incongruence between one's experienced/expressed gender and natal gender of at least 6 mo in duration, as manifested by at least two of the following:
1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics)
2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)
3. A strong desire for the primary and/or secondary sex characteristics of the other gender
4. A strong desire to be of the other gender (or some alternative gender different from one's designated gender)
5. A strong desire to be treated as the other gender (or some alternative gender different from one's designated gender)
6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's designated gender)

B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:
1. The condition exists with a disorder of sex development.
2. The condition is posttransitional, in that the individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one sex-related medical procedure or treatment regimen—namely, regular sex hormone treatment or gender reassignment surgery confirming the desired gender (*e.g.*, penectomy, vaginoplasty in natal males; mastectomy or phalloplasty in natal females).

Reference: American Psychiatric Association (14).

Downloaded from https://academic.oup.com/jcem/article/102/11/3869/4157558 by guest on 10 March 2022

of adolescents, the clinician also obtains information from the parents or guardians regarding various aspects of the child's general and psychosexual development and current functioning. On the basis of this information, the clinician:

- decides whether the individual fulfills criteria for treatment (see Tables 2 and 3) for GD/gender incongruence (DSM-5) or transsexualism (DSM-5 and/or ICD-10);
- informs the individual about the possibilities and limitations of various kinds of treatment (hormonal/surgical and nonhormonal), and if medical treatment is desired, provides correct information to prevent unrealistically high expectations;
- assesses whether medical interventions may result in unfavorable psychological and social outcomes.

In cases in which severe psychopathology, circumstances, or both seriously interfere with the diagnostic work or make satisfactory treatment unlikely, clinicians should assist the adolescent in managing these other issues. Literature on postoperative regret suggests that besides poor quality of surgery, severe psychiatric comorbidity and lack of support may interfere with positive outcomes (52–56).

For adolescents, the diagnostic procedure usually includes a complete psychodiagnostic assessment (57) and an assessment of the decision-making capability of the youth. An evaluation to assess the family's ability to endure stress, give support, and deal with the complexities of the adolescent's situation should be part of the diagnostic phase (58).

Social transitioning

A change in gender expression and role (which may involve living part time or full time in another gender role that is consistent with one's gender identity) may test the person's resolve, the capacity to function in the affirmed gender, and the adequacy of social, economic, and psychological supports. It assists both the individual and the clinician in their judgments about how to proceed (16). During social transitioning, the person's feelings about the social transformation (including coping with the responses of others) is a major focus of the counseling. The optimal timing for social transitioning may differ between individuals. Sometimes people wait until they start gender-affirming hormone treatment to make social transitioning easier, but individuals increasingly start social transitioning long before they receive medically supervised, gender-affirming hormone treatment.

Criteria

Adolescents and adults seeking gender-affirming hormone treatment and surgery should satisfy certain criteria before proceeding (16). Criteria for gender-affirming hormone therapy for adults are in Table 4, and criteria for gender-affirming hormone therapy for adolescents are in Table 5. Follow-up studies in adults meeting these criteria indicate a high satisfaction rate with treatment (59). However, the quality of evidence is usually low. A few follow-up studies on adolescents who fulfilled these criteria also indicated good treatment results (60–63).

Recommendations for Those Involved in the Gender-Affirming Hormone Treatment of Individuals With GD/Gender Incongruence

1.1. We advise that only trained MHPs who meet the following criteria should diagnose GD/gender incongruence in adults: (1) competence in using the DSM and/or the ICD for diagnostic purposes, (2) the ability to diagnose GD/gender incongruence and make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (3) training in diagnosing psychiatric conditions, (4) the ability to undertake or refer for appropriate treatment, (5) the ability to psychosocially assess the person's understanding, mental health, and social conditions that can impact gender-affirming hormone therapy, and (6) a practice of regularly attending relevant professional meetings. (Ungraded Good Practice Statement)

1.2. We advise that only MHPs who meet the following criteria should diagnose GD/gender incongruence in children and adolescents: (1) training in child and adolescent developmental psychology and psychopathology, (2) competence in using the DSM and/or ICD for diagnostic

Table 3. ICD-10 Criteria for Transsexualism

Transsexualism (F64.0) has three criteria:
1. The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatments.
2. The transsexual identity has been present persistently for at least 2 y.
3. The disorder is not a symptom of another mental disorder or a genetic, DSD, or chromosomal abnormality.

Downloaded from https://academic.oup.com/jcem/article/102/11/3869/4157558 by guest on 10 March 2022

Table 4. Criteria for Gender-Affirming Hormone Therapy for Adults

1. Persistent, well-documented gender dysphoria/gender incongruence
2. The capacity to make a fully informed decision and to consent for treatment
3. The age of majority in a given country (if younger, follow the criteria for adolescents)
4. Mental health concerns, if present, must be reasonably well controlled

Reproduced from World Professional Association for Transgender Health (16).

purposes, (3) the ability to make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (4) training in diagnosing psychiatric conditions, (5) the ability to undertake or refer for appropriate treatment, (6) the ability to psychosocially assess the person's understanding and social conditions that can impact gender-affirming hormone therapy, (7) a practice of regularly attending relevant professional meetings, and (8) knowledge of the criteria for puberty blocking and gender-affirming hormone treatment in adolescents. (Ungraded Good Practice Statement)

Evidence

Individuals with gender identity issues may have psychological or psychiatric problems (43–48, 50, 51, 64, 65). It is therefore necessary that clinicians making the diagnosis are able to make a distinction between GD/gender incongruence and conditions that have similar features. Examples of conditions with similar features are body dysmorphic disorder, body identity integrity disorder (a condition in which individuals have a sense that their anatomical configuration as an able-bodied person is somehow wrong or inappropriate) (66), or certain forms of eunuchism (in which a person is preoccupied with or engages in castration and/or penectomy for

Table 5. Criteria for Gender-Affirming Hormone Therapy for Adolescents

Adolescents are eligible for GnRH agonist treatment if:

1. A qualified MHP has confirmed that:
- the adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed),
- gender dysphoria worsened with the onset of puberty,
- any coexisting psychological, medical, or social problems that could interfere with treatment (*e.g.*, that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment,
- the adolescent has sufficient mental capacity to give informed consent to this (reversible) treatment,

2. And the adolescent:
- has been informed of the effects and side effects of treatment (including potential loss of fertility if the individual subsequently continues with sex hormone treatment) and options to preserve fertility,
- has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process,

3. And a pediatric endocrinologist or other clinician experienced in pubertal assessment
- agrees with the indication for GnRH agonist treatment,
- has confirmed that puberty has started in the adolescent (Tanner stage ≥G2/B2),
- has confirmed that there are no medical contraindications to GnRH agonist treatment.

Adolescents are eligible for subsequent sex hormone treatment if:

1. A qualified MHP has confirmed:
- the persistence of gender dysphoria,
- any coexisting psychological, medical, or social problems that could interfere with treatment (*e.g.*, that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start sex hormone treatment,
- the adolescent has sufficient mental capacity (which most adolescents have by age 16 years) to estimate the consequences of this (partly) irreversible treatment, weigh the benefits and risks, and give informed consent to this (partly) irreversible treatment,

2. And the adolescent:
- has been informed of the (irreversible) effects and side effects of treatment (including potential loss of fertility and options to preserve fertility),
- has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process,

3. And a pediatric endocrinologist or other clinician experienced in pubertal induction:
- agrees with the indication for sex hormone treatment,
- has confirmed that there are no medical contraindications to sex hormone treatment.

Reproduced from World Professional Association for Transgender Health (16).

Downloaded from https://academic.oup.com/jcem/article/102/11/3869/4157558 by guest on 10 March 2022

reasons that are not gender identity related) (11). Clinicians should also be able to diagnose psychiatric conditions accurately and ensure that these conditions are treated appropriately, particularly when the conditions may complicate treatment, affect the outcome of gender-affirming treatment, or be affected by hormone use.

Values and preferences

The task force placed a very high value on avoiding harm from hormone treatment in individuals who have conditions other than GD/gender incongruence and who may not benefit from the physical changes associated with this treatment and placed a low value on any potential benefit these persons believe they may derive from hormone treatment. This justifies the good practice statement.

1.3. We advise that decisions regarding the social transition of prepubertal youths with GD/gender incongruence are made with the assistance of an MHP or another experienced professional. (Ungraded Good Practice Statement).
1.4. We recommend against puberty blocking and gender-affirming hormone treatment in prepubertal children with GD/gender incongruence. (1 |⊕⊕○○)

Evidence

In most children diagnosed with GD/gender incongruence, it did not persist into adolescence. The percentages differed among studies, probably dependent on which version of the DSM clinicians used, the patient's age, the recruitment criteria, and perhaps cultural factors. However, the large majority (about 85%) of prepubertal children with a childhood diagnosis did not remain GD/gender incongruent in adolescence (20). If children have completely socially transitioned, they may have great difficulty in returning to the original gender role upon entering puberty (40). Social transition is associated with the persistence of GD/gender incongruence as a child progresses into adolescence. It may be that the presence of GD/gender incongruence in prepubertal children is the earliest sign that a child is destined to be transgender as an adolescent/adult (20). However, social transition (in addition to GD/gender incongruence) has been found to contribute to the likelihood of persistence.

This recommendation, however, does not imply that children should be discouraged from showing gender-variant behaviors or should be punished for exhibiting such behaviors. In individual cases, an early complete social transition may result in a more favorable outcome, but there are currently no criteria to identify the GD/gender-incongruent children to whom this applies. At the present time, clinical experience suggests that persistence of GD/gender incongruence can only be reliably assessed after the first signs of puberty.

Values and preferences

The task force placed a high value on avoiding harm with gender-affirming hormone therapy in prepubertal children with GD/gender incongruence. This justifies the strong recommendation in the face of low-quality evidence.

1.5. We recommend that clinicians inform and counsel all individuals seeking gender-affirming medical treatment regarding options for fertility preservation prior to initiating puberty suppression in adolescents and prior to treating with hormonal therapy of the affirmed gender in both adolescents and adults. (1 |⊕⊕⊕○)

Remarks

Persons considering hormone use for gender affirmation need adequate information about this treatment in general and about fertility effects of hormone treatment in particular to make an informed and balanced decision (67, 68). Because young adolescents may not feel qualified to make decisions about fertility and may not fully understand the potential effects of hormonal interventions, consent and protocol education should include parents, the referring MHP(s), and other members of the adolescent's support group. To our knowledge, there are no formally evaluated decision aids available to assist in the discussion and decision regarding the future fertility of adolescents or adults beginning gender-affirming treatment.

Treating early pubertal youth with GnRH analogs will temporarily impair spermatogenesis and oocyte maturation. Given that an increasing number of transgender youth want to preserve fertility potential, delaying or temporarily discontinuing GnRH analogs to promote gamete maturation is an option. This option is often not preferred, because mature sperm production is associated with later stages of puberty and with the significant development of secondary sex characteristics.

For those designated male at birth with GD/gender incongruence and who are in early puberty, sperm production and the development of the reproductive tract are insufficient for the cryopreservation of sperm. However, prolonged pubertal suppression using GnRH analogs is reversible and clinicians should inform these individuals that sperm production can be initiated following prolonged gonadotropin suppression. This can be accomplished by spontaneous gonadotropin recovery after

Downloaded from https://academic.oup.com/jcem/article/102/11/3869/4157558 by guest on 10 March 2022

cessation of GnRH analogs or by gonadotropin treatment and will probably be associated with physical manifestations of testosterone production, as stated above. Note that there are no data in this population concerning the time required for sufficient spermatogenesis to collect enough sperm for later fertility. In males treated for precocious puberty, spermarche was reported 0.7 to 3 years after cessation of GnRH analogs (69). In adult men with gonadotropin deficiency, sperm are noted in seminal fluid by 6 to 12 months of gonadotropin treatment. However, sperm numbers when partners of these patients conceive are far below the "normal range" (70, 71).

In girls, no studies have reported long-term, adverse effects of pubertal suppression on ovarian function after treatment cessation (72, 73). Clinicians should inform adolescents that no data are available regarding either time to spontaneous ovulation after cessation of GnRH analogs or the response to ovulation induction following prolonged gonadotropin suppression.

In males with GD/gender incongruence, when medical treatment is started in a later phase of puberty or in adulthood, spermatogenesis is sufficient for cryopreservation and storage of sperm. *In vitro* spermatogenesis is currently under investigation. Restoration of spermatogenesis after prolonged estrogen treatment has not been studied.

In females with GD/gender incongruence, the effect of prolonged treatment with exogenous testosterone on ovarian function is uncertain. There have been reports of an increased incidence of polycystic ovaries in transgender males, both prior to and as a result of androgen treatment (74–77), although these reports were not confirmed by others (78). Pregnancy has been reported in transgender males who have had prolonged androgen treatment and have discontinued testosterone but have not had genital surgery (79, 80). A reproductive endocrine gynecologist can counsel patients before gender-affirming hormone treatment or surgery regarding potential fertility options (81). Techniques for cryopreservation of oocytes, embryos, and ovarian tissue continue to improve, and oocyte maturation of immature tissue is being studied (82).

2.0 Treatment of Adolescents

During the past decade, clinicians have progressively acknowledged the suffering of young adolescents with GD/gender incongruence. In some forms of GD/gender incongruence, psychological interventions may be useful and sufficient. However, for many adolescents with GD/gender incongruence, the pubertal physical changes are unbearable. As early medical intervention may prevent psychological harm, various clinics have decided to start treating young adolescents with GD/gender incongruence with puberty-suppressing medication (a GnRH analog). As compared with starting gender-affirming treatment long after the first phases of puberty, a benefit of pubertal suppression at early puberty may be a better psychological and physical outcome.

In girls, the first physical sign of puberty is the budding of the breasts followed by an increase in breast and fat tissue. Breast development is also associated with the pubertal growth spurt, and menarche occurs ~2 years later. In boys, the first physical change is testicular growth. A testicular volume ≥4 mL is seen as consistent with the initiation of physical puberty. At the beginning of puberty, estradiol and testosterone levels are still low and are best measured in the early morning with an ultrasensitive assay. From a testicular volume of 10 mL, daytime testosterone levels increase, leading to virilization (83). Note that pubic hair and/or axillary hair/odor may not reflect the onset of gonadarche; instead, it may reflect adrenarche alone.

2.1. We suggest that adolescents who meet diagnostic criteria for GD/gender incongruence, fulfill criteria for treatment (Table 5), and are requesting treatment should initially undergo treatment to suppress pubertal development. (2 I⊕⊕○○)

2.2. We suggest that clinicians begin pubertal hormone suppression after girls and boys first exhibit physical changes of puberty (Tanner stages G2/B2). (2 I⊕⊕○○)

Evidence

Pubertal suppression can expand the diagnostic phase by a long period, giving the subject more time to explore options and to live in the experienced gender before making a decision to proceed with gender-affirming sex hormone treatments and/or surgery, some of which is irreversible (84, 85). Pubertal suppression is fully reversible, enabling full pubertal development in the natal gender, after cessation of treatment, if appropriate. The experience of full endogenous puberty is an undesirable condition for the GD/gender-incongruent individual and may seriously interfere with healthy psychological functioning and well-being. Treating GD/gender-incongruent adolescents entering puberty with GnRH analogs has been shown to improve psychological functioning in several domains (86).

Another reason to start blocking pubertal hormones early in puberty is that the physical outcome is improved compared with initiating physical transition after puberty has been completed (60, 62). Looking like a man or woman when living as the opposite sex creates difficult

Downloaded from https://academic.oup.com/jcem/article/102/11/3869/4157558 by guest on 10 March 2022

barriers with enormous life-long disadvantages. We therefore advise starting suppression in early puberty to prevent the irreversible development of undesirable secondary sex characteristics. However, adolescents with GD/gender incongruence should experience the first changes of their endogenous spontaneous puberty, because their emotional reaction to these first physical changes has diagnostic value in establishing the persistence of GD/gender incongruence (85). Thus, Tanner stage 2 is the optimal time to start pubertal suppression. However, pubertal suppression treatment in early puberty will limit the growth of the penis and scrotum, which will have a potential effect on future surgical treatments (87).

Clinicians can also use pubertal suppression in adolescents in later pubertal stages to stop menses in transgender males and prevent facial hair growth in transgender females. However, in contrast to the effects in early pubertal adolescents, physical sex characteristics (such as more advanced breast development in transgender boys and lowering of the voice and outgrowth of the jaw and brow in transgender girls) are not reversible.

Values and preferences

These recommendations place a high value on avoiding an unsatisfactory physical outcome when secondary sex characteristics have become manifest and irreversible, a higher value on psychological well-being, and a lower value on avoiding potential harm from early pubertal suppression.

Remarks

Table 6 lists the Tanner stages of breast and male genital development. Careful documentation of hallmarks of pubertal development will ensure precise timing when initiating pubertal suppression once puberty has started. Clinicians can use pubertal LH and sex steroid levels to confirm that puberty has progressed sufficiently before starting pubertal suppression (88). Reference ranges for sex steroids by Tanner stage may vary depending on the assay used. Ultrasensitive sex steroid and gonadotropin assays will help clinicians document early pubertal changes.

Irreversible and, for GD/gender-incongruent adolescents, undesirable sex characteristics in female puberty are breasts, female body habitus, and, in some cases, relative short stature. In male puberty, they are a prominent Adam's apple; low voice; male bone configuration, such as a large jaw, big feet and hands, and tall stature; and male hair pattern on the face and extremities.

2.3. We recommend that, where indicated, GnRH analogues are used to suppress pubertal hormones. (1 |⊕⊕○○)

Evidence

Clinicians can suppress pubertal development and gonadal function most effectively via gonadotropin suppression using GnRH analogs. GnRH analogs are long-acting agonists that suppress gonadotropins by GnRH receptor desensitization after an initial increase of gonadotropins during ~10 days after the first and (to a lesser degree) the second injection (89). Antagonists immediately suppress pituitary gonadotropin secretion (90, 91). Long-acting GnRH analogs are the currently preferred treatment option. Clinicians may consider long-acting GnRH antagonists when evidence on their safety and efficacy in adolescents becomes available.

During GnRH analog treatment, slight development of secondary sex characteristics may regress, and in a later phase of pubertal development, it will stop. In girls, breast tissue will become atrophic, and menses will stop. In boys, virilization will stop, and testicular volume may decrease (92).

An advantage of using GnRH analogs is the reversibility of the intervention. If, after extensive exploration of his/her transition wish, the individual no longer desires transition, they can discontinue pubertal suppression. In subjects with

Downloaded from https://academic.oup.com/jcem/article/102/11/3869/4157558 by guest on 10 March 2022

Table 6. Tanner Stages of Breast Development and Male External Genitalia

The description of Tanner stages for breast development:
1. Prepubertal
2. Breast and papilla elevated as small mound; areolar diameter increased
3. Breast and areola enlarged, no contour separation
4. Areola and papilla form secondary mound
5. Mature; nipple projects, areola part of general breast contour

For penis and testes:
1. Prepubertal, testicular volume <4 mL
2. Slight enlargement of penis; enlarged scrotum, pink, texture altered, testes 4–6 mL
3. Penis longer, testes larger (8–12 mL)
4. Penis and glans larger, including increase in breadth; testes larger (12–15 mL), scrotum dark
5. Penis adult size; testicular volume > 15 ml

Adapted from Lawrence (56).

precocious puberty, spontaneous pubertal development has been shown to resume after patients discontinue taking GnRH analogs (93).

Recommendations 2.1 to 2.3 are supported by a prospective follow-up study from The Netherlands. This report assessed mental health outcomes in 55 transgender adolescents/young adults (22 transgender females and 33 transgender males) at three time points: (1) before the start of GnRH agonist (average age of 14.8 years at start of treatment), (2) at initiation of gender-affirming hormones (average age of 16.7 years at start of treatment), and (3) 1 year after "gender-reassignment surgery" (average age of 20.7 years) (63). Despite a decrease in depression and an improvement in general mental health functioning, GD/gender incongruence persisted through pubertal suppression, as previously reported (86). However, following sex hormone treatment and gender-reassignment surgery, GD/gender incongruence was resolved and psychological functioning steadily improved (63). Furthermore, well-being was similar to or better than that reported by age-matched young adults from the general population, and none of the study participants regretted treatment. This study represents the first long-term follow-up of individuals managed according to currently existing clinical practice guidelines for transgender youth, and it underscores the benefit of the multidisciplinary approach pioneered in The Netherlands; however, further studies are needed.

Side effects

The primary risks of pubertal suppression in GD/gender-incongruent adolescents may include adverse effects on bone mineralization (which can theoretically be reversed with sex hormone treatment), compromised fertility if the person subsequently is treated with sex hormones, and unknown effects on brain development. Few data are available on the effect of GnRH analogs on BMD in adolescents with GD/gender incongruence. Initial data in GD/gender-incongruent subjects demonstrated no change of absolute areal BMD during 2 years of GnRH analog therapy but a decrease in BMD *z* scores (85). A recent study also suggested suboptimal bone mineral accrual during GnRH analog treatment. The study reported a decrease in areal BMD *z* scores and of bone mineral apparent density *z* scores (which takes the size of the bone into account) in 19 transgender males treated with GnRH analogs from a mean age of 15.0 years (standard deviation = 2.0 years) for a median duration of 1.5 years (0.3 to 5.2 years) and in 15 transgender females treated from 14.9 (±1.9) years for 1.3 years (0.5 to 3.8 years), although not all changes were statistically significant (94). There was incomplete catch-up at age 22 years after sex hormone treatment from age 16.6 (±1.4) years for a median duration of 5.8 years (3.0 to 8.0 years) in transgender females and from age 16.4 (±2.3) years for 5.4 years (2.8 to 7.8 years) in transgender males. Little is known about more prolonged use of GnRH analogs. Researchers reported normal BMD *z* scores at age 35 years in one individual who used GnRH analogs from age 13.7 years until age 18.6 years before initiating sex hormone treatment (65).

Additional data are available from individuals with late puberty or GnRH analog treatment of other indications. Some studies reported that men with constitutionally delayed puberty have decreased BMD in adulthood (95). However, other studies reported that these men have normal BMD (96, 97). Treating adults with GnRH analogs results in a decrease of BMD (98). In children with central precocious puberty, treatment with GnRH analogs has been found to result in a decrease of BMD during treatment by some (99) but not others (100). Studies have reported normal BMD after discontinuing therapy (69, 72, 73, 101, 102). In adolescents treated with growth hormone who are small for gestational age and have normal pubertal timing, 2-year GnRH analog treatments did not adversely affect BMD (103). Calcium supplementation may be beneficial in optimizing bone health in GnRH analog–treated individuals (104). There are no studies of vitamin D supplementation in this context, but clinicians should offer supplements to vitamin D–deficient adolescents. Physical activity, especially during growth, is important for bone mass in healthy individuals (103) and is therefore likely to be beneficial for bone health in GnRH analog–treated subjects.

GnRH analogs did not induce a change in body mass index standard deviation score in GD/gender-incongruent adolescents (94) but caused an increase in fat mass and decrease in lean body mass percentage (92). Studies in girls treated for precocious puberty also reported a stable body mass index standard deviation score during treatment (72) and body mass index and body composition comparable to controls after treatment (73).

Arterial hypertension has been reported as an adverse effect in a few girls treated with GnRH analogs for precocious/early puberty (105, 106). Blood pressure monitoring before and during treatment is recommended.

Individuals may also experience hot flashes, fatigue, and mood alterations as a consequence of pubertal suppression. There is no consensus on treatment of these side effects in this context.

It is recommended that any use of pubertal blockers (and subsequent use of sex hormones, as detailed below) include a discussion about implications for fertility (see recommendation 1.3). Transgender adolescents may

Downloaded from https://academic.oup.com/jcem/article/102/11/3869/4157558 by guest on 10 March 2022

want to preserve fertility, which may be otherwise compromised if puberty is suppressed at an early stage and the individual completes phenotypic transition with the use of sex hormones.

Limited data are available regarding the effects of GnRH analogs on brain development. A single cross-sectional study demonstrated no compromise of executive function (107), but animal data suggest there may be an effect of GnRH analogs on cognitive function (108).

Values and preferences

Our recommendation of GnRH analogs places a higher value on the superior efficacy, safety, and reversibility of the pubertal hormone suppression achieved (as compared with the alternatives) and a relatively lower value on limiting the cost of therapy. Of the available alternatives, depot and oral progestin preparations are effective. Experience with this treatment dates back prior to the emergence of GnRH analogs for treating precocious puberty in papers from the 1960s and early 1970s (109–112). These compounds are usually safe, but some side effects have been reported (113–115). Only two recent studies involved transgender youth (116, 117). One of these studies described the use of oral lynestrenol monotherapy followed by the addition of testosterone treatment in transgender boys who were at Tanner stage B4 or further at the start of treatment (117). They found lynestrenol safe, but gonadotropins were not fully suppressed. The study reported metrorrhagia in approximately half of the individuals, mainly in the first 6 months. Acne, headache, hot flashes, and fatigue were other frequent side effects. Another progestin that has been studied in the United States is medroxyprogesterone. This agent is not as effective as GnRH analogs in lowering endogenous sex hormones either and may be associated with other side effects (116). Progestin preparations may be an acceptable treatment for persons without access to GnRH analogs or with a needle phobia. If GnRH analog treatment is not available (insurance denial, prohibitive cost, or other reasons), postpubertal, transgender female adolescents may be treated with an antiandrogen that directly suppresses androgen synthesis or action (see adult section).

Remarks

Measurements of gonadotropin and sex steroid levels give precise information about gonadal axis suppression, although there is insufficient evidence for any specific short-term monitoring scheme in children treated with GnRH analogs (88). If the gonadal axis is not completely suppressed—as evidenced by (for example) menses, erections, or progressive hair growth—the interval of GnRH analog treatment can be shortened or the dose increased. During treatment, adolescents should be monitored for negative effects of delaying puberty, including a halted growth spurt and impaired bone mineral accretion. Table 7 illustrates a suggested clinical protocol.

Anthropometric measurements and X-rays of the left hand to monitor bone age are informative for evaluating growth. To assess BMD, clinicians can perform dual-energy X-ray absorptiometry scans.

2.4. In adolescents who request sex hormone treatment (given this is a partly irreversible treatment), we recommend initiating treatment using a gradually increasing dose schedule (see Table 8) after a multidisciplinary team of medical and MHPs has confirmed the persistence of GD/gender incongruence and sufficient mental capacity to give informed consent, which most adolescents have by age 16 years (Table 5). (1 |⊕⊕○○)

2.5. We recognize that there may be compelling reasons to initiate sex hormone treatment prior to the age of 16 years in some adolescents with GD/gender incongruence, even though there are minimal published studies of gender-affirming hormone treatments administered before age 13.5 to 14 years. As with the care of adolescents ≥16 years of age, we recommend that an expert multidisciplinary team of medical and MHPs manage this treatment. (1 |⊕○○○)

2.6. We suggest monitoring clinical pubertal development every 3 to 6 months and laboratory parameters every 6 to 12 months during sex hormone treatment (Table 9). (2 |⊕⊕○○)

Table 7. Baseline and Follow-Up Protocol During Suppression of Puberty

Every 3–6 mo
Anthropometry: height, weight, sitting height, blood pressure, Tanner stages
Every 6–12 mo
Laboratory: LH, FSH, E2/T, 25OH vitamin D
Every 1–2 y
Bone density using DXA
Bone age on X-ray of the left hand (if clinically indicated)

Adapted from Hembree *et al.* (118).

Abbreviations: DXA, dual-energy X-ray absorptiometry; E2, estradiol; FSH, follicle stimulating hormone; LH, luteinizing hormone; T, testosterone;

Downloaded from https://academic.oup.com/jcem/article/102/11/3869/4157558 by guest on 10 March 2022

Table 8. Protocol Induction of Puberty

Induction of female puberty with oral 17β-estradiol, increasing the dose every 6 mo:
5 μg/kg/d
10 μg/kg/d
15 μg/kg/d
20 μg/kg/d
Adult dose = 2–6 mg/d
In postpubertal transgender female adolescents, the dose of 17β-estradiol can be increased more rapidly:
1 mg/d for 6 mo
2 mg/d
Induction of female puberty with transdermal 17β-estradiol, increasing the dose every 6 mo (new patch is placed every 3.5 d):
6.25–12.5 μg/24 h (cut 25-μg patch into quarters, then halves)
25 μg/24 h
37.5 μg/24 h
Adult dose = 50–200 μg/24 h
For alternatives once at adult dose, see Table 11.
Adjust maintenance dose to mimic physiological estradiol levels (see Table 15).
Induction of male puberty with testosterone esters increasing the dose every 6 mo (IM or SC):
25 mg/m^2/2 wk (or alternatively, half this dose weekly, or double the dose every 4 wk)
50 mg/m^2/2 wk
75 mg/m^2/2 wk
100 mg/m^2/2 wk
Adult dose = 100–200 mg every 2 wk
In postpubertal transgender male adolescents the dose of testosterone esters can be increased more rapidly:
75 mg/2 wk for 6 mo
125 mg/2 wk
For alternatives once at adult dose, see Table 11.
Adjust maintenance dose to mimic physiological testosterone levels (see Table 14).

Adapted from Hembree *et al.* (118).

Abbreviations: IM, intramuscularly; SC, subcutaneously.

Evidence

Adolescents develop competence in decision making at their own pace. Ideally, the supervising medical professionals should individually assess this competence, although no objective tools to make such an assessment are currently available.

Many adolescents have achieved a reasonable level of competence by age 15 to 16 years (119), and in many countries 16-year-olds are legally competent with regard to medical decision making (120). However, others believe that although some capacities are generally achieved before age 16 years, other abilities (such as good risk assessment) do not develop until well after 18 years (121). They suggest that health care procedures should be divided along a matrix of relative risk, so that younger adolescents can be allowed to decide about low-risk procedures, such as most diagnostic tests and common therapies, but not about high-risk procedures, such as most surgical procedures (121).

Currently available data from transgender adolescents support treatment with sex hormones starting at age 16 years (63, 122). However, some patients may incur potential risks by waiting until age 16 years. These include the potential risk to bone health if puberty is suppressed

Table 9. Baseline and Follow-up Protocol During Induction of Puberty

Every 3–6 mo
•Anthropometry: height, weight, sitting height, blood pressure, Tanner stages
Every 6–12 mo
•In transgender males: hemoglobin/hematocrit, lipids, testosterone, 25OH vitamin D
•In transgender females: prolactin, estradiol, 25OH vitamin D
Every 1–2 y
•BMD using DXA
•Bone age on X-ray of the left hand (if clinically indicated)
BMD should be monitored into adulthood (until the age of 25–30 y or until peak bone mass has been reached).
For recommendations on monitoring once pubertal induction has been completed, see Tables 14 and 15.

Adapted from Hembree *et al.* (118).

Abbreviation: DXA, dual-energy X-ray absorptiometry.

Downloaded from https://academic.oup.com/jcem/article/102/11/3869/4157558 by guest on 10 March 2022

for 6 to 7 years before initiating sex hormones (*e.g.*, if someone reached Tanner stage 2 at age 9-10 years old). Additionally, there may be concerns about inappropriate height and potential harm to mental health (emotional and social isolation) if initiation of secondary sex characteristics must wait until the person has reached 16 years of age. However, only minimal data supporting earlier use of gender-affirming hormones in transgender adolescents currently exist (63). Clearly, long-term studies are needed to determine the optimal age of sex hormone treatment in GD/gender-incongruent adolescents.

The MHP who has followed the adolescent during GnRH analog treatment plays an essential role in assessing whether the adolescent is eligible to start sex hormone therapy and capable of consenting to this treatment (Table 5). Support of the family/environment is essential. Prior to the start of sex hormones, clinicians should discuss the implications for fertility (see recommendation 1.5). Throughout pubertal induction, an MHP and a pediatric endocrinologist (or other clinician competent in the evaluation and induction of pubertal development) should monitor the adolescent. In addition to monitoring therapy, it is also important to pay attention to general adolescent health issues, including healthy life style choices, such as not smoking, contraception, and appropriate vaccinations (*e.g.*, human papillomavirus).

For the induction of puberty, clinicians can use a similar dose scheme for hypogonadal adolescents with GD/gender incongruence as they use in other individuals with hypogonadism, carefully monitoring for desired and undesired effects (Table 8). In transgender female adolescents, transdermal 17β-estradiol may be an alternative for oral 17β-estradiol. It is increasingly used for pubertal induction in hypogonadal females. However, the absence of low-dose estrogen patches may be a problem. As a result, individuals may need to cut patches to size themselves to achieve appropriate dosing (123). In transgender male adolescents, clinicians can give testosterone injections intramuscularly or subcutaneously (124, 125).

When puberty is initiated with a gradually increasing schedule of sex steroid doses, the initial levels will not be high enough to suppress endogenous sex steroid secretion. Gonadotropin secretion and endogenous production of testosterone may resume and interfere with the effectiveness of estrogen treatment, in transgender female adolescents (126, 127). Therefore, continuation of GnRH analog treatment is advised until gonadectomy. Given that GD/gender-incongruent adolescents may opt not to have gonadectomy, long-term studies are necessary to examine the potential risks of prolonged GnRH analog treatment. Alternatively, in transgender male adolescents, GnRH analog treatment can be discontinued once an adult dose of testosterone has been reached and the individual is well virilized. If uterine bleeding occurs, a progestin can be added. However, the combined use of a GnRH analog (for ovarian suppression) and testosterone may enable phenotypic transition with a lower dose of testosterone in comparison with testosterone alone. If there is a wish or need to discontinue GnRH analog treatment in transgender female adolescents, they may be treated with an antiandrogen that directly suppresses androgen synthesis or action (see section 3.0 "Hormonal Therapy for Transgender Adults").

Values and preferences

The recommendation to initiate pubertal induction only when the individual has sufficient mental capacity (roughly age 16 years) to give informed consent for this partly irreversible treatment places a higher value on the ability of the adolescent to fully understand and oversee the partially irreversible consequences of sex hormone treatment and to give informed consent. It places a lower value on the possible negative effects of delayed puberty. We may not currently have the means to weigh adequately the potential benefits of waiting until around age 16 years to initiate sex hormones vs the potential risks/harm to BMD and the sense of social isolation from having the timing of puberty be so out of sync with peers (128).

Remarks

Before starting sex hormone treatment, effects on fertility and options for fertility preservation should be discussed. Adult height may be a concern in transgender adolescents. In a transgender female adolescent, clinicians may consider higher doses of estrogen or a more rapid tempo of dose escalation during pubertal induction. There are no established treatments yet to augment adult height in a transgender male adolescent with open epiphyses during pubertal induction. It is not uncommon for transgender adolescents to present for clinical services after having completed or nearly completed puberty. In such cases, induction of puberty with sex hormones can be done more rapidly (see Table 8). Additionally, an adult dose of testosterone in transgender male adolescents may suffice to suppress the gonadal axis without the need to use a separate agent. At the appropriate time, the multidisciplinary team should adequately prepare the adolescent for transition to adult care.

3.0 Hormonal Therapy for Transgender Adults

The two major goals of hormonal therapy are (1) to reduce endogenous sex hormone levels, and thus reduce

Downloaded from https://academic.oup.com/jcem/article/102/11/3869/4157558 by guest on 10 March 2022

the secondary sex characteristics of the individual's designated gender, and (2) to replace endogenous sex hormone levels consistent with the individual's gender identity by using the principles of hormone replacement treatment of hypogonadal patients. The timing of these two goals and the age at which to begin treatment with the sex hormones of the chosen gender is codetermined in collaboration with both the person pursuing transition and the health care providers. The treatment team should include a medical provider knowledgeable in transgender hormone therapy, an MHP knowledgeable in GD/gender incongruence and the mental health concerns of transition, and a primary care provider able to provide care appropriate for transgender individuals. The physical changes induced by this sex hormone transition are usually accompanied by an improvement in mental well-being (129, 130).

3.1. We recommend that clinicians confirm the diagnostic criteria of GD/gender incongruence and the criteria for the endocrine phase of gender transition before beginning treatment. (1 |⊕⊕⊕○)

3.2. We recommend that clinicians evaluate and address medical conditions that can be exacerbated by hormone depletion and treatment with sex hormones of the affirmed gender before beginning treatment (Table 10). (1 |⊕⊕⊕○)

3.3. We suggest that clinicians measure hormone levels during treatment to ensure that endogenous sex steroids are suppressed and administered sex steroids are maintained in the normal physiologic range for the affirmed gender. (2 |⊕⊕○○)

Evidence

It is the responsibility of the treating clinician to confirm that the person fulfills criteria for treatment. The treating clinician should become familiar with the terms and criteria presented in Tables 1–5 and take a thorough history from the patient in collaboration with the other members of the treatment team. The treating clinician must ensure that the desire for transition is appropriate; the consequences, risks, and benefits of treatment are well understood; and the desire for transition persists. They also need to discuss fertility preservation options (see recommendation 1.3) (67, 68).

Transgender males

Clinical studies have demonstrated the efficacy of several different androgen preparations to induce masculinization in transgender males (Appendix A) (113, 114, 131–134). Regimens to change secondary sex characteristics follow the general principle of hormone replacement treatment of male hypogonadism (135). Clinicians can use either parenteral or transdermal preparations to achieve testosterone values in the normal male range (this is dependent on the specific assay, but is typically 320 to 1000 ng/dL) (Table 11) (136). Sustained supraphysiologic levels of testosterone increase the risk of adverse reactions (see section 4.0 "Adverse Outcome Prevention and Long-Term Care") and should be avoided.

Similar to androgen therapy in hypogonadal men, testosterone treatment in transgender males results in increased muscle mass and decreased fat mass, increased facial hair and acne, male pattern baldness in those genetically predisposed, and increased sexual desire (137).

Table 10. Medical Risks Associated With Sex Hormone Therapy

Transgender female: estrogen
Very high risk of adverse outcomes:
•Thromboembolic disease
Moderate risk of adverse outcomes:
•Macroprolactinoma
•Breast cancer
•Coronary artery disease
•Cerebrovascular disease
•Cholelithiasis
•Hypertriglyceridemia
Transgender male: testosterone
Very high risk of adverse outcomes:
•Erythrocytosis (hematocrit > 50%)
Moderate risk of adverse outcomes:
•Severe liver dysfunction (transaminases > threefold upper limit of normal)
•Coronary artery disease
•Cerebrovascular disease
•Hypertension
•Breast or uterine cancer

Downloaded from https://academic.oup.com/jcem/article/102/11/3869/4157558 by guest on 10 March 2022

Table 11. Hormone Regimens in Transgender Persons

Transgender females[a]	
Estrogen	
Oral	
Estradiol	2.0–6.0 mg/d
Transdermal	
Estradiol transdermal patch	0.025–0.2 mg/d
(New patch placed every 3–5 d)	
Parenteral	
Estradiol valerate or cypionate	5–30 mg IM every 2 wk
	2–10 mg IM every week
Anti-androgens	
Spironolactone	100–300 mg/d
Cyproterone acetate[b]	25–50 mg/d
GnRH agonist	3.75 mg SQ (SC) monthly
	11.25 mg SQ (SC) 3-monthly
Transgender males	
Testosterone	
Parenteral testosterone	
Testosterone enanthate or cypionate	100–200 mg SQ (IM) every 2 wk or SQ (SC) 50% per week
Testosterone undecanoate[c]	1000 mg every 12 wk
Transdermal testosterone	
Testosterone gel 1.6%[d]	50–100 mg/d
Testosterone transdermal patch	2.5–7.5 mg/d

Abbreviations: IM, intramuscularly; SQ, sequentially; SC, subcutaneously.

[a]Estrogens used with or without antiandrogens or GnRH agonist.

[b]Not available in the United States.

[c]One thousand milligrams initially followed by an injection at 6 wk then at 12-wk intervals.

[d]Avoid cutaneous transfer to other individuals.

In transgender males, testosterone will result in clitoromegaly, temporary or permanent decreased fertility, deepening of the voice, cessation of menses (usually), and a significant increase in body hair, particularly on the face, chest, and abdomen. Cessation of menses may occur within a few months with testosterone treatment alone, although high doses of testosterone may be required. If uterine bleeding continues, clinicians may consider the addition of a progestational agent or endometrial ablation (138). Clinicians may also administer GnRH analogs or depot medroxyprogesterone to stop menses prior to testosterone treatment.

Transgender females

The hormone regimen for transgender females is more complex than the transgender male regimen (Appendix B). Treatment with physiologic doses of estrogen alone is insufficient to suppress testosterone levels into the normal range for females (139). Most published clinical studies report the need for adjunctive therapy to achieve testosterone levels in the female range (21, 113, 114, 132–134, 139, 140).

Multiple adjunctive medications are available, such as progestins with antiandrogen activity and GnRH agonists (141). Spironolactone works by directly blocking androgens during their interaction with the androgen receptor (114, 133, 142). It may also have estrogenic activity (143). Cyproterone acetate, a progestational compound with antiandrogenic properties (113, 132, 144), is widely used in Europe. 5α-Reductase inhibitors do not reduce testosterone levels and have adverse effects (145).

Dittrich *et al.* (141) reported that monthly doses of the GnRH agonist goserelin acetate in combination with estrogen were effective in reducing testosterone levels with a low incidence of adverse reactions in 60 transgender females. Leuprolide and transdermal estrogen were as effective as cyproterone and transdermal estrogen in a comparative retrospective study (146).

Patients can take estrogen as oral conjugated estrogens, oral 17β-estradiol, or transdermal 17β-estradiol. Among estrogen options, the increased risk of thromboembolic events associated with estrogens in general seems most concerning with ethinyl estradiol specifically (134, 140, 141), which is why we specifically suggest that it not be used in any transgender treatment plan. Data distinguishing among other estrogen options are less well established although there is some thought that oral routes of administration are more thrombogenic due to the "first pass effect" than are transdermal and parenteral routes, and that the risk of thromboembolic events is dose-dependent. Injectable estrogen and sublingual

Downloaded from https://academic.oup.com/jcem/article/102/11/3869/4157558 by guest on 10 March 2022

estrogen may benefit from avoiding the first pass effect, but they can result in more rapid peaks with greater overall periodicity and thus are more difficult to monitor (147, 148). However, there are no data demonstrating that increased periodicity is harmful otherwise.

Clinicians can use serum estradiol levels to monitor oral, transdermal, and intramuscular estradiol. Blood tests cannot monitor conjugated estrogens or synthetic estrogen use. Clinicians should measure serum estradiol and serum testosterone and maintain them at the level for premenopausal females (100 to 200 pg/mL and <50 ng/dL, respectively). The transdermal preparations and injectable estradiol cypionate or valerate preparations may confer an advantage in older transgender females who may be at higher risk for thromboembolic disease (149).

Values

Our recommendation to maintain levels of gender-affirming hormones in the normal adult range places a high value on the avoidance of the long-term complications of pharmacologic doses. Those patients receiving endocrine treatment who have relative contraindications to hormones should have an in-depth discussion with their physician to balance the risks and benefits of therapy.

Remarks

Clinicians should inform all endocrine-treated individuals of all risks and benefits of gender-affirming hormones prior to initiating therapy. Clinicians should strongly encourage tobacco use cessation in transgender females to avoid increased risk of VTE and cardiovascular complications. We strongly discourage the unsupervised use of hormone therapy (150).

Not all individuals with GD/gender incongruence seek treatment as described (*e.g.*, male-to-eunuchs and individuals seeking partial transition). Tailoring current protocols to the individual may be done within the context of accepted safety guidelines using a multidisciplinary approach including mental health. No evidence-based protocols are available for these groups (151). We need prospective studies to better understand treatment options for these persons.

3.4. We suggest that endocrinologists provide education to transgender individuals undergoing treatment about the onset and time course of physical changes induced by sex hormone treatment. (2 |⊕○○○)

Evidence

Transgender males

Physical changes that are expected to occur during the first 1 to 6 months of testosterone therapy include cessation of menses, increased sexual desire, increased facial and body hair, increased oiliness of skin, increased muscle, and redistribution of fat mass. Changes that occur within the first year of testosterone therapy include deepening of the voice (152, 153), clitoromegaly, and male pattern hair loss (in some cases) (114, 144, 154, 155) (Table 12).

Transgender females

Physical changes that may occur in transgender females in the first 3 to 12 months of estrogen and antiandrogen therapy include decreased sexual desire, decreased spontaneous erections, decreased facial and body hair (usually mild), decreased oiliness of skin, increased breast tissue growth, and redistribution of fat mass (114, 139, 149, 154, 155, 161) (Table 13). Breast development is generally maximal at 2 years after initiating hormones (114, 139, 149, 155). Over a long period of time, the prostate gland and testicles will undergo atrophy.

Although the time course of breast development in transgender females has been studied (150), precise information about other changes induced by sex hormones is lacking (141). There is a great deal of variability among individuals, as evidenced during pubertal development. We all know that a major concern for transgender females is breast development. If we work with estrogens, the result will be often not what the transgender female expects.

Alternatively, there are transgender females who report an anecdotal improved breast development, mood, or sexual desire with the use of progestogens. However, there have been no well-designed studies of the role of progestogens in feminizing hormone regimens, so the question is still open.

Our knowledge concerning the natural history and effects of different cross-sex hormone therapies on breast

Table 12. Masculinizing Effects in Transgender Males

Effect	Onset	Maximum
Skin oiliness/acne	1–6 mo	1–2 y
Facial/body hair growth	6–12 mo	4–5 y
Scalp hair loss	6–12 mo	—[a]
Increased muscle mass/strength	6–12 mo	2–5 y
Fat redistribution	1–6 mo	2–5 y
Cessation of menses	1–6 mo	—[b]
Clitoral enlargement	1–6 mo	1–2 y
Vaginal atrophy	1–6 mo	1–2 y
Deepening of voice	6–12 mo	1–2 y

Estimates represent clinical observations: Toorians *et al.* (149), Asscheman *et al.* (156), Gooren *et al.* (157), Wierckx *et al.* (158).

[a]Prevention and treatment as recommended for biological men.

[b]Menorrhagia requires diagnosis and treatment by a gynecologist.

Downloaded from https://academic.oup.com/jcem/article/102/11/3869/4157558 by guest on 10 March 2022

Table 13. Feminizing Effects in Transgender Females

Effect	Onset	Maximum
Redistribution of body fat	3–6 mo	2–3 y
Decrease in muscle mass and strength	3–6 mo	1–2 y
Softening of skin/decreased oiliness	3–6 mo	Unknown
Decreased sexual desire	1–3 mo	3–6 mo
Decreased spontaneous erections	1–3 mo	3–6 mo
Male sexual dysfunction	Variable	Variable
Breast growth	3–6 mo	2–3 y
Decreased testicular volume	3–6 mo	2–3 y
Decreased sperm production	Unknown	>3 y
Decreased terminal hair growth	6–12 mo	>3 y[a]
Scalp hair	Variable	—[b]
Voice changes	None	—[c]

Estimates represent clinical observations: Toorians *et al.* (149), Asscheman *et al.* (156), Gooren *et al.* (157).

[a]Complete removal of male sexual hair requires electrolysis or laser treatment or both.

[b]Familial scalp hair loss may occur if estrogens are stopped.

[c]Treatment by speech pathologists for voice training is most effective.

development in transgender females is extremely sparse and based on the low quality of evidence. Current evidence does not indicate that progestogens enhance breast development in transgender females, nor does evidence prove the absence of such an effect. This prevents us from drawing any firm conclusion at this moment and demonstrates the need for further research to clarify these important clinical questions (162).

Values and preferences

Transgender persons have very high expectations regarding the physical changes of hormone treatment and are aware that body changes can be enhanced by surgical procedures (*e.g.*, breast, face, and body habitus). Clear expectations for the extent and timing of sex hormone–induced changes may prevent the potential harm and expense of unnecessary procedures.

4.0 Adverse Outcome Prevention and Long-Term Care

Hormone therapy for transgender males and females confers many of the same risks associated with sex hormone replacement therapy in nontransgender persons. The risks arise from and are worsened by inadvertent or intentional use of supraphysiologic doses of sex hormones, as well as use of inadequate doses of sex hormones to maintain normal physiology (131, 139).

4.1. We suggest regular clinical evaluation for physical changes and potential adverse changes in response to sex steroid hormones and laboratory monitoring of sex steroid hormone levels every 3 months during the first year of hormone therapy for transgender males and females and then once or twice yearly. (2 |⊕⊕○○)

Evidence

Pretreatment screening and appropriate regular medical monitoring are recommended for both transgender males and females during the endocrine transition and periodically thereafter (26, 155). Clinicians should monitor weight and blood pressure, conduct physical exams, and assess routine health questions, such as tobacco use, symptoms of depression, and risk of adverse events such as deep vein thrombosis/pulmonary embolism and other adverse effects of sex steroids.

Transgender males

Table 14 contains a standard monitoring plan for transgender males on testosterone therapy (154, 159). Key issues include maintaining testosterone levels in the physiologic normal male range and avoiding adverse events resulting from excess testosterone therapy, particularly erythrocytosis, sleep apnea, hypertension, excessive weight gain, salt retention, lipid changes, and excessive or cystic acne (135).

Because oral 17-alkylated testosterone is not recommended, serious hepatic toxicity is not anticipated with parenteral or transdermal testosterone use (163, 164). Past concerns regarding liver toxicity with testosterone have been alleviated with subsequent reports that indicate the risk of serious liver disease is minimal (144, 165, 166).

Transgender females

Table 15 contains a standard monitoring plan for transgender females on estrogens, gonadotropin suppression, or antiandrogens (160). Key issues include avoiding supraphysiologic doses or blood levels of estrogen that may lead to increased risk for thromboembolic disease, liver dysfunction, and hypertension. Clinicians should monitor serum estradiol levels using laboratories participating in external quality control, as measurements of estradiol in blood can be very challenging (167).

VTE may be a serious complication. A study reported a 20-fold increase in venous thromboembolic disease in a large cohort of Dutch transgender subjects (161). This increase may have been associated with the use of the synthetic estrogen, ethinyl estradiol (149). The incidence decreased when clinicians stopped administering ethinyl estradiol (161). Thus, the use of synthetic estrogens and conjugated estrogens is undesirable because of the inability to regulate doses by measuring serum levels and the risk of thromboembolic disease. In a German gender clinic, deep vein thrombosis occurred in 1 of 60 of transgender females treated with a GnRH analog and oral

Downloaded from https://academic.oup.com/jcem/article/102/11/3869/4157558 by guest on 10 March 2022

Table 14. Monitoring of Transgender Persons on Gender-Affirming Hormone Therapy: Transgender Male

1. Evaluate patient every 3 mo in the first year and then one to two times per year to monitor for appropriate signs of virilization and for development of adverse reactions.
2. Measure serum testosterone every 3 mo until levels are in the normal physiologic male range:[a]
   a. For testosterone enanthate/cypionate injections, the testosterone level should be measured midway between injections. The target level is 400–700 ng/dL to 400 ng/dL. Alternatively, measure peak and trough levels to ensure levels remain in the normal male range.
   b. For parenteral testosterone undecanoate, testosterone should be measured just before the following injection. If the level is <400 ng/dL, adjust dosing interval.
   c. For transdermal testosterone, the testosterone level can be measured no sooner than after 1 wk of daily application (at least 2 h after application).
3. Measure hematocrit or hemoglobin at baseline and every 3 mo for the first year and then one to two times a year. Monitor weight, blood pressure, and lipids at regular intervals.
4. Screening for osteoporosis should be conducted in those who stop testosterone treatment, are not compliant with hormone therapy, or who develop risks for bone loss.
5. If cervical tissue is present, monitoring as recommended by the American College of Obstetricians and Gynecologists.
6. Ovariectomy can be considered after completion of hormone transition.
7. Conduct sub- and periareolar annual breast examinations if mastectomy performed. If mastectomy is not performed, then consider mammograms as recommended by the American Cancer Society.

[a]Adapted from Lapauw *et al.* (154) and Ott *et al.* (159).

estradiol (141). The patient who developed a deep vein thrombosis was found to have a homozygous C677 T mutation in the methylenetetrahydrofolate reductase gene. In an Austrian gender clinic, administering gender-affirming hormones to 162 transgender females and 89 transgender males was not associated with VTE, despite an 8.0% and 5.6% incidence of thrombophilia (159). A more recent multinational study reported only 10 cases of VTE from a cohort of 1073 subjects (168). Thrombophilia screening of transgender persons initiating hormone treatment should be restricted to those with a personal or family history of VTE (159). Monitoring D-dimer levels during treatment is not recommended (169).

4.2. We suggest periodically monitoring prolactin levels in transgender females treated with estrogens. (2 l⊕⊕○○)

Evidence

Estrogen therapy can increase the growth of pituitary lactrotroph cells. There have been several reports of prolactinomas occurring after long-term, high-dose estrogen therapy (170–173). Up to 20% of transgender females treated with estrogens may have elevations in prolactin levels associated with enlargement of the pituitary gland (156). In most cases, the serum prolactin levels will return to the normal range with a reduction or discontinuation of the estrogen therapy or discontinuation of cyproterone acetate (157, 174, 175).

The onset and time course of hyperprolactinemia during estrogen treatment are not known. Clinicians should measure prolactin levels at baseline and then at least annually during the transition period and every 2 years thereafter. Given that only a few case studies reported prolactinomas, and prolactinomas were not reported in large cohorts of estrogen-treated persons, the risk is likely to be very low. Because the major presenting findings of microprolactinomas (hypogonadism and sometimes gynecomastia) are not apparent in transgender females, clinicians may perform radiologic examinations of the pituitary in those patients whose prolactin levels persistently increase despite stable or reduced estrogen levels. Some transgender individuals receive psychotropic medications that can increase prolactin levels (174).

Table 15. Monitoring of Transgender Persons on Gender-Affirming Hormone Therapy: Transgender Female

1. Evaluate patient every 3 mo in the first year and then one to two times per year to monitor for appropriate signs of feminization and for development of adverse reactions.
2. Measure serum testosterone and estradiol every 3 mo.
   a. Serum testosterone levels should be <50 ng/dL.
   b. Serum estradiol should not exceed the peak physiologic range: 100–200 pg/mL.
3. For individuals on spironolactone, serum electrolytes, particularly potassium, should be monitored every 3 mo in the first year and annually thereafter.
4. Routine cancer screening is recommended, as in nontransgender individuals (all tissues present).
5. Consider BMD testing at baseline (160). In individuals at low risk, screening for osteoporosis should be conducted at age 60 years or in those who are not compliant with hormone therapy.

This table presents strong recommendations and does not include lower level recommendations.

Downloaded from https://academic.oup.com/jcem/article/102/11/3869/4157558 by guest on 10 March 2022

4.3. We suggest that clinicians evaluate transgender persons treated with hormones for cardiovascular risk factors using fasting lipid profiles, diabetes screening, and/or other diagnostic tools. (2 |⊕⊕○○)

Evidence

Transgender males

Administering testosterone to transgender males results in a more atherogenic lipid profile with lowered high-density lipoprotein cholesterol and higher triglyceride and low-density lipoprotein cholesterol values (176–179). Studies of the effect of testosterone on insulin sensitivity have mixed results (178, 180). A randomized, open-label uncontrolled safety study of transgender males treated with testosterone undecanoate demonstrated no insulin resistance after 1 year (181, 182). Numerous studies have demonstrated the effects of sex hormone treatment on the cardiovascular system (160, 179, 183, 184). Long-term studies from The Netherlands found no increased risk for cardiovascular mortality (161). Likewise, a meta-analysis of 19 randomized trials in nontransgender males on testosterone replacement showed no increased incidence of cardiovascular events (185). A systematic review of the literature found that data were insufficient (due to very low–quality evidence) to allow a meaningful assessment of patient-important outcomes, such as death, stroke, myocardial infarction, or VTE in transgender males (176). Future research is needed to ascertain the potential harm of hormonal therapies (176). Clinicians should manage cardiovascular risk factors as they emerge according to established guidelines (186).

Transgender females

A prospective study of transgender females found favorable changes in lipid parameters with increased high-density lipoprotein and decreased low-density lipoprotein concentrations (178). However, increased weight, blood pressure, and markers of insulin resistance attenuated these favorable lipid changes. In a meta-analysis, only serum triglycerides were higher at ≥24 months without changes in other parameters (187). The largest cohort of transgender females (mean age 41 years, followed for a mean of 10 years) showed no increase in cardiovascular mortality despite a 32% rate of tobacco use (161).

Thus, there is limited evidence to determine whether estrogen is protective or detrimental on lipid and glucose metabolism in transgender females (176). With aging, there is usually an increase of body weight. Therefore, as with nontransgender individuals, clinicians should monitor and manage glucose and lipid metabolism and blood pressure regularly according to established guidelines (186).

4.4. We recommend that clinicians obtain BMD measurements when risk factors for osteoporosis exist, specifically in those who stop sex hormone therapy after gonadectomy. (1 |⊕⊕○○)

Evidence

Transgender males

Baseline bone mineral measurements in transgender males are generally in the expected range for their pretreatment gender (188). However, adequate dosing of testosterone is important to maintain bone mass in transgender males (189, 190). In one study (190), serum LH levels were inversely related to BMD, suggesting that low levels of sex hormones were associated with bone loss. Thus, LH levels in the normal range may serve as an indicator of the adequacy of sex steroid administration to preserve bone mass. The protective effect of testosterone may be mediated by peripheral conversion to estradiol, both systemically and locally in the bone.

Transgender females

A baseline study of BMD reported T scores less than −2.5 in 16% of transgender females (191). In aging males, studies suggest that serum estradiol more positively correlates with BMD than does testosterone (192, 193) and is more important for peak bone mass (194). Estrogen preserves BMD in transgender females who continue on estrogen and antiandrogen therapies (188, 190, 191, 195, 196).

Fracture data in transgender males and females are not available. Transgender persons who have undergone gonadectomy may choose not to continue consistent sex steroid treatment after hormonal and surgical sex reassignment, thereby becoming at risk for bone loss. There have been no studies to determine whether clinicians should use the sex assigned at birth or affirmed gender for assessing osteoporosis (*e.g.*, when using the FRAX tool). Although some researchers use the sex assigned at birth (with the assumption that bone mass has usually peaked for transgender people who initiate hormones in early adulthood), this should be assessed on a case-by-case basis until there are more data available. This assumption will be further complicated by the increasing prevalence of transgender people who undergo hormonal transition at a pubertal age or soon after puberty. Sex for comparison within risk assessment tools may be based on the age at which hormones were initiated and the length of exposure to hormones. In some cases, it may be

Downloaded from https://academic.oup.com/jcem/article/102/11/3869/4157558 by guest on 10 March 2022

reasonable to assess risk using both the male and female calculators and using an intermediate value. Because all subjects underwent normal pubertal development, with known effects on bone size, reference values for birth sex were used for all participants (154).

4.5. We suggest that transgender females with no known increased risk of breast cancer follow breast-screening guidelines recommended for those designated female at birth. (2 |⊕⊕○○)

4.6. We suggest that transgender females treated with estrogens follow individualized screening according to personal risk for prostatic disease and prostate cancer. (2 |⊕○○○)

Evidence

Studies have reported a few cases of breast cancer in transgender females (197–200). A Dutch study of 1800 transgender females followed for a mean of 15 years (range of 1 30 years) found one case of breast cancer. The Women's Health Initiative study reported that females taking conjugated equine estrogen without progesterone for 7 years did not have an increased risk of breast cancer as compared with females taking placebo (137).

In transgender males, a large retrospective study conducted at the U.S. Veterans Affairs medical health system identified seven breast cancers (194). The authors reported that this was not above the expected rate of breast cancers in cisgender females in this cohort. Furthermore, they did report one breast cancer that developed in a transgender male patient after mastectomy, supporting the fact that breast cancer can occur even after mastectomy. Indeed, there have been case reports of breast cancer developing in subareolar tissue in transgender males, which occurred after mastectomy (201, 202).

Women with primary hypogonadism (Turner syndrome) treated with estrogen replacement exhibited a significantly decreased incidence of breast cancer as compared with national standardized incidence ratios (203, 204). These studies suggest that estrogen therapy does not increase the risk of breast cancer in the short term (<20 to 30 years). We need long-term studies to determine the actual risk, as well as the role of screening mammograms. Regular examinations and gynecologic advice should determine monitoring for breast cancer.

Prostate cancer is very rare before the age of 40, especially with androgen deprivation therapy (205). Childhood or pubertal castration results in regression of the prostate and adult castration reverses benign prostate hypertrophy (206). Although van Kesteren *et al.* (207) reported that estrogen therapy does not induce hypertrophy or premalignant changes in the prostates of transgender females, studies have reported cases of benign prostatic hyperplasia in transgender females treated with estrogens for 20 to 25 years (208, 209). Studies have also reported a few cases of prostate carcinoma in transgender females (210–214).

Transgender females may feel uncomfortable scheduling regular prostate examinations. Gynecologists are not trained to screen for prostate cancer or to monitor prostate growth. Thus, it may be reasonable for transgender females who transitioned after age 20 years to have annual screening digital rectal examinations after age 50 years and prostate-specific antigen tests consistent with U.S. Preventive Services Task Force Guidelines (215).

4.7. We advise that clinicians determine the medical necessity of including a total hysterectomy and oophorectomy as part of gender-affirming surgery. (Ungraded Good Practice Statement)

Evidence

Although aromatization of testosterone to estradiol in transgender males has been suggested as a risk factor for endometrial cancer (216), no cases have been reported. When transgender males undergo hysterectomy, the uterus is small and there is endometrial atrophy (217, 218). Studies have reported cases of ovarian cancer (219, 220). Although there is limited evidence for increased risk of reproductive tract cancers in transgender males, health care providers should determine the medical necessity of a laparoscopic total hysterectomy as part of a gender-affirming surgery to prevent reproductive tract cancer (221).

Values

Given the discomfort that transgender males experience accessing gynecologic care, our recommendation for the medical necessity of total hysterectomy and oophorectomy places a high value on eliminating the risks of female reproductive tract disease and cancer and a lower value on avoiding the risks of these surgical procedures (related to the surgery and to the potential undesirable health consequences of oophorectomy) and their associated costs.

Remarks

The sexual orientation and type of sexual practices will determine the need and types of gynecologic care required following transition. Additionally, in certain countries, the approval required to change the sex in a birth certificate for transgender males may be dependent on having a complete hysterectomy. Clinicians should help patients research nonmedical administrative criteria and

Downloaded from https://academic.oup.com/jcem/article/102/11/3869/4157558 by guest on 10 March 2022

provide counseling. If individuals decide not to undergo hysterectomy, screening for cervical cancer is the same as all other females.

5.0 Surgery for Sex Reassignment and Gender Confirmation

For many transgender adults, genital gender-affirming surgery may be the necessary step toward achieving their ultimate goal of living successfully in their desired gender role. The type of surgery falls into two main categories: (1) those that directly affect fertility and (2) those that do not. Those that change fertility (previously called sex reassignment surgery) include genital surgery to remove the penis and gonads in the male and removal of the uterus and gonads in the female. The surgeries that effect fertility are often governed by the legal system of the state or country in which they are performed. Other gender-conforming surgeries that do not directly affect fertility are not so tightly governed.

Gender-affirming surgical techniques have improved markedly during the past 10 years. Reconstructive genital surgery that preserves neurologic sensation is now the standard. The satisfaction rate with surgical reassignment of sex is now very high (187). Additionally, the mental health of the individual seems to be improved by participating in a treatment program that defines a pathway of gender-affirming treatment that includes hormones and surgery (130, 144) (Table 16).

Surgery that affects fertility is irreversible. The World Professional Association for Transgender Health Standards of Care (222) emphasizes that the "threshold of 18 should not be seen as an indication in itself for active intervention." If the social transition has not been satisfactory, if the person is not satisfied with or is ambivalent about the effects of sex hormone treatment, or if the person is ambivalent about surgery then the individual should not be referred for surgery (223, 224).

Gender-affirming genital surgeries for transgender females that affect fertility include gonadectomy, penectomy, and creation of a neovagina (225, 226). Surgeons often invert the skin of the penis to form the wall of the vagina, and several literatures reviews have reported on outcomes (227). Sometimes there is inadequate tissue to form a full neovagina, so clinicians have revisited using intestine and found it to be successful (87, 228, 229). Some newer vaginoplasty techniques may involve autologuous oral epithelial cells (230, 231).

The scrotum becomes the labia majora. Surgeons use reconstructive surgery to fashion the clitoris and its hood, preserving the neurovascular bundle at the tip of the penis as the neurosensory supply to the clitoris. Some surgeons are also creating a sensate pedicled-spot adding a G spot to the neovagina to increase sensation (232). Most recently, plastic surgeons have developed techniques to fashion labia minora. To further complete the feminization, uterine transplants have been proposed and even attempted (233).

Neovaginal prolapse, rectovaginal fistula, delayed healing, vaginal stenosis, and other complications do sometimes occur (234, 235). Clinicians should strongly remind the transgender person to use their dilators to maintain the depth and width of the vagina throughout the postoperative period. Genital sexual responsivity and other aspects of sexual function are usually preserved following genital gender-affirming surgery (236, 237).

Ancillary surgeries for more feminine or masculine appearance are not within the scope of this guideline. Voice therapy by a speech language pathologist is available to transform speech patterns to the affirmed gender (148). Spontaneous voice deepening occurs during testosterone treatment of transgender males (152, 238). No studies have compared the effectiveness of speech therapy, laryngeal surgery, or combined treatment.

Breast surgery is a good example of gender-confirming surgery that does not affect fertility. In all females, breast size exhibits a very broad spectrum. For transgender females to make the best informed decision, clinicians should delay breast augmentation surgery until the patient has completed at least 2 years of estrogen therapy, because the breasts continue to grow during that time (141, 155).

Another major procedure is the removal of facial and masculine-appearing body hair using either electrolysis or

Table 16. Criteria for Gender-Affirming Surgery, Which Affects Fertility

1. Persistent, well-documented gender dysphoria
2. Legal age of majority in the given country
3. Having continuously and responsibly used gender-affirming hormones for 12 mo (if there is no medical contraindication to receiving such therapy)
4. Successful continuous full-time living in the new gender role for 12 mo
5. If significant medical or mental health concerns are present, they must be well controlled
6. Demonstrable knowledge of all practical aspects of surgery (*e.g.*, cost, required lengths of hospitalizations, likely complications, postsurgical rehabilitation)

Downloaded from https://academic.oup.com/jcem/article/102/11/3869/4157558 by guest on 10 March 2022

laser treatments. Other feminizing surgeries, such as that to feminize the face, are now becoming more popular (239–241).

In transgender males, clinicians usually delay gender-affirming genital surgeries until after a few years of androgen therapy. Those surgeries that affect fertility in this group include oophorectomy, vaginectomy, and complete hysterectomy. Surgeons can safely perform them vaginally with laparoscopy. These are sometimes done in conjunction with the creation of a neopenis. The cosmetic appearance of a neopenis is now very good, but the surgery is multistage and very expensive (242, 243). Radial forearm flap seems to be the most satisfactory procedure (228, 244). Other flaps also exist (245). Surgeons can make neopenile erections possible by reinervation of the flap and subsequent contraction of the muscle, leading to stiffening of the neopenis (246, 247), but results are inconsistent (248). Surgeons can also stiffen the penis by imbedding some mechanical device (*e.g.*, a rod or some inflatable apparatus) (249, 250). Because of these limitations, the creation of a neopenis has often been less than satisfactory. Recently, penis transplants are being proposed (233).

In fact, most transgender males do not have any external genital surgery because of the lack of access, high cost, and significant potential complications. Some choose a metaoidioplasty that brings forward the clitoris, thereby allowing them to void in a standing position without wetting themselves (251, 252). Surgeons can create the scrotum from the labia majora with good cosmetic effect and can implant testicular prostheses (253).

The most important masculinizing surgery for the transgender male is mastectomy, and it does not affect fertility. Breast size only partially regresses with androgen therapy (155). In adults, discussions about mastectomy usually take place after androgen therapy has started. Because some transgender male adolescents present after significant breast development has occurred, they may also consider mastectomy 2 years after they begin androgen therapy and before age 18 years. Clinicians should individualize treatment based on the physical and mental health status of the individual. There are now newer approaches to mastectomy with better outcomes (254, 255). These often involve chest contouring (256). Mastectomy is often necessary for living comfortably in the new gender (256).

5.1. We recommend that a patient pursue genital gender-affirming surgery only after the MHP and the clinician responsible for endocrine transition therapy both agree that surgery is medically necessary and would benefit the patient's overall health and/or well-being. (1 |⊕⊕○○)

5.2. We advise that clinicians approve genital gender-affirming surgery only after completion of at least 1 year of consistent and compliant hormone treatment, unless hormone therapy is not desired or medically contraindicated. (Ungraded Good Practice Statement)

5.3. We advise that the clinician responsible for endocrine treatment and the primary care provider ensure appropriate medical clearance of transgender individuals for genital gender-affirming surgery and collaborate with the surgeon regarding hormone use during and after surgery. (Ungraded Good Practice Statement)

5.4. We recommend that clinicians refer hormone-treated transgender individuals for genital surgery when: (1) the individual has had a satisfactory social role change, (2) the individual is satisfied about the hormonal effects, and (3) the individual desires definitive surgical changes. (1 |⊕○○○)

5.5. We suggest that clinicians delay gender-affirming genital surgery involving gonadectomy and/or hysterectomy until the patient is at least 18 years old or legal age of majority in his or her country. (2 |⊕⊕○○).

5.6. We suggest that clinicians determine the timing of breast surgery for transgender males based upon the physical and mental health status of the individual. There is insufficient evidence to recommend a specific age requirement. (2 |⊕○○○)

Evidence

Owing to the lack of controlled studies, incomplete follow-up, and lack of valid assessment measures, evaluating various surgical approaches and techniques is difficult. However, one systematic review including a large numbers of studies reported satisfactory cosmetic and functional results for vaginoplasty/neovagina construction (257). For transgender males, the outcomes are less certain. However, the problems are now better understood (258). Several postoperative studies report significant long-term psychological and psychiatric pathology (259–261). One study showed satisfaction with breasts, genitals, and femininity increased significantly and showed the importance of surgical treatment as a key therapeutic option for transgender females (262). Another analysis demonstrated that, despite the young average age at death following surgery and the relatively larger number of individuals with somatic morbidity, the study does not allow for determination of

Downloaded from https://academic.oup.com/jcem/article/102/11/3869/4157558 by guest on 10 March 2022

causal relationships between, for example, specific types of hormonal or surgical treatment received and somatic morbidity and mortality (263). Reversal surgery in regretful male-to-female transsexuals after sexual reassignment surgery represents a complex, multistage procedure with satisfactory outcomes. Further insight into the characteristics of persons who regret their decision postoperatively would facilitate better future selection of applicants eligible for sexual reassignment surgery. We need more studies with appropriate controls that examine long-term quality of life, psychosocial outcomes, and psychiatric outcomes to determine the long-term benefits of surgical treatment.

When a transgender individual decides to have gender-affirming surgery, both the hormone prescribing clinician and the MHP must certify that the patient satisfies criteria for gender-affirming surgery (Table 16).

There is some concern that estrogen therapy may cause an increased risk for venous thrombosis during or following surgery (176). For this reason, the surgeon and the hormone-prescribing clinician should collaborate in making a decision about the use of hormones before and following surgery. One study suggests that preoperative factors (such as compliance) are less important for patient satisfaction than are the physical postoperative results (56). However, other studies and clinical experience dictate that individuals who do not follow medical instructions and do not work with their physicians toward a common goal do not achieve treatment goals (264) and experience higher rates of postoperative infections and other complications (265, 266). It is also important that the person requesting surgery feels comfortable with the anatomical changes that have occurred during hormone therapy. Dissatisfaction with social and physical outcomes during the hormone transition may be a contraindication to surgery (223).

An endocrinologist or experienced medical provider should monitor transgender individuals after surgery. Those who undergo gonadectomy will require hormone replacement therapy, surveillance, or both to prevent adverse effects of chronic hormone deficiency.

Financial Disclosures of the Task Force*

Wylie C. Hembree (chair)—financial or business/organizational interests: none declared, significant financial interest or leadership position: none declared. **Peggy T. Cohen-Kettenis**—financial or business/organizational interests: none declared, significant financial interest or leadership position: none declared. **Louis Gooren**—financial or business/organizational interests: none declared, significant financial interest or leadership position: none declared. **Sabine E. Hannema**—financial or business/organizational interests: none declared, significant financial interest or leadership position: Ferring Pharmaceuticals Inc. (lecture/conference), Pfizer (lecture). **Walter J. Meyer**—financial or business/organizational interests: none declared, significant financial interest or leadership position: none declared. **M. Hassan Murad****—financial or business/organizational interests: Mayo Clinic, Evidence-based Practice Center, significant financial interest or leadership position: none declared. **Stephen M. Rosenthal**—financial or business/organizational interests: AbbVie (consultant), National Institutes of Health (grantee), significant financial interest or leadership position: Pediatric Endocrine Society (immediate past president). **Joshua D. Safer, FACP**—financial or business/organizational interests: none declared, significant financial interest or leadership position: none declared. **Vin Tangpricha**—financial or business/organizational interests: Cystic Fibrosis Foundation (grantee), National Institutes of Health (grantee), significant financial interest or leadership position, Elsevier *Journal of Clinical and Translational Endocrinology* (editor). **Guy G. T'Sjoen**—financial or business/organizational interests: none declared, significant financial interest or leadership position: none declared.* Financial, business, and organizational disclosures of the task force cover the year prior to publication. Disclosures prior to this time period are archived.**Evidence-based reviews for this guideline were prepared under contract with the Endocrine Society.

Acknowledgments

Correspondence and Reprint Requests: The Endocrine Society, 2055 L Street NW, Suite 600, Washington, DC 20036. E-mail: publications@endocrine.org; Phone: 202971-3636.

Disclosure Summary: See Financial Disclosures.

Disclaimer: The Endocrine Society's clinical practice guidelines are developed to be of assistance to endocrinologists by providing guidance and recommendations for particular areas of practice. The guidelines should not be considered inclusive of all proper approaches or methods, or exclusive of others. The guidelines cannot guarantee any specific outcome, nor do they establish a standard of care. The guidelines are not intended to dictate the treatment of a particular patient. Treatment decisions must be made based on the independent judgement of healthcare providers and each patient's individual circumstances.

The Endocrine Society makes no warranty, express or implied, regarding the guidelines and specifically excludes any warranties of merchantability and fitness for a particular use or purpose. The Society shall not be liable for direct, indirect,

Downloaded from https://academic.oup.com/jcem/article/102/11/3869/4157558 by guest on 10 March 2022

special, incidental, or consequential damages related to the use of the information contained herein.

References

1. Atkins D, Best D, Briss PA, Eccles M, Falck-Ytter Y, Flottorp S, Guyatt GH, Harbour RT, Haugh MC, Henry D, Hill S, Jaeschke R, Leng G, Liberati A, Magrini N, Mason J, Middleton P, Mrukowicz J, O'Connell D, Oxman AD, Phillips B, Schünemann HJ, Edejer T, Varonen H, Vist GE, Williams JW, Jr, Zaza S; GRADE Working Group. Grading quality of evidence and strength of recommendations. *BMJ*. 2004;**328**(7454):1490.
2. Swiglo BA, Murad MH, Schünemann HJ, Kunz R, Vigersky RA, Guyatt GH, Montori VM. A case for clarity, consistency, and helpfulness: state-of-the-art clinical practice guidelines in endocrinology using the grading of recommendations, assessment, development, and evaluation system. *J Clin Endocrinol Metab*. 2008;**93**(3):666–673.
3. Bullough VL. Transsexualism in history. *Arch Sex Behav*. 1975; **4**(5):561–571.
4. Benjamin H. The transsexual phenomenon. *Trans N Y Acad Sci*. 1967;**29**(4):428–430.
5. Meyerowitz J. *How Sex Changed: A History of Transsexuality in the United States*. Cambridge, MA: Harvard University Press; 2002.
6. Hirschfeld M. *Was muss das Volk vom Dritten Geschlecht wissen*. Verlag Max Spohr, Leipzig; 1901.
7. Fisk NM. Editorial: Gender dysphoria syndrome—the conceptualization that liberalizes indications for total gender reorientation and implies a broadly based multi-dimensional rehabilitative regimen. *West J Med*. 1974;**120**(5):386–391.
8. Diamond L. Transgender experience and identity. In: Schwartz SJ, Luyckx K, Vignoles VL, eds. *Handbook of Identity Theory and Research*. New York, NY: Springer; 2011:629–647.
9. Queen C, Schimel L, eds. *PoMoSexuals: Challenging Assumptions About Gender and Sexuality*. San Francisco, CA: Cleis Press; 1997.
10. Case LK, Ramachandran VS. Alternating gender incongruity: a new neuropsychiatric syndrome providing insight into the dynamic plasticity of brain-sex. *Med Hypotheses*. 2012;**78**(5): 626–631.
11. Johnson TW, Wassersug RJ. Gender identity disorder outside the binary: when gender identity disorder-not otherwise specified is not good enough. *Arch Sex Behav*. 2010;**39**(3):597–598.
12. Wibowo E, Wassersug R, Warkentin K, Walker L, Robinson J, Brotto L, Johnson T. Impact of androgen deprivation therapy on sexual function: a response. *Asian J Androl*. 2012;**14**(5):793–794.
13. Pasquesoone V. 7 countries giving transgender people fundamental rights the U.S. still won't. 2014. Available at: https://mic.com/articles/87149/7-countries-giving-transgender-people-fundamental-rights-the-u-s-still-won-t. Accessed 26 August 2016.
14. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed. Arlington, VA: American Psychiatric Association Publishing.
15. Drescher J, Cohen-Kettenis P, Winter S. Minding the body: situating gender identity diagnoses in the ICD-11. *Int Rev Psychiatry*. 2012;**24**(6):568–577.
16. World Professional Association for Transgender Health. Standards of care for the health of transsexual, transgender, and gender nonconforming people. Available at: http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351&pk_association_webpage=3926. Accessed 1 September 2017.
17. Kreukels BP, Haraldsen IR, De Cuypere G, Richter-Appelt H, Gijs L, Cohen-Kettenis PT. A European network for the investigation of gender incongruence: the ENIGI initiative. *Eur Psychiatry*. 2012;**27**(6):445–450.
18. Dekker MJ, Wierckx K, Van Caenegem E, Klaver M, Kreukels BP, Elaut E, Fisher AD, van Trotsenburg MA, Schreiner T, den Heijer M, T'Sjoen G. A European network for the investigation of gender incongruence: endocrine part. *J Sex Med*. 2016;**13**(6):994–999.
19. Ruble DN, Martin CL, Berenbaum SA. Gender development. In: Damon WL, Lerner RM, Eisenberg N, eds. *Handbook of Child Psychology: Social, Emotional, and Personality Development*. **Vol. 3**. 6th ed. New York, NY: Wiley; 2006;858–931.
20. Steensma TD, Kreukels BP, de Vries AL, Cohen-Kettenis PT. Gender identity development in adolescence. *Horm Behav*. 2013; **64**(2):288–297.
21. Rosenthal SM. Approach to the patient: transgender youth: endocrine considerations. *J Clin Endocrinol Metab*. 2014;**99**(12): 4379–4389.
22. Saraswat A, Weinand JD, Safer JD. Evidence supporting the biologic nature of gender identity. *Endocr Pract*. 2015;**21**(2): 199–204.
23. Gooren L. The biology of human psychosexual differentiation. *Horm Behav*. 2006;**50**(4):589–601.
24. Berenbaum SA, Meyer-Bahlburg HF. Gender development and sexuality in disorders of sex development. *Horm Metab Res*. 2015; **47**(5):361–366.
25. Dessens AB, Slijper FME, Drop SLS. Gender dysphoria and gender change in chromosomal females with congenital adrenal hyperplasia. *Arch Sex Behav*. 2005;**34**(4):389–397.
26. Meyer-Bahlburg HFL, Dolezal C, Baker SW, Ehrhardt AA, New MI. Gender development in women with congenital adrenal hyperplasia as a function of disorder severity. *Arch Sex Behav*. 2006; **35**(6):667–684.
27. Frisén L, Nordenström A, Falhammar H, Filipsson H, Holmdahl G, Janson PO, Thorén M, Hagenfeldt K, Möller A, Nordenskjöld A. Gender role behavior, sexuality, and psychosocial adaptation in women with congenital adrenal hyperplasia due to CYP21A2 deficiency. *J Clin Endocrinol Metab*. 2009;**94**(9):3432–3439.
28. Meyer-Bahlburg HFL, Dolezal C, Baker SW, Carlson AD, Obeid JS, New MI. Prenatal androgenization affects gender-related behavior but not gender identity in 5–12-year-old girls with congenital adrenal hyperplasia. *Arch Sex Behav*. 2004;**33**(2):97–104.
29. Cohen-Kettenis PT. Gender change in 46,XY persons with 5α-reductase-2 deficiency and 17β-hydroxysteroid dehydrogenase-3 deficiency. *Arch Sex Behav*. 2005;**34**(4):399–410.
30. Reiner WG, Gearhart JP. Discordant sexual identity in some genetic males with cloacal exstrophy assigned to female sex at birth. *N Engl J Med*. 2004;**350**(4):333–341.
31. Meyer-Bahlburg HFL. Gender identity outcome in female-raised 46,XY persons with penile agenesis, cloacal exstrophy of the bladder, or penile ablation. *Arch Sex Behav*. 2005;**34**(4):423–438.
32. Coolidge FL, Thede LL, Young SE. The heritability of gender identity disorder in a child and adolescent twin sample. *Behav Genet*. 2002;**32**(4):251–257.
33. Heylens G, De Cuypere G, Zucker KJ, Schelfaut C, Elaut E, Vanden Bossche H, De Baere E, T'Sjoen G. Gender identity disorder in twins: a review of the case report literature. *J Sex Med*. 2012;**9**(3):751–757.
34. Fernández R, Esteva I, Gómez-Gil E, Rumbo T, Almaraz MC, Roda E, Haro-Mora J-J, Guillamón A, Pásaro E. Association study of ERβ, AR, and CYP19A1 genes and MtF transsexualism. *J Sex Med*. 2014;**11**(12):2986–2994.
35. Henningsson S, Westberg L, Nilsson S, Lundström B, Ekselius L, Bodlund O, Lindström E, Hellstrand M, Rosmond R, Eriksson E, Landén M. Sex steroid-related genes and male-to-female transsexualism. *Psychoneuroendocrinology*. 2005;**30**(7):657–664.
36. Hare L, Bernard P, Sánchez FJ, Baird PN, Vilain E, Kennedy T, Harley VR. Androgen receptor repeat length polymorphism associated with male-to-female transsexualism. *Biol Psychiatry*. 2009;**65**(1):93–96.
37. Lombardo F, Toselli L, Grassetti D, Paoli D, Masciandaro P, Valentini F, Lenzi A, Gandini L. Hormone and genetic study in

Downloaded from https://academic.oup.com/jcem/article/102/11/3869/4157558 by guest on 10 March 2022

male to female transsexual patients. *J Endocrinol Invest*. 2013; **36**(8):550–557.
38. Ujike H, Otani K, Nakatsuka M, Ishii K, Sasaki A, Oishi T, Sato T, Okahisa Y, Matsumoto Y, Namba Y, Kimata Y, Kuroda S. Association study of gender identity disorder and sex hormone-related genes. *Prog Neuropsychopharmacol Biol Psychiatry*. 2009;**33**(7):1241–1244.
39. Kreukels BP, Guillamon A. Neuroimaging studies in people with gender incongruence. *Int Rev Psychiatry*. 2016;**28**(1): 120–128.
40. Steensma TD, Biemond R, de Boer F, Cohen-Kettenis PT. Desisting and persisting gender dysphoria after childhood: a qualitative follow-up study. *Clin Child Psychol Psychiatry*. 2011;**16**(4):499–516.
41. Wallien MSC, Cohen-Kettenis PT. Psychosexual outcome of gender-dysphoric children. *J Am Acad Child Adolesc Psychiatry*. 2008;**47**(12):1413–1423.
42. Steensma TD, McGuire JK, Kreukels BPC, Beekman AJ, Cohen-Kettenis PT. Factors associated with desistence and persistence of childhood gender dysphoria: a quantitative follow-up study. *J Am Acad Child Adolesc Psychiatry*. 2013;**52**(6):582–590.
43. Cohen-Kettenis PT, Owen A, Kaijser VG, Bradley SJ, Zucker KJ. Demographic characteristics, social competence, and behavior problems in children with gender identity disorder: a cross-national, cross-clinic comparative analysis. *J Abnorm Child Psychol*. 2003;**31**(1):41–53.
44. Dhejne C, Van Vlerken R, Heylens G, Arcelus J. Mental health and gender dysphoria: a review of the literature. *Int Rev Psychiatry*. 2016;**28**(1):44–57.
45. Pasterski V, Gilligan L, Curtis R. Traits of autism spectrum disorders in adults with gender dysphoria. *Arch Sex Behav*. 2014; **43**(2):387–393.
46. Spack NP, Edwards-Leeper L, Feldman HA, Leibowitz S, Mandel F, Diamond DA, Vance SR. Children and adolescents with gender identity disorder referred to a pediatric medical center. *Pediatrics*. 2012;**129**(3):418–425.
47. Terada S, Matsumoto Y, Sato T, Okabe N, Kishimoto Y, Uchitomi Y. Factors predicting psychiatric co-morbidity in gender-dysphoric adults. *Psychiatry Res*. 2012;**200**(2-3):469–474.
48. VanderLaan DP, Leef JH, Wood H, Hughes SK, Zucker KJ. Autism spectrum disorder risk factors and autistic traits in gender dysphoric children. *J Autism Dev Disord*. 2015;**45**(6):1742–1750.
49. de Vries ALC, Doreleijers TAH, Steensma TD, Cohen-Kettenis PT. Psychiatric comorbidity in gender dysphoric adolescents. *J Child Psychol Psychiatry*. 2011;**52**(11):1195–1202.
50. de Vries ALC, Noens ILJ, Cohen-Kettenis PT, van Berckelaer-Onnes IA, Doreleijers TA. Autism spectrum disorders in gender dysphoric children and adolescents. *J Autism Dev Disord*. 2010; **40**(8):930–936.
51. Wallien MSC, Swaab H, Cohen-Kettenis PT. Psychiatric comorbidity among children with gender identity disorder. *J Am Acad Child Adolesc Psychiatry*. 2007;**46**(10):1307–1314.
52. Kuiper AJ, Cohen-Kettenis PT. Gender role reversal among postoperative transsexuals. Available at: https://www.atria.nl/ezines/web/IJT/97-03/numbers/symposion/ijtc0502.htm. Accessed 26 August 2016.
53. Landén M, Wålinder J, Hambert G, Lundström B. Factors predictive of regret in sex reassignment. *Acta Psychiatr Scand*. 1998; **97**(4):284–289.
54. Olsson S-E, Möller A. Regret after sex reassignment surgery in a male-to-female transsexual: a long-term follow-up. *Arch Sex Behav*. 2006;**35**(4):501–506.
55. Pfäfflin F, Junge A, eds. *Geschlechtsumwandlung: Abhandlungen zur Transsexualität*. Stuttgart, Germany: Schattauer; 1992.
56. Lawrence AA. Factors associated with satisfaction or regret following male-to-female sex reassignment surgery. *Arch Sex Behav*. 2003;**32**(4):299–315.
57. Cohen-Kettenis PT, Pfäfflin F. *Transgenderism and Intersexuality in Childhood and Adolescence: Making Choices*. Thousand Oaks, CA: SAGE Publications; 2003.
58. Di Ceglie D, Freedman D, McPherson S, Richardson P. Children and adolescents referred to a specialist gender identity development service: clinical features and demographic characteristics. Available at: https://www.researchgate.net/publication/276061306_Children_and_Adolescents_Referred_to_a_Specialist_Gender_Identity_Development_Service_Clinical_Features_and_Demographic_Characteristics. Accessed 20 July 2017.
59. Gijs L, Brewaeys A. Surgical treatment of gender dysphoria in adults and adolescents: recent developments, effectiveness, and challenges. *Annu Rev Sex Res*. 2007;**18**:178–224.
60. Cohen-Kettenis PT, van Goozen SHM. Sex reassignment of adolescent transsexuals: a follow-up study. *J Am Acad Child Adolesc Psychiatry*. 1997;**36**(2):263–271.
61. Smith YLS, van Goozen SHM, Cohen-Kettenis PT. Adolescents with gender identity disorder who were accepted or rejected for sex reassignment surgery: a prospective follow-up study. *J Am Acad Child Adolesc Psychiatry*. 2001;**40**(4):472–481.
62. Smith YLS, Van Goozen SHM, Kuiper AJ, Cohen-Kettenis PT. Sex reassignment: outcomes and predictors of treatment for adolescent and adult transsexuals. *Psychol Med*. 2005;**35**(1):89–99.
63. de Vries ALC, McGuire JK, Steensma TD, Wagenaar ECF, Doreleijers TAH, Cohen-Kettenis PT. Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics*. 2014;**134**(4):696–704.
64. Cole CM, O'Boyle M, Emory LE, Meyer WJ III. Comorbidity of gender dysphoria and other major psychiatric diagnoses. *Arch Sex Behav*. 1997;**26**(1):13–26.
65. Cohen-Kettenis PT, Schagen SEE, Steensma TD, de Vries ALC, Delemarre-van de Waal HA. Puberty suppression in a gender-dysphoric adolescent: a 22-year follow-up. *Arch Sex Behav*. 2011; **40**(4):843–847.
66. First MB. Desire for amputation of a limb: paraphilia, psychosis, or a new type of identity disorder. *Psychol Med*. 2005;**35**(6): 919–928.
67. Wierckx K, Van Caenegem E, Pennings G, Elaut E, Dedecker D, Van de Peer F, Weyers S, De Sutter P, T'Sjoen G. Reproductive wish in transsexual men. *Hum Reprod*. 2012;**27**(2):483–487.
68. Wierckx K, Stuyver I, Weyers S, Hamada A, Agarwal A, De Sutter P, T'Sjoen G. Sperm freezing in transsexual women. *Arch Sex Behav*. 2012;**41**(5):1069–1071.
69. Bertelloni S, Baroncelli GI, Ferdeghini M, Menchini-Fabris F, Saggese G. Final height, gonadal function and bone mineral density of adolescent males with central precocious puberty after therapy with gonadotropin-releasing hormone analogues. *Eur J Pediatr*. 2000;**159**(5):369–374.
70. Büchter D, Behre HM, Kliesch S, Nieschlag E. Pulsatile GnRH or human chorionic gonadotropin/human menopausal gonadotropin as effective treatment for men with hypogonadotropic hypogonadism: a review of 42 cases. *Eur J Endocrinol*. 1998; **139**(3):298–303.
71. Liu PY, Turner L, Rushford D, McDonald J, Baker HW, Conway AJ, Handelsman DJ. Efficacy and safety of recombinant human follicle stimulating hormone (Gonal-F) with urinary human chorionic gonadotrophin for induction of spermatogenesis and fertility in gonadotrophin-deficient men. *Hum Reprod*. 1999; **14**(6):1540–1545.
72. Pasquino AM, Pucarelli I, Accardo F, Demiraj V, Segni M, Di Nardo R. Long-term observation of 87 girls with idiopathic central precocious puberty treated with gonadotropin-releasing hormone analogs: impact on adult height, body mass index, bone mineral content, and reproductive function. *J Clin Endocrinol Metab*. 2008;**93**(1):190–195.
73. Magiakou MA, Manousaki D, Papadaki M, Hadjidakis D, Levidou G, Vakaki M, Papaefstathiou A, Lalioti N, Kanaka-Gantenbein C, Piaditis G, Chrousos GP, Dacou-Voutetakis C. The

Downloaded from https://academic.oup.com/jcem/article/102/11/3869/4157558 by guest on 10 March 2022

efficacy and safety of gonadotropin-releasing hormone analog treatment in childhood and adolescence: a single center, long-term follow-up study. *J Clin Endocrinol Metab*. 2010;**95**(1):109–117.
74. Baba T, Endo T, Honnma H, Kitajima Y, Hayashi T, Ikeda H, Masumori N, Kamiya H, Moriwaka O, Saito T. Association between polycystic ovary syndrome and female-to-male transsexuality. *Hum Reprod*. 2007;**22**(4):1011–1016.
75. Spinder T, Spijkstra JJ, van den Tweel JG, Burger CW, van Kessel H, Hompes PGA, Gooren LJG. The effects of long term testosterone administration on pulsatile luteinizing hormone secretion and on ovarian histology in eugonadal female to male transsexual subjects. *J Clin Endocrinol Metab*. 1989;**69**(1):151–157.
76. Baba T, Endo T, Ikeda K, Shimizu A, Honnma H, Ikeda H, Masumori N, Ohmura T, Kiya T, Fujimoto T, Koizumi M, Saito T. Distinctive features of female-to-male transsexualism and prevalence of gender identity disorder in Japan. *J Sex Med*. 2011; **8**(6):1686–1693.
77. Vujovic S, Popovic S, Sbutega-Milosevic G, Djordjevic M, Gooren L. Transsexualism in Serbia: a twenty-year follow-up study. *J Sex Med*. 2009;**6**(4):1018–1023.
78. Ikeda K, Baba T, Noguchi H, Nagasawa K, Endo T, Kiya T, Saito T. Excessive androgen exposure in female-to-male transsexual persons of reproductive age induces hyperplasia of the ovarian cortex and stroma but not polycystic ovary morphology. *Hum Reprod*. 2013;**28**(2):453–461.
79. Trebay G. He's pregnant. You're speechles. New York Times. 22 June 2008.
80. Light AD, Obedin-Maliver J, Sevelius JM, Kerns JL. Transgender men who experienced pregnancy after female-to-male gender transitioning. *Obstet Gynecol*. 2014;**124**(6):1120–1127.
81. De Sutter P. Donor inseminations in partners of female-to-male transsexuals: should the question be asked? *Reprod Biomed Online*. 2003;**6**(3):382, author reply 282–283.
82. De Roo C, Tilleman K, T'Sjoen G, De Sutter P. Fertility options in transgender people. *Int Rev Psychiatry*. 2016;**28**(1):112–119.
83. Wennink JMB, Delemarre-van de Waal HA, Schoemaker R, Schoemaker H, Schoemaker J. Luteinizing hormone and follicle stimulating hormone secretion patterns in boys throughout puberty measured using highly sensitive immunoradiometric assays. *Clin Endocrinol (Oxf)*. 1989;**31**(5):551–564.
84. Cohen-Kettenis PT, Delemarre-van de Waal HA, Gooren LJG. The treatment of adolescent transsexuals: changing insights. *J Sex Med*. 2008;**5**(8):1892–1897.
85. Delemarre-van de Waal HA, Cohen-Kettenis PT. Clinical management of gender identity disorder in adolescents: a protocol on psychological and paediatric endocrinology aspects. *Eur J Endocrinol*. 2006;**155**:S131–S137.
86. de Vries ALC, Steensma TD, Doreleijers TAH, Cohen-Kettenis PT. Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study. *J Sex Med*. 2011;**8**(8):2276–2283.
87. Bouman MB, van Zeijl MCT, Buncamper ME, Meijerink WJHJ, van Bodegraven AA, Mullender MG. Intestinal vaginoplasty revisited: a review of surgical techniques, complications, and sexual function. *J Sex Med*. 2014;**11**(7):1835–1847.
88. Carel JC, Eugster EA, Rogol A, Ghizzoni L, Palmert MR, Antoniazzi F, Berenbaum S, Bourguignon JP, Chrousos GP, Coste J, Deal S, de Vries L, Foster C, Heger S, Holland J, Jahnukainen K, Juul A, Kaplowitz P, Lahlou N, Lee MM, Lee P, Merke DP, Neely EK, Oostdijk W, Phillip M, Rosenfield RL, Shulman D, Styne D, Tauber M, Wit JM; ESPE-LWPES GnRH Analogs Consensus Conference Group. Consensus statement on the use of gonadotropin-releasing hormone analogs in children. *Pediatrics*. 2009;**123**(4):e752–e762.
89. Roth CL, Brendel L, Rückert C, Hartmann K. Antagonistic and agonistic GnRH analogue treatment of precocious puberty: tracking gonadotropin concentrations in urine. *Horm Res*. 2005; **63**(5):257–262.
90. Roth C. Therapeutic potential of GnRH antagonists in the treatment of precocious puberty. *Expert Opin Investig Drugs*. 2002;**11**(9):1253–1259.
91. Tuvemo T. Treatment of central precocious puberty. *Expert Opin Investig Drugs*. 2006;**15**(5):495–505.
92. Schagen SE, Cohen-Kettenis PT, Delemarre-van de Waal HA, Hannema SE. Efficacy and safety of gonadotropin-releasing hormone agonist treatment to suppress puberty in gender dysphoric adolescents. *J Sex Med*. 2016;**13**(7):1125–1132.
93. Manasco PK, Pescovitz OH, Feuillan PP, Hench KD, Barnes KM, Jones J, Hill SC, Loriaux DL, Cutler GB, Jr. Resumption of puberty after long term luteinizing hormone-releasing hormone agonist treatment of central precocious puberty. *J Clin Endocrinol Metab*. 1988;**67**(2):368–372.
94. Klink D, Caris M, Heijboer A, van Trotsenburg M, Rotteveel J. Bone mass in young adulthood following gonadotropin-releasing hormone analog treatment and cross-sex hormone treatment in adolescents with gender dysphoria. *J Clin Endocrinol Metab*. 2015;**100**(2):E270–E275.
95. Finkelstein JS, Klibanski A, Neer RM. A longitudinal evaluation of bone mineral density in adult men with histories of delayed puberty. *J Clin Endocrinol Metab*. 1996;**81**(3):1152–1155.
96. Bertelloni S, Baroncelli GI, Ferdeghini M, Perri G, Saggese G. Normal volumetric bone mineral density and bone turnover in young men with histories of constitutional delay of puberty. *J Clin Endocrinol Metab*. 1998;**83**(12):4280–4283.
97. Darelid A, Ohlsson C, Nilsson M, Kindblom JM, Mellström D, Lorentzon M. Catch up in bone acquisition in young adult men with late normal puberty. *J Bone Miner Res*. 2012;**27**(10): 2198–2207.
98. Mittan D, Lee S, Miller E, Perez RC, Basler JW, Bruder JM. Bone loss following hypogonadism in men with prostate cancer treated with GnRH analogs. *J Clin Endocrinol Metab*. 2002;**87**(8): 3656–3661.
99. Saggese G, Bertelloni S, Baroncelli GI, Battini R, Franchi G. Reduction of bone density: an effect of gonadotropin releasing hormone analogue treatment in central precocious puberty. *Eur J Pediatr*. 1993;**152**(9):717–720.
100. Neely EK, Bachrach LK, Hintz RL, Habiby RL, Slemenda CW, Feezle L, Pescovitz OH. Bone mineral density during treatment of central precocious puberty. *J Pediatr*. 1995;**127**(5):819–822.
101. Bertelloni S, Baroncelli GI, Sorrentino MC, Perri G, Saggese G. Effect of central precocious puberty and gonadotropin-releasing hormone analogue treatment on peak bone mass and final height in females. *Eur J Pediatr*. 1998;**157**(5):363–367.
102. Thornton P, Silverman LA, Geffner ME, Neely EK, Gould E, Danoff TM. Review of outcomes after cessation of gonadotropin-releasing hormone agonist treatment of girls with precocious puberty. *Pediatr Endocrinol Rev*. 2014;**11**(3):306–317.
103. Lem AJ, van der Kaay DC, Hokken-Koelega AC. Bone mineral density and body composition in short children born SGA during growth hormone and gonadotropin releasing hormone analog treatment. *J Clin Endocrinol Metab*. 2013;**98**(1):77–86.
104. Antoniazzi F, Zamboni G, Bertoldo F, Lauriola S, Mengarda F, Pietrobelli A, Tatò L. Bone mass at final height in precocious puberty after gonadotropin-releasing hormone agonist with and without calcium supplementation. *J Clin Endocrinol Metab*. 2003;**88**(3):1096–1101.
105. Calcaterra V, Mannarino S, Corana G, Codazzi AC, Mazzola A, Brambilla P, Larizza D. Hypertension during therapy with triptorelin in a girl with precocious puberty. *Indian J Pediatr*. 2013; **80**(10):884–885.
106. Siomou E, Kosmeri C, Pavlou M, Vlahos AP, Argyropoulou MI, Siamopoulou A. Arterial hypertension during treatment with triptorelin in a child with Williams-Beuren syndrome. *Pediatr Nephrol*. 2014;**29**(9):1633–1636.
107. Staphorsius AS, Kreukels BPC, Cohen-Kettenis PT, Veltman DJ, Burke SM, Schagen SEE, Wouters FM, Delemarre-van de Waal

Downloaded from https://academic.oup.com/jcem/article/102/11/3869/4157558 by guest on 10 March 2022

HA, Bakker J. Puberty suppression and executive functioning: an fMRI-study in adolescents with gender dysphoria. *Psychoneuroendocrinology*. 2015;**56**:190–199.
108. Hough D, Bellingham M, Haraldsen IR, McLaughlin M, Rennie M, Robinson JE, Solbakk AK, Evans NP. Spatial memory is impaired by peripubertal GnRH agonist treatment and testosterone replacement in sheep. *Psychoneuroendocrinology*. 2017; **75**:173–182.
109. Collipp PJ, Kaplan SA, Boyle DC, Plachte F, Kogut MD. Constitutional Isosexual Precocious Puberty. *Am J Dis Child*. 1964; **108**:399–405.
110. Hahn HB, Jr, Hayles AB, Albert A. Medroxyprogesterone and constitutional precocious puberty. *Mayo Clin Proc*. 1964;**39**: 182–190.
111. Kaplan SA, Ling SM, Irani NG. Idiopathic isosexual precocity. *Am J Dis Child*. 1968;**116**(6):591–598.
112. Schoen EJ. Treatment of idiopathic precocious puberty in boys. *J Clin Endocrinol Metab*. 1966;**26**(4):363–370.
113. Gooren L. Hormone treatment of the adult transsexual patient. *Horm Res*. 2005;**64**(Suppl 2):31–36.
114. Moore E, Wisniewski A, Dobs A. Endocrine treatment of transsexual people: a review of treatment regimens, outcomes, and adverse effects. *J Clin Endocrinol Metab*. 2003;**88**(8):3467–3473.
115. Krueger RB, Hembree W, Hill M. Prescription of medroxyprogesterone acetate to a patient with pedophilia, resulting in Cushing's syndrome and adrenal insufficiency. *Sex Abuse*. 2006; **18**(2):227–228.
116. Lynch MM, Khandheria MM, Meyer WJ. Retrospective study of the management of childhood and adolescent gender identity disorder using medroxyprogesterone acetate. *Int J Transgenderism*. 2015;**16**:201–208.
117. Tack LJW, Craen M, Dhondt K, Vanden Bossche H, Laridaen J, Cools M. Consecutive lynestrenol and cross-sex hormone treatment in biological female adolescents with gender dysphoria: a retrospective analysis. *Biol Sex Differ*. 2016;**7**:14.
118. Hembree WC, Cohen-Kettenis P, Delemarre-van de Waal HA, Gooren LJ, Meyer WJ 3rd, Spack NP, Tangpricha V, Montori VM; Endocrine Society. Endocrine treatment of transsexual persons: an Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*. 2009;**94**(9):3132–3154.
119. Mann L, Harmoni R, Power C. Adolescent decision-making: the development of competence. *J Adolesc*. 1989;**12**(3):265–278.
120. Stultiëns L, Goffin T, Borry P, Dierickx K, Nys H. Minors and informed consent: a comparative approach. *Eur J Health Law*. 2007;**14**(1):21–46.
121. Arshagouni P. "But I'm an adult now … sort of". Adolescent consent in health care decision-making and the adolescent brain. Available at: http://digitalcommons.law.umaryland.edu/cgi/viewcontent.cgi?article=1124&context=jhclp. Accessed 25 June 2017.
122. NHS. Prescribing of cross-sex hormones as part of the gender identity development service for children and adolescents. Available at: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/08/clinical-com-pol-16046p.pdf. Accessed 14 June 2017.
123. Ankarberg-Lindgren C, Kriström B, Norjavaara E. Physiological estrogen replacement therapy for puberty induction in girls: a clinical observational study. *Horm Res Paediatr*. 2014;**81**(4): 239–244.
124. Olson J, Schrager SM, Clark LF, Dunlap SL, Belzer M. Subcutaneous testosterone: an effective delivery mechanism for masculinizing young transgender men. *LGBT Health*. 2014;**1**(3): 165–167.
125. Spratt DI, Stewart I, Savage C, Craig W, Spack NP, Chandler DW, Spratt LV, Eimicke T, Olshan JS. Subcutaneous injection of testosterone is an effective and preferred alternative to intramuscular injection: demonstration in female-to-male transgender patients. *J Clin Endocrinol Metab*. 2017. doi:10.1210/jc.2017-00359
126. Eisenegger C, von Eckardstein A, Fehr E, von Eckardstein S. Pharmacokinetics of testosterone and estradiol gel preparations in healthy young men. *Psychoneuroendocrinology*. 2013;**38**(2): 171–178.
127. de Ronde W, ten Kulve J, Woerdeman J, Kaufman J-M, de Jong FH. Effects of oestradiol on gonadotrophin levels in normal and castrated men. *Clin Endocrinol (Oxf)*. 2009;**71**(6):874–879.
128. Money J, Ehrhardt A. Man & woman, boy & girl: differentiation and dimorphism of gender identity from conception to maturity. Baltimore, MD: Johns Hopkins University Press; 1972:202–206.
129. Heylens G, Verroken C, De Cock S, T'Sjoen G, De Cuypere G. Effects of different steps in gender reassignment therapy on psychopathology: a prospective study of persons with a gender identity disorder. *J Sex Med*. 2014;**11**(1):119–126.
130. Costa R, Colizzi M. The effect of cross-sex hormonal treatment on gender dysphoria individuals' mental health: a systematic review. *Neuropsychiatr Dis Treat*. 2016;**12**:1953–1966.
131. Gooren LJG, Giltay EJ. Review of studies of androgen treatment of female-to-male transsexuals: effects and risks of administration of androgens to females. *J Sex Med*. 2008;**5**(4):765–776.
132. Levy A, Crown A, Reid R. Endocrine intervention for transsexuals. *Clin Endocrinol (Oxf)*. 2003;**59**(4):409–418.
133. Tangpricha V, Ducharme SH, Barber TW, Chipkin SR. Endocrinologic treatment of gender identity disorders. *Endocr Pract*. 2003;**9**(1):12–21.
134. Meriggiola MC, Gava G. Endocrine care of transpeople part I. A review of cross-sex hormonal treatments, outcomes and adverse effects in transmen. *Clin Endocrinol (Oxf)*. 2015;**83**(5):597–606.
135. Bhasin S, Cunningham GR, Hayes FJ, Matsumoto AM, Snyder PJ, Swerdloff RS, Montori VM. Testosterone therapy in adult men with androgen deficiency syndromes: an endocrine society clinical practice guideline. *J Clin Endocrinol Metab*. 2006;**91**(6): 1995–2010.
136. Pelusi C, Costantino A, Martelli V, Lambertini M, Bazzocchi A, Ponti F, Battista G, Venturoli S, Meriggiola MC. Effects of three different testosterone formulations in female-to-male transsexual persons. *J Sex Med*. 2014;**11**(12):3002–3011.
137. Anderson GL, Limacher M, Assaf AR, Bassford T, Beresford SA, Black H, Bonds D, Brunner R, Brzyski R, Caan B, Chlebowski R, Curb D, Gass M, Hays J, Heiss G, Hendrix S, Howard BV, Hsia J, Hubbell A, Jackson R, Johnson KC, Judd H, Kotchen JM, Kuller L, LaCroix AZ, Lane D, Langer RD, Lasser N, Lewis CE, Manson J, Margolis K, Ockene J, O'Sullivan MJ, Phillips L, Prentice RL, Ritenbaugh C, Robbins J, Rossouw JE, Sarto G, Stefanick ML, Van Horn L, Wactawski-Wende J, Wallace R, Wassertheil-Smoller S; Women's Health Initiative Steering Committee. Effects of conjugated equine estrogen in postmenopausal women with hysterectomy: the Women's Health Initiative randomized controlled trial. *JAMA*. 2004;**291**(14):1701–1712.
138. Dickersin K, Munro MG, Clark M, Langenberg P, Scherer R, Frick K, Zhu Q, Hallock L, Nichols J, Yalcinkaya TM; Surgical Treatments Outcomes Project for Dysfunctional Uterine Bleeding (STOP-DUB) Research Group. Hysterectomy compared with endometrial ablation for dysfunctional uterine bleeding: a randomized controlled trial. *Obstet Gynecol*. 2007;**110**(6): 1279–1289.
139. Gooren LJ, Giltay EJ, Bunck MC. Long-term treatment of transsexuals with cross-sex hormones: extensive personal experience. *J Clin Endocrinol Metab*. 2008;**93**(1):19–25.
140. Prior JC, Vigna YM, Watson D. Spironolactone with physiological female steroids for presurgical therapy of male-to-female transsexualism. *Arch Sex Behav*. 1989;**18**(1):49–57.
141. Dittrich R, Binder H, Cupisti S, Hoffmann I, Beckmann MW, Mueller A. Endocrine treatment of male-to-female transsexuals using gonadotropin-releasing hormone agonist. *Exp Clin Endocrinol Diabetes*. 2005;**113**(10):586–592.

Downloaded from https://academic.oup.com/jcem/article/102/11/3869/4157558 by guest on 10 March 2022

142. Stripp B, Taylor AA, Bartter FC, Gillette JR, Loriaux DL, Easley R, Menard RH. Effect of spironolactone on sex hormones in man. *J Clin Endocrinol Metab*. 1975;**41**(4):777–781.
143. Levy J, Burshell A, Marbach M, Afllalo L, Glick SM. Interaction of spironolactone with oestradiol receptors in cytosol. *J Endocrinol*. 1980;**84**(3):371–379.
144. Wierckx K, Elaut E, Van Hoorde B, Heylens G, De Cuypere G, Monstrey S, Weyers S, Hoebeke P, T'Sjoen G. Sexual desire in trans persons: associations with sex reassignment treatment. *J Sex Med*. 2014;**11**(1):107–118.
145. Chiriacò G, Cauci S, Mazzon G, Trombetta C. An observational retrospective evaluation of 79 young men with long-term adverse effects after use of finasteride against androgenetic alopecia. *Andrology*. 2016;**4**(2):245–250.
146. Gava G, Cerpolini S, Martelli V, Battista G, Seracchioli R, Meriggiola MC. Cyproterone acetate vs leuprolide acetate in combination with transdermal oestradiol in transwomen: a comparison of safety and effectiveness. *Clin Endocrinol (Oxf)*. 2016; **85**(2):239–246.
147. Casper RF, Yen SS. Rapid absorption of micronized estradiol-17 beta following sublingual administration. *Obstet Gynecol*. 1981; **57**(1):62–64.
148. Price TM, Blauer KL, Hansen M, Stanczyk F, Lobo R, Bates GW. Single-dose pharmacokinetics of sublingual versus oral administration of micronized 17β-estradiol. *Obstet Gynecol*. 1997;**89**(3): 340–345.
149. Toorians AWFT, Thomassen MCLGD, Zweegman S, Magdeleyns EJP, Tans G, Gooren LJG, Rosing J. Venous thrombosis and changes of hemostatic variables during cross-sex hormone treatment in transsexual people. *J Clin Endocrinol Metab*. 2003;**88**(12): 5723–5729.
150. Mepham N, Bouman WP, Arcelus J, Hayter M, Wylie KR. People with gender dysphoria who self-prescribe cross-sex hormones: prevalence, sources, and side effects knowledge. *J Sex Med*. 2014; **11**(12):2995–3001.
151. Richards C, Bouman WP, Seal L, Barker MJ, Nieder TO, T'Sjoen G. Non-binary or genderqueer genders. *Int Rev Psychiatry*. 2016; **28**(1):95–102.
152. Cosyns M, Van Borsel J, Wierckx K, Dedecker D, Van de Peer F, Daelman T, Laenen S, T'Sjoen G. Voice in female-to-male transsexual persons after long-term androgen therapy. *Laryngoscope*. 2014;**124**(6):1409–1414.
153. Deuster D, Matulat P, Knief A, Zitzmann M, Rosslau K, Szukaj M, am Zehnhoff-Dinnesen A, Schmidt CM. Voice deepening under testosterone treatment in female-to-male gender dysphoric individuals. *Eur Arch Otorhinolaryngol*. 2016;**273**(4):959–965.
154. Lapauw B, Taes Y, Simoens S, Van Caenegem E, Weyers S, Goemaere S, Toye K, Kaufman J-M, T'Sjoen GG. Body composition, volumetric and areal bone parameters in male-to-female transsexual persons. *Bone*. 2008;**43**(6):1016–1021.
155. Meyer III WJ, Webb A, Stuart CA, Finkelstein JW, Lawrence B, Walker PA. Physical and hormonal evaluation of transsexual patients: a longitudinal study. *Arch Sex Behav*. 1986;**15**(2): 121–138.
156. Asscheman H, Gooren LJ, Assies J, Smits JP, de Slegte R. Prolactin levels and pituitary enlargement in hormone-treated male-to-female transsexuals. *Clin Endocrinol (Oxf)*. 1988;**28**(6):583–588.
157. Gooren LJ, Harmsen-Louman W, van Kessel H. Follow-up of prolactin levels in long-term oestrogen-treated male-to-female transsexuals with regard to prolactinoma induction. *Clin Endocrinol (Oxf)*. 1985;**22**(2):201–207.
158. Wierckx K, Van Caenegem E, Schreiner T, Haraldsen I, Fisher AD, Toye K, Kaufman JM, T'Sjoen G. Cross-sex hormone therapy in trans persons is safe and effective at short-time follow-up: results from the European network for the investigation of gender incongruence. *J Sex Med*. 2014;**11**(8):1999–2011.
159. Ott J, Kaufmann U, Bentz EK, Huber JC, Tempfer CB. Incidence of thrombophilia and venous thrombosis in transsexuals under cross-sex hormone therapy. *Fertil Steril*. 2010;**93**(4):1267–1272.
160. Giltay EJ, Hoogeveen EK, Elbers JMH, Gooren LJG, Asscheman H, Stehouwer CDA. Effects of sex steroids on plasma total homocysteine levels: a study in transsexual males and females. *J Clin Endocrinol Metab*. 1998;**83**(2):550–553.
161. van Kesteren PJM, Asscheman H, Megens JAJ, Gooren LJG. Mortality and morbidity in transsexual subjects treated with cross-sex hormones. *Clin Endocrinol (Oxf)*. 1997;**47**(3): 337–343.
162. Wierckx K, Gooren L, T'Sjoen G. Clinical review: breast development in trans women receiving cross-sex hormones. *J Sex Med*. 2014;**11**(5):1240–1247.
163. Bird D, Vowles K, Anthony PP. Spontaneous rupture of a liver cell adenoma after long term methyltestosterone: report of a case successfully treated by emergency right hepatic lobectomy. *Br J Surg*. 1979;**66**(3):212–213.
164. Westaby D, Ogle SJ, Paradinas FJ, Randell JB, Murray-Lyon IM. Liver damage from long-term methyltestosterone. *Lancet*. 1977; **2**(8032):262–263.
165. Weinand JD, Safer JD. Hormone therapy in transgender adults is safe with provider supervision; a review of hormone therapy sequelae for transgender individuals. *J Clin Transl Endocrinol*. 2015;**2**(2):55–60.
166. Roberts TK, Kraft CS, French D, Ji W, Wu AH, Tangpricha V, Fantz CR. Interpreting laboratory results in transgender patients on hormone therapy. *Am J Med*. 2014;**127**(2):159–162.
167. Vesper HW, Botelho JC, Wang Y. Challenges and improvements in testosterone and estradiol testing. *Asian J Androl*. 2014;**16**(2): 178–184.
168. Asscheman H, T'Sjoen G, Lemaire A, Mas M, Meriggiola MC, Mueller A, Kuhn A, Dhejne C, Morel-Journel N, Gooren LJ. Venous thrombo-embolism as a complication of cross-sex hormone treatment of male-to-female transsexual subjects: a review. *Andrologia*. 2014;**46**(7):791–795.
169. Righini M, Perrier A, De Moerloose P, Bounameaux H. D-dimer for venous thromboembolism diagnosis: 20 years later. *J Thromb Haemost*. 2008;**6**(7):1059–1071.
170. Gooren LJ, Assies J, Asscheman H, de Slegte R, van Kessel H. Estrogen-induced prolactinoma in a man. *J Clin Endocrinol Metab*. 1988;**66**(2):444–446.
171. Kovacs K, Stefaneanu L, Ezzat S, Smyth HS. Prolactin-producing pituitary adenoma in a male-to-female transsexual patient with protracted estrogen administration. A morphologic study. *Arch Pathol Lab Med*. 1994;**118**(5):562–565.
172. Serri O, Noiseux D, Robert F, Hardy J. Lactotroph hyperplasia in an estrogen treated male-to-female transsexual patient. *J Clin Endocrinol Metab*. 1996;**81**(9):3177–3179.
173. Cunha FS, Domenice S, Câmara VL, Sircili MH, Gooren LJ, Mendonça BB, Costa EM. Diagnosis of prolactinoma in two male-to-female transsexual subjects following high-dose cross-sex hormone therapy. *Andrologia*. 2015;**47**(6):680–684.
174. Nota NM, Dekker MJHJ, Klaver M, Wiepjes CM, van Trotsenburg MA, Heijboer AC, den Heijer M. Prolactin levels during short- and long-term cross-sex hormone treatment: an observational study in transgender persons. *Andrologia*. 2017;**49**(6).
175. Bunck MC, Debono M, Giltay EJ, Verheijen AT, Diamant M, Gooren LJ. Autonomous prolactin secretion in two male-to-female transgender patients using conventional oestrogen dosages. *BMJ Case Rep*. 2009;**2009**:bcr0220091589.
176. Elamin MB, Garcia MZ, Murad MH, Erwin PJ, Montori VM. Effect of sex steroid use on cardiovascular risk in transsexual individuals: a systematic review and meta-analyses. *Clin Endocrinol (Oxf)*. 2010;**72**(1):1–10.
177. Berra M, Armillotta F, D'Emidio L, Costantino A, Martorana G, Pelusi G, Meriggiola MC. Testosterone decreases adiponectin

Downloaded from https://academic.oup.com/jcem/article/102/11/3869/4157558 by guest on 10 March 2022

levels in female to male transsexuals. *Asian J Androl*. 2006;**8**(6): 725–729.
178. Elbers JMH, Giltay EJ, Teerlink T, Scheffer PG, Asscheman H, Seidell JC, Gooren LJG. Effects of sex steroids on components of the insulin resistance syndrome in transsexual subjects. *Clin Endocrinol (Oxf)*. 2003;**58**(5):562–571.
179. Giltay EJ, Lambert J, Gooren LJG, Elbers JMH, Steyn M, Stehouwer CDA. Sex steroids, insulin, and arterial stiffness in women and men. *Hypertension*. 1999;**34**(4 Pt 1):590–597.
180. Polderman KH, Gooren LJ, Asscheman H, Bakker A, Heine RJ. Induction of insulin resistance by androgens and estrogens. *J Clin Endocrinol Metab*. 1994;**79**(1):265–271.
181. Maraka S. Effect of sex steroids on lipids, venous thromboembolism, cardiovascular disease and mortality in transgender individuals: a systematic review and meta-analysis. Available at: http://press.endocrine.org/doi/abs/10.1210/endo-meetings.2016.RE.15.FRI-136. Accessed 3 July 2017.
182. Meriggiola MC, Armillotta F, Costantino A, Altieri P, Saad F, Kalhorn T, Perrone AM, Ghi T, Pelusi C, Pelusi G. Effects of testosterone undecanoate administered alone or in combination with letrozole or dutasteride in female to male transsexuals. *J Sex Med*. 2008;**5**(10):2442–2453.
183. Giltay EJ, Toorians AW, Sarabdjitsingh AR, de Vries NA, Gooren LJ. Established risk factors for coronary heart disease are unrelated to androgen-induced baldness in female-to-male transsexuals. *J Endocrinol*. 2004;**180**(1):107–112.
184. Giltay EJ, Verhoef P, Gooren LJG, Geleijnse JM, Schouten EG, Stehouwer CDA. Oral and transdermal estrogens both lower plasma total homocysteine in male-to-female transsexuals. *Atherosclerosis*. 2003;**168**(1):139–146.
185. Calof OM, Singh AB, Lee ML, Kenny AM, Urban RJ, Tenover JL, Bhasin S. Adverse events associated with testosterone replacement in middle-aged and older men: a meta-analysis of randomized, placebo-controlled trials. *J Gerontol A Biol Sci Med Sci*. 2005; **60**(11):1451–1457.
186. Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults. Executive summary of the Third Report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III). *JAMA*. 2001;**285**(19):2486–2497.
187. Murad MH, Elamin MB, Garcia MZ, Mullan RJ, Murad A, Erwin PJ, Montori VM. Hormonal therapy and sex reassignment: a systematic review and meta-analysis of quality of life and psychosocial outcomes. *Clin Endocrinol (Oxf)*. 2010;**72**(2): 214–231.
188. Van Caenegem E, Wierckx K, Taes Y, Schreiner T, Vandewalle S, Toye K, Lapauw B, Kaufman JM, T'Sjoen G. Body composition, bone turnover, and bone mass in trans men during testosterone treatment: 1-year follow-up data from a prospective case-controlled study (ENIGI). *Eur J Endocrinol*. 2015;**172**(2): 163–171.
189. Turner A, Chen TC, Barber TW, Malabanan AO, Holick MF, Tangpricha V. Testosterone increases bone mineral density in female-to-male transsexuals: a case series of 15 subjects. *Clin Endocrinol (Oxf)*. 2004;**61**(5):560–566.
190. van Kesteren P, Lips P, Gooren LJG, Asscheman H, Megens J. Long-term follow-up of bone mineral density and bone metabolism in transsexuals treated with cross-sex hormones. *Clin Endocrinol (Oxf)*. 1998;**48**(3):347–354.
191. Van Caenegem E, Taes Y, Wierckx K, Vandewalle S, Toye K, Kaufman JM, Schreiner T, Haraldsen I, T'Sjoen G. Low bone mass is prevalent in male-to-female transsexual persons before the start of cross-sex hormonal therapy and gonadectomy. *Bone*. 2013;**54**(1):92–97.
192. Amin S, Zhang Y, Sawin CT, Evans SR, Hannan MT, Kiel DP, Wilson PW, Felson DT. Association of hypogonadism and estradiol levels with bone mineral density in elderly men from the Framingham study. *Ann Intern Med*. 2000;**133**(12):951–963.
193. Gennari L, Khosla S, Bilezikian JP. Estrogen and fracture risk in men. *J Bone Miner Res*. 2008;**23**(10):1548–1551.
194. Khosla S, Melton LJ III, Atkinson EJ, O'Fallon WM, Klee GG, Riggs BL. Relationship of serum sex steroid levels and bone turnover markers with bone mineral density in men and women: a key role for bioavailable estrogen. *J Clin Endocrinol Metab*. 1998;**83**(7):2266–2274.
195. Mueller A, Dittrich R, Binder H, Kuehnel W, Maltaris T, Hoffmann I, Beckmann MW. High dose estrogen treatment increases bone mineral density in male-to-female transsexuals receiving gonadotropin-releasing hormone agonist in the absence of testosterone. *Eur J Endocrinol*. 2005;**153**(1):107–113.
196. Ruetsche AG, Kneubuehl R, Birkhaeuser MH, Lippuner K. Cortical and trabecular bone mineral density in transsexuals after long-term cross-sex hormonal treatment: a cross-sectional study. *Osteoporos Int*. 2005;**16**(7):791–798.
197. Ganly I, Taylor EW. Breast cancer in a trans-sexual man receiving hormone replacement therapy. *Br J Surg*. 1995;**82**(3):341.
198. Pritchard TJ, Pankowsky DA, Crowe JP, Abdul-Karim FW. Breast cancer in a male-to-female transsexual. A case report. *JAMA*. 1988;**259**(15):2278–2280.
199. Symmers WS. Carcinoma of breast in trans-sexual individuals after surgical and hormonal interference with the primary and secondary sex characteristics. *BMJ*. 1968;**2**(5597):83–85.
200. Brown GR. Breast cancer in transgender veterans: a ten-case series. *LGBT Health*. 2015;**2**(1):77–80.
201. Shao T, Grossbard ML, Klein P. Breast cancer in female-to-male transsexuals: two cases with a review of physiology and management. *Clin Breast Cancer*. 2011;**11**(6):417–419.
202. Nikolic DV, Djordjevic ML, Granic M, Nikolic AT, Stanimirovic VV, Zdravkovic D, Jelic S. Importance of revealing a rare case of breast cancer in a female to male transsexual after bilateral mastectomy. *World J Surg Oncol*. 2012;**10**:280.
203. Bösze P, Tóth A, Török M. Hormone replacement and the risk of breast cancer in Turner's syndrome. *N Engl J Med*. 2006;**355**(24): 2599–2600.
204. Schoemaker MJ, Swerdlow AJ, Higgins CD, Wright AF, Jacobs PA; UK Clinical Cytogenetics Group. Cancer incidence in women with Turner syndrome in Great Britain: a national cohort study. *Lancet Oncol*. 2008;**9**(3):239–246.
205. Smith RA, Cokkinides V, Eyre HJ. American Cancer Society guidelines for the early detection of cancer, 2006. *CA Cancer J Clin*. 2006;**56**(1):11–25, quiz 49–50.
206. Wilson JD, Roehrborn C. Long-term consequences of castration in men: lessons from the Skoptzy and the eunuchs of the Chinese and Ottoman courts. *J Clin Endocrinol Metab*. 1999;**84**(12): 4324–4331.
207. van Kesteren P, Meinhardt W, van der Valk P, Geldof A, Megens J, Gooren L. Effects of estrogens only on the prostates of aging men. *J Urol*. 1996;**156**(4):1349–1353.
208. Brown JA, Wilson TM. Benign prostatic hyperplasia requiring transurethral resection of the prostate in a 60-year-old male-to-female transsexual. *Br J Urol*. 1997;**80**(6):956–957.
209. Casella R, Bubendorf L, Schaefer DJ, Bachmann A, Gasser TC, Sulser T. Does the prostate really need androgens to grow? Transurethral resection of the prostate in a male-to-female transsexual 25 years after sex-changing operation. *Urol Int*. 2005;**75**(3):288–290.
210. Dorff TB, Shazer RL, Nepomuceno EM, Tucker SJ. Successful treatment of metastatic androgen-independent prostate carcinoma in a transsexual patient. *Clin Genitourin Cancer*. 2007;**5**(5): 344–346.
211. Thurston AV. Carcinoma of the prostate in a transsexual. *Br J Urol*. 1994;**73**(2):217.

Downloaded from https://academic.oup.com/jcem/article/102/11/3869/4157558 by guest on 10 March 2022

212. van Harst EP, Newling DW, Gooren LJ, Asscheman H, Prenger DM. Metastatic prostatic carcinoma in a male-to-female transsexual. *BJU Int*. 1998;**81**:776.
213. Turo R, Jallad S, Prescott S, Cross WR. Metastatic prostate cancer in transsexual diagnosed after three decades of estrogen therapy. *Can Urol Assoc J*. 2013;**7**(7–8):E544–E546.
214. Miksad RA, Bubley G, Church P, Sanda M, Rofsky N, Kaplan I, Cooper A. Prostate cancer in a transgender woman 41 years after initiation of feminization. *JAMA*. 2006;**296**(19):2316–2317.
215. Moyer VA; U.S. Preventive Services Task Force. Screening for prostate cancer: U.S. Preventive Services Task Force recommendation statement. *Ann Intern Med*. 2012;**157**(2):120–134.
216. Futterweit W. Endocrine therapy of transsexualism and potential complications of long-term treatment. *Arch Sex Behav*. 1998; **27**(2):209–226.
217. Miller N, Bédard YC, Cooter NB, Shaul DL. Histological changes in the genital tract in transsexual women following androgen therapy. *Histopathology*. 1986;**10**(7):661–669.
218. O'Hanlan KA, Dibble SL, Young-Spint M. Total laparoscopic hysterectomy for female-to-male transsexuals. *Obstet Gynecol*. 2007;**110**(5):1096–1101.
219. Dizon DS, Tejada-Berges T, Koelliker S, Steinhoff M, Granai CO. Ovarian cancer associated with testosterone supplementation in a female-to-male transsexual patient. *Gynecol Obstet Invest*. 2006; **62**(4):226–228.
220. Hage JJ, Dekker JJML, Karim RB, Verheijen RHM, Bloemena E. Ovarian cancer in female-to-male transsexuals: report of two cases. *Gynecol Oncol*. 2000;**76**(3):413–415.
221. Mueller A, Gooren L. Hormone-related tumors in transsexuals receiving treatment with cross-sex hormones. *Eur J Endocrinol*. 2008;**159**(3):197–202.
222. Coleman E, Bockting W, Botzer M, Cohen-Kettenis P, DeCuypere G, Feldman J, Fraser L, Green J, Knudson G, Meyer WJ, Monstrey S, Adler RK, Brown GR, Devor AH, Ehrbar R, Ettner R, Eyler E, Garofalo R, Karasic DH, Lev AI, Mayer G, Meyer-Bahlburg H, Hall BP, Pfaefflin F, Rachlin K, Robinson B, Schechter LS, Tangpricha V, van Trotsenburg M, Vitale A, Winter S, Whittle S, Wylie KR, Zucker K. Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7. *Int J Transgenderism*. 2012;**13**:165–232.
223. Colebunders B, D'Arpa S, Weijers S, Lumen N, Hoebeke P, Monstrey S. Female-to-male gender reassignment surgery. In: Ettner R, Monstrey S, Coleman E, eds. *Principles of Transgender Medicine and Surgery*. 2nd ed. New York, NY: Routledge Taylor & Francis Group; 2016:279–317.
224. Monstrey S, Hoebeke P, Dhont M, De Cuypere G, Rubens R, Moerman M, Hamdi M, Van Landuyt K, Blondeel P. Surgical therapy in transsexual patients: a multi-disciplinary approach. *Acta Chir Belg*. 2001;**101**(5):200–209.
225. Selvaggi G, Ceulemans P, De Cuypere G, VanLanduyt K, Blondeel P, Hamdi M, Bowman C, Monstrey S. Gender identity disorder: general overview and surgical treatment for vaginoplasty in male-to-female transsexuals. *Plast Reconstr Surg*. 2005;**116**(6): 135e–145e.
226. Tugnet N, Goddard JC, Vickery RM, Khoosal D, Terry TR. Current management of male-to-female gender identity disorder in the UK. *Postgrad Med J*. 2007;**83**(984):638–642.
227. Horbach SER, Bouman M-B, Smit JM, Özer M, Buncamper ME, Mullender MG. Outcome of vaginoplasty in male-to-female transgenders: a systematic review of surgical techniques. *J Sex Med*. 2015;**12**(6):1499–1512.
228. Wroblewski P, Gustafsson J, Selvaggi G. Sex reassignment surgery for transsexuals. *Curr Opin Endocrinol Diabetes Obes*. 2013; **20**(6):570–574.
229. Morrison SD, Satterwhite T, Grant DW, Kirby J, Laub DR, Sr, VanMaasdam J. Long-term outcomes of rectosigmoid neocolporrhaphy in male-to-female gender reassignment surgery. *Plast Reconstr Surg*. 2015;**136**(2):386–394.
230. Dessy LA, Mazzocchi M, Corrias F, Ceccarelli S, Marchese C, Scuderi N. The use of cultured autologous oral epithelial cells for vaginoplasty in male-to-female transsexuals: a feasibility, safety, and advantageousness clinical pilot study. *Plast Reconstr Surg*. 2014;**133**(1):158–161.
231. Li FY, Xu YS, Zhou CD, Zhou Y, Li SK, Li Q. Long-term outcomes of vaginoplasty with autologous buccal micromucosa. *Obstet Gynecol*. 2014;**123**(5):951–956.
232. Kanhai RC. Sensate vagina pedicled-spot for male-to-female transsexuals: the experience in the first 50 patients. *Aesthetic Plast Surg*. 2016;**40**(2):284–287.
233. Straayer C. Transplants for transsexuals? Ambitions, concerns, ideology. Paper presented at: Trans*Studies: An International Transdisciplinary Conference on Gender, Embodiment, and Sexuality; 7–10 September 2016; University of Arizona, Tucson, AZ.
234. Bucci S, Mazzon G, Liguori G, Napoli R, Pavan N, Bormioli S, Ollandini G, De Concilio B, Trombetta C. Neovaginal prolapse in male-to-female transsexuals: an 18-year-long experience. *Biomed Res Int*. 2014;**2014**:240761.
235. Raigosa M, Avvedimento S, Yoon TS, Cruz-Gimeno J, Rodriguez G, Fontdevila J. Male-to-female genital reassignment surgery: a retrospective review of surgical technique and complications in 60 patients. *J Sex Med*. 2015;**12**(8):1837–1845.
236. Green R. Sexual functioning in post-operative transsexuals: male-to-female and female-to-male. *Int J Impot Res*. 1998;**10**(Suppl 1): S22–S24.
237. Hess J, Rossi Neto R, Panic L, Rübben H, Senf W. Satisfaction with male-to-female gender reassignment surgery. *Dtsch Arztebl Int*. 2014;**111**(47):795–801.
238. Nygren U, Nordenskjold A, Arver S, Sodersten M. Effects on voice fundamental frequency and satisfaction with voice in trans men during testosterone treatment—a longitudinal study. *J Voice*. 2016;**30**(6):766.e23-766.e34.
239. Becking AG, Tuinzing DB, Hage JJ, Gooren LJG. Transgender feminization of the facial skeleton. *Clin Plast Surg*. 2007;**34**(3): 557–564.
240. Giraldo F, Esteva I, Bergero T, Cano G, González C, Salinas P, Rivada E, Lara JS, Soriguer F; Andalusia Gender Team. Corona glans clitoroplasty and urethropreputial vestibuloplasty in male-to-female transsexuals: the vulval aesthetic refinement by the Andalusia Gender Team. *Plast Reconstr Surg*. 2004;**114**(6): 1543–1550.
241. Goddard JC, Vickery RM, Terry TR. Development of feminizing genitoplasty for gender dysphoria. *J Sex Med*. 2007;**4**(4 Pt 1): 981–989.
242. Hage JJ, de Graaf FH, Bouman FG, Bloem JJAM. Sculpturing the glans in phalloplasty. *Plast Reconstr Surg*. 1993;**92**(1):157–161, discussion 162.
243. Thiagaraj D, Gunasegaram R, Loganath A, Peh KL, Kottegoda SR, Ratnam SS. Histopathology of the testes from male transsexuals on oestrogen therapy. *Ann Acad Med Singapore*. 1987; **16**(2):347–348.
244. Monstrey SJ, Ceulemans P, Hoebeke P. Sex reassignment surgery in the female-to-male transsexual. *Semin Plast Surg*. 2011;**25**(3): 229–244.
245. Perovic SV, Djinovic R, Bumbasirevic M, Djordjevic M, Vukovic P. Total phalloplasty using a musculocutaneous latissimus dorsi flap. *BJU Int*. 2007;**100**(4):899–905, discussion 905.
246. Vesely J, Hyza P, Ranno R, Cigna E, Monni N, Stupka I, Justan I, Dvorak Z, Novak P, Ranno S. New technique of total phalloplasty with reinnervated latissimus dorsi myocutaneous free flap in female-to-male transsexuals. *Ann Plast Surg*. 2007;**58**(5): 544–550.
247. Ranno R, Veselý J, Hýza P, Stupka I, Justan I, Dvorák Z, Monni N, Novák P, Ranno S. Neo-phalloplasty with re-innervated latissimus dorsi free flap: a functional study of a novel technique. *Acta Chir Plast*. 2007;**49**(1):3–7.

Downloaded from https://academic.oup.com/jcem/article/102/11/3869/4157558 by guest on 10 March 2022

248. Garcia MM, Christopher NA, De Luca F, Spilotros M, Ralph DJ. Overall satisfaction, sexual function, and the durability of neophallus dimensions following staged female to male genital gender confirming surgery: the Institute of Urology, London U.K. experience. *Transl Androl Urol*. 2014;**3**(2):156–162.
249. Chen H-C, Gedebou TM, Yazar S, Tang Y-B. Prefabrication of the free fibula osteocutaneous flap to create a functional human penis using a controlled fistula method. *J Reconstr Microsurg*. 2007;**23**(3):151–154.
250. Hoebeke PB, Decaestecker K, Beysens M, Opdenakker Y, Lumen N, Monstrey SM. Erectile implants in female-to-male transsexuals: our experience in 129 patients. *Eur Urol*. 2010;**57**(2):334–341.
251. Hage JJ. Metaidoioplasty: an alternative phalloplasty technique in transsexuals. *Plast Reconstr Surg*. 1996;**97**(1):161–167.
252. Cohanzad S. Extensive metoidioplasty as a technique capable of creating a compatible analogue to a natural penis in female transsexuals. *Aesthetic Plast Surg*. 2016;**40**(1):130–138.
253. Selvaggi G, Hoebeke P, Ceulemans P, Hamdi M, Van Landuyt K, Blondeel P, De Cuypere G, Monstrey S. Scrotal reconstruction in female-to-male transsexuals: a novel scrotoplasty. *Plast Reconstr Surg*. 2009;**123**(6):1710–1718.
254. Bjerrome Ahlin H, Kölby L, Elander A, Selvaggi G. Improved results after implementation of the Ghent algorithm for subcutaneous mastectomy in female-to-male transsexuals. *J Plast Surg Hand Surg*. 2014;**48**(6):362–367.
255. Wolter A, Diedrichson J, Scholz T, Arens-Landwehr A, Liebau J. Sexual reassignment surgery in female-to-male transsexuals: an algorithm for subcutaneous mastectomy. *J Plast Reconstr Aesthet Surg*. 2015;**68**(2):184–191.
256. Richards C, Barrett J. The case for bilateral mastectomy and male chest contouring for the female-to-male transsexual. *Ann R Coll Surg Engl*. 2013;**95**(2):93–95.
257. Sutcliffe PA, Dixon S, Akehurst RL, Wilkinson A, Shippam A, White S, Richards R, Caddy CM. Evaluation of surgical procedures for sex reassignment: a systematic review. *J Plast Reconstr Aesthet Surg*. 2009;**62**(3):294–306, discussion 306–308.
258. Selvaggi G, Elander A. Penile reconstruction/formation. *Curr Opin Urol*. 2008;**18**(6):589–597.
259. Dhejne C, Lichtenstein P, Boman M, Johansson ALV, Långström N, Landén M. Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden. *PLoS One*. 2011;**6**(2):e16885.
260. Kuhn A, Bodmer C, Stadlmayr W, Kuhn P, Mueller MD, Birkhäuser M. Quality of life 15 years after sex reassignment surgery for transsexualism. *Fertil Steril*. 2009;**92**(5):1685–1689.e3.
261. Papadopulos NA, Lellé JD, Zavlin D, Herschbach P, Henrich G, Kovacs L, Ehrenberger B, Kluger AK, Machens HG, Schaff J. Quality of life and patient satisfaction following male-to-female sex reassignment surgery. *J Sex Med*. 2017;**14**(5):721–730.
262. Simonsen RK, Hald GM, Kristensen E, Giraldi A. Long-term follow-up of individuals undergoing sex-reassignment surgery: somatic morbidity and cause of death. *Sex Med*. 2016;**4**(1):e60–e68.
263. Djordjevic ML, Bizic MR, Duisin D, Bouman MB, Buncamper M. Reversal Surgery in regretful male-to-female transsexuals after sex reassignment surgery. *J Sex Med*. 2016;**13**(6):1000–1007.
264. Liberopoulos EN, Florentin M, Mikhailidis DP, Elisaf MS. Compliance with lipid-lowering therapy and its impact on cardiovascular morbidity and mortality. *Expert Opin Drug Saf*. 2008;**7**(6):717–725.
265. Forbes SS, Stephen WJ, Harper WL, Loeb M, Smith R, Christoffersen EP, McLean RF. Implementation of evidence-based practices for surgical site infection prophylaxis: results of a pre- and postintervention study. *J Am Coll Surg*. 2008;**207**(3):336–341.
266. Davis PJ, Spady D, de Gara C, Forgie SE. Practices and attitudes of surgeons toward the prevention of surgical site infections: a provincial survey in Alberta, Canada. *Infect Control Hosp Epidemiol*. 2008;**29**(12):1164–1166.

Downloaded from https://academic.oup.com/jcem/article/102/11/3869/4157558 by guest on 10 March 2022

Agenda for Leadership Meeting 2.24.2022

1. Random Moment Time Studies
   A. Meet our RMTS Coordinator for the Region, Monica Perez
   B. RMTS Communication Expectations- we must respond to Monica when she is reaching out. The worker will be the first contact and then she will within a few hours be following up with the supervisor and then a few hours with the PD and up the chain. Every RMTS that we complete is equivalent to $40k for our agency.
2. Specific Cases
   A. When you get a case that involves the specific allegation we talked about you need to immediately send an email to your PD, your PA, Lisa Guyton, and Gabina DeHoyoz for tracking and to possibly schedule a staffing. We want to be involved to help guide staff and provide assistance as we know these can be difficult.
   B. Any communication you have regarding these cases needs to be done in a Teams meeting, telephone call, or face to face. Do not send text messages or emails in regards to these specific cases.
   C. Our General Counsel for the agency is going to be working on disposition guidelines. We will be working closely with her in the beginning on dispositioning these specific cases.
   D. PA meeting discussion- specific workers? Worker V?
3. Worker V
   A. The audit has been approved and I am hopeful our Worker V position will be posted in the next week. If you have ideas how we can utilize this position in our region please let your PD and PA know.
4. Master Investigator Assistance
   A. Good News in April we will be getting 30 MI's deployed to our region to assist us in case resolution.
   B. They will be paired one on one with our high workloads.
   C. They will be in our region for approximately 3 months.
   D. PD's, PA's and I will meet weekly to discuss progress being made.
   E. Weekly meetings will start in March for planning.
   F. This is a great opportunity for us to really get our region back in a good place. We need to really take full advantage of it.

PLX 17

WPATH WORLD PROFESSIONAL ASSOCIATION for TRANSGENDER HEALTH

www.wpath.org

Standards of Care

for the Health of Transsexual, Transgender, and Gender-Nonconforming People

The World Professional Association for Transgender Health

EXHIBIT
DEFENDANTS 1
exhibitsticker.com

Version 7

WPATH WORLD PROFESSIONAL ASSOCIATION for TRANSGENDER HEALTH

Standards of Care

for the Health of Transsexual, Transgender, and Gender-Nonconforming People

Eli Coleman, Walter Bockting, Marsha Botzer, Peggy Cohen-Kettenis, Griet DeCuypere, Jamie Feldman, Lin Fraser, Jamison Green, Gail Knudson, Walter J. Meyer, Stan Monstrey, Richard K. Adler, George R. Brown, Aaron H. Devor, Randall Ehrbar, Randi Ettner, Evan Eyler, Rob Garofalo, Dan H. Karasic, Arlene Istar Lev, Gal Mayer, Heino Meyer-Bahlburg, Blaine Paxton Hall, Friedmann Pfäfflin, Katherine Rachlin, Bean Robinson, Loren S. Schechter, Vin Tangpricha, Mick van Trotsenburg, Anne Vitale, Sam Winter, Stephen Whittle, Kevan R. Wylie & Ken Zucker

© 2012 World Professional Association for Transgender Health (WPATH). All rights reserved.

7th Version[1] | www.wpath.org

ISBN: X-XXX-XXXXX-XX

1 This is the seventh version of the *Standards of Care* since the original 1979 document. Previous revisions were in 1980, 1981, 1990, 1998, and 2001. Version seven was published in the International Journal of Transgenderism, 13(4), 165–232. doi:10.1080/15532739.2011.700873

Table of Contents

I. Purpose and Use of the *Standards of Care* 1
II. Global Applicability of the *Standards of Care* 3
III. The Difference Between Gender Nonconformity and Gender Dysphoria 4
IV. Epidemiologic Considerations 6
V. Overview of Therapeutic Approaches for Gender Dysphoria 8
VI. Assessment and Treatment of Children and Adolescents with Gender Dysphoria 10
VII. Mental Health 21
VIII. Hormone Therapy 33
IX. Reproductive Health 50
X. Voice and Communication Therapy 52
XI. Surgery 54
XII. Postoperative Care and Follow-Up 64
XIII. Lifelong Preventive and Primary Care 65
XIV. Applicability of the *Standards of Care* to People Living in Institutional Environments . . . 67
XV. Applicability of the *Standards of Care* to People with Disorders of Sex Development 69

References 72

Appendices

A. Glossary 95
B. Overview of Medical Risks of Hormone Therapy 97
C. Summary of Criteria for Hormone Therapy and Surgeries 104
D. Evidence for Clinical Outcomes of Therapeutic Approaches 107
E. Development Process for the *Standards of Care, Version 7* 109

Purpose and Use of the *Standards of Care*

The World Professional Association for Transgender Health (WPATH)[I] is an international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect in transsexual and transgender health. The vision of WPATH is a world wherein transsexual, transgender, and gender-nonconforming people benefit from access to evidence-based health care, social services, justice, and equality.

One of the main functions of WPATH is to promote the highest standards of health care for individuals through the articulation of *Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People*. The *SOC* are based on the best available science and expert professional consensus.[II] Most of the research and experience in this field comes from a North American and Western European perspective; thus, adaptations of the *SOC* to other parts of the world are necessary. Suggestions for ways of thinking about cultural relativity and cultural competence are included in this version of the *SOC*.

The overall goal of the *SOC* is to provide clinical guidance for health professionals to assist transsexual, transgender, and gender-nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfillment. This assistance may include primary care, gynecologic and urologic care, reproductive options, voice and communication therapy, mental health services (e.g., assessment, counseling, psychotherapy), and hormonal and surgical treatments. While this is primarily a document for health professionals, the *SOC* may also be used by individuals, their families, and social institutions to understand how they can assist with promoting optimal health for members of this diverse population.

WPATH recognizes that health is dependent upon not only good clinical care but also social and political climates that provide and ensure social tolerance, equality, and the full rights of citizenship. Health is promoted through public policies and legal reforms that promote tolerance and equity

I Formerly the Harry Benjamin International Gender Dysphoria Association

II The *Standards of Care (SOC), Version 7,* represents a significant departure from previous versions. Changes in this version are based upon significant cultural shifts, advances in clinical knowledge, and appreciation of the many health care issues that can arise for transsexual, transgender, and gender-nonconforming people beyond hormone therapy and surgery (Coleman, 2009a, b, c, d).

for gender and sexual diversity and that eliminate prejudice, discrimination, and stigma. WPATH is committed to advocacy for these changes in public policies and legal reforms.

The *Standards of Care* Are Flexible Clinical Guidelines

The *SOC* are intended to be flexible in order to meet the diverse health care needs of transsexual, transgender, and gender-nonconforming people. While flexible, they offer standards for promoting optimal health care and guiding the treatment of people experiencing gender dysphoria—broadly defined as discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b).

As in all previous versions of the *SOC*, the criteria put forth in this document for hormone therapy and surgical treatments for gender dysphoria are clinical guidelines; individual health professionals and programs may modify them. Clinical departures from the *SOC* may come about because of a patient's unique anatomic, social, or psychological situation; an experienced health professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm-reduction strategies. These departures should be recognized as such, explained to the patient, and documented through informed consent for quality patient care and legal protection. This documentation is also valuable for the accumulation of new data, which can be retrospectively examined to allow for health care—and the *SOC*—to evolve.

The *SOC* articulate standards of care but also acknowledge the role of making informed choices and the value of harm-reduction approaches. In addition, this version of the *SOC* recognizes and validates various expressions of gender that may not necessitate psychological, hormonal, or surgical treatments. Some patients who present for care will have made significant self-directed progress towards gender role changes, transition, or other resolutions regarding their gender identity or gender dysphoria. Other patients will require more intensive services. Health professionals can use the *SOC* to help patients consider the full range of health services open to them, in accordance with their clinical needs and goals for gender expression.

Global Applicability of the *Standards of Care*

While the *SOC* are intended for worldwide use, WPATH acknowledges that much of the recorded clinical experience and knowledge in this area of health care is derived from North American and Western European sources. From place to place, both across and within nations, there are differences in all of the following: social attitudes towards transsexual, transgender, and gender-nonconforming people; constructions of gender roles and identities; language used to describe different gender identities; epidemiology of gender dysphoria; access to and cost of treatment; therapies offered; number and type of professionals who provide care; and legal and policy issues related to this area of health care (Winter, 2009).

It is impossible for the *SOC* to reflect all of these differences. In applying these standards to other cultural contexts, health professionals must be sensitive to these differences and adapt the *SOC* according to local realities. For example, in a number of cultures, gender-nonconforming people are found in such numbers and living in such ways as to make them highly socially visible (Peletz, 2006). In settings such as these, it is common for people to initiate a change in their gender expression and physical characteristics while in their teens or even earlier. Many grow up and live in a social, cultural, and even linguistic context quite unlike that of Western cultures. Yet almost all experience prejudice (Peletz, 2006; Winter, 2009). In many cultures, social stigma towards gender nonconformity is widespread and gender roles are highly prescriptive (Winter et al., 2009). Gender-nonconforming people in these settings are forced to be hidden and, therefore, may lack opportunities for adequate health care (Winter, 2009).

The *SOC* are not intended to limit efforts to provide the best available care to all individuals. Health professionals throughout the world—even in areas with limited resources and training opportunities—can apply the many core principles that undergird the *SOC*. These principles include the following: Exhibit respect for patients with nonconforming gender identities (do not pathologize differences in gender identity or expression); provide care (or refer to knowledgeable colleagues) that affirms patients' gender identities and reduces the distress of gender dysphoria, when present; become knowledgeable about the health care needs of transsexual, transgender, and gender-nonconforming people, including the benefits and risks of treatment options for gender dysphoria; match the treatment approach to the specific needs of patients, particularly their goals for gender expression and need for relief from gender dysphoria; facilitate access to appropriate care; seek patients' informed consent before providing treatment; offer continuity of care; and be prepared to support and advocate for patients within their families and communities (schools, workplaces, and other settings).

Terminology is culture- and time-dependent and is rapidly evolving. It is important to use respectful language in different places and times, and among different people. As the *SOC* are translated into other languages, great care must be taken to ensure that the meanings of terms are accurately translated. Terminology in English may not be easily translated into other languages, and vice versa. Some languages do not have equivalent words to describe the various terms within this document; hence, translators should be cognizant of the underlying goals of treatment and articulate culturally applicable guidance for reaching those goals.

III

The Difference Between Gender Nonconformity and Gender Dysphoria

Being Transsexual, Transgender, or Gender-Nonconforming Is a Matter of Diversity, Not Pathology

WPATH released a statement in May 2010 urging the de-psychopathologization of gender nonconformity worldwide (WPATH Board of Directors, 2010). This statement noted that "the expression of gender characteristics, including identities, that are not stereotypically associated with one's assigned sex at birth is a common and culturally diverse human phenomenon [that] should not be judged as inherently pathological or negative."

Unfortunately, there is stigma attached to gender nonconformity in many societies around the world. Such stigma can lead to prejudice and discrimination, resulting in "minority stress" (I. H. Meyer, 2003). Minority stress is unique (additive to general stressors experienced by all people), socially based, and chronic, and may make transsexual, transgender, and gender-nonconforming individuals more vulnerable to developing mental health concerns such as anxiety and depression (Institute of Medicine, 2011). In addition to prejudice and discrimination in society at large, stigma can contribute to abuse and neglect in one's relationships with peers and family members, which in turn can lead to psychological distress. However, these symptoms are socially induced and are not inherent to being transsexual, transgender, or gender-nonconforming.

Gender Nonconformity Is Not the Same as Gender Dysphoria

Gender nonconformity refers to the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex (Institute of Medicine, 2011). *Gender dysphoria* refers to discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b). Only *some* gender-nonconforming people experience gender dysphoria at *some* point in their lives.

Treatment is available to assist people with such distress to explore their gender identity and find a gender role that is comfortable for them (Bockting & Goldberg, 2006). Treatment is individualized: What helps one person alleviate gender dysphoria might be very different from what helps another person. This process may or may not involve a change in gender expression or body modifications. Medical treatment options include, for example, feminization or masculinization of the body through hormone therapy and/or surgery, which are effective in alleviating gender dysphoria and are medically necessary for many people. Gender identities and expressions are diverse, and hormones and surgery are just two of many options available to assist people with achieving comfort with self and identity.

Gender dysphoria can in large part be alleviated through treatment (Murad et al., 2010). Hence, while transsexual, transgender, and gender-nonconforming people may experience gender dysphoria at some points in their lives, many individuals who receive treatment will find a gender role and expression that is comfortable for them, even if these differ from those associated with their sex assigned at birth, or from prevailing gender norms and expectations.

Diagnoses Related to Gender Dysphoria

Some people experience gender dysphoria at such a level that the distress meets criteria for a formal diagnosis that might be classified as a mental disorder. Such a diagnosis is not a license for stigmatization or for the deprivation of civil and human rights. Existing classification systems such as the *Diagnostic Statistical Manual of Mental Disorders (DSM)* (American Psychiatric Association, 2000) and the *International Classification of Diseases* (*ICD*) (World Health Organization, 2007) define hundreds of mental disorders that vary in onset, duration, pathogenesis, functional disability, and treatability. All of these systems attempt to classify clusters of symptoms and conditions, not the individuals themselves. A disorder is a description of something with which a person might struggle, not a description of the person or the person's identity.

Thus, transsexual, transgender, and gender-nonconforming individuals are not inherently disordered. Rather, the distress of gender dysphoria, when present, is the concern that might be diagnosable and for which various treatment options are available. The existence of a diagnosis for such dysphoria often facilitates access to health care and can guide further research into effective treatments.

Research is leading to new diagnostic nomenclatures, and terms are changing in both the *DSM* (Cohen-Kettenis & Pfäfflin, 2010; Knudson, De Cuypere, & Bockting, 2010b; Meyer-Bahlburg, 2010; Zucker, 2010) and the *ICD*. For this reason, familiar terms are employed in the *SOC* and definitions are provided for terms that may be emerging. Health professionals should refer to the most current diagnostic criteria and appropriate codes to apply in their practice areas.

IV
Epidemiologic Considerations

Formal epidemiologic studies on the incidence[III] and prevalence[IV] of transsexualism specifically or transgender and gender-nonconforming identities in general have not been conducted, and efforts to achieve realistic estimates are fraught with enormous difficulties (Institute of Medicine, 2011; Zucker & Lawrence, 2009). Even if epidemiologic studies established that a similar proportion of transsexual, transgender, or gender-nonconforming people existed all over the world, it is likely that cultural differences from one country to another would alter both the behavioral expressions of different gender identities and the extent to which gender dysphoria—distinct from one's gender identity—is actually occurring in a population. While in most countries, crossing normative gender boundaries generates moral censure rather than compassion, there are examples in certain cultures of gender-nonconforming behaviors (e.g., in spiritual leaders) that are less stigmatized and even revered (Besnier, 1994; Bolin, 1988; Chiñas, 1995; Coleman, Colgan, & Gooren, 1992; Costa & Matzner, 2007; Jackson & Sullivan, 1999; Nanda, 1998; Taywaditep, Coleman, & Dumronggittigule, 1997).

For various reasons, researchers who have studied incidence and prevalence have tended to focus on the most easily counted subgroup of gender-nonconforming individuals: transsexual individuals who experience gender dysphoria and who present for gender-transition-related care at specialist gender clinics (Zucker & Lawrence, 2009). Most studies have been conducted in European countries such as Sweden (Wålinder, 1968, 1971), the United Kingdom (Hoenig & Kenna, 1974),

III **incidence**—the number of new cases arising in a given period (e.g., a year)
IV **prevalence**—the number of individuals having a condition, divided by the number of people in the general population

the Netherlands (Bakker, Van Kesteren, Gooren, & Bezemer, 1993; Eklund, Gooren, & Bezemer, 1988; van Kesteren, Gooren, & Megens, 1996), Germany (Weitze & Osburg, 1996), and Belgium (De Cuypere et al., 2007). One was conducted in Singapore (Tsoi, 1988).

De Cuypere and colleagues (2007) reviewed such studies, as well as conducted their own. Together, those studies span 39 years. Leaving aside two outlier findings from Pauly in 1965 and Tsoi in 1988, ten studies involving eight countries remain. The prevalence figures reported in these ten studies range from 1:11,900 to 1:45,000 for male-to-female individuals (MtF) and 1:30,400 to 1:200,000 for female-to-male (FtM) individuals. Some scholars have suggested that the prevalence is much higher, depending on the methodology used in the research (e.g., Olyslager & Conway, 2007).

Direct comparisons across studies are impossible, as each differed in their data collection methods and in their criteria for documenting a person as transsexual (e.g., whether or not a person had undergone genital reconstruction, versus had initiated hormone therapy, versus had come to the clinic seeking medically supervised transition services). The trend appears to be towards higher prevalence rates in the more recent studies, possibly indicating increasing numbers of people seeking clinical care. Support for this interpretation comes from research by Reed and colleagues (2009), who reported a doubling of the numbers of people accessing care at gender clinics in the United Kingdom every five or six years. Similarly, Zucker and colleagues (2008) reported a four- to five-fold increase in child and adolescent referrals to their Toronto, Canada clinic over a 30-year period.

The numbers yielded by studies such as these can be considered minimum estimates at best. The published figures are mostly derived from clinics where patients met criteria for severe gender dysphoria and had access to health care at those clinics. These estimates do not take into account that treatments offered in a particular clinic setting might not be perceived as affordable, useful, or acceptable by all self-identified gender dysphoric individuals in a given area. By counting only those people who present at clinics for a specific type of treatment, an unspecified number of gender dysphoric individuals are overlooked.

Other clinical observations (not yet firmly supported by systematic study) support the likelihood of a higher prevalence of gender dysphoria: (i) Previously unrecognized gender dysphoria is occasionally diagnosed when patients are seen with anxiety, depression, conduct disorder, substance abuse, dissociative identity disorders, borderline personality disorder, sexual disorders, and disorders of sex development (Cole, O'Boyle, Emory, & Meyer III, 1997). (ii) Some crossdressers, drag queens/kings or female/male impersonators, and gay and lesbian individuals may be experiencing gender dysphoria (Bullough & Bullough, 1993). (iii) The intensity of some people's gender dysphoria fluctuates below and above a clinical threshold (Docter, 1988). (iv) Gender nonconformity among FtM individuals tends to be relatively invisible in many cultures, particularly to Western health

professionals and researchers who have conducted most of the studies on which the current estimates of prevalence and incidence are based (Winter, 2009).

Overall, the existing data should be considered a starting point, and health care would benefit from more rigorous epidemiologic study in different locations worldwide.

V

Overview of Therapeutic Approaches for Gender Dysphoria

Advancements in the Knowledge and Treatment of Gender Dysphoria

In the second half of the 20th century, awareness of the phenomenon of gender dysphoria increased when health professionals began to provide assistance to alleviate gender dysphoria by supporting changes in primary and secondary sex characteristics through hormone therapy and surgery, along with a change in gender role. Although Harry Benjamin already acknowledged a spectrum of gender nonconformity (Benjamin, 1966), the initial clinical approach largely focused on identifying who was an appropriate candidate for sex reassignment to facilitate a physical change from male to female or female to male as completely as possible (e.g., Green & Fleming, 1990; Hastings, 1974). This approach was extensively evaluated and proved to be highly effective. Satisfaction rates across studies ranged from 87% of MtF patients to 97% of FtM patients (Green & Fleming, 1990), and regrets were extremely rare (1–1.5% of MtF patients and <1% of FtM patients; Pfäfflin, 1993). Indeed, hormone therapy and surgery have been found to be medically necessary to alleviate gender dysphoria in many people (American Medical Association, 2008; Anton, 2009; World Professional Association for Transgender Health, 2008).

As the field matured, health professionals recognized that while many individuals need both hormone therapy and surgery to alleviate their gender dysphoria, others need only one of these treatment options and some need neither (Bockting & Goldberg, 2006; Bockting, 2008; Lev, 2004). Often with the help of psychotherapy, some individuals integrate their trans- or cross-gender feelings into the gender role they were assigned at birth and do not feel the need to feminize or masculinize their body. For others, changes in gender role and expression are sufficient to alleviate

gender dysphoria. Some patients may need hormones, a possible change in gender role, but not surgery; others may need a change in gender role along with surgery, but not hormones. In other words, treatment for gender dysphoria has become more individualized.

As a generation of transsexual, transgender, and gender-nonconforming individuals has come of age—many of whom have benefitted from different therapeutic approaches—they have become more visible as a community and demonstrated considerable diversity in their gender identities, roles, and expressions. Some individuals describe themselves not as gender-nonconforming but as unambiguously cross-sexed (i.e., as a member of the other sex; Bockting, 2008). Other individuals affirm their unique gender identity and no longer consider themselves to be either male or female (Bornstein, 1994; Kimberly, 1997; Stone, 1991; Warren, 1993). Instead, they may describe their gender identity in specific terms such as transgender, bigender, or genderqueer, affirming their unique experiences that may transcend a male/female binary understanding of gender (Bockting, 2008; Ekins & King, 2006; Nestle, Wilchins, & Howell, 2002). They may not experience their process of identity affirmation as a "transition," because they never fully embraced the gender role they were assigned at birth or because they actualize their gender identity, role, and expression in a way that does not involve a change from one gender role to another. For example, some youth identifying as genderqueer have always experienced their gender identity and role as such (genderqueer). Greater public visibility and awareness of gender diversity (Feinberg, 1996) has further expanded options for people with gender dysphoria to actualize an identity and find a gender role and expression that are comfortable for them.

Health professionals can assist gender dysphoric individuals with affirming their gender identity, exploring different options for expression of that identity, and making decisions about medical treatment options for alleviating gender dysphoria.

Options for Psychological and Medical Treatment of Gender Dysphoria

For individuals seeking care for gender dysphoria, a variety of therapeutic options can be considered. The number and type of interventions applied and the order in which these take place may differ from person to person (e.g., Bockting, Knudson, & Goldberg, 2006; Bolin, 1994; Rachlin, 1999; Rachlin, Green, & Lombardi, 2008; Rachlin, Hansbury, & Pardo, 2010). Treatment options include the following:

- Changes in gender expression and role (which may involve living part time or full time in another gender role, consistent with one's gender identity);
- Hormone therapy to feminize or masculinize the body;

- Surgery to change primary and/or secondary sex characteristics (e.g., breasts/chest, external and/or internal genitalia, facial features, body contouring);
- Psychotherapy (individual, couple, family, or group) for purposes such as exploring gender identity, role, and expression; addressing the negative impact of gender dysphoria and stigma on mental health; alleviating internalized transphobia; enhancing social and peer support; improving body image; or promoting resilience.

Options for Social Support and Changes in Gender Expression

In addition (or as an alternative) to the psychological- and medical-treatment options described above, other options can be considered to help alleviate gender dysphoria, for example:

- In-person and online peer support resources, groups, or community organizations that provide avenues for social support and advocacy;
- In-person and online support resources for families and friends;
- Voice and communication therapy to help individuals develop verbal and non-verbal communication skills that facilitate comfort with their gender identity;
- Hair removal through electrolysis, laser treatment, or waxing;
- Breast binding or padding, genital tucking or penile prostheses, padding of hips or buttocks;
- Changes in name and gender marker on identity documents.

VI

Assessment and Treatment of Children and Adolescents With Gender Dysphoria

There are a number of differences in the phenomenology, developmental course, and treatment approaches for gender dysphoria in children, adolescents, and adults. In children and adolescents, a rapid and dramatic developmental process (physical, psychological, and sexual) is involved and

there is greater fluidity and variability in outcomes, particularly in prepubertal children. Accordingly, this section of the *SOC* offers specific clinical guidelines for the assessment and treatment of gender dysphoric children and adolescents.

Differences Between Children and Adolescents with Gender Dysphoria

An important difference between gender dysphoric children and adolescents is in the proportion for whom dysphoria persists into adulthood. Gender dysphoria during childhood does not inevitably continue into adulthood.[V] Rather, in follow-up studies of prepubertal children (mainly boys) who were referred to clinics for assessment of gender dysphoria, the dysphoria persisted into adulthood for only 6–23% of children (Cohen-Kettenis, 2001; Zucker & Bradley, 1995). Boys in these studies were more likely to identify as gay in adulthood than as transgender (Green, 1987; Money & Russo, 1979; Zucker & Bradley, 1995; Zuger, 1984). Newer studies, also including girls, showed a 12–27% persistence rate of gender dysphoria into adulthood (Drummond, Bradley, Peterson-Badali, & Zucker, 2008; Wallien & Cohen-Kettenis, 2008).

In contrast, the persistence of gender dysphoria into adulthood appears to be much higher for adolescents. No formal prospective studies exist. However, in a follow-up study of 70 adolescents who were diagnosed with gender dysphoria and given puberty-suppressing hormones, all continued with actual sex reassignment, beginning with feminizing/masculinizing hormone therapy (de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2010).

Another difference between gender dysphoric children and adolescents is in the sex ratios for each age group. In clinically referred, gender dysphoric children under age 12, the male/female ratio ranges from 6:1 to 3:1 (Zucker, 2004). In clinically referred, gender dysphoric adolescents older than age 12, the male/female ratio is close to 1:1 (Cohen-Kettenis & Pfäfflin, 2003).

As discussed in section IV and by Zucker and Lawrence (2009), formal epidemiologic studies on gender dysphoria—in children, adolescents, and adults—are lacking. Additional research is needed to refine estimates of its prevalence and persistence in different populations worldwide.

V Gender-nonconforming behaviors in children may continue into adulthood, but such behaviors are not necessarily indicative of gender dysphoria and a need for treatment. As described in section III, gender dysphoria is not synonymous with diversity in gender expression.

Phenomenology in Children

Children as young as age two may show features that could indicate gender dysphoria. They may express a wish to be of the other sex and be unhappy about their physical sex characteristics and functions. In addition, they may prefer clothes, toys, and games that are commonly associated with the other sex and prefer playing with other-sex peers. There appears to be heterogeneity in these features: Some children demonstrate extremely gender-nonconforming behavior and wishes, accompanied by persistent and severe discomfort with their primary sex characteristics. In other children, these characteristics are less intense or only partially present (Cohen-Kettenis et al., 2006; Knudson, De Cuypere, & Bockting, 2010a).

It is relatively common for gender dysphoric children to have coexisting internalizing disorders such as anxiety and depression (Cohen-Kettenis, Owen, Kaijser, Bradley, & Zucker, 2003; Wallien, Swaab, & Cohen-Kettenis, 2007; Zucker, Owen, Bradley, & Ameeriar, 2002). The prevalence of autism spectrum disorders seems to be higher in clinically referred, gender dysphoric children than in the general population (de Vries, Noens, Cohen-Kettenis, van Berckelaer-Onnes, & Doreleijers, 2010).

Phenomenology in Adolescents

In most children, gender dysphoria will disappear before, or early in, puberty. However, in some children these feelings will intensify and body aversion will develop or increase as they become adolescents and their secondary sex characteristics develop (Cohen-Kettenis, 2001; Cohen-Kettenis & Pfäfflin, 2003; Drummond et al., 2008; Wallien & Cohen-Kettenis, 2008; Zucker & Bradley, 1995). Data from one study suggest that more extreme gender nonconformity in childhood is associated with persistence of gender dysphoria into late adolescence and early adulthood (Wallien & Cohen-Kettenis, 2008). Yet many adolescents and adults presenting with gender dysphoria do not report a history of childhood gender-nonconforming behaviors (Docter, 1988; Landén, Wålinder, & Lundström, 1998). Therefore, it may come as a surprise to others (parents, other family members, friends, and community members) when a youth's gender dysphoria first becomes evident in adolescence.

Adolescents who experience their primary and/or secondary sex characteristics and their sex assigned at birth as inconsistent with their gender identity may be intensely distressed about it. Many, but not all, gender dysphoric adolescents have a strong wish for hormones and surgery. Increasing numbers of adolescents have already started living in their desired gender role upon entering high school (Cohen-Kettenis & Pfäfflin, 2003).

Among adolescents who are referred to gender identity clinics, the number considered eligible for early medical treatment—starting with GnRH analogues to suppress puberty in the first Tanner stages—differs among countries and centers. Not all clinics offer puberty suppression. If such treatment is offered, the pubertal stage at which adolescents are allowed to start varies from Tanner stage 2 to stage 4 (Delemarre-van de Waal & Cohen-Kettenis, 2006; Zucker et al., 2012). The percentages of treated adolescents are likely influenced by the organization of health care, insurance aspects, cultural differences, opinions of health professionals, and diagnostic procedures offered in different settings.

Inexperienced clinicians may mistake indications of gender dysphoria for delusions. Phenomenologically, there is a qualitative difference between the presentation of gender dysphoria and the presentation of delusions or other psychotic symptoms. The vast majority of children and adolescents with gender dysphoria are not suffering from underlying severe psychiatric illness such as psychotic disorders (Steensma, Biemond, de Boer, & Cohen-Kettenis, published online ahead of print January 7, 2011).

It is more common for adolescents with gender dysphoria to have coexisting internalizing disorders such as anxiety and depression, and/or externalizing disorders such as oppositional defiant disorder (de Vries et al., 2010). As in children, there seems to be a higher prevalence of autistic spectrum disorders in clinically referred, gender dysphoric adolescents than in the general adolescent population (de Vries et al., 2010).

Competency of Mental Health Professionals Working with Children or Adolescents with Gender Dysphoria

The following are recommended minimum credentials for mental health professionals who assess, refer, and offer therapy to children and adolescents presenting with gender dysphoria:

1. Meet the competency requirements for mental health professionals working with adults, as outlined in section VII;

2. Trained in childhood and adolescent developmental psychopathology;

3. Competent in diagnosing and treating the ordinary problems of children and adolescents.

Roles of Mental Health Professionals Working with Children and Adolescents with Gender Dysphoria

The roles of mental health professionals working with gender dysphoric children and adolescents may include the following:

1. Directly assess gender dysphoria in children and adolescents (see general guidelines for assessment, below).

2. Provide family counseling and supportive psychotherapy to assist children and adolescents with exploring their gender identity, alleviating distress related to their gender dysphoria, and ameliorating any other psychosocial difficulties.

3. Assess and treat any coexisting mental health concerns of children or adolescents (or refer to another mental health professional for treatment). Such concerns should be addressed as part of the overall treatment plan.

4. Refer adolescents for additional physical interventions (such as puberty-suppressing hormones) to alleviate gender dysphoria. The referral should include documentation of an assessment of gender dysphoria and mental health, the adolescent's eligibility for physical interventions (outlined below), the mental health professional's relevant expertise, and any other information pertinent to the youth's health and referral for specific treatments.

5. Educate and advocate on behalf of gender dysphoric children, adolescents, and their families in their community (e.g., day care centers, schools, camps, other organizations). This is particularly important in light of evidence that children and adolescents who do not conform to socially prescribed gender norms may experience harassment in school (Grossman, D'Augelli, & Salter, 2006; Grossman, D'Augelli, Howell, & Hubbard, 2006; Sausa, 2005), putting them at risk for social isolation, depression, and other negative sequelae (Nuttbrock et al., 2010).

6. Provide children, youth, and their families with information and referral for peer support, such as support groups for parents of gender-nonconforming and transgender children (Gold & MacNish, 2011; Pleak, 1999; Rosenberg, 2002).

Assessment and psychosocial interventions for children and adolescents are often provided within a multidisciplinary gender identity specialty service. If such a multidisciplinary service is not available, a mental health professional should provide consultation and liaison arrangements with a pediatric endocrinologist for the purpose of assessment, education, and involvement in any decisions about physical interventions.

Psychological Assessment of Children and Adolescents

When assessing children and adolescents who present with gender dysphoria, mental health professionals should broadly conform to the following guidelines:

1. Mental health professionals should not dismiss or express a negative attitude towards nonconforming gender identities or indications of gender dysphoria. Rather, they should acknowledge the presenting concerns of children, adolescents, and their families; offer a thorough assessment for gender dysphoria and any coexisting mental health concerns; and educate clients and their families about therapeutic options, if needed. Acceptance, and alleviation of secrecy, can bring considerable relief to gender dysphoric children/adolescents and their families.

2. Assessment of gender dysphoria and mental health should explore the nature and characteristics of a child's or adolescent's gender identity. A psychodiagnostic and psychiatric assessment—covering the areas of emotional functioning, peer and other social relationships, and intellectual functioning/school achievement—should be performed. Assessment should include an evaluation of the strengths and weaknesses of family functioning. Emotional and behavioral problems are relatively common, and unresolved issues in a child's or youth's environment may be present (de Vries, Doreleijers, Steensma, & Cohen-Kettenis, 2011; Di Ceglie & Thümmel, 2006; Wallien et al., 2007).

3. For adolescents, the assessment phase should also be used to inform youth and their families about the possibilities and limitations of different treatments. This is necessary for informed consent, but also important for assessment. The way that adolescents respond to information about the reality of sex reassignment can be diagnostically informative. Correct information may alter a youth's desire for certain treatment, if the desire was based on unrealistic expectations of its possibilities.

Psychological and Social Interventions for Children and Adolescents

When supporting and treating children and adolescents with gender dysphoria, health professionals should broadly conform to the following guidelines:

1. Mental health professionals should help families to have an accepting and nurturing response to the concerns of their gender dysphoric child or adolescent. Families play an important role in the psychological health and well-being of youth (Brill & Pepper, 2008; Lev, 2004). This also applies to peers and mentors from the community, who can be another source of social support.

2. Psychotherapy should focus on reducing a child's or adolescent's distress related to the gender dysphoria and on ameliorating any other psychosocial difficulties. For youth pursuing sex reassignment, psychotherapy may focus on supporting them before, during, and after reassignment. Formal evaluations of different psychotherapeutic approaches for this situation have not been published, but several counseling methods have been described (Cohen-Kettenis, 2006; de Vries, Cohen-Kettenis, & Delemarre-van de Waal, 2006; Di Ceglie & Thümmel, 2006; Hill, Menvielle, Sica, & Johnson, 2010; Malpas, in press; Menvielle & Tuerk, 2002; Rosenberg, 2002; Vanderburgh, 2009; Zucker, 2006).

   Treatment aimed at trying to change a person's gender identity and expression to become more congruent with sex assigned at birth has been attempted in the past without success (Gelder & Marks, 1969; Greenson, 1964), particularly in the long term (Cohen-Kettenis & Kuiper, 1984; Pauly, 1965). Such treatment is no longer considered ethical.

3. Families should be supported in managing uncertainty and anxiety about their child's or adolescent's psychosexual outcomes and in helping youth to develop a positive self-concept.

4. Mental health professionals should not impose a binary view of gender. They should give ample room for clients to explore different options for gender expression. Hormonal or surgical interventions are appropriate for some adolescents, but not for others.

5. Clients and their families should be supported in making difficult decisions regarding the extent to which clients are allowed to express a gender role that is consistent with their gender identity, as well as the timing of changes in gender role and possible social transition. For example, a client might attend school while undergoing social transition only partly (e.g., by wearing clothing and having a hairstyle that reflects gender identity) or completely (e.g., by also using a name and pronouns congruent with gender identity). Difficult issues include whether and when to inform other people of the client's situation, and how others in their lives might respond.

6. Health professionals should support clients and their families as educators and advocates in their interactions with community members and authorities such as teachers, school boards, and courts.

7. Mental health professionals should strive to maintain a therapeutic relationship with gender-nonconforming children/adolescents and their families throughout any subsequent social changes or physical interventions. This ensures that decisions about gender expression and the treatment of gender dysphoria are thoughtfully and recurrently considered. The same reasoning applies if a child or adolescent has already socially changed gender role prior to being seen by a mental health professional.

Social Transition in Early Childhood

Some children state that they want to make a social transition to a different gender role long before puberty. For some children, this may reflect an expression of their gender identity. For others, this could be motivated by other forces. Families vary in the extent to which they allow their young children to make a social transition to another gender role. Social transitions in early childhood do occur within some families with early success. This is a controversial issue, and divergent views are held by health professionals. The current evidence base is insufficient to predict the long-term outcomes of completing a gender role transition during early childhood. Outcomes research with children who completed early social transitions would greatly inform future clinical recommendations.

Mental health professionals can help families to make decisions regarding the timing and process of any gender role changes for their young children. They should provide information and help parents to weigh the potential benefits and challenges of particular choices. Relevant in this respect are the previously described relatively low persistence rates of childhood gender dysphoria (Drummond et al., 2008; Wallien & Cohen-Kettenis, 2008). A change back to the original gender role can be highly distressing and even result in postponement of this second social transition on the child's part (Steensma & Cohen-Kettenis, 2011). For reasons such as these, parents may want to present this role change as an exploration of living in another gender role rather than an irreversible situation. Mental health professionals can assist parents in identifying potential in-between solutions or compromises (e.g., only when on vacation). It is also important that parents explicitly let the child know that there is a way back.

Regardless of a family's decisions regarding transition (timing, extent), professionals should counsel and support them as they work through the options and implications. If parents do not allow their young child to make a gender-role transition, they may need counseling to assist them with meeting their child's needs in a sensitive and nurturing way, ensuring that the child has ample possibilities to explore gender feelings and behavior in a safe environment. If parents do allow their young child to make a gender role transition, they may need counseling to facilitate a positive experience for their child. For example, they may need support in using correct pronouns, maintaining a safe and supportive environment for their transitioning child (e.g., in school, peer group settings), and communicating with other people in their child's life. In either case, as a child nears puberty, further assessment may be needed as options for physical interventions become relevant.

Physical Interventions for Adolescents

Before any physical interventions are considered for adolescents, extensive exploration of psychological, family, and social issues should be undertaken, as outlined above. The duration of this exploration may vary considerably depending on the complexity of the situation.

Physical interventions should be addressed in the context of adolescent development. Some identity beliefs in adolescents may become firmly held and strongly expressed, giving a false impression of irreversibility. An adolescent's shift towards gender conformity can occur primarily to please the parents and may not persist or reflect a permanent change in gender dysphoria (Hembree et al., 2009; Steensma et al., published online ahead of print January 7, 2011).

Physical interventions for adolescents fall into three categories or stages (Hembree et al., 2009):

1. *Fully reversible interventions*. These involve the use of GnRH analogues to suppress estrogen or testosterone production and consequently delay the physical changes of puberty. Alternative treatment options include progestins (most commonly medroxyprogesterone) or other medications (such as spironolactone) that decrease the effects of androgens secreted by the testicles of adolescents who are not receiving GnRH analogues. Continuous oral contraceptives (or depot medroxyprogesterone) may be used to suppress menses.

2. *Partially reversible interventions*. These include hormone therapy to masculinize or feminize the body. Some hormone-induced changes may need reconstructive surgery to reverse the effect (e.g., gynaecomastia caused by estrogens), while other changes are not reversible (e.g., deepening of the voice caused by testosterone).

3. *Irreversible interventions*. These are surgical procedures.

A staged process is recommended to keep options open through the first two stages. Moving from one stage to another should not occur until there has been adequate time for adolescents and their parents to assimilate fully the effects of earlier interventions.

Fully Reversible Interventions

Adolescents may be eligible for puberty-suppressing hormones as soon as pubertal changes have begun. In order for adolescents and their parents to make an informed decision about pubertal delay, it is recommended that adolescents experience the onset of puberty to at least Tanner Stage 2. Some children may arrive at this stage at very young ages (e.g., 9 years of age). Studies

evaluating this approach have only included children who were at least 12 years of age (Cohen-Kettenis, Schagen, Steensma, de Vries, & Delemarre-van de Waal, 2011; de Vries, Steensma et al., 2010; Delemarre-van de Waal, van Weissenbruch, & Cohen Kettenis, 2004; Delemarre-van de Waal & Cohen-Kettenis, 2006).

Two goals justify intervention with puberty-suppressing hormones: (i) their use gives adolescents more time to explore their gender nonconformity and other developmental issues; and (ii) their use may facilitate transition by preventing the development of sex characteristics that are difficult or impossible to reverse if adolescents continue on to pursue sex reassignment.

Puberty suppression may continue for a few years, at which time a decision is made to either discontinue all hormone therapy or transition to a feminizing/masculinizing hormone regimen. Pubertal suppression does not inevitably lead to social transition or to sex reassignment.

Criteria for Puberty-Suppressing Hormones

In order for adolescents to receive puberty-suppressing hormones, the following minimum criteria must be met:

1. The adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed);

2. Gender dysphoria emerged or worsened with the onset of puberty;

3. Any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment;

4. The adolescent has given informed consent and, particularly when the adolescent has not reached the age of medical consent, the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process.

Regimens, Monitoring, and Risks for Puberty Suppression

For puberty suppression, adolescents with male genitalia should be treated with GnRH analogues, which stop luteinizing hormone secretion and therefore testosterone secretion. Alternatively, they may be treated with progestins (such as medroxyprogesterone) or with other medications that block testosterone secretion and/or neutralize testosterone action. Adolescents with female genitalia should be treated with GnRH analogues, which stop the production of estrogens and

progesterone. Alternatively, they may be treated with progestins (such as medroxyprogesterone). Continuous oral contraceptives (or depot medroxyprogesterone) may be used to suppress menses. In both groups of adolescents, use of GnRH analogues is the preferred treatment (Hembree et al., 2009), but their high cost is prohibitive for some patients.

During pubertal suppression, an adolescent's physical development should be carefully monitored—preferably by a pediatric endocrinologist—so that any necessary interventions can occur (e.g., to establish an adequate gender appropriate height, to improve iatrogenic low bone mineral density) (Hembree et al., 2009).

Early use of puberty-suppressing hormones may avert negative social and emotional consequences of gender dysphoria more effectively than their later use would. Intervention in early adolescence should be managed with pediatric endocrinological advice, when available. Adolescents with male genitalia who start GnRH analogues early in puberty should be informed that this could result in insufficient penile tissue for penile inversion vaginoplasty techniques (alternative techniques, such as the use of a skin graft or colon tissue, are available).

Neither puberty suppression nor allowing puberty to occur is a neutral act. On the one hand, functioning in later life can be compromised by the development of irreversible secondary sex characteristics during puberty and by years spent experiencing intense gender dysphoria. On the other hand, there are concerns about negative physical side effects of GnRH analogue use (e.g., on bone development and height). Although the very first results of this approach (as assessed for adolescents followed over 10 years) are promising (Cohen-Kettenis et al., 2011; Delemarre-van de Waal & Cohen-Kettenis, 2006), the long-term effects can only be determined when the earliest-treated patients reach the appropriate age.

Partially Reversible Interventions

Adolescents may be eligible to begin feminizing/masculinizing hormone therapy, preferably with parental consent. In many countries, 16-year-olds are legal adults for medical decision-making and do not require parental consent. Ideally, treatment decisions should be made among the adolescent, the family, and the treatment team.

Regimens for hormone therapy in gender dysphoric adolescents differ substantially from those used in adults (Hembree et al., 2009). The hormone regimens for youth are adapted to account for the somatic, emotional, and mental development that occurs throughout adolescence (Hembree et al., 2009).

Irreversible Interventions

Genital surgery should not be carried out until (i) patients reach the legal age of majority to give consent for medical procedures in a given country, and (ii) patients have lived continuously for at least 12 months in the gender role that is congruent with their gender identity. The age threshold should be seen as a minimum criterion and not an indication in and of itself for active intervention.

Chest surgery in FtM patients could be carried out earlier, preferably after ample time of living in the desired gender role and after one year of testosterone treatment. The intent of this suggested sequence is to give adolescents sufficient opportunity to experience and socially adjust in a more masculine gender role, before undergoing irreversible surgery. However, different approaches may be more suitable, depending on an adolescent's specific clinical situation and goals for gender identity expression.

Risks of Withholding Medical Treatment for Adolescents

Refusing timely medical interventions for adolescents might prolong gender dysphoria and contribute to an appearance that could provoke abuse and stigmatization. As the level of gender-related abuse is strongly associated with the degree of psychiatric distress during adolescence (Nuttbrock et al., 2010), withholding puberty suppression and subsequent feminizing or masculinizing hormone therapy is not a neutral option for adolescents.

VII
Mental Health

Transsexual, transgender, and gender-nonconforming people might seek the assistance of a mental health professional for any number of reasons. Regardless of a person's reason for seeking care, mental health professionals should have familiarity with gender nonconformity, act with appropriate cultural competence, and exhibit sensitivity in providing care.

This section of the *SOC* focuses on the role of mental health professionals in the care of adults seeking help for gender dysphoria and related concerns. Professionals working with gender dysphoric children, adolescents, and their families should consult section VI.

Competency of Mental Health Professionals Working with Adults Who Present with Gender Dysphoria

The training of mental health professionals competent to work with gender dysphoric adults rests upon basic general clinical competence in the assessment, diagnosis, and treatment of mental health concerns. Clinical training may occur within any discipline that prepares mental health professionals for clinical practice, such as psychology, psychiatry, social work, mental health counseling, marriage and family therapy, nursing, or family medicine with specific training in behavioral health and counseling. The following are recommended minimum credentials for mental health professionals who work with adults presenting with gender dysphoria:

1. A master's degree or its equivalent in a clinical behavioral science field. This degree, or a more advanced one, should be granted by an institution accredited by the appropriate national or regional accrediting board. The mental health professional should have documented credentials from a relevant licensing board or equivalent for that country.

2. Competence in using the *Diagnostic Statistical Manual of Mental Disorders* and/or the *International Classification of Diseases* for diagnostic purposes.

3. Ability to recognize and diagnose coexisting mental health concerns and to distinguish these from gender dysphoria.

4. Documented supervised training and competence in psychotherapy or counseling.

5. Knowledgeable about gender-nonconforming identities and expressions, and the assessment and treatment of gender dysphoria.

6. Continuing education in the assessment and treatment of gender dysphoria. This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from a mental health professional with relevant experience; or participating in research related to gender nonconformity and gender dysphoria.

In addition to the minimum credentials above, it is recommended that mental health professionals develop and maintain cultural competence to facilitate their work with transsexual, transgender, and gender-nonconforming clients. This may involve, for example, becoming knowledgeable about current community, advocacy, and public policy issues relevant to these clients and their families. Additionally, knowledge about sexuality, sexual health concerns, and the assessment and treatment of sexual disorders is preferred.

Mental health professionals who are new to the field (irrespective of their level of training and other experience) should work under the supervision of a mental health professional with established competence in the assessment and treatment of gender dysphoria.

Tasks of Mental Health Professionals Working with Adults Who Present with Gender Dysphoria

Mental health professionals may serve transsexual, transgender, and gender-nonconforming individuals and their families in many ways, depending on a client's needs. For example, mental health professionals may serve as a psychotherapist, counselor, or family therapist, or as a diagnostician/assessor, advocate, or educator.

Mental health professionals should determine a client's reasons for seeking professional assistance. For example, a client may be presenting for any combination of the following health care services: psychotherapeutic assistance to explore gender identity and expression or to facilitate a coming-out process; assessment and referral for feminizing/masculinizing medical interventions; psychological support for family members (partners, children, extended family); psychotherapy unrelated to gender concerns; or other professional services.

Below are general guidelines for common tasks that mental health professionals may fulfill in working with adults who present with gender dysphoria.

Tasks Related to Assessment and Referral

1. Assess Gender Dysphoria

Mental health professionals assess clients' gender dysphoria in the context of an evaluation of their psychosocial adjustment (Bockting et al., 2006; Lev, 2004, 2009). The evaluation includes, at a minimum, assessment of gender identity and gender dysphoria, history and development of gender dysphoric feelings, the impact of stigma attached to gender nonconformity on mental health, and the availability of support from family, friends, and peers (for example, in-person or online contact with other transsexual, transgender, or gender-nonconforming individuals or groups). The evaluation may result in no diagnosis, in a formal diagnosis related to gender dysphoria, and/or in other diagnoses that describe aspects of the client's health and psychosocial adjustment. The role

of mental health professionals includes making reasonably sure that the gender dysphoria is not secondary to, or better accounted for, by other diagnoses.

Mental health professionals with the competencies described above (hereafter called "a qualified mental health professional") are best prepared to conduct this assessment of gender dysphoria. However, this task may instead be conducted by another type of health professional who has appropriate training in behavioral health and is competent in the assessment of gender dysphoria, particularly when functioning as part of a multidisciplinary specialty team that provides access to feminizing/masculinizing hormone therapy. This professional may be the prescribing hormone therapy provider or a member of that provider's health care team.

2. Provide Information Regarding Options for Gender Identity and Expression and Possible Medical Interventions

An important task of mental health professionals is to educate clients regarding the diversity of gender identities and expressions and the various options available to alleviate gender dysphoria. Mental health professionals then may facilitate a process (or refer elsewhere) in which clients explore these various options, with the goals of finding a comfortable gender role and expression and becoming prepared to make a fully informed decision about available medical interventions, if needed. This process may include referral for individual, family, and group therapy and/or to community resources and avenues for peer support. The professional and the client discuss the implications, both short- and long-term, of any changes in gender role and use of medical interventions. These implications can be psychological, social, physical, sexual, occupational, financial, and legal (Bockting et al., 2006; Lev, 2004).

This task is also best conducted by a qualified mental health professional, but may be conducted by another health professional with appropriate training in behavioral health and with sufficient knowledge about gender-nonconforming identities and expressions and about possible medical interventions for gender dysphoria, particularly when functioning as part of a multidisciplinary specialty team that provides access to feminizing/masculinizing hormone therapy.

3. Assess, Diagnose, and Discuss Treatment Options for Coexisting Mental Health Concerns

Clients presenting with gender dysphoria may struggle with a range of mental health concerns (Gómez-Gil, Trilla, Salamero, Godás, & Valdés, 2009; Murad et al., 2010) whether related or unrelated to what is often a long history of gender dysphoria and/or chronic minority stress. Possible concerns include anxiety, depression, self-harm, a history of abuse and neglect, compulsivity, substance abuse, sexual concerns, personality disorders, eating disorders, psychotic disorders, and autistic spectrum disorders (Bockting et al., 2006; Nuttbrock et al., 2010; Robinow, 2009). Mental health professionals should screen for these and other mental health concerns and incorporate

the identified concerns into the overall treatment plan. These concerns can be significant sources of distress and, if left untreated, can complicate the process of gender identity exploration and resolution of gender dysphoria (Bockting et al., 2006; Fraser, 2009a; Lev, 2009). Addressing these concerns can greatly facilitate the resolution of gender dysphoria, possible changes in gender role, the making of informed decisions about medical interventions, and improvements in quality of life.

Some clients may benefit from psychotropic medications to alleviate symptoms or treat coexisting mental health concerns. Mental health professionals are expected to recognize this and either provide pharmacotherapy or refer to a colleague who is qualified to do so. The presence of coexisting mental health concerns does not necessarily preclude possible changes in gender role or access to feminizing/masculinizing hormones or surgery; rather, these concerns need to be optimally managed prior to, or concurrent with, treatment of gender dysphoria. In addition, clients should be assessed for their ability to provide educated and informed consent for medical treatments.

Qualified mental health professionals are specifically trained to assess, diagnose, and treat (or refer to treatment for) these coexisting mental health concerns. Other health professionals with appropriate training in behavioral health, particularly when functioning as part of a multidisciplinary specialty team providing access to feminizing/masculinizing hormone therapy, may also screen for mental health concerns and, if indicated, provide referral for comprehensive assessment and treatment by a qualified mental health professional.

4. If Applicable, Assess Eligibility, Prepare, and Refer for Hormone Therapy

The *SOC* provide criteria to guide decisions regarding feminizing/masculinizing hormone therapy (outlined in section VIII and Appendix C). Mental health professionals can help clients who are considering hormone therapy to be both psychologically prepared (e.g., client has made a fully informed decision with clear and realistic expectations; is ready to receive the service in line with the overall treatment plan; has included family and community as appropriate) and practically prepared (e.g., has been evaluated by a physician to rule out or address medical contraindications to hormone use; has considered the psychosocial implications). If clients are of childbearing age, reproductive options (section IX) should be explored before initiating hormone therapy.

It is important for mental health professionals to recognize that decisions about hormones are first and foremost a client's decisions—as are all decisions regarding healthcare. However, mental health professionals have a responsibility to encourage, guide, and assist clients with making fully informed decisions and becoming adequately prepared. To best support their clients' decisions, mental health professionals need to have functioning working relationships with their clients and sufficient information about them. Clients should receive prompt and attentive evaluation, with the goal of alleviating their gender dysphoria and providing them with appropriate medical services.

Referral for feminizing/masculinizing hormone therapy

People may approach a specialized provider in any discipline to pursue feminizing/masculinizing hormone therapy. However, transgender health care is an interdisciplinary field, and coordination of care and referral among a client's overall care team is recommended.

Hormone therapy can be initiated with a referral from a qualified mental health professional. Alternatively, a health professional who is appropriately trained in behavioral health and competent in the assessment of gender dysphoria may assess eligibility, prepare, and refer the patient for hormone therapy, particularly in the absence of significant coexisting mental health concerns and when working in the context of a multidisciplinary specialty team. The referring health professional should provide documentation—in the chart and/or referral letter—of the patient's personal and treatment history, progress, and eligibility. Health professionals who recommend hormone therapy share the ethical and legal responsibility for that decision with the physician who provides the service.

The recommended content of the referral letter for feminizing/masculinizing hormone therapy is as follows:

1. The client's general identifying characteristics;

2. Results of the client's psychosocial assessment, including any diagnoses;

3. The duration of the referring health professional's relationship with the client, including the type of evaluation and therapy or counseling to date;

4. An explanation that the criteria for hormone therapy have been met, and a brief description of the clinical rationale for supporting the client's request for hormone therapy;

5. A statement that informed consent has been obtained from the patient;

6. A statement that the referring health professional is available for coordination of care and welcomes a phone call to establish this.

For providers working within a multidisciplinary specialty team, a letter may not be necessary; rather, the assessment and recommendation can be documented in the patient's chart.

5. If Applicable, Assess Eligibility, Prepare, and Refer for Surgery

The *SOC* also provide criteria to guide decisions regarding breast/chest surgery and genital surgery (outlined in section XI and Appendix C). Mental health professionals can help clients who are

considering surgery to be both psychologically prepared (e.g., has made a fully informed decision with clear and realistic expectations; is ready to receive the service in line with the overall treatment plan; has included family and community as appropriate) and practically prepared (e.g., has made an informed choice about a surgeon to perform the procedure; has arranged aftercare). If clients are of childbearing age, reproductive options (section IX) should be explored before undergoing genital surgery.

The *SOC* do not state criteria for other surgical procedures, such as feminizing or masculinizing facial surgery; however, mental health professionals can play an important role in helping their clients to make fully informed decisions about the timing and implications of such procedures in the context of the overall coming-out or transition process.

It is important for mental health professionals to recognize that decisions about surgery are first and foremost a client's decisions—as are all decisions regarding healthcare. However, mental health professionals have a responsibility to encourage, guide, and assist clients with making fully informed decisions and becoming adequately prepared. To best support their clients' decisions, mental health professionals need to have functioning working relationships with their clients and sufficient information about them. Clients should receive prompt and attentive evaluation, with the goal of alleviating their gender dysphoria and providing them with appropriate medical services.

Referral for surgery

Surgical treatments for gender dysphoria can be initiated by a referral (one or two, depending on the type of surgery) from a qualified mental health professional. The mental health professional provides documentation—in the chart and/or referral letter—of the patient's personal and treatment history, progress, and eligibility. Mental health professionals who recommend surgery share the ethical and legal responsibility for that decision with the surgeon.

- One referral from a qualified mental health professional is needed for breast/chest surgery (e.g., mastectomy, chest reconstruction, or augmentation mammoplasty).

- Two referrals—from qualified mental health professionals who have independently assessed the patient—are needed for genital surgery (i.e., hysterectomy/salpingo-oophorectomy, orchiectomy, genital reconstructive surgeries). If the first referral is from the patient's psychotherapist, the second referral should be from a person who has only had an evaluative role with the patient. Two separate letters, or one letter signed by both (e.g., if practicing within the same clinic) may be sent. Each referral letter, however, is expected to cover the same topics in the areas outlined below.

The recommended content of the referral letters for surgery is as follows:

1. The client's general identifying characteristics;
2. Results of the client's psychosocial assessment, including any diagnoses;
3. The duration of the mental health professional's relationship with the client, including the type of evaluation and therapy or counseling to date;
4. An explanation that the criteria for surgery have been met, and a brief description of the clinical rationale for supporting the patient's request for surgery;
5. A statement about the fact that informed consent has been obtained from the patient;
6. A statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this.

For providers working within a multidisciplinary specialty team, a letter may not be necessary, rather, the assessment and recommendation can be documented in the patient's chart.

Relationship of Mental Health Professionals with Hormone-Prescribing Physicians, Surgeons, and Other Health Professionals

It is ideal for mental health professionals to perform their work and periodically discuss progress and obtain peer consultation from other professionals (both in mental health care and other health disciplines) who are competent in the assessment and treatment of gender dysphoria. The relationship among professionals involved in a client's health care should remain collaborative, with coordination and clinical dialogue taking place as needed. Open and consistent communication may be necessary for consultation, referral, and management of postoperative concerns.

Tasks Related to Psychotherapy

1. Psychotherapy Is Not an Absolute Requirement for Hormone Therapy and Surgery

A mental health screening and/or assessment as outlined above is needed for referral to hormonal and surgical treatments for gender dysphoria. In contrast, psychotherapy—although highly recommended—is not a requirement.

The *SOC* do not recommend a minimum number of psychotherapy sessions prior to hormone therapy or surgery. The reasons for this are multifaceted (Lev, 2009). First, a minimum number of sessions tends to be construed as a hurdle, which discourages the genuine opportunity for personal growth. Second, mental health professionals can offer important support to clients throughout all phases of exploration of gender identity, gender expression, and possible transition—not just prior to any possible medical interventions. Third, clients and their psychotherapists differ in their abilities to attain similar goals in a specified time period.

2. Goals of Psychotherapy for Adults with Gender Concerns

The general goal of psychotherapy is to find ways to maximize a person's overall psychological well-being, quality of life, and self-fulfillment. Psychotherapy is not intended to alter a person's gender identity; rather, psychotherapy can help an individual to explore gender concerns and find ways to alleviate gender dysphoria, if present (Bockting et al., 2006; Bockting & Coleman, 2007; Fraser, 2009a; Lev, 2004). Typically, the overarching treatment goal is to help transsexual, transgender, and gender-nonconforming individuals achieve long-term comfort in their gender identity expression, with realistic chances for success in their relationships, education, and work. For additional details, see Fraser (Fraser, 2009c).

Therapy may consist of individual, couple, family, or group psychotherapy, the latter being particularly important to foster peer support.

3. Psychotherapy for Transsexual, Transgender, and Gender-Nonconforming Clients, Including Counseling and Support for Changes in Gender Role

Finding a comfortable gender role is, first and foremost, a psychosocial process. Psychotherapy can be invaluable in assisting transsexual, transgender, and gender-nonconforming individuals with all of the following: (i) clarifying and exploring gender identity and role, (ii) addressing the impact of stigma and minority stress on one's mental health and human development, and (iii) facilitating a coming-out process (Bockting & Coleman, 2007; Devor, 2004; Lev, 2004), which for some individuals may include changes in gender role expression and the use of feminizing/masculinizing medical interventions.

Mental health professionals can provide support and promote interpersonal skills and resilience in individuals and their families as they navigate a world that often is ill-prepared to accommodate and respect transgender, transsexual, and gender-nonconforming people. Psychotherapy can also aid in alleviating any coexisting mental health concerns (e.g., anxiety, depression) identified during screening and assessment.

For transsexual, transgender, and gender-nonconforming individuals who plan to change gender roles permanently and make a social gender role transition, mental health professionals can facilitate the development of an individualized plan with specific goals and timelines. While the experience of changing one's gender role differs from person to person, the social aspects of the experience are usually challenging—often more so than the physical aspects. Because changing gender role can have profound personal and social consequences, the decision to do so should include an awareness of what the familial, interpersonal, educational, vocational, economic, and legal challenges are likely to be, so that people can function successfully in their gender role.

Many transsexual, transgender, and gender-nonconforming people will present for care without ever having been related to, or accepted in, the gender role that is most congruent with their gender identity. Mental health professionals can help these clients to explore and anticipate the implications of changes in gender role, and to pace the process of implementing these changes. Psychotherapy can provide a space for clients to begin to express themselves in ways that are congruent with their gender identity and, for some clients, overcome fears about changes in gender expression. Calculated risks can be taken outside of therapy to gain experience and build confidence in the new role. Assistance with coming out to family and community (friends, school, workplace) can be provided.

Other transsexual, transgender, and gender-nonconforming individuals will present for care already having acquired experience (minimal, moderate, or extensive) living in a gender role that differs from that associated with their birth-assigned sex. Mental health professionals can help these clients to identify and work through potential challenges and foster optimal adjustment as they continue to express changes in their gender role.

4. Family Therapy or Support for Family Members

Decisions about changes in gender role and medical interventions for gender dysphoria have implications for, not only clients, but also their families (Emerson & Rosenfeld, 1996; Fraser, 2009a; Lev, 2004). Mental health professionals can assist clients with making thoughtful decisions about communicating with family members and others about their gender identity and treatment decisions. Family therapy may include work with spouses or partners, as well as with children and other members of a client's extended family.

Clients may also request assistance with their relationships and sexual health. For example, they may want to explore their sexuality and intimacy-related concerns.

Family therapy might be offered as part of the client's individual therapy and, if clinically appropriate, by the same provider. Alternatively, referrals can be made to other therapists with relevant expertise

for working with family members or to sources of peer support (e.g., in-person or offline support networks of partners or families).

5. Follow-Up Care Throughout Life

Mental health professionals may work with clients and their families at many stages of their lives. Psychotherapy may be helpful at different times and for various issues throughout the life cycle.

6. E-Therapy, Online Counseling, or Distance Counseling

Online or e-therapy has been shown to be particularly useful for people who have difficulty accessing competent in-person psychotherapeutic treatment and who may experience isolation and stigma (Derrig-Palumbo & Zeine, 2005; Fenichel et al., 2004; Fraser, 2009b). By extrapolation, e-therapy may be a useful modality for psychotherapy with transsexual, transgender, and gender-nonconforming people. E-therapy offers opportunities for potentially enhanced, expanded, creative, and tailored delivery of services; however, as a developing modality it may also carry unexpected risk. Telemedicine guidelines are clear in some disciplines in some parts of the United States (Fraser, 2009b; Maheu, Pulier, Wilhelm, McMenamin, & Brown-Connolly, 2005) but not all; the international situation is even less well-defined (Maheu et al., 2005). Until sufficient evidence-based data on this use of e-therapy is available, caution in its use is advised.

Mental health professionals engaging in e-therapy are advised to stay current with their particular licensing board, professional association, and country's regulations, as well as the most recent literature pertaining to this rapidly evolving medium. A more thorough description of the potential uses, processes, and ethical concerns related to e-therapy has been published (Fraser, 2009b).

Other Tasks of Mental Health Professionals

1. Educate and Advocate on Behalf of Clients Within Their Community (Schools, Workplaces, Other Organizations) and Assist Clients with Making Changes in Identity Documents

Transsexual, transgender, and gender-nonconforming people may face challenges in their professional, educational, and other types of settings as they actualize their gender identity and expression (Lev, 2004, 2009). Mental health professionals can play an important role by educating people in these settings regarding gender nonconformity and by advocating on behalf of their clients (Currah, Juang, & Minter, 2006; Currah & Minter, 2000). This role may involve consultation

with school counselors, teachers, and administrators, human resources staff, personnel managers and employers, and representatives from other organizations and institutions. In addition, health providers may be called upon to support changes in a client's name and/or gender marker on identity documents such as passports, driver's licenses, birth certificates, and diplomas.

2. Provide Information and Referral for Peer Support

For some transsexual, transgender, and gender-nonconforming people, an experience in peer support groups may be more instructive regarding options for gender expression than anything individual psychotherapy could offer (Rachlin, 2002). Both experiences are potentially valuable, and all people exploring gender issues should be encouraged to participate in community activities, if possible. Resources for peer support and information should be made available.

Culture and Its Ramifications for Assessment and Psychotherapy

Health professionals work in enormously different environments across the world. Forms of distress that cause people to seek professional assistance in any culture are understood and classified by people in terms that are products of their own cultures (Frank & Frank, 1993). Cultural settings also largely determine how such conditions are understood by mental health professionals. Cultural differences related to gender identity and expression can affect patients, mental health professionals, and accepted psychotherapy practice. WPATH recognizes that the *SOC* have grown out of a Western tradition and may need to be adapted depending on the cultural context.

Ethical Guidelines Related to Mental Health Care

Mental health professionals need to be certified or licensed to practice in a given country according to that country's professional regulations (Fraser, 2009b; Pope & Vasquez, 2011). Professionals must adhere to the ethical codes of their professional licensing or certifying organizations in all of their work with transsexual, transgender, and gender-nonconforming clients.

Treatment aimed at trying to change a person's gender identity and lived gender expression to become more congruent with sex assigned at birth has been attempted in the past (Gelder & Marks, 1969; Greenson, 1964), yet without success, particularly in the long-term (Cohen-Kettenis & Kuiper, 1984; Pauly, 1965). Such treatment is no longer considered ethical.

If mental health professionals are uncomfortable with, or inexperienced in, working with transsexual, transgender, and gender-nonconforming individuals and their families, they should refer clients to a competent provider or, at minimum, consult with an expert peer. If no local practitioners are available, consultation may be done via telehealth methods, assuming local requirements for distance consultation are met.

Issues of Access to Care

Qualified mental health professionals are not universally available; thus, access to quality care might be limited. WPATH aims to improve access and provides regular continuing education opportunities to train professionals from various disciplines to provide quality, transgender-specific health care. Providing mental health care from a distance through the use of technology may be one way to improve access (Fraser, 2009b).

In many places around the world, access to health care for transsexual, transgender, and gender-nonconforming people is also limited by a lack of health insurance or other means to pay for needed care. WPATH urges health insurance companies and other third-party payers to cover the medically necessary treatments to alleviate gender dysphoria (American Medical Association, 2008; Anton, 2009; The World Professional Association for Transgender Health, 2008).

When faced with a client who is unable to access services, referral to available peer support resources (offline and online) is recommended. Finally, harm-reduction approaches might be indicated to assist clients with making healthy decisions to improve their lives.

VIII
Hormone Therapy

Medical Necessity of Hormone Therapy

Feminizing/masculinizing hormone therapy—the administration of exogenous endocrine agents to induce feminizing or masculinizing changes—is a medically necessary intervention for many transsexual, transgender, and gender-nonconforming individuals with gender dysphoria

(Newfield, Hart, Dibble, & Kohler, 2006; Pfäfflin & Junge, 1998). Some people seek maximum feminization/masculinization, while others experience relief with an androgynous presentation resulting from hormonal minimization of existing secondary sex characteristics (Factor & Rothblum, 2008). Evidence for the psychosocial outcomes of hormone therapy is summarized in Appendix D.

Hormone therapy must be individualized based on a patient's goals, the risk/benefit ratio of medications, the presence of other medical conditions, and consideration of social and economic issues. Hormone therapy can provide significant comfort to patients who do not wish to make a social gender role transition or undergo surgery, or who are unable to do so (Meyer III, 2009). Hormone therapy is a recommended criterion for some, but not all, surgical treatments for gender dysphoria (see section XI and Appendix C).

Criteria for Hormone Therapy

Initiation of hormone therapy may be undertaken after a psychosocial assessment has been conducted and informed consent has been obtained by a qualified health professional, as outlined in section VII of the *SOC*. A referral is required from the mental health professional who performed the assessment, unless the assessment was done by a hormone provider who is also qualified in this area.

The criteria for hormone therapy are as follows:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* outlined in section VI);
4. If significant medical or mental health concerns are present, they must be reasonably well-controlled.

As noted in section VII of the *SOC*, the presence of coexisting mental health concerns does not necessarily preclude access to feminizing/masculinizing hormones; rather, these concerns need to be managed prior to, or concurrent with, treatment of gender dysphoria.

In selected circumstances, it can be acceptable practice to provide hormones to patients who have not fulfilled these criteria. Examples include facilitating the provision of monitored therapy using hormones of known quality as an alternative to illicit or unsupervised hormone use or to patients

who have already established themselves in their affirmed gender and who have a history of prior hormone use. It is unethical to deny availability or eligibility for hormone therapy solely on the basis of blood seropositivity for blood-borne infections such as HIV or hepatitis B or C.

In rare cases, hormone therapy may be contraindicated due to serious individual health conditions. Health professionals should assist these patients with accessing nonhormonal interventions for gender dysphoria. A qualified mental health professional familiar with the patient is an excellent resource in these circumstances.

Informed Consent

Feminizing/masculinizing hormone therapy may lead to irreversible physical changes. Thus, hormone therapy should be provided only to those who are legally able to provide informed consent. This includes people who have been declared by a court to be emancipated minors, incarcerated people, and cognitively impaired people who are considered competent to participate in their medical decisions (Bockting et al., 2006). Providers should document in the medical record that comprehensive information has been provided and understood about all relevant aspects of the hormone therapy, including both possible benefits and risks and the impact on reproductive capacity.

Relationship Between the *Standards of Care* and Informed Consent Model Protocols

A number of community health centers in the United States have developed protocols for providing hormone therapy based on an approach that has become known as the Informed Consent Model (Callen Lorde Community Health Center, 2000, 2011; Fenway Community Health Transgender Health Program, 2007; Tom Waddell Health Center, 2006). These protocols are consistent with the guidelines presented in the WPATH *Standards of Care, Version 7*. The *SOC* are flexible clinical guidelines; they allow for tailoring of interventions to the needs of the individual receiving services and for tailoring of protocols to the approach and setting in which these services are provided (Ehrbar & Gorton, 2010).

Obtaining informed consent for hormone therapy is an important task of providers to ensure that patients understand the psychological and physical benefits and risks of hormone therapy, as well as its psychosocial implications. Providers prescribing the hormones or health professionals recommending the hormones should have the knowledge and experience to assess gender

dysphoria. They should inform individuals of the particular benefits, limitations, and risks of hormones, given the patient's age, previous experience with hormones, and concurrent physical or mental health concerns.

Screening for and addressing acute or current mental health concerns is an important part of the informed consent process. This may be done by a mental health professional or by an appropriately trained prescribing provider (see section VII of the *SOC*). The same provider or another appropriately trained member of the health care team (e.g., a nurse) can address the psychosocial implications of taking hormones when necessary (e.g., the impact of masculinization/feminization on how one is perceived and its potential impact on relationships with family, friends, and coworkers). If indicated, these providers will make referrals for psychotherapy and for the assessment and treatment of coexisting mental health concerns such as anxiety or depression.

The difference between the Informed Consent Model and *SOC, Version 7,* is that the *SOC* puts greater emphasis on the important role that mental health professionals can play in alleviating gender dysphoria and facilitating changes in gender role and psychosocial adjustment. This may include a comprehensive mental health assessment and psychotherapy, when indicated. In the Informed Consent Model, the focus is on obtaining informed consent as the threshold for the initiation of hormone therapy in a multidisciplinary, harm-reduction environment. Less emphasis is placed on the provision of mental health care until the patient requests it, unless significant mental health concerns are identified that would need to be addressed before hormone prescription.

Physical Effects of Hormone Therapy

Feminizing/masculinizing hormone therapy will induce physical changes that are more congruent with a patient's gender identity.

- In FtM patients, the following physical changes are expected to occur: deepened voice, clitoral enlargement (variable), growth in facial and body hair, cessation of menses, atrophy of breast tissue, and decreased percentage of body fat compared to muscle mass.

- In MtF patients, the following physical changes are expected to occur: breast growth (variable), decreased erectile function, decreased testicular size, and increased percentage of body fat compared to muscle mass.

Most physical changes, whether feminizing or masculinizing, occur over the course of two years. The amount of physical change and the exact timeline of effects can be highly variable. Tables 1a and 1b outline the approximate time course of these physical changes.

TABLE 1A: EFFECTS AND EXPECTED TIME COURSE OF MASCULINIZING HORMONES [A]

Effect	Expected onset[B]	Expected maximum effect[B]
Skin oiliness/acne	1–6 months	1–2 years
Facial/body hair growth	3–6 months	3–5 years
Scalp hair loss	>12 months[C]	Variable
Increased muscle mass/strength	6–12 months	2–5 years[D]
Body fat redistribution	3–6 months	2–5 years
Cessation of menses	2–6 months	n/a
Clitoral enlargement	3–6 months	1–2 years
Vaginal atrophy	3–6 months	1–2 years
Deepened voice	3–12 months	1–2 years

[A] Adapted with permission from Hembree et al.(2009). Copyright 2009, The Endocrine Society.
[B] Estimates represent published and unpublished clinical observations.
[C] Highly dependent on age and inheritance; may be minimal.
[D] Significantly dependent on amount of exercise.

TABLE 1B: EFFECTS AND EXPECTED TIME COURSE OF FEMINIZING HORMONES [A]

Effect	Expected onset[B]	Expected maximum effect[B]
Body fat redistribution	3–6 months	2–5 years
Decreased muscle mass/ strength	3–6 months	1–2 years[C]
Softening of skin/decreased oiliness	3–6 months	Unknown
Decreased libido	1–3 months	1–2 years
Decreased spontaneous erections	1–3 months	3–6 months
Male sexual dysfunction	Variable	Variable
Breast growth	3–6 months	2–3 years
Decreased testicular volume	3–6 months	2–3 years
Decreased sperm production	Variable	Variable
Thinning and slowed growth of body and facial hair	6–12 months	> 3 years[D]
Male pattern baldness	No regrowth, loss stops 1–3 months	1–2 years

[A] Adapted with permission from Hembree et al. (2009). Copyright 2009, The Endocrine Society.
[B] Estimates represent published and unpublished clinical observations.
[C] Significantly dependent on amount of exercise.
[D] Complete removal of male facial and body hair requires electrolysis, laser treatment, or both.

The degree and rate of physical effects depends in part on the dose, route of administration, and medications used, which are selected in accordance with a patient's specific medical goals (e.g., changes in gender role expression, plans for sex reassignment) and medical risk profile. There is no current evidence that response to hormone therapy—with the possible exception of voice deepening in FtM persons—can be reliably predicted based on age, body habitus, ethnicity, or family appearance. All other factors being equal, there is no evidence to suggest that any medically approved type or method of administering hormones is more effective than any other in producing the desired physical changes.

Risks of Hormone Therapy

All medical interventions carry risks. The likelihood of a serious adverse event is dependent on numerous factors: the medication itself, dose, route of administration, and a patient's clinical characteristics (age, comorbidities, family history, health habits). It is thus impossible to predict whether a given adverse effect will happen in an individual patient.

The risks associated with feminizing/masculinizing hormone therapy for the transsexual, transgender, and gender-nonconforming population as a whole are summarized in Table 2. Based on the level of evidence, risks are categorized as follows: (i) likely increased risk with hormone therapy, (ii) possibly increased risk with hormone therapy, or (iii) inconclusive or no increased risk. Items in the last category include those that may present risk, but for which the evidence is so minimal that no clear conclusion can be reached.

Additional detail about these risks can be found in Appendix B, which is based on two comprehensive, evidence-based literature reviews of masculinizing/feminizing hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009), along with a large cohort study (Asscheman et al., 2011). These reviews can serve as detailed references for providers, along with other widely recognized, published clinical materials (Dahl, Feldman, Goldberg, & Jaberi, 2006; Ettner, Monstrey, & Eyler, 2007).

TABLE 2: RISKS ASSOCIATED WITH HORMONE THERAPY. BOLDED ITEMS ARE CLINICALLY SIGNIFICANT

Risk Level	Feminizing hormones	Masculinizing hormones
Likely increased risk	**Venous thromboembolic disease**[A] Gallstones Elevated liver enzymes Weight gain **Hypertriglyceridemia**	**Polycythemia** Weight gain Acne Androgenic alopecia (balding) Sleep apnea
Likely increased risk with presence of additional risk factors[B]	Cardiovascular disease	
Possible increased risk	**Hypertension** Hyperprolactinemia or prolactinoma	Elevated liver enzymes **Hyperlipidemia**
Possible increased risk with presence of additional risk factors[B]	**Type 2 diabetes**[A]	**Destabilization of certain psychiatric disorders**[C] **Cardiovascular disease** **Hypertension** **Type 2 diabetes**
No increased risk or inconclusive	**Breast cancer**	Loss of bone density **Breast cancer** **Cervical cancer** **Ovarian cancer** **Uterine cancer**

[*] **Note:** Risk is greater with oral estrogen administration than with transdermal estrogen administration.
[A] Risk is greater with oral estrogen administration than with transdermal estrogen administration.
[B] Additional risk factors include age.
[C] Includes bipolar, schizoaffective, and other disorders that may include manic or psychotic symptoms. This adverse event appears to be associated with higher doses or supraphysiologic blood levels of testosterone.

Competency of Hormone-Prescribing Physicians, Relationship with Other Health Professionals

Feminizing/masculinizing hormone therapy is best undertaken in the context of a complete approach to health care that includes comprehensive primary care and a coordinated approach to psychosocial issues (Feldman & Safer, 2009). While psychotherapy or ongoing counseling is not required for the initiation of hormone therapy, if a therapist is involved, then regular communication among health professionals is advised (with the patient's consent) to ensure that the transition process is going well, both physically and psychosocially.

With appropriate training, feminizing/masculinizing hormone therapy can be managed by a variety of providers, including nurse practitioners, physician assistants, and primary care physicians (Dahl et al., 2006). Medical visits relating to hormone maintenance provide an opportunity to deliver broader care to a population that is often medically underserved (Clements, Wilkinson, Kitano, & Marx, 1999; Feldman, 2007; Xavier, 2000). Many of the screening tasks and management of comorbidities associated with long-term hormone use, such as cardiovascular risk factors and cancer screening, fall more uniformly within the scope of primary care rather than specialist care (American Academy of Family Physicians, 2005; Eyler, 2007; World Health Organization, 2008), particularly in locations where dedicated gender teams or specialized physicians are not available.

Given the multidisciplinary needs of transsexual, transgender, and gender-nonconforming people seeking hormone therapy, as well as the difficulties associated with fragmentation of care in general (World Health Organization, 2008), WPATH strongly encourages the increased training and involvement of primary care providers in the area of feminizing/masculinizing hormone therapy. If hormones are prescribed by a specialist, there should be close communication with the patient's primary care provider. Conversely, an experienced hormone provider or endocrinologist should be involved if the primary care physician has no experience with this type of hormone therapy, or if the patient has a pre-existing metabolic or endocrine disorder that could be affected by endocrine therapy.

While formal training programs in transgender medicine do not yet exist, hormone providers have a responsibility to obtain appropriate knowledge and experience in this field. Clinicians can increase their experience and comfort in providing feminizing/masculinizing hormone therapy by co-managing care or consulting with a more experienced provider, or by providing more limited types of hormone therapy before progressing to initiation of hormone therapy. Because this field of medicine is evolving, clinicians should become familiar and keep current with the medical literature, and discuss emerging issues with colleagues. Such discussions might occur through networks established by WPATH and other national/local organizations.

Responsibilities of Hormone-Prescribing Physicians

In general, clinicians who prescribe hormone therapy should engage in the following tasks:

1. Perform an initial evaluation that includes discussion of a patient's physical transition goals, health history, physical examination, risk assessment, and relevant laboratory tests.

2. Discuss with patients the expected effects of feminizing/masculinizing medications and the possible adverse health effects. These effects can include a reduction in fertility (Feldman & Safer, 2009; Hembree et al., 2009). Therefore, reproductive options should be discussed with patients before starting hormone therapy (see section IX).

3. Confirm that patients have the capacity to understand the risks and benefits of treatment and are capable of making an informed decision about medical care.

4. Provide ongoing medical monitoring, including regular physical and laboratory examination to monitor hormone effectiveness and side effects.

5. Communicate as needed with a patient's primary care provider, mental health professional, and surgeon.

6. If needed, provide patients with a brief written statement indicating that they are under medical supervision and care that includes feminizing/masculinizing hormone therapy. Particularly during the early phases of hormone treatment, a patient may wish to carry this statement at all times to help prevent difficulties with the police and other authorities.

Depending on the clinical situation for providing hormones (see below), some of these responsibilities are less relevant. Thus, the degree of counseling, physical examinations, and laboratory evaluations should be individualized to a patient's needs.

Clinical Situations for Hormone Therapy

There are circumstances in which clinicians may be called upon to provide hormones without necessarily initiating or maintaining long-term feminizing/masculinizing hormone therapy. By acknowledging these different clinical situations (see below, from least to highest level of complexity), it may be possible to involve clinicians in feminizing/masculinizing hormone therapy who might not otherwise feel able to offer this treatment.

1. Bridging

Whether prescribed by another clinician or obtained through other means (e.g., purchased over the Internet), patients may present for care already on hormone therapy. Clinicians can provide a limited (1–6 month) prescription for hormones while helping patients find a provider who can prescribe long-term hormone therapy. Providers should assess a patient's current regimen for safety and drug interactions and substitute safer medications or doses when indicated (Dahl et al., 2006; Feldman & Safer, 2009). If hormones were previously prescribed, medical records should be requested (with the patient's permission) to obtain the results of baseline examinations and laboratory tests and any adverse events. Hormone providers should also communicate with any mental health professional who is currently involved in a patient's care. If a patient has never had a psychosocial assessment as recommended by the *SOC* (see section VII), clinicians should refer the patient to a qualified mental health professional if appropriate and feasible (Feldman & Safer, 2009). Providers who prescribe bridging hormones need to work with patients to establish limits as to the duration of bridging therapy.

2. Hormone Therapy Following Gonad Removal

Hormone replacement with estrogen or testosterone is usually continued lifelong after an oophorectomy or orchiectomy, unless medical contraindications arise. Because hormone doses are often decreased after these surgeries (Basson, 2001; Levy, Crown, & Reid, 2003; Moore, Wisniewski, & Dobs, 2003) and only adjusted for age and comorbid health concerns, hormone management in this situation is quite similar to hormone replacement in any hypogonadal patient.

3. Hormone Maintenance Prior to Gonad Removal

Once patients have achieved maximal feminizing/masculinizing benefits from hormones (typically two or more years), they remain on a maintenance dose. The maintenance dose is then adjusted for changes in health conditions, aging, or other considerations such as lifestyle changes (Dahl et al., 2006). When a patient on maintenance hormones presents for care, the provider should assess the patient's current regimen for safety and drug interactions and substitute safer medications or doses when indicated. The patient should continue to be monitored by physical examinations and laboratory testing on a regular basis, as outlined in the literature (Feldman & Safer, 2009; Hembree et al., 2009). The dose and form of hormones should be revisited regularly with any changes in the patient's health status and available evidence on the potential long-term risks of hormones (See *Hormone Regimens,* below).

4. Initiating Hormonal Feminization/Masculinization

This clinical situation requires the greatest commitment in terms of provider time and expertise. Hormone therapy must be individualized based on a patient's goals, the risk/benefit ratio of medications, the presence of other medical conditions, and consideration of social and economic issues. Although a wide variety of hormone regimens have been published (Dahl et al., 2006; Hembree et al., 2009; Moore et al., 2003), there are no published reports of randomized clinical trials comparing safety and efficacy. Despite this variation, a reasonable framework for initial risk assessment and ongoing monitoring of hormone therapy can be constructed, based on the efficacy and safety evidence presented above.

Risk Assessment and Modification for Initiating Hormone Therapy

The initial evaluation for hormone therapy assesses a patient's clinical goals and risk factors for hormone-related adverse events. During the risk assessment, the patient and clinician should develop a plan for reducing risks wherever possible, either prior to initiating therapy or as part of ongoing harm reduction.

All assessments should include a thorough physical exam, including weight, height, and blood pressure. The need for breast, genital, and rectal exams, which are sensitive issues for most transsexual, transgender, and gender-nonconforming patients, should be based on individual risks and preventive health care needs (Feldman & Goldberg, 2006; Feldman, 2007).

Preventive Care

Hormone providers should address preventive health care with patients, particularly if a patient does not have a primary care provider. Depending on a patient's age and risk profile, there may be appropriate screening tests or exams for conditions affected by hormone therapy. Ideally, these screening tests should be carried out prior to the start of hormone therapy.

Risk Assessment and Modification for Feminizing Hormone Therapy (MtF)

There are no absolute contraindications to feminizing therapy per se, but absolute contraindications exist for the different feminizing agents, particularly estrogen. These include previous venous thrombotic events related to an underlying hypercoagulable condition, history of estrogen-sensitive neoplasm, and end-stage chronic liver disease (Gharib et al., 2005).

Other medical conditions, as noted in Table 2 and Appendix B, can be exacerbated by estrogen or androgen blockade, and therefore should be evaluated and reasonably well controlled prior to starting hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009). Clinicians should particularly attend to tobacco use, as it is associated with increased risk of venous thrombosis, which is further increased with estrogen use. Consultation with a cardiologist may be advisable for patients with known cardio- or cerebrovascular disease.

Baseline laboratory values are important to both assess initial risk and evaluate possible future adverse events. Initial labs should be based on the risks of feminizing hormone therapy outlined in Table 2, as well as individual patient risk factors, including family history. Suggested initial lab panels have been published (Feldman & Safer, 2009; Hembree et al., 2009). These can be modified for patients or health care systems with limited resources, and in otherwise healthy patients.

Risk Assessment and Modification for Masculinizing Hormone Therapy (FtM)

Absolute contraindications to testosterone therapy include pregnancy, unstable coronary artery disease, and untreated polycythemia with a hematocrit of 55% or higher (Carnegie, 2004). Because the aromatization of testosterone to estrogen may increase risk in patients with a history of breast or other estrogen dependent cancers (Moore et al., 2003), consultation with an oncologist may be indicated prior to hormone use. Comorbid conditions likely to be exacerbated by testosterone use should be evaluated and treated, ideally prior to starting hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009). Consultation with a cardiologist may be advisable for patients with known cardio- or cerebrovascular disease. (Dhejne et al., 2011).

An increased prevalence of polycystic ovarian syndrome (PCOS) has been noted among FtM patients even in the absence of testosterone use (Baba et al., 2007; Balen, Schachter, Montgomery, Reid, & Jacobs, 1993; Bosinski et al., 1997). While there is no evidence that PCOS is related to the development of a transsexual, transgender, or gender-nonconforming identity, PCOS is associated with increased risk of diabetes, cardiac disease, high blood pressure, and ovarian and endometrial cancers (Cattrall & Healy, 2004). Signs and symptoms of PCOS should be evaluated prior to initiating testosterone therapy, as testosterone may affect many of these conditions. Testosterone can affect the developing fetus (*Physicians' Desk Reference,* 2010), and patients at risk of becoming pregnant require highly effective birth control.

Baseline laboratory values are important to both assess initial risk and evaluate possible future adverse events. Initial labs should be based on the risks of masculinizing hormone therapy outlined in Table 2, as well as individual patient risk factors, including family history. Suggested initial lab panels have been published (Feldman & Safer, 2009; Hembree et al., 2009). These can be modified for patients or health care systems with limited resources, and in otherwise healthy patients.

Clinical Monitoring During Hormone Therapy for Efficacy and Adverse Events

The purpose of clinical monitoring during hormone use is to assess the degree of feminization/masculinization and the possible presence of adverse effects of medication. However, as with the monitoring of any long-term medication, monitoring should take place in the context of comprehensive health care. Suggested clinical monitoring protocols have been published (Feldman & Safer, 2009; Hembree et al., 2009). Patients with comorbid medical conditions may need to be monitored more frequently. Healthy patients in geographically remote or resource-poor areas may be able to use alternative strategies, such as telehealth, or cooperation with local providers such as nurses and physician assistants. In the absence of other indications, health professionals may prioritize monitoring for those risks that are either likely to be increased by hormone therapy or possibly increased by hormone therapy but clinically serious in nature.

Efficacy and Risk Monitoring During Feminizing Hormone Therapy (MtF)

The best assessment of hormone efficacy is clinical response: Is a patient developing a feminized body while minimizing masculine characteristics, consistent with that patient's gender goals? In order to more rapidly predict the hormone dosages that will achieve clinical response, one can measure testosterone levels for suppression below the upper limit of the normal female range and estradiol levels within a premenopausal female range but well below supraphysiologic levels (Feldman & Safer, 2009; Hembree et al., 2009).

Monitoring for adverse events should include both clinical and laboratory evaluation. Follow-up should include careful assessment for signs of cardiovascular impairment and venous thromboembolism (VTE) through measurement of blood pressure, weight, and pulse; heart and lung exams; and examination of the extremities for peripheral edema, localized swelling, or pain (Feldman & Safer, 2009). Laboratory monitoring should be based on the risks of hormone therapy described above, a patient's individual comorbidities and risk factors, and the specific hormone regimen itself. Specific lab-monitoring protocols have been published (Feldman & Safer, 2009; Hembree et al., 2009).

Efficacy and Risk Monitoring During Masculinizing Hormone Therapy (FtM)

The best assessment of hormone efficacy is clinical response: Is a patient developing a masculinized body while minimizing feminine characteristics, consistent with that patient's gender goals? Clinicians can achieve a good clinical response with the least likelihood of adverse events by maintaining testosterone levels within the normal male range while avoiding supraphysiological

levels (Dahl et al., 2006; Hembree et al., 2009). For patients using intramuscular (IM) testosterone cypionate or enanthate, some clinicians check trough levels while others prefer midcycle levels (Dahl et al., 2006; Hembree et al., 2009; Tangpricha, Turner, Malabanan, & Holick, 2001; Tangpricha, Ducharme, Barber, & Chipkin, 2003).

Monitoring for adverse events should include both clinical and laboratory evaluation. Follow-up should include careful assessment for signs and symptoms of excessive weight gain, acne, uterine break-through bleeding, and cardiovascular impairment, as well as psychiatric symptoms in at-risk patients. Physical examinations should include measurement of blood pressure, weight, and pulse; and heart, lung, and skin exams (Feldman & Safer, 2009). Laboratory monitoring should be based on the risks of hormone therapy described above, a patient's individual comorbidities and risk factors, and the specific hormone regimen itself. Specific lab monitoring protocols have been published (Feldman & Safer, 2009; Hembree et al., 2009).

Hormone Regimens

To date, no controlled clinical trials of any feminizing/masculinizing hormone regimen have been conducted to evaluate safety or efficacy in producing physical transition. As a result, wide variation in doses and types of hormones have been published in the medical literature (Moore et al., 2003; Tangpricha et al., 2003; van Kesteren, Asscheman, Megens, & Gooren, 1997). In addition, access to particular medications may be limited by a patient's geographical location and/or social or econonomic situations. For these reasons, WPATH does not describe or endorse a particular feminizing/masculinizing hormone regimen. Rather, the medication classes and routes of administration used in most published regimens are broadly reviewed.

As outlined above, there are demonstrated safety differences in individual elements of various regimens. The Endocrine Society Guidelines (Hembree et al., 2009) and Feldman and Safer (2009) provide specific guidance regarding the types of hormones and suggested dosing to maintain levels within physiologic ranges for a patient's desired gender expression (based on goals of full feminization/masculinization). It is strongly recommend that hormone providers regularly review the literature for new information and use those medications that safely meet individual patient needs with available local resources.

Regimens for Feminizing Hormone Therapy (MtF)

Estrogen

Use of oral estrogen, and specifically ethinyl estradiol, appears to increase the risk of VTE. Because of this safety concern, ethinyl estradiol is not recommended for feminizing hormone therapy. Transdermal estrogen is recommended for those patients with risks factors for VTE. The risk of adverse events increases with higher doses, particular doses resulting in supraphysiologic levels (Hembree et al., 2009). Patients with co-morbid conditions that can be affected by estrogen should avoid oral estrogen if possible and be started at lower levels. Some patients may not be able to safely use the levels of estrogen needed to get the desired results. This possibility needs to be discussed with patients well in advance of starting hormone therapy.

Androgen-reducing medications ("anti-androgens")

A combination of estrogen and "anti-androgens" is the most commonly studied regimen for feminization. Androgen-reducing medications, from a variety of classes of drugs, have the effect of reducing either endogenous testosterone levels or testosterone activity, and thus diminishing masculine characteristics such as body hair. They minimize the dosage of estrogen needed to suppress testosterone, thereby reducing the risks associated with high-dose exogenous estrogen (Prior, Vigna, Watson, Diewold, & Robinow, 1986; Prior, Vigna, & Watson, 1989).

Common anti-androgens include the following:

- Spironolactone, an antihypertensive agent, directly inhibits testosterone secretion and androgen binding to the androgen receptor. Blood pressure and electrolytes need to be monitored because of the potential for hyperkalemia.

- Cyproterone acetate is a progestational compound with anti-androgenic properties. This medication is not approved in the United States because of concerns over potential hepatotoxicity, but it is widely used elsewhere (De Cuypere et al., 2005).

- GnRH agonists (e.g., goserelin, buserelin, triptorelin) are neurohormones that block the gonadtropin-releasing hormone receptor, thus blocking the release of follicle stimulating hormone and luteinizing hormone. This leads to highly effective gonadal blockade. However, these medications are expensive and only available as injectables or implants.

- 5-alpha reductase inhibitors (finasteride and dutasteride) block the conversion of testosterone to the more active agent, 5-alpha-dihydrotestosterone. These medications have beneficial effects on scalp hair loss, body hair growth, sebaceous glands, and skin consistency.

Cyproterone and spironolactone are the most commonly used anti-androgens and are likely the most cost-effective.

Progestins

With the exception of cyproterone, the inclusion of progestins in feminizing hormone therapy is controversial (Oriel, 2000). Because progestins play a role in mammary development on a cellular level, some clinicians believe that these agents are necessary for full breast development (Basson & Prior, 1998; Oriel, 2000). However, a clinical comparison of feminization regimens with and without progestins found that the addition of progestins neither enhanced breast growth nor lowered serum levels of free testosterone (Meyer et al., 1986). There are concerns regarding potential adverse effects of progestins, including depression, weight gain, and lipid changes (Meyer et al., 1986; Tangpricha et al., 2003). Progestins (especially medroxyprogesterone) are also suspected to increase breast cancer risk and cardiovascular risk in women (Rossouw et al., 2002). Micronized progesterone may be better tolerated and have a more favorable impact on the lipid profile than medroxyprogesterone does (de Lignières, 1999; Fitzpatrick, Pace, & Wiita, 2000).

Regimens for Masculinizing Hormone Therapy (FtM)

Testosterone

Testosterone generally can be given orally, transdermally, or parenterally (IM), although buccal and implantable preparations are also available. Oral testosterone undecanoate, available outside the United States, results in lower serum testosterone levels than nonoral preparations and has limited efficacy in suppressing menses (Feldman, 2005, April; Moore et al., 2003). Because intramuscular testosterone cypionate or enanthate are often administered every 2–4 weeks, some patients may notice cyclic variation in effects (e.g., fatigue and irritability at the end of the injection cycle, aggression or expansive mood at the beginning of the injection cycle), as well as more time outside the normal physiologic levels (Jockenhövel, 2004). This may be mitigated by using a lower but more frequent dosage schedule or by using a daily transdermal preparation (Dobs et al., 1999; Jockenhövel, 2004; Nieschlag et al., 2004). Intramuscular testosterone undecanoate (not currently available in the United States) maintains stable, physiologic testosterone levels over approximately 12 weeks and has been effective in both the setting of hypogonadism and in FtM individuals (Mueller, Kiesewetter, Binder, Beckmann, & Dittrich, 2007; Zitzmann, Saad, & Nieschlag, 2006). There is evidence that transdermal and intramuscular testosterone achieve similar masculinizing results, although the timeframe may be somewhat slower with transdermal preparations (Feldman, 2005, April). Especially as patients age, the goal is to use the lowest dose needed to maintain the desired clinical result, with appropriate precautions being made to maintain bone density.

Other agents

Progestins, most commonly medroxyprogesterone, can be used for a short period of time to assist with menstrual cessation early in hormone therapy. GnRH agonists can be used similarly, as well as for refractory uterine bleeding in patients without an underlying gynecological abnormality.

Bioidentical and Compounded Hormones

As discussion surrounding the use of bioidentical hormones in postmenopausal hormone replacement has heightened, interest has also increased in the use of similar compounds in feminizing/masculinizing hormone therapy. There is no evidence that custom compounded bioidentical hormones are safer or more effective than government agency-approved bioidentical hormones (Sood, Shuster, Smith, Vincent, & Jatoi, 2011). Therefore, it has been advised by the North American Menopause Society (2010) and others to assume that, whether the hormone is from a compounding pharmacy or not, if the active ingredients are similar, it should have a similar side-effect profile. WPATH concurs with this assessment.

IX
Reproductive Health

Many transgender, transsexual, and gender-nonconforming people will want to have children. Because feminizing/masculinizing hormone therapy limits fertility (Darney, 2008; Zhang, Gu, Wang, Cui, & Bremner, 1999), it is desirable for patients to make decisions concerning fertility before starting hormone therapy or undergoing surgery to remove/alter their reproductive organs. Cases are known of people who received hormone therapy and genital surgery and later regretted their inability to parent genetically related children (De Sutter, Kira, Verschoor, & Hotimsky, 2002).

Health care professionals—including mental health professionals recommending hormone therapy or surgery, hormone-prescribing physicians, and surgeons—should discuss reproductive options with patients prior to initiation of these medical treatments for gender dysphoria. These discussions should occur even if patients are not interested in these issues at the time of treatment, which may be more common for younger patients (De Sutter, 2009). Early discussions are desirable, but not always possible. If an individual has not had complete sex reassignment surgery, it may be possible to stop hormones long enough for natal hormones to recover, allowing

the production of mature gametes (Payer, Meyer, & Walker, 1979; Van den Broecke, Van der Elst, Liu, Hovatta, & Dhont, 2001).

Besides debate and opinion papers, very few research papers have been published on the reproductive health issues of individuals receiving different medical treatments for gender dysphoria. Another group who faces the need to preserve reproductive function in light of loss or damage to their gonads are people with malignancies that require removal of reproductive organs or use of damaging radiation or chemotherapy. Lessons learned from that group can be applied to people treated for gender dysphoria.

MtF patients, especially those who have not already reproduced, should be informed about sperm-preservation options and encouraged to consider banking their sperm prior to hormone therapy. In a study examining testes that were exposed to high-dose estrogen (Payer et al., 1979), findings suggest that stopping estrogen may allow the testes to recover. In an article reporting on the opinions of MtF individuals towards sperm freezing (De Sutter et al., 2002), the vast majority of 121 survey respondents felt that the availability of freezing sperm should be discussed and offered by the medical world. Sperm should be collected before hormone therapy or after stopping the therapy until the sperm count rises again. Cryopreservation should be discussed even if there is poor semen quality. In adults with azoospermia, a testicular biopsy with subsequent cryopreservation of biopsied material for sperm is possible, but may not be successful.

Reproductive options for FtM patients might include oocyte (egg) or embryo freezing. The frozen gametes and embryo could later be used with a surrogate woman to carry to pregnancy. Studies of women with polycystic ovarian disease suggest that the ovary can recover in part from the effects of high testosterone levels (Hunter & Sterrett, 2000). Stopping the testosterone briefly might allow for ovaries to recover enough to release eggs; success likely depends on the patient's age and duration of testosterone treatment. While not systematically studied, some FtM individuals are doing exactly that, and some have been able to become pregnant and deliver children (More, 1998).

Patients should be advised that these techniques are not available everywhere and can be very costly. Transsexual, transgender, and gender-nonconforming people should not be refused reproductive options for any reason.

A special group of individuals are prepubertal or pubertal adolescents who will never develop reproductive function in their natal sex due to blockers or cross-gender hormones. At this time there is no technique for preserving function from the gonads of these individuals.

X

Voice and Communication Therapy

Communication, both verbal and nonverbal, is an important aspect of human behavior and gender expression. Transsexual, transgender, and gender-nonconforming people might seek the assistance of a voice and communication specialist to develop vocal characteristics (e.g., pitch, intonation, resonance, speech rate, phrasing patterns) and non-verbal communication patterns (e.g., gestures, posture/movement, facial expressions) that facilitate comfort with their gender identity. Voice and communication therapy may help to alleviate gender dysphoria and be a positive and motivating step towards achieving one's goals for gender role expression.

Competency of Voice and Communication Specialists Working with Transsexual, Transgender, and Gender-Nonconforming Clients

Specialists may include speech-language pathologists, speech therapists, and speech-voice clinicians. In most countries the professional association for speech-language pathologists requires specific qualifications and credentials for membership. In some countries the government regulates practice through licensing, certification, or registration processes (American Speech-Language-Hearing Association, 2011; Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia).

The following are recommended minimum credentials for voice and communication specialists working with transsexual, transgender, and gender-nonconforming clients:

1. Specialized training and competence in the assessment and development of communication skills in transsexual, transgender, and gender-nonconforming clients.

2. A basic understanding of transgender health, including hormonal and surgical treatments for feminization/masculinization and trans-specific psychosocial issues as outlined in the *SOC*; and familiarity with basic sensitivity protocols such as the use of preferred gender pronoun and name (Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia).

3. Continuing education in the assessment and development of communication skills in transsexual, transgender, and gender-nonconforming clients. This may include attendance at professional meetings, workshops, or seminars; participation in research related to gender identity issues; independent study; or mentoring from an experienced, certified clinician.

Other professionals such as vocal coaches, theatre professionals, singing teachers, and movement experts may play a valuable adjunct role. Such professionals will ideally have experience working with, or be actively collaborating with, speech-language pathologists.

Assessment and Treatment Considerations

The overall purpose of voice and communication therapy is to help clients adapt their voice and communication in a way that is both safe and authentic, resulting in communication patterns that clients feel are congruent with their gender identity and that reflect their sense of self (Adler, Hirsch, & Mordaunt, 2006). It is essential that voice and communication specialists be sensitive to individual communication preferences. Communication—style, voice, choice of language, etc.—is personal. Individuals should not be counseled to adopt behaviors with which they are not comfortable or which do not feel authentic. Specialists can best serve their clients by taking the time to understand a person's gender concerns and goals for gender-role expression (American Speech-Language-Hearing Association, 2011; Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia).

Individuals may choose the communication behaviors that they wish to acquire in accordance with their gender identity. These decisions are also informed and supported by the knowledge of the voice and communication specialist and by the assessment data for a specific client (Hancock, Krissinger, & Owen, 2010). Assessment includes a client's self-evaluation and a specialist's evaluation of voice, resonance, articulation, spoken language, and non-verbal communication (Adler et al., 2006; Hancock et al., 2010).

Voice-and-communication treatment plans are developed by considering the available research evidence, the clinical knowledge and experience of the specialist, and the client's own goals and values (American Speech-Language-Hearing Association, 2011; Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia). Targets of treatment typically include pitch, intonation, loudness and stress patterns, voice quality, resonance, articulation, speech rate and phrasing, language, and nonverbal communication (Adler et al., 2006; Davies & Goldberg, 2006; de Bruin, Coerts, & Greven, 2000; Gelfer, 1999; McNeill, 2006; Oates & Dacakis, 1983). Treatment may involve individual and/or group sessions. The frequency and duration of treatment will vary according to a client's needs. Existing protocols for voice-and-communication treatment can be considered in

developing an individualized therapy plan (Carew, Dacakis, & Oates, 2007; Dacakis, 2000; Davies & Goldberg, 2006; Gelfer, 1999; McNeill, Wilson, Clark, & Deakin, 2008; Mount & Salmon, 1988).

Feminizing or masculinizing the voice involves non-habitual use of the voice production mechanism. Prevention measures are necessary to avoid the possibility of vocal misuse and long-term vocal damage. All voice and communication therapy services should therefore include a vocal health component (Adler et al., 2006).

Vocal Health Considerations After Voice Feminization Surgery

As noted in section XI, some transsexual, transgender, and gender-nonconforming people will undergo voice feminization surgery. (Voice deepening can be achieved through masculinizing hormone therapy, but feminizing hormones do not have an impact on the adult MtF voice.) There are varying degrees of satisfaction, safety, and long-term improvement in patients who have had such surgery. It is recommended that individuals undergoing voice feminization surgery also consult a voice and communication specialist to maximize the surgical outcome, help protect vocal health, and learn nonpitch related aspects of communication. Voice surgery procedures should include follow-up sessions with a voice and communication specialist who is licensed and/or credentialed by the board responsible for speech therapists/speech-language pathologists in that country (Kanagalingam et al., 2005; Neumann & Welzel, 2004).

XI
Surgery

Sex Reassignment Surgery Is Effective and Medically Necessary

Surgery – particularly genital surgery – is often the last and the most considered step in the treatment process for gender dysphoria. While many transsexual, transgender, and gender-nonconforming individuals find comfort with their gender identity, role, and expression without surgery, for many others surgery is essential and medically necessary to alleviate their gender dysphoria (Hage & Karim, 2000). For the latter group, relief from gender dysphoria cannot be achieved

without modification of their primary and/or secondary sex characteristics to establish greater congruence with their gender identity. Moreover, surgery can help patients feel more at ease in the presence of sex partners or in venues such as physicians' offices, swimming pools, or health clubs. In some settings, surgery might reduce risk of harm in the event of arrest or search by police or other authorities.

Follow-up studies have shown an undeniable beneficial effect of sex reassignment surgery on postoperative outcomes such as subjective well-being, cosmesis, and sexual function (De Cuypere et al., 2005; Gijs & Brewaeys, 2007; Klein & Gorzalka, 2009; Pfäfflin & Junge, 1998). Additional information on the outcomes of surgical treatments are summarized in Appendix D.

Ethical Questions Regarding Sex Reassignment Surgery

In ordinary surgical practice, pathological tissues are removed to restore disturbed functions, or alterations are made to body features to improve a patient's self image. Some people, including some health professionals, object on ethical grounds to surgery as a treatment for gender dysphoria, because these conditions are thought not to apply.

It is important that health professionals caring for patients with gender dysphoria feel comfortable about altering anatomically normal structures. In order to understand how surgery can alleviate the psychological discomfort and distress of individuals with gender dysphoria, professionals need to listen to these patients discuss their symptoms, dilemmas, and life histories. The resistance against performing surgery on the ethical basis of "above all do no harm" should be respected, discussed, and met with the opportunity to learn from patients themselves about the psychological distress of having gender dysphoria and the potential for harm caused by denying access to appropriate treatments.

Genital and breast/chest surgical treatments for gender dysphoria are not merely another set of elective procedures. Typical elective procedures involve only a private mutually consenting contract between a patient and a surgeon. Genital and breast/chest surgeries as medically necessary treatments for gender dysphoria are to be undertaken only after assessment of the patient by qualified mental health professionals, as outlined in section VII of the *SOC*. These surgeries may be performed once there is written documentation that this assessment has occurred and that the person has met the criteria for a specific surgical treatment. By following this procedure, mental health professionals, surgeons, and patients share responsibility for the decision to make irreversible changes to the body.

It is unethical to deny availability or eligibility for sex reassignment surgeries solely on the basis of blood seropositivity for blood-borne infections such as HIV or hepatitis C or B.

Relationship of Surgeons with Mental Health Professionals, Hormone-Prescribing Physicians (if Applicable), and Patients (Informed Consent)

The role of a surgeon in the treatment of gender dysphoria is not that of a mere technician. Rather, conscientious surgeons will have insight into each patient's history and the rationale that led to the referral for surgery. To that end, surgeons must talk at length with their patients and have close working relationships with other health professionals who have been actively involved in their clinical care.

Consultation is readily accomplished when a surgeon practices as part of an interdisciplinary health care team. In the absence of this, a surgeon must be confident that the referring mental health professional(s), and if applicable the physician who prescribes hormones, is/are competent in the assessment and treatment of gender dysphoria, because the surgeon is relying heavily on his/her/their expertise.

Once a surgeon is satisfied that the criteria for specific surgeries have been met (as outlined below), surgical treatment should be considered and a preoperative surgical consultation should take place. During this consultation, the procedure and postoperative course should be extensively discussed with the patient. Surgeons are responsible for discussing all of the following with patients seeking surgical treatments for gender dysphoria:

- The different surgical techniques available (with referral to colleagues who provide alternative options);
- The advantages and disadvantages of each technique;
- The limitations of a procedure to achieve "ideal" results; surgeons should provide a full range of before-and-after photographs of their own patients, including both successful and unsuccessful outcomes;
- The inherent risks and possible complications of the various techniques; surgeons should inform patients of their own complication rates with each procedure.

These discussions are the core of the informed consent process, which is both an ethical and legal requirement for any surgical procedure. Ensuring that patients have a realistic expectation of outcomes is important in achieving a result that will alleviate their gender dysphoria.

All of this information should be provided to patients in writing, in a language in which they are fluent, and in graphic illustrations. Patients should receive the information in advance (possibly

via the Internet) and be given ample time to review it carefully. The elements of informed consent should always be discussed face-to-face prior to the surgical intervention. Questions can then be answered and written informed consent can be provided by the patient. Because these surgeries are irreversibile, care should be taken to ensure that patients have sufficient time to absorb information fully before they are asked to provide informed consent. A minimum of 24 hours is suggested.

Surgeons should provide immediate aftercare and consultation with other physicians serving the patient in the future. Patients should work with their surgeon to develop an adequate aftercare plan for the surgery.

Overview of Surgical Procedures for the Treatment of Patients with Gender Dysphoria

For the Male-to-Female (MtF) Patient, Surgical Procedures May Include the Following:

1. Breast/chest surgery: augmentation mammoplasty (implants/lipofilling);

2. Genital surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, vulvoplasty;

3. Nongenital, nonbreast surgical interventions: facial feminization surgery, liposuction, lipofilling, voice surgery, thyroid cartilage reduction, gluteal augmentation (implants/lipofilling), hair reconstruction, and various aesthetic procedures.

For the Female-to-Male (FtM) Patient, Surgical Procedures May Include the Following:

1. Breast/chest surgery: subcutaneous mastectomy, creation of a male chest;

2. Genital surgery: hysterectomy/salpingo-oophorectomy, reconstruction of the fixed part of the urethra, which can be combined with a metoidioplasty or with a phalloplasty (employing a pedicled or free vascularized flap), vaginectomy, scrotoplasty, and implantation of erection and/or testicular prostheses;

3. Nongenital, nonbreast surgical interventions: voice surgery (rare), liposuction, lipofilling, pectoral implants, and various aesthetic procedures.

Reconstructive Versus Aesthetic Surgery

The question of whether sex reassignment surgery should be considered "aesthetic" surgery or "reconstructive" surgery is pertinent not only from a philosophical point of view, but also from a financial point of view. Aesthetic or cosmetic surgery is mostly regarded as not medically necessary and therefore is typically paid for entirely by the patient. In contrast, reconstructive procedures are considered medically necessary—with unquestionable therapeutic results—and thus paid for partially or entirely by national health systems or insurance companies.

Unfortunately, in the field of plastic and reconstructive surgery (both in general and specifically for gender-related surgeries), there is no clear distinction between what is purely reconstructive and what is purely cosmetic. Most plastic surgery procedures actually are a mixture of both reconstructive and cosmetic components.

While most professionals agree that genital surgery and mastectomy cannot be considered purely cosmetic, opinions diverge as to what degree other surgical procedures (e.g., breast augmentation, facial feminization surgery) can be considered purely reconstructive. Although it may be much easier to see a phalloplasty or a vaginoplasty as an intervention to end lifelong suffering, for certain patients an intervention like a reduction rhinoplasty can have a radical and permanent effect on their quality of life, and therefore is much more medically necessary than for somebody without gender dysphoria.

Criteria for Surgeries

As for all of the *SOC*, the criteria for initiation of surgical treatments for gender dysphoria were developed to promote optimal patient care. While the *SOC* allow for an individualized approach to best meet a patient's health care needs, a criterion for all breast/chest and genital surgeries is documentation of persistent gender dysphoria by a qualified mental health professional. For some surgeries, additional criteria include preparation and treatment consisting of feminizing/masculinizing hormone therapy and one year of continuous living in a gender role that is congruent with one's gender identity.

These criteria are outlined below. Based on the available evidence and expert clinical consensus, different recommendations are made for different surgeries.

The *SOC* do not specify an order in which different surgeries should occur. The number and sequence of surgical procedures may vary from patient to patient, according to their clinical needs.

Criteria for Breast/Chest Surgery (One Referral)

Criteria for mastectomy and creation of a male chest in FtM patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Hormone therapy is not a prerequisite.

Criteria for breast augmentation (implants/lipofilling) in MtF patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Although not an explicit criterion, it is recommended that MtF patients undergo feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery. The purpose is to maximize breast growth in order to obtain better surgical (aesthetic) results.

Criteria for Genital Surgery (Two Referrals)

The criteria for genital surgery are specific to the type of surgery being requested.

Criteria for hysterectomy and salpingo-oophorectomy in FtM patients and for orchiectomy in MtF patients:

1. Persistent, well-documented gender dysphoria;

2. Capacity to make a fully informed decision and to consent for treatment;

3. Age of majority in a given country;

4. If significant medical or mental health concerns are present, they must be well controlled.

5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless hormones are not clinically indicated for the individual).

The aim of hormone therapy prior to gonadectomy is primarily to introduce a period of reversible estrogen or testosterone suppression, before the patient undergoes irreversible surgical intervention.

These criteria do not apply to patients who are having these procedures for medical indications other than gender dysphoria.

Criteria for metoidioplasty or phalloplasty in FtM patients and for vaginoplasty in MtF patients:

1. Persistent, well-documented gender dysphoria;

2. Capacity to make a fully informed decision and to consent for treatment;

3. Age of majority in a given country;

4. If significant medical or mental health concerns are present, they must be well controlled;

5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless hormones are not clinically indicated for the individual).

6. 12 continuous months of living in a gender role that is congruent with their gender identity.

Although not an explicit criterion, it is recommended that these patients also have regular visits with a mental health or other medical professional.

Rationale for a preoperative, 12-month experience of living in an identity-congruent gender role:

The criterion noted above for some types of genital surgeries—i.e., that patients engage in 12 continuous months of living in a gender role that is congruent with their gender identity—is based on expert clinical consensus that this experience provides ample opportunity for patients to experience and socially adjust in their desired gender role, before undergoing irreversible surgery. As noted in section VII, the social aspects of changing one's gender role are usually challenging—

often more so than the physical aspects. Changing gender role can have profound personal and social consequences, and the decision to do so should include an awareness of what the familial, interpersonal, educational, vocational, economic, and legal challenges are likely to be, so that people can function successfully in their gender role. Support from a qualified mental health professional and from peers can be invaluable in ensuring a successful gender role adaptation (Bockting, 2008).

The duration of 12 months allows for a range of different life experiences and events that may occur throughout the year (e.g., family events, holidays, vacations, season-specific work or school experiences). During this time, patients should present consistently, on a day-to-day basis and across all settings of life, in their desired gender role. This includes coming out to partners, family, friends, and community members (e.g., at school, work, other settings).

Health professionals should clearly document a patient's experience in the gender role in the medical chart, including the start date of living full time for those who are preparing for genital surgery. In some situations, if needed, health professionals may request verification that this criterion has been fulfilled: They may communicate with individuals who have related to the patient in an identity-congruent gender role, or request documentation of a legal name and/or gender marker change, if applicable.

Surgery for People with Psychotic Conditions and Other Serious Mental Illnesses

When patients with gender dysphoria are also diagnosed with severe psychiatric disorders and impaired reality testing (e.g., psychotic episodes, bipolar disorder, dissociative identity disorder, borderline personality disorder), an effort must be made to improve these conditions with psychotropic medications and/or psychotherapy before surgery is contemplated. (Dhejne et al., 2011). Reevaluation by a mental health professional qualified to assess and manage psychotic conditions should be conducted prior to surgery, describing the patient's mental status and readiness for surgery. It is preferable that this mental health professional be familiar with the patient. No surgery should be performed while a patient is actively psychotic (De Cuypere & Vercruysse, 2009).

Competency of Surgeons Performing Breast/Chest or Genital Surgery

Physicians who perform surgical treatments for gender dsyphoria should be urologists, gynecologists, plastic surgeons, or general surgeons, and board-certified as such by the relevant national

and/or regional association. Surgeons should have specialized competence in genital reconstructive techniques as indicated by documented supervised training with a more experienced surgeon. Even experienced surgeons must be willing to have their surgical skills reviewed by their peers. An official audit of surgical outcomes and publication of these results would be greatly reassuring to both referring health professionals and patients. Surgeons should regularly attend professional meetings where new techniques are presented. The internet is often effectively used by patients to share information on their experience with surgeons and their teams.

Ideally, surgeons should be knowledgeable about more than one surgical technique for genital reconstruction so that they, in consultation with patients, can choose the ideal technique for each individual. Alternatively, if a surgeon is skilled in a single technique and this procedure is either not suitable for or desired by a patient, the surgeon should inform the patient about other procedures and offer referral to another appropriately skilled surgeon.

Breast/Chest Surgery Techniques and Complications

Although breast/chest appearance is an important secondary sex characteristic, breast presence or size is not involved in the legal definitions of sex and gender and is not necessary for reproduction. The performance of breast/chest operations for treatment of gender dysphoria should be considered with the same care as beginning hormone therapy, as both produce relatively irreversible changes to the body.

For the MtF patient, a breast augmentation (sometimes called "chest reconstruction") is not different from the procedure in a natal female patient. It is usually performed through implantation of breast prostheses and occasionally with the lipofilling technique. Infections and capsular fibrosis are rare complications of augmentation mammoplasty in MtF patients (Kanhai, Hage, Karim, & Mulder, 1999).

For the FtM patient, a mastectomy or "male chest contouring" procedure is available. For many FtM patients, this is the only surgery undertaken. When the amount of breast tissue removed requires skin removal, a scar will result and the patient should be so informed. Complications of subcutaneous mastectomy can include nipple necrosis, contour irregularities, and unsightly scarring (Monstrey et al., 2008).

Genital Surgery Techniques and Complications

Genital surgical procedures for the MtF patient may include orchiectomy, penectomy, vaginoplasty, clitoroplasty, and labiaplasty. Techniques include penile skin inversion, pedicled colosigmoid

transplant, and free skin grafts to line the neovagina. Sexual sensation is an important objective in vaginoplasty, along with creation of a functional vagina and acceptable cosmesis.

Surgical complications of MtF genital surgery may include complete or partial necrosis of the vagina and labia, fistulas from the bladder or bowel into the vagina, stenosis of the urethra, and vaginas that are either too short or too small for coitus. While the surgical techniques for creating a neovagina are functionally and aesthetically excellent, anorgasmia following the procedure has been reported, and a second stage labiaplasty may be needed for cosmesis (Klein & Gorzalka, 2009; Lawrence, 2006).

Genital surgical procedures for FtM patients may include hysterectomy, salpingo-oophorectomy, vaginectomy, metoidioplasty, scrotoplasty, urethroplasty, placement of testicular prostheses, and phalloplasty. For patients without former abdominal surgery, the laparoscopic technique for hysterectomy and salpingo-oophorectomy is recommended to avoid a lower-abdominal scar. Vaginal access may be difficult as most patients are nulliparous and have often not experienced penetrative intercourse. Current operative techniques for phalloplasty are varied. The choice of techniques may be restricted by anatomical or surgical considerations and by a client's financial considerations. If the objectives of phalloplasty are a neophallus of good appearance, standing micturition, sexual sensation, and/or coital ability, patients should be clearly informed that there are several separate stages of surgery and frequent technical difficulties, which may require additional operations. Even metoidioplasty, which in theory is a one-stage procedure for construction of a microphallus, often requires more than one operation. The objective of standing micturition with this technique can not always be ensured (Monstrey et al., 2009).

Complications of phalloplasty in FtMs may include frequent urinary tract stenoses and fistulas, and occasionally necrosis of the neophallus. Metoidioplasty results in a micropenis, without the capacity for standing urination. Phalloplasty, using a pedicled or a free vascularized flap, is a lengthy, multi-stage procedure with significant morbidity that includes frequent urinary complications and unavoidable donor site scarring. For this reason, many FtM patients never undergo genital surgery other than hysterectomy and salpingo-oophorectomy (Hage & De Graaf, 1993).

Even patients who develop severe surgical complications seldom regret having undergone surgery. The importance of surgery can be appreciated by the repeated finding that quality of surgical results is one of the best predictors of the overall outcome of sex reassignment (Lawrence, 2006).

Other Surgeries

Other surgeries for assisting in body feminization include reduction thyroid chondroplasty (reduction of the Adam's apple), voice modification surgery, suction-assisted lipoplasty (contour

modeling) of the waist, rhinoplasty (nose correction), facial bone reduction, face-lift, and blepharoplasty (rejuvenation of the eyelid). Other surgeries for assisting in body masculinization include liposuction, lipofilling, and pectoral implants. Voice surgery to obtain a deeper voice is rare but may be recommended in some cases, such as when hormone therapy has been ineffective.

Although these surgeries do not require referral by mental health professionals, such professionals can play an important role in assisting clients in making a fully informed decision about the timing and implications of such procedures in the context of the social transition.

Although most of these procedures are generally labeled "purely aesthetic," these same operations in an individual with severe gender dysphoria can be considered medically necessary, depending on the unique clinical situation of a given patient's condition and life situation. This ambiguity reflects reality in clinical situations, and allows for individual decisions as to the need and desirability of these procedures.

XII

Postoperative Care and Follow-Up

Long-term postoperative care and follow-up after surgical treatments for gender dysphoria are associated with good surgical and psychosocial outcomes (Monstrey et al., 2009). Follow-up is important to a patient's subsequent physical and mental health and to a surgeon's knowledge about the benefits and limitations of surgery. Surgeons who operate on patients coming from long distances should include personal follow-up in their care plan and attempt to ensure affordable local long-term aftercare in their patients' geographic region.

Postoperative patients may sometimes exclude themselves from follow-up by specialty providers, including the hormone-prescribing physician (for patients receiving hormones), not recognizing that these providers are often best able to prevent, diagnose, and treat medical conditions that are unique to hormonally and surgically treated patients. The need for follow-up equally extends to mental health professionals, who may have spent a longer period of time with the patient than any other professional and therefore are in an excellent position to assist in any postoperative adjustment difficulties. Health professionals should stress the importance of postoperative follow-up care with their patients and offer continuity of care.

Postoperative patients should undergo regular medical screening according to recommended guidelines for their age. This is discussed more in the next section.

XIII
Lifelong Preventive and Primary Care

Transsexual, transgender, and gender-nonconforming people need health care throughout their lives. For example, to avoid the negative secondary effects of having a gonadectomy at a relatively young age and/or receiving long-term, high-dose hormone therapy, patients need thorough medical care by providers experienced in primary care and transgender health. If one provider is not able to provide all services, ongoing communication among providers is essential.

Primary care and health maintenance issues should be addressed before, during, and after any possible changes in gender role and medical interventions to alleviate gender dysphoria. While hormone providers and surgeons play important roles in preventive care, every transsexual, transgender, and gender-nonconforming person should partner with a primary care provider for overall health care needs (Feldman, 2007).

General Preventive Health Care

Screening guidelines developed for the general population are appropriate for organ systems that are unlikely to be affected by feminizing/masculinizing hormone therapy. However, in areas such as cardiovascular risk factors, osteoporosis, and some cancers (breast, cervical, ovarian, uterine, and prostate), such general guidelines may either over- or underestimate the cost-effectiveness of screening individuals who are receiving hormone therapy.

Several resources provide detailed protocols for the primary care of patients undergoing feminizing/masculinizing hormone therapy, including therapy that is provided after sex reassignment surgeries (Center of Excellence for Transgender Health, UCSF, 2011; Feldman & Goldberg, 2006; Feldman, 2007; Gorton, Buth, & Spade, 2005). Clinicians should consult their national evidence-based guidelines and discuss screening with their patients in light of the effects of hormone therapy on their baseline risk.

Cancer Screening

Cancer screening of organ systems that are associated with sex can present particular medical and psychosocial challenges for transsexual, transgender, and gender-nonconforming patients and their health care providers. In the absence of large-scale prospective studies, providers are unlikely to have enough evidence to determine the appropriate type and frequency of cancer screenings for this population. Over-screening results in higher health care costs, high false positive rates, and often unnecessary exposure to radiation and/or diagnostic interventions such as biopsies. Under-screening results in diagnostic delay for potentially treatable cancers. Patients may find cancer screening gender affirming (such as mammograms for MtF patients) or both physically and emotionally painful (such as Pap smears offer continuity of care for FtM patients).

Urogenital Care

Gynecologic care may be necessary for transsexual, transgender, and gender-nonconforming people of both sexes. For FtM patients, such care is needed predominantly for individuals who have not had genital surgery. For MtF patients, such care is needed after genital surgery. While many surgeons counsel patients regarding postoperative urogenital care, primary care clinicians and gynecologists should also be familiar with the special genital concerns of this population.

All MtF patients should receive counseling regarding genital hygiene, sexuality, and prevention of sexually transmitted infections; those who have had genital surgery should also be counseled on the need for regular vaginal dilation or penetrative intercourse in order to maintain vaginal depth and width (van Trotsenburg, 2009). Due to the anatomy of the male pelvis, the axis and the dimensions of the neovagina differ substantially from those of a biologic vagina. This anatomic difference can affect intercourse if not understood by MtF patients and their partners (van Trotsenburg, 2009).

Lower urinary tract infections occur frequently in MtF patients who have had surgery because of the reconstructive requirements of the shortened urethra. In addition, these patients may suffer from functional disorders of the lower urinary tract; such disorders may be caused by damage of the autonomous nerve supply of the bladder floor during dissection between the rectum and the bladder, and by a change of the position of the bladder itself. A dysfunctional bladder (e.g., overactive bladder, stress or urge urinary incontinence) may occur after sex reassignment surgery (Hoebeke et al., 2005; Kuhn, Hiltebrand, & Birkhauser, 2007).

Most FtM patients do not undergo vaginectomy (colpectomy). For patients who take masculinizing hormones, despite considerable conversion of testosterone to estrogens, atrophic changes of the vaginal lining can be observed regularly and may lead to pruritus or burning. Examination can be

both physically and emotionally painful, but lack of treatment can seriously aggravate the situation. Gynecologists treating the genital complaints of FtM patients should be aware of the sensitivity that patients with a male gender identity and masculine gender expression might have around having genitals typically associated with the female sex.

XIV

Applicability of the *Standards of Care* to People Living in Institutional Environments

The *SOC* in their entirety apply to all transsexual, transgender, and gender-nonconforming people, irrespective of their housing situation. People should not be discriminated against in their access to appropriate health care based on where they live, including institutional environments such as prisons or long-/intermediate-term health care facilities (Brown, 2009). Health care for transsexual, transgender, and gender-nonconforming people living in an institutional environment should mirror that which would be available to them if they were living in a non-institutional setting within the same community.

All elements of assessment and treatment as described in the *SOC* can be provided to people living in institutions (Brown, 2009). Access to these medically necessary treatments should not be denied on the basis of institutionalization or housing arrangements. If the in-house expertise of health professionals in the direct or indirect employ of the institution does not exist to assess and/or treat people with gender dysphoria, it is appropriate to obtain outside consultation from professionals who are knowledgeable about this specialized area of health care.

People with gender dysphoria in institutions may also have coexisting mental health conditions (Cole et al., 1997). These conditions should be evaluated and treated appropriately.

People who enter an institution on an appropriate regimen of hormone therapy should be continued on the same, or similar, therapies and monitored according to the *SOC*. A "freeze frame" approach is not considered appropriate care in most situations *(Kosilek v. Massachusetts Department of Corrections/Maloney,* C.A. No. 92–12820-MLW, 2002). People with gender dysphoria who are deemed appropriate for hormone therapy (following the *SOC*) should be started on such therapy. The consequences of abrupt withdrawal of hormones or lack of initiation of hormone therapy when medically necessary include a high likelihood of negative outcomes such as surgical self-treatment by autocastration, depressed mood, dysphoria, and/or suicidality (Brown, 2010).

Reasonable accommodations to the institutional environment can be made in the delivery of care consistent with the *SOC*, if such accommodations do not jeopardize the delivery of medically necessary care to people with gender dysphoria. An example of a reasonable accommodation is the use of injectable hormones, if not medically contraindicated, in an environment where diversion of oral preparations is highly likely (Brown, 2009). Denial of needed changes in gender role or access to treatments, including sex reassignment surgery, on the basis of residence in an institution are not reasonable accommodations under the *SOC* (Brown, 2010).

Housing and shower/bathroom facilities for transsexual, transgender, and gender-nonconforming people living in institutions should take into account their gender identity and role, physical status, dignity, and personal safety. Placement in a single-sex housing unit, ward, or pod on the sole basis of the appearance of the external genitalia may not be appropriate and may place the individual at risk for victimization (Brown, 2009).

Institutions where transsexual, transgender, and gender-nonconforming people reside and receive health care should monitor for a tolerant and positive climate to ensure that residents are not under attack by staff or other residents.

XV

Applicability of the *Standards of Care* to People With Disorders of Sex Development

Terminology

The term *disorder of sex development* (DSD) refers to a somatic condition of atypical development of the reproductive tract (Hughes, Houk, Ahmed, Lee, & LWPES/ESPE Consensus Group, 2006). DSDs include the condition that used to be called *intersexuality*. Although the terminology was changed to DSD during an international consensus conference in 2005 (Hughes et al., 2006), disagreement about language use remains. Some people object strongly to the "disorder" label, preferring instead to view these congenital conditions as a matter of diversity (Diamond, 2009) and to continue using the terms *intersex* or *intersexuality*. In the *SOC*, WPATH uses the term DSD in an objective and value-free manner, with the goal of ensuring that health professionals recognize this medical term and use it to access relevant literature as the field progresses. WPATH remains

open to new terminology that will further illuminate the experience of members of this diverse population and lead to improvements in health care access and delivery.

Rationale for Addition to the *SOC*

Previously, individuals with a DSD who also met the *DSM-IV-TR's* behavioral criteria for Gender Identity Disorder (American Psychiatric Association, 2000) were excluded from that general diagnosis. Instead, they were categorized as having a "Gender Identity Disorder - Not Otherwise Specified." They were also excluded from the WPATH *Standards of Care*.

The current proposal for *DSM-5* (www.dsm5.org) is to replace the term *gender identity disorder* with *gender dysphoria*. Moreover, the proposed changes to the *DSM* consider gender dysphoric people with a DSD to have a subtype of gender dysphoria. This proposed categorization—which explicitly differentiates between gender dysphoric individuals with and without a DSD—is justified: In people with a DSD, gender dysphoria differs in its phenomenological presentation, epidemiology, life trajectories, and etiology (Meyer-Bahlburg, 2009).

Adults with a DSD and gender dysphoria have increasingly come to the attention of health professionals. Accordingly, a brief discussion of their care is included in this version of the *SOC*.

Health History Considerations

Health professionals assisting patients with both a DSD and gender dysphoria need to be aware that the medical context in which such patients have grown up is typically very different from that of people without a DSD.

Some people are recognized as having a DSD through the observation of gender-atypical genitals at birth. (Increasingly this observation is made during the prenatal period by way of imaging procedures such as ultrasound.) These infants then undergo extensive medical diagnostic procedures. After consultation among the family and health professionals—during which the specific diagnosis, physical and hormonal findings, and feedback from long-term outcome studies (Cohen-Kettenis, 2005; Dessens, Slijper, & Drop, 2005; Jurgensen, Hiort, Holterhus, & Thyen, 2007; Mazur, 2005; Meyer-Bahlburg, 2005; Stikkelbroeck et al., 2003; Wisniewski, Migeon, Malouf, & Gearhart, 2004) are considered—the newborn is assigned a sex, either male or female.

Other individuals with a DSD come to the attention of health professionals around the age of puberty through the observation of atypical development of secondary sex characteristics. This observation also leads to a specific medical evaluation.

The type of DSD and severity of the condition has significant implications for decisions about a patient's initial sex assignment, subsequent genital surgery, and other medical and psychosocial care (Meyer-Bahlburg, 2009). For instance, the degree of prenatal androgen exposure in individuals with a DSD has been correlated with the degree of masculinization of gender-related *behavior* (that is, *gender role and expression*); however, the correlation is only moderate, and considerable behavioral variability remains unaccounted for by prenatal androgen exposure (Jurgensen et al., 2007; Meyer-Bahlburg, Dolezal, Baker, Ehrhardt, & New, 2006). Notably, a similar correlation of prenatal hormone exposure with gender *identity* has not been demonstrated (e.g., Meyer-Bahlburg et al., 2004). This is underlined by the fact that people with the same (core) gender identity can vary widely in the degree of masculinization of their gender-related behavior.

Assessment and Treatment of Gender Dysphoria in People with Disorders of Sex Development

Very rarely are individuals with a DSD identified as having gender dysphoria *before* a DSD diagnosis has been made. Even so, a DSD diagnosis is typically apparent with an appropriate history and basic physical exam—both of which are part of a medical evaluation for the appropriateness of hormone therapy or surgical interventions for gender dysphoria. Mental health professionals should ask their clients presenting with gender dysphoria to have a physical exam, particularly if they are not currently seeing a primary care (or other health care) provider.

Most people with a DSD who are born with genital ambiguity do not develop gender dysphoria (e.g., Meyer-Bahlburg, Dolezal, et al., 2004; Wisniewski et al., 2004). However, some people with a DSD will develop chronic gender dysphoria and even undergo a change in their birth-assigned sex and/or their gender role (Meyer-Bahlburg, 2005; Wilson, 1999; Zucker, 1999). If there are persistent and strong indications that gender dysphoria is present, a comprehensive evaluation by clinicians skilled in the assessment and treatment of gender dysphoria is essential, irrespective of the patient's age. Detailed recommendations have been published for conducting such an assessment and for making treatment decisions to address gender dysphoria in the context of a DSD (Meyer-Bahlburg, 2011). Only after thorough assessment should steps be taken in the direction of changing a patient's birth-assigned sex or gender role.

Clinicians assisting these patients with treatment options to alleviate gender dysphoria may profit from the insights gained from providing care to patients without a DSD (Cohen-Kettenis, 2010).

However, certain criteria for treatment (e.g., age, duration of experience with living in the desired gender role) are usually not routinely applied to people with a DSD; rather, the criteria are interpreted in light of a patient's specific situation (Meyer-Bahlburg, 2011). In the context of a DSD, changes in birth-assigned sex and gender role have been made at any age between early elementary-school age and middle adulthood. Even genital surgery may be performed much earlier in these patients than in gender dysphoric individuals without a DSD if the surgery is well justified by the diagnosis, by the evidence-based gender-identity prognosis for the given syndrome and syndrome severity, and by the patient's wishes.

One reason for these treatment differences is that genital surgery in individuals with a DSD is quite common in infancy and adolescence. Infertility may already be present due to either early gonadal failure or to gonadectomy because of a malignancy risk. Even so, it is advisable for patients with a DSD to undergo a full social transition to another gender role only if there is a long-standing history of gender-atypical behavior, and if gender dysphoria and/or the desire to change one's gender role has been strong and persistent for a considerable period of time. Six months is the time period of full symptom expression required for the application of the gender dysphoria diagnosis proposed for *DSM-5* (Meyer-Bahlburg, 2011).

Additional Resources

The gender-relevant medical histories of people with a DSD are often complex. Their histories may include a great variety of inborn genetic, endocrine, and somatic atypicalities, as well as various hormonal, surgical, and other medical treatments. For this reason, many additional issues need to be considered in the psychosocial and medical care of such patients, regardless of the presence of gender dysphoria. Consideration of these issues is beyond what can be covered in the *SOC*. The interested reader is referred to existing publications (e.g., Cohen-Kettenis & Pfäfflin, 2003; Meyer-Bahlburg, 2002, 2008). Some families and patients also find it useful to consult or work with community support groups.

There is a very substantial medical literature on the medical management of patients with a DSD. Much of this literature has been produced by high-level specialists in pediatric endocrinology and urology, with input from specialized mental health professionals, especially in the area of gender. Recent international consensus conferences have addressed evidence-based care guidelines (including issues of gender and of genital surgery) for DSD in general (Hughes et al., 2006) and specifically for Congenital Adrenal Hyperplasia (Joint LWPES/ESPE CAH Working Group et al., 2002; Speiser et al., 2010). Others have addressed the research needs for DSD in general (Meyer-Bahlburg & Blizzard, 2004) and for selected syndromes such as 46,XXY (Simpson et al., 2003).

References

Abramowitz, S. I. (1986). Psychosocial outcomes of sex reassignment surgery. *Journal of Consulting and Clinical Psychology, 54*(2), 183–189. doi:10.1037/0022–006X.54.2.183

ACOG Committee of Gynecologic Practice. (2005). Committee opinion #322: Compounded bioidentical hormones. *Obstetrics & Gynecology, 106*(5), 139–140.

Adler, R. K., Hirsch, S., & Mordaunt, M. (2006). *Voice and communication therapy for the transgender/transsexual client: A comprehensive clinical guide*. San Diego, CA: Plural Pub.

American Academy of Family Physicians. (2005). *Definition of family medicine*. Retrieved from http://www.aafp.org/online/en/home/policy/policies/f/fammeddef.html

American Medical Association. (2008). *Resolution 122 (A-08)*. Retrieved from http://www.ama-assn.org/ama1/pub/upload/mm/471/122.doc

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders DSM-IV-TR* (4th ed., text rev.). Washington, DC: Author.

American Speech-Language-Hearing Association. (2011). *Scope of practice*. Retrieved from www.asha.org

Anton, B. S. (2009). Proceedings of the American Psychological Association for the legislative year 2008: Minutes of the annual meeting of the council of representatives, February 22–24, 2008, Washington, DC, and August 13 and 17, 2008, Boston, MA, and minutes of the February, June, August, and December 2008 meetings of the board of directors. *American Psychologist, 64*, 372–453. doi:10.1037/a0015932

Asscheman, H., Giltay, E. J., Megens, J. A. J., de Ronde, W., van Trotsenburg, M. A. A., & Gooren, L. J. G. (2011). A long-term follow-up study of mortality in transsexuals receiving treatment with cross-sex hormones. *European Journal of Endocrinology, 164*(4), 635–642. doi:10.1530/EJE-10–1038

Baba, T., Endo, T., Honnma, H., Kitajima, Y., Hayashi, T., Ikeda, H., . . . Saito, T. (2007). Association between polycystic ovary syndrome and female-to-male transsexuality. *Human Reproduction, 22*(4), 1011–1016. doi:10.1093/humrep/del474

Bakker, A., Van Kesteren, P. J., Gooren, L. J., & Bezemer, P. D. (1993). The prevalence of transsexualism in the Netherlands. *Acta Psychiatrica Scandinavica, 87*(4), 237–238. doi:10.1111/j.1600–0447.1993.tb03364.x

Balen, A. H., Schachter, M. E., Montgomery, D., Reid, R. W., & Jacobs, H. S. (1993). Polycystic ovaries are a common finding in untreated female to male transsexuals. *Clinical Endocrinology, 38*(3), 325–329. doi:10.1111/j.1365–2265.1993.tb01013.x

Basson, R. (2001). Towards optimal hormonal treatment of male to female gender identity disorder. *Journal of Sexual and Reproductive Medicine, 1*(1), 45–51.

Basson, R., & Prior, J. C. (1998). Hormonal therapy of gender dysphoria: The male-to-female transsexual. In D. Denny (Ed.), *Current concepts in transgender identity* (pp. 277–296). New York, NY: Garland.

Benjamin, H. (1966). *The transsexual phenomenon*. New York, NY: Julian Press.

Besnier, N. (1994). Polynesian gender liminality through time and space. In G. Herdt (Ed.), *Third sex, third gender: Beyond sexual dimorphism in culture and history* (pp. 285–328). New York: Zone Books.

Bockting, W. O. (1999). From construction to context: Gender through the eyes of the transgendered. *Siecus Report, 28*(1), 3–7.

Bockting, W. O. (2008). Psychotherapy and the real-life experience: From gender dichotomy to gender diversity. *Sexologies, 17*(4), 211–224. doi:10.1016/j.sexol.2008.08.001

Bockting, W. O., & Coleman, E. (2007). Developmental stages of the transgender coming out process: Toward an integrated identity. In R. Ettner, S. Monstrey & A. Eyler (Eds.), *Principles of transgender medicine and surgery* (pp. 185–208). New York, NY: The Haworth Press.

Bockting, W. O., & Goldberg, J. M. (2006). Guidelines for transgender care (Special issue). *International Journal of Transgenderism, 9*(3/4).

Bockting, W. O., Knudson, G., & Goldberg, J. M. (2006). Counseling and mental health care for transgender adults and loved ones. *International Journal of Transgenderism, 9*(3/4), 35–82. doi:10.1300/J485v09n03_03

Bolin, A. (1988). *In search of Eve* (pp. 189–192). New York, NY: Bergin & Garvey.

Bolin, A. (1994). Transcending and transgendering: Male-to-female transsexuals, dichotomy and diversity. In G. Herdt (Ed.), *Third sex, third gender: Beyond sexual dimorphism in culture and history* (pp. 447–486). New York, NY: Zone Books.

Bornstein, K. (1994). *Gender outlaw: On men, women, and the rest of us*. New York, NY: Routledge.

Bosinski, H. A. G., Peter, M., Bonatz, G., Arndt, R., Heidenreich, M., Sippell, W. G., & Wille, R. (1997). A higher rate of hyperandrogenic disorders in female-to-male transsexuals. *Psychoneuroendocrinology, 22*(5), 361–380. doi:10.1016/S0306–4530(97)00033–4

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

Brown, G. R. (2009). Recommended revisions to The World Professional Association for Transgender Health's *Standards of Care* section on medical care for incarcerated persons with gender identity disorder. *International Journal of Transgenderism, 11*(2), 133–139. doi:10.1080/15532730903008073

Brown, G. R. (2010). Autocastration and autopenectomy as surgical self-treatment in incarcerated persons with gender identity disorder. *International Journal of Transgenderism, 12*(1), 31–39. doi:10.1080/15532731003688970

Bullough, V. L., & Bullough, B. (1993). *Cross dressing, sex, and gender*. Philadelphia, PA: University of Pennsylvania Press.

Callen Lorde Community Health Center. (2000). *Transgender health program protocols*. Retrieved from http://www.callen-lorde.org/documents/TG_Protocol_Request_Form2.pdf

Callen Lorde Community Health Center. (2011). *Transgender health program protocols*. Retrieved from http://www.callen-lorde.org/documents/TG_Protocol_Request_Form2.pdf

Canadian Association of Speech-Language Pathologists and Audiologists. (n.d.). CASLPA *clinical certification program*. Retrieved from http://www.caslpa.ca/

Carew, L., Dacakis, G., & Oates, J. (2007). The effectiveness of oral resonance therapy on the perception of femininity of voice in male-to-female transsexuals. *Journal of Voice, 21*(5), 591–603. doi:10.1016/j.jvoice.2006.05.005

Carnegie, C. (2004). Diagnosis of hypogonadism: Clinical assessments and laboratory tests. *Reviews in Urology, 6*(Suppl 6), S3–8.

Cattrall, F. R., & Healy, D. L. (2004). Long-term metabolic, cardiovascular and neoplastic risks with polycystic ovary syndrome. *Best Practice & Research Clinical Obstetrics & Gynaecology, 18*(5), 803–812. doi:10.1016/j.bpobgyn.2004.05.005

Center of Excellence for Transgender Health, UCSF. (2011). *Primary care protocol for transgender health care*. Retrieved from http://transhealth.ucsf.edu/trans?page=protocol-00–00

Chiñas, B. (1995). Isthmus Zapotec attitudes toward sex and gender anomalies. In S. O. Murray (Ed.), *Latin American male homosexualities* (pp. 293–302). Albuquerque, NM: University of New Mexico Press.

Clements, K., Wilkinson, W., Kitano, K., & Marx, R. (1999). HIV prevention and health service needs of the transgender community in San Francisco. *International Journal of Transgenderism, 3*(1), 2–17.

Cohen-Kettenis, P. T. (2001). Gender identity disorder in DSM? *Journal of the American Academy of Child & Adolescent Psychiatry, 40*(4), 391–391. doi:10.1097/00004583–200104000–00006

Cohen-Kettenis, P. T. (2005). Gender change in 46,XY persons with 5α-reductase-2 deficiency and 17β-hydroxysteroid dehydrogenase-3 deficiency. *Archives of Sexual Behavior, 34*(4), 399–410. doi:10.1007/s10508–005–4339–4

Cohen-Kettenis, P. T. (2006). Gender identity disorders. In C. Gillberg, R. Harrington & H. C. Steinhausen (Eds.), *A clinician's handbook of child and adolescent psychiatry* (pp. 695–725). New York, NY: Cambridge University Press.

Cohen-Kettenis, P. T. (2010). Psychosocial and psychosexual aspects of disorders of sex development. *Best Practice & Research Clinical Endocrinology & Metabolism, 24*(2), 325–334. doi:10.1016/j.beem.2009.11.005

Cohen-Kettenis, P. T., & Kuiper, A. J. (1984). Transseksualiteit en psychothérapie. *Tijdschrift Voor Psychotherapie, 10*, 153–166.

Cohen-Kettenis, P. T., Owen, A., Kaijser, V. G., Bradley, S. J., & Zucker, K. J. (2003). Demographic characteristics, social competence, and behavior problems in children with gender identity disorder: A cross-national, cross-clinic comparative analysis. *Journal of Abnormal Child Psychology, 31*(1), 41–53. doi:10.1023/A:1021769215342

Cohen-Kettenis, P. T., & Pfäfflin, F. (2003). *Transgenderism and intersexuality in childhood and adolescence: Making choices*. Thousand Oaks, CA: Sage.

Cohen-Kettenis, P. T., & Pfäfflin, F. (2010). The DSM diagnostic criteria for gender identity disorder in adolescents and adults. *Archives of Sexual Behavior, 39*(2), 499–513. doi:10.1007/s10508–009–9562-y

Cohen-Kettenis, P. T., Schagen, S. E. E., Steensma, T. D., de Vries, A. L. C., & Delemarre-van de Waal, H. A. (2011). Puberty suppression in a gender-dysphoric adolescent: A 22-year follow-up. *Archives of Sexual Behavior, 40*(4), 843–847. doi:0.1007/s10508–011–9758–9

Cohen-Kettenis, P. T., Wallien, M., Johnson, L. L., Owen-Anderson, A. F. H., Bradley, S. J., & Zucker, K. J. (2006). A parent-report gender identity questionnaire for children: A cross-national, cross-clinic comparative analysis. *Clinical Child Psychology and Psychiatry, 11*(3), 397–405. doi:10.1177/1359104506059135

Cole, C. M., O'Boyle, M., Emory, L. E., & Meyer III, W. J. (1997). Comorbidity of gender dysphoria and other major psychiatric diagnoses. *Archives of Sexual Behavior, 26*(1), 13–26.

Coleman, E. (2009a). Toward version 7 of the World Professional Association for Transgender Health's *Standards of Care*. *International Journal of Transgenderism, 11*(1), 1–7. doi: 10.1080/15532730902799912

Coleman, E. (2009b). Toward version 7 of the World Professional Association for Transgender Health's *Standards of Care*: Psychological assessment and approaches to treatment. *International Journal of Transgenderism, 11*(2), 69–73. doi: 10.1080/15532730903008008

Coleman, E. (2009c). Toward version 7 of the World Professional Association for Transgender Health's *Standards of Care*: Hormonal and surgical approaches to treatment. *International Journal of Transgenderism, 11*(3), 141–145. doi: 10.1080/15532730903383740

Coleman, E. (2009d). Toward version 7 of the World Professional Association for Transgender Health's *Standards of Care*: Medical and therapeutic approaches to treatment. *International Journal of Transgenderism, 11*(4), 215–219. doi: 10.1080/15532730903439450

Coleman, E., Colgan, P., & Gooren, L. (1992). Male cross-gender behavior in Myanmar (Burma): A description of the acault. *Archives of Sexual Behavior, 21*(3), 313–321.

Costa, L. M., & Matzner, A. (2007). *Male bodies, women's souls: Personal narratives of Thailand's transgendered youth*. Binghamton, NY: Haworth Press.

Currah, P., Juang, R. M., & Minter, S. (2006). *Transgender rights*. Minneapolis, MN: University of Minnesota Press.

Currah, P., & Minter, S. (2000). Unprincipled exclusions: The struggle to achieve judicial and legislative equality for transgender people. *William and Mary Journal of Women and Law, 7*, 37–60.

Dacakis, G. (2000). Long-term maintenance of fundamental frequency increases in male-to-female transsexuals. *Journal of Voice, 14*(4), 549–556. doi:10.1016/S0892–1997(00)80010–7

Dahl, M., Feldman, J. L., Goldberg, J. M., & Jaberi, A. (2006). Physical aspects of transgender endocrine therapy. *International Journal of Transgenderism, 9*(3), 111–134. doi:10.1300/J485v09n03_06

Darney, P. D. (2008). Hormonal contraception. In H. M. Kronenberg, S. Melmer, K. S. Polonsky & P. R. Larsen (Eds.), *Williams textbook of endocrinology* (11th ed., pp. 615–644). Philadelphia: Saunders.

Davies, S., & Goldberg, J. M. (2006). Clinical aspects of transgender speech feminization and masculinization. *International Journal of Transgenderism, 9*(3–4), 167–196. doi:10.1300/J485v09n03_08

de Bruin, M. D., Coerts, M. J., & Greven, A. J. (2000). Speech therapy in the management of male-to-female transsexuals. *Folia Phoniatrica Et Logopaedica, 52*(5), 220–227.

De Cuypere, G., T'Sjoen, G., Beerten, R., Selvaggi, G., De Sutter, P., Hoebeke, P., . . . Rubens, R. (2005). Sexual and physical health after sex reassignment surgery. *Archives of Sexual Behavior, 34*(6), 679–690. doi:10.1007/s10508–005–7926–5

De Cuypere, G., Van Hemelrijck, M., Michel, A., Carael, B., Heylens, G., Rubens, R., . . . Monstrey, S. (2007). Prevalence and demography of transsexualism in Belgium. *European Psychiatry, 22*(3), 137–141. doi:10.1016/j.eurpsy.2006.10.002

De Cuypere, G., & Vercruysse, H. (2009). Eligibility and readiness criteria for sex reassignment surgery: Recommendations for revision of the WPATH *standards of care*. *International Journal of Transgenderism, 11*(3), 194–205. doi:10.1080/15532730903383781

Delemarre-van de Waal, H. A., & Cohen-Kettenis, P.T. (2006). Clinical management of gender identity disorder in adolescents: A protocol on psychological and paediatric endocrinology aspects. *European Journal of Endocrinology,* 155(Suppl 1), S131–S137. doi:10.1530/eje.1.02231

Delemarre-van de Waal, H. A., van Weissenbruch, M. M., & Cohen Kettenis, P. T. (2004). Management of puberty in transsexual boys and girls. *Hormone Research in Paediatrics,* 62(Suppl 2), 75–75. doi:10.1159/000081145

de Lignières, B. (1999). Oral micronized progesterone. *Clinical Therapeutics, 21*(1), 41–60. doi:10.1016/S0149–2918(00)88267–3

Derrig-Palumbo, K., & Zeine, F. (2005). *Online therapy: A therapist's guide to expanding your practice.* New York, NY: W.W. Norton.

Dessens, A. B., Slijper, F. M. E., & Drop, S. L. S. (2005). Gender dysphoria and gender change in chromosomal females with congenital adrenal hyperplasia. *Archives of Sexual Behavior,* 34(4), 389–397. doi:10.1007/s10508-005-4338-5

De Sutter, P. (2009). Reproductive options for transpeople: Recommendations for revision of the WPATH's *standards of care*. *International Journal of Transgenderism, 11*(3), 183–185. doi:10.1080/15532730903383765

De Sutter, P., Kira, K., Verschoor, A., & Hotimsky, A. (2002). The desire to have children and the preservation of fertility in transsexual women: A survey. *International Journal of Transgenderism, 6*(3), retrieved from http://www.wpath.org/journal/www.iiav.nl/ezines/web/IJT/97–03/numbers/symposion/ijtvo06no03_02.htm

Devor, A. H. (2004). Witnessing and mirroring: A fourteen stage model. *Journal of Gay and Lesbian Psychotherapy,* 8(1/2), 41–67.

de Vries, A. L. C., Cohen-Kettenis, P. T., & Delemarre-van de Waal, H. A. (2006). Clinical management of gender dysphoria in adolescents. *International Journal of Transgenderism, 9*(3–4), 83–94. doi:10.1300/J485v09n03_04

de Vries, A. L. C., Doreleijers, T. A. H., Steensma, T. D., & Cohen-Kettenis, P. T. (2011). Psychiatric comorbidity in gender dysphoric adolescents. *Journal of Child Psychology and Psychiatry.* Advance online publication. doi:10.1111/j.1469–7610.2011.02426.x

de Vries, A. L. C., Noens, I. L. J., Cohen-Kettenis, P. T., van Berckelaer-Onnes, I. A., & Doreleijers, T. A. (2010). Autism spectrum disorders in gender dysphoric children and adolescents. *Journal of Autism and Developmental Disorders, 40*(8), 930–936. doi:10.1007/s10803–010–0935–9

de Vries, A. L. C., Steensma, T. D., Doreleijers, T. A. H., & Cohen-Kettenis, P. T. (2010). Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study. *The Journal of Sexual Medicine.* Advance online publication. doi:10.1111/j.1743–6109.2010.01943.x

Dhejne, C., Lichtenstein, P., Boman, M., Johansson, A. L. V., Langstrom, N., & Landen, M. (2011). Longterm follow-up of transsexual persons undergoing sex reassignment surgery: Cohort study in Sweden. *PloS ONE,* 6(2), 1–8. doi:10.1371/journal.pone.0016885

Diamond, M. (2009). Human intersexuality: Difference or disorder? *Archives of Sexual Behavior, 38*(2), 172–172. doi:10.1007/s10508–008–9438–6

Di Ceglie, D., & Thümmel, E. C. (2006). An experience of group work with parents of children and adolescents with gender identity disorder. *Clinical Child Psychology and Psychiatry, 11*(3), 387–396. doi:10.1177/1359104506064983

Dobs, A. S., Meikle, A. W., Arver, S., Sanders, S. W., Caramelli, K. E., & Mazer, N. A. (1999). Pharmacokinetics, efficacy, and safety of a permeation-enhanced testosterone transdermal system in comparison with bi-weekly injections of testosterone enanthate for the treatment of hypogonadal men. *Journal of Clinical Endocrinology & Metabolism, 84*(10), 3469–3478. doi:10.1210/jc.84.10.3469

Docter, R. F. (1988). *Transvestites and transsexuals: Toward a theory of cross-gender behavior*. New York, NY: Plenum Press.

Drummond, K. D., Bradley, S. J., Peterson-Badali, M., & Zucker, K. J. (2008). A follow-up study of girls with gender identity disorder. *Developmental Psychology, 44*(1), 34–45. doi:10.1037/0012–1649.44.1.34

Ehrbar, R. D., & Gorton, R. N. (2010). Exploring provider treatment models in interpreting the *standards of care*. *International Journal of Transgenderism, 12*(4), 198–2010. doi:10.1080/15532739.2010.544235

Ekins, R., & King, D. (2006). *The transgender phenomenon*. Thousand Oaks, CA: Sage.

Eklund, P. L., Gooren, L. J., & Bezemer, P. D. (1988). Prevalence of transsexualism in the Netherlands. *British Journal of Psychiatry, 152*(5), 638–640.

Eldh, J., Berg, A., & Gustafsson, M. (1997). Long-term follow up after sex reassignment surgery. *Scandinavian Journal of Plastic and Reconstructive Surgery and Hand Surgery, 31*(1), 39–45.

Emerson, S., & Rosenfeld, C. (1996). Stages of adjustment in family members of transgender individuals. *Journal of Family Psychotherapy, 7*(3), 1–12. doi:10.1300/J085V07N03_01

Emory, L. E., Cole, C. M., Avery, E., Meyer, O., & Meyer III, W. J. (2003). *Client's view of gender identity: Life, treatment status and outcome*. Paper presented at 18th Biennial Harry Benjamin Symposium, Gent, Belgium.

Ettner, R., Monstrey, S., & Eyler, A. (Eds.) (2007). *Principles of transgender medicine and surgery*. Binghamton, NY: Haworth Press.

Eyler, A. E. (2007). Primary medical care of the gender-variant patient. In R. Ettner, S. Monstrey & E. Eyler (Eds.), *Principles of transgender medicine and surgery* (pp. 15–32). Binghamton, NY: Haworth Press.

Factor, R. J., & Rothblum, E. (2008). Exploring gender identity and community among three groups of transgender individuals in the United States: MtFs, FtMs, and genderqueers. *Health Sociology Review, 17*(3), 235–253.

Feinberg, L. (1996). *Transgender warriors: Making history from Joan of Arc to Dennis Rodman*. Boston, MA: Beacon Press.

Feldman, J. (2005, April). *Masculinizing hormone therapy with testosterone 1% topical gel*. Paper presented at the 19th Biennial Symposium of the Harry Benjamin International Gender Dysphoria Association, Bologna, Italy.

Feldman, J. (2007). Preventive care of the transgendered patient. In R. Ettner, S. Monstrey & E. Eyler (Eds.), *Principles of transgender surgery and medicine* (pp. 33–72). Binghamton, NY: Haworth Press.

Feldman, J., & Goldberg, J. (2006). Transgender primary medical care. *International Journal of Transgenderism, 9*(3), 3–34. doi:10.1300/J485v09n03_02

Feldman, J., & Safer, J. (2009). Hormone therapy in adults: Suggested revisions to the sixth version of the *standards of care*. *International Journal of Transgenderism, 11*(3), 146–182. doi:10.1080/15532730903383757

Fenichel, M., Suler, J., Barak, A., Zelvin, E., Jones, G., Munro, K., . . . Walker-Schmucker, W. (2004). *Myths and realities of online clinical work, observations on the phenomena of online behavior, experience, and therapeutic relationships. A 3rd-year report from ISMHO's clinical case study group*. Retrieved from https://www.ismho.org/myths_n_realities.asp

Fenway Community Health Transgender Health Program. (2007). *Protocol for hormone therapy.* Retrieved from http://www.fenwayhealth.org/site/DocServer/Fenway_Protocols.pdf?docID=2181

Fisk, N. M. (1974). Editorial: Gender dysphoria syndrome—the conceptualization that liberalizes indications for total gender reorientation and implies a broadly based multi-dimensional rehabilitative regimen. *Western Journal of Medicine, 120*(5), 386–391.

Fitzpatrick, L. A., Pace, C., & Wiita, B. (2000). Comparison of regimens containing oral micronized progesterone or medroxyprogesterone acetate on quality of life in postmenopausal women: A cross-sectional survey. *Journal of Women's Health & Gender-Based Medicine, 9*(4), 381–387.

Frank, J. D., & Frank, J. B. (1993). *Persuasion and healing: A comparative study of psychotherapy* (3rd ed.). Baltimore, MD: Johns Hopkins University Press.

Fraser, L. (2009a). Depth psychotherapy with transgender people. *Sexual and Relationship Therapy, 24*(2), 126–142. doi:10.1080/14681990903003878

Fraser, L. (2009b). E-therapy: Ethical and clinical considerations for version 7 of The World Professional Association for Transgender Health's *Standards of Care*. *International Journal of Transgenderism, 11*(4), 247–263. doi:10.1080/15532730903439492

Fraser, L. (2009c). Psychotherapy in The World Professional Association for Transgender Health's *Standards of Care*: Background and recommendations. *International Journal of Transgenderism, 11*(2), 110–126. doi:10.1080/15532730903008057

Garaffa, G., Christopher, N. A., & Ralph, D. J. (2010). Total phallic reconstruction in female-to-male transsexuals. *European Urology, 57*(4), 715–722. doi:10.1016/j.eururo.2009.05.018

Gelder, M. G., & Marks, I. M. (1969). Aversion treatment in transvestism and transsexualism. In R. Green, & J. Money (Eds.), *Transsexualism and sex reassignment* (pp. 383–413). Baltimore, MD: Johns Hopkins University Press.

Gelfer, M. P. (1999). Voice treatment for the male-to-female transgendered client. *American Journal of Speech-Language Pathology, 8*(3), 201–208.

Gharib, S., Bigby, J., Chapin, M., Ginsburg, E., Johnson, P., Manson, J., & Solomon, C. (2005). *Menopause: A guide to management*. Boston, MA: Brigham and Women's Hospital.

Gijs, L., & Brewaeys, A. (2007). Surgical treatment of gender dysphoria in adults and adolescents: Recent developments, effectiveness, and challenges. *Annual Review of Sex Research, 18*, 178–224.

Gold, M., & MacNish, M. (2011). *Adjustment and resiliency following disclosure of transgender identity in families of adolescents and young adults: Themes and clinical implications*. Washington, DC: American Family Therapy Academy.

Gómez-Gil, E., Trilla, A., Salamero, M., Godás, T., & Valdés, M. (2009). Sociodemographic, clinical, and psychiatric characteristics of transsexuals from Spain. *Archives of Sexual Behavior, 38*(3), 378–392. doi:10.1007/s10508–007–9307–8

Gooren, L. (2005). Hormone treatment of the adult transsexual patient. *Hormone Research in Paediatrics, 64*(Suppl 2), 31–36. doi:10.1159/000087751

Gorton, R. N., Buth, J., & Spade, D. (2005). *Medical therapy and health maintenance for transgender men: A guide for health care providers*. San Francisco, CA: Lyon-Martin Women's Health Services.

Green, R. (1987). *The* "sissy boy syndrome" *and the development of homosexuality*. New Haven, CT: Yale University Press.

Green, R., & Fleming, D. (1990). Transsexual surgery follow-up: Status in the 1990s. *Annual Review of Sex Research, 1*(1), 163–174.

Greenson, R. R. (1964). On homosexuality and gender identity. *International Journal of Psycho-Analysis, 45*, 217–219.

Grossman, A. H., D'Augelli, A. R., Howell, T. J., & Hubbard, S. (2006). Parent's reactions to transgender youth's gender-nonconforming expression and identity. *Journal of Gay & Lesbian Social Services, 18*(1), 3–16. doi:10.1300/J041v18n01_02

Grossman, A. H., D'Augelli, A. R., & Salter, N. P. (2006). Male-to-female transgender youth: Gender expression milestones, gender atypicality, victimization, and parents' responses. *Journal of GLBT Family Studies, 2*(1), 71–92.

Grumbach, M. M., Hughes, I. A., & Conte, F. A. (2003). Disorders of sex differentiation. In P. R. Larsen, H. M. Kronenberg, S. Melmed & K. S. Polonsky (Eds.), *Williams textbook of endocrinology* (10th ed., pp. 842–1002). Philadelphia, PA: Saunders.

Hage, J. J., & De Graaf, F. H. (1993). Addressing the ideal requirements by free flap phalloplasty: Some reflections on refinements of technique. *Microsurgery, 14*(9), 592–598. doi:10.1002/micr.1920140910

Hage, J. J., & Karim, R. B. (2000). Ought GIDNOS get nought? Treatment options for nontranssexual gender dysphoria. *Plastic and Reconstructive Surgery, 105*(3), 1222–1227.

Hancock, A. B., Krissinger, J., & Owen, K. (2010). Voice perceptions and quality of life of transgender people. *Journal of Voice*. Advance online publication. doi:10.1016/j.jvoice.2010.07.013

Hastings, D. W. (1974). Postsurgical adjustment of male transsexual patients. *Clinics in Plastic Surgery, 1*(2), 335–344.

Hembree, W. C., Cohen-Kettenis, P., Delemarre-van de Waal, H. A., Gooren, L. J., Meyer III, W. J., Spack, N. P., . . . Montori, V. M. (2009). Endocrine treatment of transsexual persons: An Endocrine Society clinical practice guideline. *Journal of Clinical Endocrinology & Metabolism, 94*(9), 3132–3154. doi:10.1210/jc.2009–0345

Hill, D. B., Menvielle, E., Sica, K. M., & Johnson, A. (2010). An affirmative intervention for families with gender-variant children: Parental ratings of child mental health and gender. *Journal of Sex and Marital Therapy, 36*(1), 6–23. doi:10.1080/00926230903375560

Hoebeke, P., Selvaggi, G., Ceulemans, P., De Cuypere, G. D., T'Sjoen, G., Weyers, S., . . . Monstrey, S. (2005). Impact of sex reassignment surgery on lower urinary tract function. *European Urology, 47*(3), 398–402. doi:10.1016/j.eururo.2004.10.008

Hoenig, J., & Kenna, J. C. (1974). The prevalence of transsexualism in England and Wales. *British Journal of Psychiatry, 124*(579), 181–190. doi:10.1192/bjp.124.2.181

Hughes, I. A., Houk, C. P., Ahmed, S. F., Lee, P. A., & LWPES1/ESPE Consensus Group. (2006). Consensus statement on management of intersex disorders. *Archives of Disease in Childhood, 91*(7), 554–563. doi:10.1136/adc.2006.098319

Hunter, M. H., & Sterrett, J. J. (2000). Polycystic ovary syndrome: It's not just infertility. *American Family Physician, 62*(5), 1079–1095.

Institute of Medicine. (2011). *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding*. Washington, DC: The National Academies Press.

Jackson, P. A., & Sullivan, G. (Eds.). (1999). *Lady boys, tom boys, rent boys: Male and female homosexualities in contemporary Thailand*. Binghamton, NY: Haworth Press.

Jockenhövel, F. (2004). Testosterone therapy-what, when and to whom? *The Aging Male, 7*(4), 319–324. doi:10.1080/13685530400016557

Johansson, A., Sundbom, E., Höjerback, T., & Bodlund, O. (2010). A five-year follow-up study of Swedish adults with gender identity disorder. *Archives of Sexual Behavior, 39*(6), 1429–1437. doi:10.1007/s10508–009–9551–1

Joint LWPES/ESPE CAH Working Group, Clayton, P. E., Miller, W. L., Oberfield, S. E., Ritzen, E. M., Sippell, W. G., & Speiser, P. W. (2002). Consensus statement on 21-hydroxylase deficiency from the Lawson Wilkins Pediatric Endocrine Society and the European Society for Pediatric Endocrinology. *Journal of Clinical Endocrinology & Metabolism, 87*(9), 4048–4053. doi:10.1210/jc.2002–020611

Jurgensen, M., Hiort, O., Holterhus, P. M., & Thyen, U. (2007). Gender role behavior in children with XY karyotype and disorders of sex development. *Hormones and Behavior, 51*(3), 443–453. doi:0.1016/j.yhbeh.2007.01.001

Kanagalingam, J., Georgalas, C., Wood, G. R., Ahluwalia, S., Sandhu, G., & Cheesman, A. D. (2005). Cricothyroid approximation and subluxation in 21 male-to-female transsexuals. *The Laryngoscope, 115*(4), 611–618. doi:10.1097/01.mlg.0000161357.12826.33

Kanhai, R. C. J., Hage, J. J., Karim, R. B., & Mulder, J. W. (1999). Exceptional presenting conditions and outcome of augmentation mammaplasty in male-to-female transsexuals. *Annals of Plastic Surgery, 43*(5), 476–483.

Kimberly, S. (1997). I am transsexual - hear me roar. *Minnesota Law & Politics, June*, 21–49.

Klein, C., & Gorzalka, B. B. (2009). Sexual functioning in transsexuals following hormone therapy and genital surgery: A review (CME). *The Journal of Sexual Medicine, 6*(11), 2922–2939. doi:10.1111/j.1743–6109.2009.01370.x

Knudson, G., De Cuypere, G., & Bockting, W. (2010a). Process toward consensus on recommendations for revision of the DSM diagnoses of gender identity disorders by The World Professional Association for Transgender Health. *International Journal of Transgenderism, 12*(2), 54–59. doi:10.1080/15532739.2010.509213

Knudson, G., De Cuypere, G., & Bockting, W. (2010b). Recommendations for revision of the *DSM* diagnoses of gender identity disorders: Consensus statement of The World Professional Association for Transgender Health. *International Journal of Transgenderism, 12*(2), 115–118. doi:10.1080/15532739.2010.509215

Kosilek v. Massachusetts Department of Corrections/Maloney, C.A. No. 92–12820-MLW (U.S. Federal District Court, Boston, MA, 2002).

Krege, S., Bex, A., Lümmen, G., & Rübben, H. (2001). Male-to-female transsexualism: A technique, results and long-term follow-up in 66 patients. *British Journal of Urology, 88*(4), 396–402. doi:10.1046/j.1464–410X.2001.02323.x

Kuhn, A., Bodmer, C., Stadlmayr, W., Kuhn, P., Mueller, M. D., & Birkhäuser, M. (2009). Quality of life 15 years after sex reassignment surgery for transsexualism. *Fertility and Sterility, 92*(5), 1685–1689. doi:10.1016/j.fertnstert.2008.08.126

Kuhn, A., Hiltebrand, R., & Birkhauser, M. (2007). Do transsexuals have micturition disorders? *European Journal of Obstetrics & Gynecology and Reproductive Biology, 131*(2), 226–230. doi:10.1016/j.ejogrb.2006.03.019

Landén, M., Wålinder, J., & Lundström, B. (1998). Clinical characteristics of a total cohort of female and male applicants for sex reassignment: A descriptive study. *Acta Psychiatrica Scandinavica, 97*(3), 189–194. doi:10.1111/j.1600–0447.1998.tb09986.x

Lawrence, A. A. (2003). Factors associated with satisfaction or regret following male-to-female sex reassignment surgery. *Archives of Sexual Behavior, 32*(4), 299–315. doi:10.1023/A:1024086814364

Lawrence, A. A. (2006). Patient-reported complications and functional outcomes of male-to-female sex reassignment surgery. *Archives of Sexual Behavior, 35*(6), 717–727. doi:10.1007/s10508–006–9104–9

Lev, A. I. (2004). *Transgender emergence: Therapeutic guidelines for working with gender-variant people and their families.* Binghamton, NY: Haworth Clinical Practice Press.

Lev, A. I. (2009). The ten tasks of the mental health provider: Recommendations for revision of The World Professional Association for Transgender Health's *standards of care. International Journal of Transgenderism, 11*(2), 74–99. doi:10.1080/15532730903008032

Levy, A., Crown, A., & Reid, R. (2003). Endocrine intervention for transsexuals. *Clinical Endocrinology, 59*(4), 409–418. doi:10.1046/j.1365–2265.2003.01821.x

MacLaughlin, D. T., & Donahoe, P. K. (2004). Sex determination and differentiation. *New England Journal of Medicine, 350*(4), 367–378.

Maheu, M. M., Pulier, M. L., Wilhelm, F. H., McMenamin, J. P., & Brown-Connolly, N. E. (2005). *The mental health professional and the new technologies: A handbook for practice today*. Mahwah, NJ: Lawrence Erlbaum.

Malpas, J. (2011). Between pink and blue: A multi-dimensional family approach to gender nonconforming children and their families. *Family Process, 50*(4), 453–470 doi: 10.1111/j.1545–5300.2011.01371.x

Mazur, T. (2005). Gender dysphoria and gender change in androgen insensitivity or micropenis. *Archives of Sexual Behavior, 34*(4), 411–421. doi:10.1007/s10508–005–4341-x

McNeill, E. J. M. (2006). Management of the transgender voice. *The Journal of Laryngology & Otology, 120*(07), 521–523. doi:10.1017/S0022215106001174

McNeill, E. J. M., Wilson, J. A., Clark, S., & Deakin, J. (2008). Perception of voice in the transgender client. *Journal of Voice, 22*(6), 727–733. doi:10.1016/j.jvoice.2006.12.010

Menvielle, E. J., & Tuerk, C. (2002). A support group for parents of gender-nonconforming boys. *Journal of the American Academy of Child & Adolescent Psychiatry, 41*(8), 1010–1013. doi:10.1097/00004583–200208000–00021

Meyer, I. H. (2003). Prejudice as stress: Conceptual and measurement problems. *American Journal of Public Health, 93*(2), 262–265.

Meyer, J. K., & Reter, D. J. (1979). Sex reassignment: Follow-up. *Archives of General Psychiatry, 36*(9), 1010–1015.

Meyer, W. J. III. (2009). World Professional Association for Transgender Health's *standards of care* requirements of hormone therapy for adults with gender identity disorder. *International Journal of Transgenderism, 11*(2), 127–132. doi:10.1080/15532730903008065

Meyer, W. J. III. Webb, A., Stuart, C. A., Finkelstein, J. W., Lawrence, B., & Walker, P. A. (1986). Physical and hormonal evaluation of transsexual patients: A longitudinal study. *Archives of Sexual Behavior, 15*(2), 121–138. doi:10.1007/BF01542220

Meyer-Bahlburg, H. F. L. (2002). Gender assignment and reassignment in intersexuality: Controversies, data, and guidelines for research. *Advances in Experimental Medicine and Biology, 511*, 199–223. doi:10.1007/978–1-4615–0621–8_12

Meyer-Bahlburg, H. F. L. (2005). Gender identity outcome in female-raised 46,XY persons with penile agenesis, cloacal exstrophy of the bladder, or penile ablation. *Archives of Sexual Behavior, 34*(4), 423–438. doi:10.1007/s10508–005–4342–9

Meyer-Bahlburg, H. F. L. (2008). Treatment guidelines for children with disorders of sex development. *Neuropsychiatrie De l'Enfance Et De l'Adolescence, 56*(6), 345–349. doi:10.1016/j.neurenf.2008.06.002

Meyer-Bahlburg, H. F. L. (2009). Variants of gender differentiation in somatic disorders of sex development. *International Journal of Transgenderism, 11*(4), 226–237. doi:10.1080/15532730903439476

Meyer-Bahlburg, H. F. L. (2010). From mental disorder to iatrogenic hypogonadism: Dilemmas in conceptualizing gender identity variants as psychiatric conditions. *Archives of Sexual Behavior, 39*(2), 461–476. doi:10.1007/s10508–009–9532–4

Meyer-Bahlburg, H. F. L. (2011). Gender monitoring and gender reassignment of children and adolescents with a somatic disorder of sex development. *Child & Adolescent Psychiatric Clinics of North America. 20*(4), 639–649. doi: 10.1016/;. ch.2011.07.002.

Meyer-Bahlburg, H. F. L., & Blizzard, R. M. (2004). Conference proceedings: Research on intersex: Summary of a planning workshop. *The Endocrinologist, 14*(2), 59–69. doi:10.1097/01.ten.0000123701.61007.4e

Meyer-Bahlburg, H. F. L., Dolezal, C., Baker, S. W., Carlson, A. D., Obeid, J. S., & New, M. I. (2004). Prenatal androgenization affects gender-related behavior but not gender identity in 5–12-year-old girls with congenital adrenal hyperplasia. *Archives of Sexual Behavior, 33*(2), 97–104. doi:10.1023/B:ASEB.0000014324.25718.51

Meyer-Bahlburg, H. F. L., Dolezal, C., Baker, S. W., Ehrhardt, A. A., & New, M. I. (2006). Gender development in women with congenital adrenal hyperplasia as a function of disorder severity. *Archives of Sexual Behavior, 35*(6), 667–684. doi:10.1007/s10508–006–9068–9

Meyer-Bahlburg, H. F. L., Migeon, C. J., Berkovitz, G. D., Gearhart, J. P., Dolezal, C., & Wisniewski, A. B. (2004). Attitudes of adult 46,XY intersex persons to clinical management policies. *The Journal of Urology, 171*(4), 1615–1619. doi:10.1097/01.ju.0000117761.94734.b7

Money, J., & Ehrhardt, A. A. (1972). *Man and woman, boy and girl*. Baltimore, MD: Johns Hopkins University Press.

Money, J., & Russo, A. J. (1979). Homosexual outcome of discordant gender identity/role in childhood: Longitudinal follow-up. *Journal of Pediatric Psychology, 4*(1), 29–41. doi:10.1093/jpepsy/4.1.29

Monstrey, S., Hoebeke, P., Selvaggi, G., Ceulemans, P., Van Landuyt, K., Blondeel, P., . . . De Cuypere, G. (2009). Penile reconstruction: Is the radial forearm flap really the standard technique? *Plastic and Reconstructive Surgery, 124*(2), 510–518.

Monstrey, S., Selvaggi, G., Ceulemans, P., Van Landuyt, K., Bowman, C., Blondeel, P., . . . De Cuypere, G. (2008). Chest-wall contouring surgery in female-to-male transsexuals: A new algorithm. *Plastic and Reconstructive Surgery, 121*(3), 849–859. doi:10.1097/01.prs.0000299921.15447.b2

Moore, E., Wisniewski, A., & Dobs, A. (2003). Endocrine treatment of transsexual people: A review of treatment regimens, outcomes, and adverse effects. *Journal of Clinical Endocrinology & Metabolism, 88*(8), 3467–3473. doi:10.1210/jc.2002–021967

More, S. D. (1998). The pregnant man – an oxymoron? *Journal of Gender Studies, 7*(3), 319–328. doi:10.1080/09589236.1998.9960725

Mount, K. H., & Salmon, S. J. (1988). Changing the vocal characteristics of a postoperative transsexual patient: A longitudinal study. *Journal of Communication Disorders, 21*(3), 229–238. doi:10.1016/0021–9924(88)90031–7

Mueller, A., Kiesewetter, F., Binder, H., Beckmann, M. W., & Dittrich, R. (2007). Long-term administration of testosterone undecanoate every 3 months for testosterone supplementation in female-to-male transsexuals. *Journal of Clinical Endocrinology & Metabolism, 92*(9), 3470–3475. doi:10.1210/jc.2007–0746

Murad, M. H., Elamin, M. B., Garcia, M. Z., Mullan, R. J., Murad, A., Erwin, P. J., & Montori, V. M. (2010). Hormonal therapy and sex reassignment: A systematic review and meta-analysis of quality of life and psychosocial outcomes. *Clinical Endocrinology, 72*(2), 214–231. doi:10.1111/j.1365–2265.2009.03625.x

Nanda, S. (1998). *Neither man nor woman: The hijras of India*. Belmont, CA: Wadsworth.

Nestle, J., Wilchins, R. A., & Howell, C. (2002). *Genderqueer: Voices from beyond the sexual binary*. Los Angeles, CA: Alyson Publications.

Neumann, K., & Welzel, C. (2004). The importance of voice in male-to-female transsexualism. *Journal of Voice, 18*(1), 153–167.

Newfield, E., Hart, S., Dibble, S., & Kohler, L. (2006). Female-to-male transgender quality of life. *Quality of Life Research, 15*(9), 1447–1457. doi:10.1007/s11136–006–0002–3

Nieschlag, E., Behre, H. M., Bouchard, P., Corrales, J. J., Jones, T. H., Stalla, G. K., . . . Wu, F. C. W. (2004). Testosterone replacement therapy: Current trends and future directions. *Human Reproduction Update, 10*(5), 409–419. doi:10.1093/humupd/dmh035

North American Menopause Society. (2010). Estrogen and progestogen use in postmenopausal women: 2010 position statement. *Menopause, 17*(2), 242–255. doi:10.1097/gme.0b013e3181d0f6b9

Nuttbrock, L., Hwahng, S., Bockting, W., Rosenblum, A., Mason, M., Macri, M., & Becker, J. (2010). Psychiatric impact of gender-related abuse across the life course of male-to-female transgender persons. *Journal of Sex Research, 47*(1), 12–23. doi:10.1080/00224490903062258

Oates, J. M., & Dacakis, G. (1983). Speech pathology considerations in the management of transsexualism—a review. *International Journal of Language & Communication Disorders, 18*(3), 139–151. doi:10.3109/13682828309012237

Olyslager, F., & Conway, L. (2007). *On the calculation of the prevalence of transsexualism*. Paper presented at the World Professional Association for Transgender Health 20th International Symposium, Chicago, Illinois. Retrieved from http://www.changelingaspects.com/PDF/2007–09–06-Prevalence_of_Transsexualism.pdf

Oriel, K. A. (2000). Clinical update: Medical care of transsexual patients. *Journal of the Gay and Lesbian Medical Association, 4*(4), 185–194. doi:1090–7173/00/1200–0185$18.00/1

Pauly, I. B. (1965). Male psychosexual inversion: Transsexualism: A review of 100 cases. *Archives of General Psychiatry, 13*(2), 172–181.

Pauly, I. B. (1981). Outcome of sex reassignment surgery for transsexuals. *Australian and New Zealand Journal of Psychiatry, 15*(1), 45–51. doi:10.3109/00048678109159409

Payer, A. F., Meyer, W. J. III. & Walker, P. A. (1979). The ultrastructural response of human leydig cells to exogenous estrogens. *Andrologia, 11*(6), 423–436. doi:10.1111/j.1439–0272.1979.tb02232.x

Peletz, M. G. (2006). Transgenderism and gender pluralism in southeast Asia since early modern times. *Current Anthropology, 47*(2), 309–340. doi:10.1086/498947

Pfäfflin, F. (1993). Regrets after sex reassignment surgery. *Journal of Psychology & Human Sexuality, 5*(4), 69–85.

Pfäfflin, F., & Junge, A. (1998). Sex reassignment. Thirty years of international follow-up studies after sex reassignment surgery: A comprehensive review, 1961–1991. *International Journal of Transgenderism*. Retrieved from http://web.archive.org/web/20070503090247/http://www.symposion.com/ijt/pfaefflin/1000.htm

Physicians' desk reference. (61st ed.). (2007). Montvale, NJ: PDR.

Physicians' desk reference. (65th ed.). (2010). Montvale, NJ: PDR.

Pleak, R. R. (1999). Ethical issues in diagnosing and treating gender-dysphoric children and adolescents. In M. Rottnek (Ed.), *Sissies and tomboys: Gender noncomformity and homosexual childhood* (pp. 34–51). New York: New York University Press.

Pope, K. S., & Vasquez, M. J. (2011). *Ethics in psychotherapy and counseling: A practical guide* (4TH ed.). Hoboken, NJ: John Wiley.

Prior, J. C., Vigna, Y. M., & Watson, D. (1989). Spironolactone with physiological female steroids for presurgical therapy of male-to-female transsexualism. *Archives of Sexual Behavior, 18*(1), 49–57. doi:10.1007/BF01579291

Prior, J. C., Vigna, Y. M., Watson, D., Diewold, P., & Robinow, O. (1986). Spironolactone in the presurgical therapy of male to female transsexuals: Philosophy and experience of the Vancouver Gender Dysphoria Clinic. *Journal of Sex Information & Education Council of Canada, 1*, 1–7.

Rachlin, K. (1999). Factors which influence individual's decisions when considering female-to-male genital reconstructive surgery. *International Journal of Transgenderism, 3*(3). Retrieved from http://www.WPATH.org

Rachlin, K. (2002). Transgendered individuals' experiences of psychotherapy. *International Journal of Transgenderism, 6*(1). Retrieved from http://www.wpath.org/journal/www.iiav.nl /ezines/web/IJT/97–03/numbers/symposion/ijtvo06no01_03.htm.

Rachlin, K., Green, J., & Lombardi, E. (2008). Utilization of health care among female-to-male transgender individuals in the United States. *Journal of Homosexuality, 54*(3), 243–258. doi:10.1080/00918360801982124

Rachlin, K., Hansbury, G., & Pardo, S. T. (2010). Hysterectomy and oophorectomy experiences of female-to-male transgender individuals. *International Journal of Transgenderism, 12*(3), 155–166. doi:10.1080/15532739.2010.514220

Reed, B., Rhodes, S., Schofield, P. & Wylie, K. (2009). *Gender variance in the UK: Prevalence, incidence, growth and geographic distribution.* Retrieved June 8, 2011, from http://www.gires.org.uk/assets/Medpro-Assets/GenderVarianceUK-report.pdf

Rehman, J., Lazer, S., Benet, A. E., Schaefer, L. C., & Melman, A. (1999). The reported sex and surgery satisfactions of 28 postoperative male-to-female transsexual patients. *Archives of Sexual Behavior, 28*(1), 71–89. doi:10.1023/A:1018745706354

Robinow, O. (2009). Paraphilia and transgenderism: A connection with Asperger's disorder? *Sexual and Relationship Therapy, 24*(2), 143–151. doi:10.1080/14681990902951358

Rosenberg, M. (2002). Children with gender identity issues and their parents in individual and group treatment. *Journal of the American Academy of Child and Adolescent Psychiatry, 41*(5), 619–621. doi:10.1097/00004583–200205000–00020

Rossouw, J. E., Anderson, G. L., Prentice, R. L., LaCroix, A. Z., Kooperberg, C., Stefanick, M. L., . . . Johnson, K. C. (2002). Risks and benefits of estrogen plus progestin in healthy postmenopausal women: Principal results from the women's health initiative randomized controlled trial. *JAMA: The Journal of the American Medical Association, 288*(3), 321–333.

Royal College of Speech Therapists, United Kingdom. http://www.rcslt.org/

Ruble, D. N., Martin, C. L., & Berenbaum, S. A. (2006). Gender development. In N. Eisenberg, W. Damon & R. M. Lerner (Eds.), *Handbook of child psychology* (6TH ed., pp. 858–932). Hoboken, NJ: John Wiley.

Sausa, L. A. (2005). Translating research into practice: Trans youth recommendations for improving school systems. *Journal of Gay & Lesbian Issues in Education, 3*(1), 15–28. doi:10.1300/J367v03n01_04

Simpson, J. L., de la Cruz, F., Swerdloff, R. S., Samango-Sprouse, C., Skakkebaek, N. E., Graham, J. M. J., . . . Willard, H. F. (2003). Klinefelter syndrome: Expanding the phenotype and identifying new research directions. *Genetics in Medicine, 5*(6), 460–468. doi:10.1097/01.GIM.0000095626.54201.D0

Smith, Y. L. S., Van Goozen, S. H. M., Kuiper, A. J., & Cohen-Kettenis, P. T. (2005). Sex reassignment: Outcomes and predictors of treatment for adolescent and adult transsexuals. *Psychological Medicine, 35*(1), 89–99. doi:10.1017/S0033291704002776

Sood, R., Shuster, L., Smith, R., Vincent, A., & Jatoi, A. (2011). Counseling postmenopausal women about bioidentical hormones: Ten discussion points for practicing physicians. *Journal of the American Board of Family Practice, 24*(2), 202–210. doi:10.3122/jabfm.2011.02.100194

Speech Pathology Australia. http://www.speechpathologyaustralia.org.au/

Speiser, P. W., Azziz, R., Baskin, L. S., Ghizzoni, L., Hensle, T. W., Merke, D. P., . . . Oberfield, S. E. (2010). Congenital adrenal hyperplasia due to steroid 21-hydroxylase deficiency: An endocrine society clinical practice guideline. *Journal of Clinical Endocrinology & Metabolism, 95*(9), 4133–4160. doi:10.1210/jc.2009–2631

Steensma, T. D., Biemond, R., de Boer, F., & Cohen-Kettenis, P. T. (2011). Desisting and persisting gender dysphoria after childhood: A qualitative follow-up study. *Clinical Child Psychology and Psychiatry.* Advance online publication. doi:10.1177/1359104510378303

Steensma, T. D., & Cohen-Kettenis, P. T. (2011). Gender transitioning before puberty? *Archives of Sexual Behavior, 40*(4), 649–650. doi:10.1007/s10508–011–9752–2

Stikkelbroeck, N. M. M. L., Beerendonk, C., Willemsen, W. N. P., Schreuders-Bais, C. A., Feitz, W. F. J., Rieu, P. N. M. A., . . . Otten, B. J. (2003). The long term outcome of feminizing genital surgery for congenital adrenal hyperplasia: Anatomical, functional and cosmetic outcomes, psychosexual development, and satisfaction in adult female patients. *Journal of Pediatric and Adolescent Gynecology, 16*(5), 289–296. doi:10.1016/S1083–3188(03)00155–4

Stoller, R. J. (1964). A contribution to the study of gender identity. *International Journal of Psychoanalysis, 45*, 220–226.

Stone, S. (1991). The empire strikes back: A posttransexual manifesto. In J. Epstein, & K. Straub (Eds.), *Body guards: The cultural politics of gender ambiguity* (pp. 280–304). London: Routledge.

Tangpricha, V., Ducharme, S. H., Barber, T. W., & Chipkin, S. R. (2003). Endocrinologic treatment of gender identity disorders. *Endocrine Practice, 9*(1), 12–21.

Tangpricha, V., Turner, A., Malabanan, A., & Holick, M. (2001). Effects of testosterone therapy on bone mineral density in the FtM patient. *International Journal of Transgenderism, 5*(4).

Taywaditep, K. J., Coleman, E., & Dumronggittigule, P. (1997). Thailand (Muang Thai). In R. Francoeur (Ed.), *International encyclopedia of sexuality*. New York, NY: Continuum.

Thole, Z., Manso, G., Salgueiro, E., Revuelta, P., & Hidalgo, A. (2004). Hepatotoxicity induced by antiandrogens: A review of the literature. *Urologia Internationalis, 73*(4), 289–295. doi:10.1159/000081585

Tom Waddell Health Center. (2006). *Protocols for hormonal reassignment of gender.* Retrieved from http://www.sfdph.org/dph/comupg/oservices/medSvs/hlthCtrs/TransGendprotocols122006.pdf

Tsoi, W. F. (1988). The prevalence of transsexualism in Singapore. *Acta Psychiatrica Scandinavica, 78*(4), 501–504. doi:10.1111/j.1600–0447.1988.tb06373.x

Van den Broecke, R., Van der Elst, J., Liu, J., Hovatta, O., & Dhont, M. (2001). The female-to-male transsexual patient: A source of human ovarian cortical tissue for experimental use. *Human Reproduction, 16*(1), 145–147. doi:10.1093/humrep/16.1.145

Vanderburgh, R. (2009). Appropriate therapeutic care for families with pre-pubescent transgender/gender-dissonant children. *Child and Adolescent Social Work Journal, 26*(2), 135–154. doi:10.1007/s10560–008–0158–5

van Kesteren, P. J. M., Asscheman, H., Megens, J. A. J., & Gooren, L. J. G. (1997). Mortality and morbidity in transsexual subjects treated with cross-sex hormones. *Clinical Endocrinology, 47*(3), 337–343. doi:10.1046/j.1365–2265.1997.2601068.x

van Kesteren, P. J. M., Gooren, L. J., & Megens, J. A. (1996). An epidemiological and demographic study of transsexuals in the Netherlands. *Archives of Sexual Behavior, 25*(6), 589–600. doi:10.1007/BF02437841

van Trotsenburg, M. A. A. (2009). Gynecological aspects of transgender healthcare. *International Journal of Transgenderism, 11*(4), 238–246. doi:10.1080/15532730903439484

Vilain, E. (2000). Genetics of sexual development. *Annual Review of Sex Research, 11*, 1–25.

Wålinder, J. (1968). Transsexualism: Definition, prevalence and sex distribution. *Acta Psychiatrica Scandinavica, 43*(S203), 255–257.

Wålinder, J. (1971). Incidence and sex ratio of transsexualism in Sweden. *The British Journal of Psychiatry, 119*(549), 195–196.

Wallien, M. S. C., & Cohen-Kettenis, P. T. (2008). Psychosexual outcome of gender-dysphoric children. *Journal of the American Academy of Child & Adolescent Psychiatry, 47*(12), 1413–1423. doi:10.1097/CHI.0b013e31818956b9

Wallien, M. S. C., Swaab, H., & Cohen-Kettenis, P. T. (2007). Psychiatric comorbidity among children with gender identity disorder. *Journal of the American Academy of Child & Adolescent Psychiatry, 46*(10), 1307–1314. doi:10.1097/chi.0b013e3181373848

Warren, B. E. (1993). Transsexuality, identity and empowerment. A view from the frontlines. *SIECUS Report, February/March,* 14–16.

Weitze, C., & Osburg, S. (1996). Transsexualism in Germany: Empirical data on epidemiology and application of the German Transsexuals' Act during its first ten years. *Archives of Sexual Behavior, 25*(4), 409–425.

Wilson, J. D. (1999). The role of androgens in male gender role behavior. *Endocrine Reviews, 20*(5), 726–737. doi:10.1210/er.20.5.726

Winter, S. (2009). Cultural considerations for The World Professional Association for Transgender Health's *standards of care*: The Asian perspective. *International Journal of Transgenderism, 11*(1), 19–41. doi:10.1080/15532730902799938

Winter, S., Chalungsooth, P., Teh, Y. K., Rojanalert, N., Maneerat, K., Wong, Y. W., . . . Macapagal, R. A. (2009). Transpeople, transprejudice and pathologization: A seven-country factor analytic study. *International Journal of Sexual Health, 21*(2), 96–118. doi:10.1080/19317610902922537

Wisniewski, A. B., Migeon, C. J., Malouf, M. A., & Gearhart, J. P. (2004). Psychosexual outcome in women affected by congenital adrenal hyperplasia due to 21-hydroxylase deficiency. *The Journal of Urology, 171*(6, Part 1), 2497–2501. doi:10.1097/01.ju.0000125269.91938.f7

World Health Organization. (2007). *International classification of diseases and related health problems-10th revision*. Geneva, Switzerland: World Health Organization.

World Health Organization. (2008). *The world health report 2008: Primary health care—now more than ever*. Geneva, Switzerland: World Health Organization.

World Professional Association for Transgender Health, Inc. (2008). *WPATH clarification on medical necessity of treatment, sex reassignment, and insurance coverage in the U.S.A.* Retrieved from http://www.wpath.org/documents/Med%20Nec%20on%202008%20Letterhead.pdf

WPATH Board of Directors. (2010). *De-psychopathologisation statement released May 26, 2010.* Retrieved from http://wpath.org/announcements_detail.cfm?pk_announcement=17

Xavier, J. M. (2000). *The Washington, D.C. transgender needs assessment survey: Final report for phase two*. Washington, DC: Administration for HIV/AIDS of District of Columbia Government.

Zhang, G., Gu, Y., Wang, X., Cui, Y., & Bremner, W. J. (1999). A clinical trial of injectable testosterone undecanoate as a potential male contraceptive in normal Chinese men. *Journal of Clinical Endocrinology & Metabolism, 84*(10), 3642–3647. doi:10.1210/jc.84.10.3642

Zitzmann, M., Saad, F., & Nieschlag, E. (2006, April). *Long term experience of more than 8 years with a novel formulation of testosterone undecanoate (nebido) in substitution therapy of hypogonadal men.* Paper presented at European Congress of Endocrinology, Glasgow, UK.

Zucker, K. J. (1999). Intersexuality and gender identity differentiation. *Annual Review of Sex Research, 10*(1), 1–69.

Zucker, K. J. (2004). Gender identity development and issues. *Child and Adolescent Psychiatric Clinics of North America, 13*(3), 551–568. doi:10.1016/j.chc.2004.02.006

Zucker, K. J. (2006). "I'm half-boy, half-girl": Play psychotherapy and parent counseling for gender identity disorder. In R. L. Spitzer, M. B. First, J. B. W. Williams & M. Gibbons (Eds.), *DSM-IV-TR casebook, volume 2* (pp. 321–334). Arlington, VA: American Psychiatric Publishing, Inc.

Zucker, K. J. (2010). The DSM diagnostic criteria for gender identity disorder in children. *Archives of Sexual Behavior, 39*(2), 477–498. doi:10.1007/s10508–009–9540–4

Zucker, K. J., & Bradley, S. J. (1995). *Gender identity disorder and psychosexual problems in children and adolescents*. New York, NY: Guilford Press.

Zucker, K. J., Bradley, S. J., Owen-Anderson, A., Kibblewhite, S. J., & Cantor, J. M. (2008). Is gender identity disorder in adolescents coming out of the closet? *Journal of Sex & Marital Therapy, 34*(4), 287–290. doi:10.1080/00926230802096192

Zucker, K. J., Bradley, S. J., Owen-Anderson, A., Kibblewhite, S. J., Wood, H., Singh, D., & Choi, K. (in press). Demographics, behavior problems, and psychosexual characteristics of adolescents with gender identity disorder or transvestic fetishism. *Journal of Sex & Marital Therapy, 38*(2), 151–189.

Zucker, K. J., & Lawrence, A. A. (2009). Epidemiology of gender identity disorder: Recommendations for the *standards of care* of The World Professional Association for Transgender Health. *International Journal of Transgenderism, 11*(1), 8–18. doi:10.1080/15532730902799946

Zucker, K. J., Owen, A., Bradley, S. J., & Ameeriar, L. (2002). Gender-dysphoric children and adolescents: A comparative analysis of demographic characteristics and behavioral problems. *Clinical Child Psychology and Psychiatry, 7*(3), 398–411.

Zuger, B. (1984). Early effeminate behavior in boys: Outcome and significance for homosexuality. *Journal of Nervous and Mental Disease, 172*(2), 90–97.

APPENDIX A
GLOSSARY

Terminology in the area of health care for transsexual, transgender, and gender-nonconforming people is rapidly evolving; new terms are being introduced, and the definitions of existing terms are changing. Thus, there is often misunderstanding, debate, or disagreement about language in this field. Terms that may be unfamiliar or that have specific meanings in the *SOC* are defined below for the purpose of this document only. Others may adopt these definitions, but WPATH acknowledges that these terms may be defined differently in different cultures, communities, and contexts.

WPATH also acknowledges that many terms used in relation to this population are not ideal. For example, the terms *transsexual* and *transvestite*—and, some would argue, the more recent term *transgender*—have been applied to people in an objectifying fashion. Yet such terms have been more or less adopted by many people who are making their best effort to make themselves understood. By continuing to use these terms, WPATH intends only to ensure that concepts and processes are comprehensible, in order to facilitate the delivery of quality health care to transsexual, transgender, and gender-nonconforming people. WPATH remains open to new terminology that will further illuminate the experience of members of this diverse population and lead to improvements in health care access and delivery.

Bioidentical hormones: Hormones that are *structurally* identical to those found in the human body (ACOG Committee of Gynecologic Practice, 2005). The hormones used in bioidentical hormone therapy (BHT) are generally derived from plant sources and are structurally similar to endogenous human hormones, but they need to be commercially processed to become bioidentical.

Bioidentical compounded hormone therapy (BCHT): Use of hormones that are prepared, mixed, assembled, packaged, or labeled as a drug by a pharmacist and custom-made for a patient according to a physician's specifications. Government drug agency approval is not possible for each compounded product made for an individual consumer.

Cross-dressing (transvestism): Wearing clothing and adopting a gender role presentation that, in a given culture, is more typical of the other sex.

Disorders of sex development (DSD): Congenital conditions in which the development of chromosomal, gonadal, or anatomic sex is atypical. Some people strongly object to the "disorder" label and instead view these conditions as a matter of diversity (Diamond, 2009), preferring the terms *intersex* and *intersexuality*.

Female-to-Male (FtM): Adjective to describe individuals assigned female at birth who are changing or who have changed their body and/or gender role from birth-assigned female to a more masculine body or role.

Gender dysphoria: Distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b).

Gender identity: A person's intrinsic sense of being male (a boy or a man), female (a girl or woman), or an alternative gender (e.g., boygirl, girlboy, transgender, genderqueer, eunuch) (Bockting, 1999; Stoller, 1964).

Gender identity disorder: Formal diagnosis set forth by the *Diagnostic Statistical Manual of Mental Disorders, 4th Edition, Text Rev (DSM IV-TR)* (American Psychiatric Association, 2000). Gender identity disorder is characterized by a strong and persistent cross-gender identification and a persistent discomfort with one's sex or sense of inappropriateness in the gender role of that sex, causing clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Gender-nonconforming: Adjective to describe individuals whose gender identity, role, or expression differs from what is normative for their assigned sex in a given culture and historical period.

Gender role or expression: Characteristics in personality, appearance, and behavior that in a given culture and historical period are designated as masculine or feminine (that is, more typical of the male or female social role) (Ruble, Martin, & Berenbaum, 2006). While most individuals present socially in clearly masculine or feminine gender roles, some people present in an alternative gender role such as genderqueer or specifically transgender. All people tend to incorporate both masculine and feminine characteristics in their gender expression in varying ways and to varying degrees (Bockting, 2008).

Genderqueer: Identity label that may be used by individuals whose gender identity and/or role does not conform to a binary understanding of gender as limited to the categories of man or woman, male or female (Bockting, 2008).

Internalized transphobia: Discomfort with one's own transgender feelings or identity as a result of internalizing society's normative gender expectations.

Male-to-Female (MtF): Adjective to describe individuals assigned male at birth who are changing or who have changed their body and/or gender role from birth-assigned male to a more feminine body or role.

Natural hormones: Hormones that are derived from natural *sources* such as plants or animals. Natural hormones may or may not be bioidentical.

Sex: Sex is assigned at birth as male or female, usually based on the appearance of the external genitalia. When the external genitalia are ambiguous, other components of sex (internal genitalia, chromosomal and hormonal sex) are considered in order to assign sex (Grumbach, Hughes, & Conte, 2003; MacLaughlin & Donahoe, 2004; Money & Ehrhardt, 1972; Vilain, 2000). For most people, gender identity and expression are consistent with their sex assigned at birth; for transsexual, transgender, and gender-nonconforming individuals, gender identity or expression differ from their sex assigned at birth.

Sex reassignment surgery (gender affirmation surgery): Surgery to change primary and/or secondary sex characteristics to affirm a person's gender identity. Sex reassignment surgery can be an important part of medically necessary treatment to alleviate gender dysphoria.

Transgender: Adjective to describe a diverse group of individuals who cross or transcend culturally defined categories of gender. The gender identity of transgender people differs to varying degrees from the sex they were assigned at birth (Bockting, 1999).

Transition: Period of time when individuals change from the gender role associated with their sex assigned at birth to a different gender role. For many people, this involves learning how to live socially in another gender role; for others this means finding a gender role and expression that are most comfortable for them. Transition may or may not include feminization or masculinization of the body through hormones or other medical procedures. The nature and duration of transition are variable and individualized.

Transsexual: Adjective (often applied by the medical profession) to describe individuals who seek to change or who have changed their primary and/or secondary sex characteristics through femininizing or masculinizing medical interventions (hormones and/or surgery), typically accompanied by a permanent change in gender role.

APPENDIX B
OVERVIEW OF MEDICAL RISKS OF HORMONE THERAPY

The risks outlined below are based on two comprehensive, evidence-based literature reviews of masculinizing/feminizing hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009), along with a large cohort study (Asscheman et al., 2011). These reviews can serve as detailed references for providers, along with other widely recognized, published clinical materials (e.g., Dahl et al., 2006; Ettner et al., 2007).

Risks of Feminizing Hormone Therapy (MtF)

Likely Increased Risk:

Venous thromboembolic disease

- Estrogen use increases the risk of venous thromboembolic events (VTE), particularly in patients who are over age 40, smokers, highly sedentary, obese, and who have underlying thrombophilic disorders.
- This risk is increased with the additional use of third generation progestins.
- This risk is decreased with use of the transdermal (versus oral) route of estradiol administration, which is recommended for patients at higher risk of VTE.

Cardiovascular, cerebrovascular disease

- Estrogen use increases the risk of cardiovascular events in patients over age 50 with underlying cardiovascular risk factors. Additional progestin use may increase this risk.

Lipids

- Oral estrogen use may markedly increase triglycerides in patients, increasing the risk of pancreatitis and cardiovascular events.
- Different routes of administration will have different metabolic effects on levels of HDL cholesterol, LDL cholesterol and lipoprotein(a).
- In general, clinical evidence suggests that MtF patients with pre-existing lipid disorders may benefit from the use of transdermal rather than oral estrogen.

Liver/gallbladder

- Estrogen and cyproterone acetate use may be associated with transient liver enzyme elevations and, rarely, clinical hepatotoxicity.
- Estrogen use increases the risk of cholelithiasis (gall stones) and subsequent cholecystectomy.

Possible Increased Risk:

Type 2 diabetes mellitus

- Feminizing hormone therapy, particularly estrogen, may increase the risk of type 2 diabetes, particularly among patients with a family history of diabetes or other risk factors for this disease.

Hypertension

- Estrogen use may increase blood pressure, but the effect on incidence of overt hypertension is unknown.
- Spironolactone reduces blood pressure and is recommended for at-risk or hypertensive patients desiring feminization.

Prolactinoma

- Estrogen use increases the risk of hyperprolactinemia among MtF patients in the first year of treatment, but this risk is unlikely thereafter.
- High-dose estrogen use may promote the clinical appearance of preexisting but clinically unapparent prolactinoma.

Inconclusive or No Increased Risk:

Items in this category include those that may present risk, but for which the evidence is so minimal that no clear conclusion can be reached.

Breast cancer

- MtF persons who have taken feminizing hormones do experience breast cancer, but it is unknown how their degree of risk compares to that of persons born with female genitalia.
- Longer duration of feminizing hormone exposure (i.e., number of years taking estrogen preparations), family history of breast cancer, obesity (BMI >35), and the use of progestins likely influence the level of risk.

Other Side Effects of Feminizing Therapy:

The following effects may be considered minor or even desired, depending on the patient, but are clearly associated with feminizing hormone therapy.

Fertility and sexual function

- Feminizing hormone therapy may impair fertility.
- Feminizing hormone therapy may decrease libido.
- Feminizing hormone therapy reduces nocturnal erections, with variable impact on sexually stimulated erections.

Risks of Anti-Androgen Medications:

Feminizing hormone regimens often include a variety of agents that affect testosterone production or action. These include GnRH agonists, progestins (including cyproterone acetate), spironolactone, and 5-alpha reductase inhibitors. An extensive discussion of the specific risks of these agents is beyond the scope of the *SOC*. However, both spironolactone and cyproterone acetate are widely used and deserve some comment.

Cyproterone acetate is a progestational compound with anti-androgenic properties (Gooren, 2005; Levy et al., 2003). Although widely used in Europe, it is not approved for use in the United States because of concerns about hepatotoxicity (Thole, Manso, Salgueiro, Revuelta, & Hidalgo, 2004). Spironolactone is commonly used as an anti-androgen in feminizing hormone therapy, particularly in regions where cyproterone is not approved for use (Dahl et al., 2006; Moore et al., 2003; Tangpricha et al., 2003). Spironolactone has a long history of use in treating hypertension and congestive heart failure. Its common side effects include hyperkalemia, dizziness, and gastrointestinal symptoms (*Physicians' Desk Reference*, 2007).

Risks of Masculinizing Hormone Therapy (FtM)

Likely Increased Risk:

Polycythemia

- Masculinizing hormone therapy involving testosterone or other androgenic steroids increases the risk of polycythemia (hematocrit > 50%), particularly in patients with other risk factors.
- Transdermal administration and adaptation of dosage may reduce this risk.

Weight gain/visceral fat

- Masculinizing hormone therapy can result in modest weight gain, with an increase in visceral fat.

Possible Increased Risk:

Lipids

- Testosterone therapy decreases HDL, but variably affects LDL and triglycerides.
- Supraphysiologic (beyond normal male range) serum levels of testosterone, often found with extended intramuscular dosing, may worsen lipid profiles, whereas transdermal administration appears to be more lipid neutral.
- Patients with underlying polycystic ovarian syndrome or dyslipidemia may be at increased risk of worsening dyslipidemia with testosterone therapy.

Liver

- Transient elevations in liver enzymes may occur with testosterone therapy.
- Hepatic dysfunction and malignancies have been noted with oral methyltestosterone. However, methyltestosterone is no longer available in most countries and should no longer be used.

Psychiatric

Masculinizing therapy involving testosterone or other androgenic steroids may increase the risk of hypomanic, manic, or psychotic symptoms in patients with underlying psychiatric disorders that include such symptoms. This adverse event appears to be associated with higher doses or supraphysiologic blood levels of testosterone.

Inconclusive or No Increased Risk:

Items in this category include those that may present risk, but for which the evidence is so minimal that no clear conclusion can be reached.

Osteoporosis

- Testosterone therapy maintains or increases bone mineral density among FtM patients prior to oophorectomy, at least in the first three years of treatment.
- There is an increased risk of bone density loss after oophorectomy, particularly if testosterone therapy is interrupted or insufficient. This includes patients utilizing solely oral testosterone.

Cardiovascular

- Masculinizing hormone therapy at normal physiologic doses does not appear to increase the risk of cardiovascular events among healthy patients.
- Masculinizing hormone therapy may increase the risk of cardiovascular disease in patients with underlying risks factors.

Hypertension

- Masculinizing hormone therapy at normal physiologic doses may increase blood pressure but does not appear to increase the risk of hypertension.
- Patients with risk factors for hypertension, such as weight gain, family history, or polycystic ovarian syndrome, may be at increased risk.

Type 2 diabetes mellitus

- Testosterone therapy does not appear to increase the risk of type 2 diabetes among FtM patients overall, unless other risk factors are present.
- Testosterone therapy may further increase the risk of type 2 diabetes in patients with other risk factors, such as significant weight gain, family history, and polycystic ovarian syndrome. There are no data that suggest or show an increase in risk in those with risk factors for dyslipidemia.

Breast cancer

- Testosterone therapy in FtM patients does not increase the risk of breast cancer.

Cervical cancer

- Testosterone therapy in FtM patients does not increase the risk of cervical cancer, although it may increase the risk of minimally abnormal Pap smears due to atrophic changes.

Ovarian cancer

- Analogous to persons born with female genitalia with elevated androgen levels, testosterone therapy in FtM patients may increase the risk of ovarian cancer, although evidence is limited.

Endometrial (uterine) cancer

- Testosterone therapy in FtM patients may increase the risk of endometrial cancer, although evidence is limited.

Other Side Effects of Masculinizing Therapy:

The following effects may be considered minor or even desired, depending on the patient, but are clearly associated with masculinization.

Fertility and sexual function

- Testosterone therapy in FtM patients reduces fertility, although the degree and reversibility are unknown.

- Testosterone therapy can induce permanent anatomic changes in the developing embryo or fetus.
- Testosterone therapy induces clitoral enlargement and increases libido.

Acne, androgenic alopecia

Acne and varying degrees of male pattern hair loss (androgenic alopecia) are common side effects of masculinizing hormone therapy.

APPENDIX C
SUMMARY OF CRITERIA FOR HORMONE THERAPY AND SURGERIES

As for all previous versions of the *SOC*, the criteria put forth in the *SOC* for hormone therapy and surgical treatments for gender dysphoria are clinical guidelines; individual health professionals and programs may modify them. Clinical departures from the *SOC* may come about because of a patient's unique anatomic, social, or psychological situation; an experienced health professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm-reduction strategies. These departures should be recognized as such, explained to the patient, and documented through informed consent for quality patient care and legal protection. This documentation is also valuable to accumulate new data, which can be retrospectively examined to allow for health care—and the *SOC*—to evolve.

Criteria for Feminizing/Masculinizing Hormone Therapy (One Referral or Chart Documentation of Psychosocial Assessment)

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to give consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental concerns are present, they must be reasonably well controlled.

Criteria for Breast/Chest Surgery (One Referral)

Mastectomy and Creation of a Male Chest in FtM Patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to give consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Hormone therapy is not a prerequisite.

Breast Augmentation (Implants/Lipofilling) in MtF Patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to give consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Although not an explicit criterion, it is recommended that MtF patients undergo feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery. The purpose is to maximize breast growth in order to obtain better surgical (aesthetic) results.

Criteria for Genital Surgery (Two Referrals)

Hysterectomy and Salpingo-Oophorectomy in FtM Patients and Orchiectomy in MtF Patients:

1. Persistent, well documented gender dysphoria;
2. Capacity to make a fully informed decision and to give consent for treatment;

3. Age of majority in a given country;

4. If significant medical or mental health concerns are present, they must be well controlled;

5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless hormones are not clinically indicated for the individual).

The aim of hormone therapy prior to gonadectomy is primarily to introduce a period of reversible estrogen or testosterone suppression, before a patient undergoes irreversible surgical intervention.

These criteria do not apply to patients who are having these surgical procedures for medical indications other than gender dysphoria.

Metoidioplasty or Phalloplasty in FtM Patients and Vaginoplasty in MtF Patients:

1. Persistent, well documented gender dysphoria;

2. Capacity to make a fully informed decision and to give consent for treatment;

3. Age of majority in a given country;

4. If significant medical or mental health concerns are present, they must be well controlled;

5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless hormones are not clinically indicated for the individual);

6. 12 continuous months of living in a gender role that is congruent with their gender identity.

Although not an explicit criterion, it is recommended that these patients also have regular visits with a mental health or other medical professional.

The criterion noted above for some types of genital surgeries—that is, that patients engage in 12 continuous months of living in a gender role that is congruent with their gender identity—is based on expert clinical consensus that this experience provides ample opportunity for patients to experience and socially adjust in their desired gender role, before undergoing irreversible surgery.

APPENDIX D
EVIDENCE FOR CLINICAL OUTCOMES OF THERAPEUTIC APPROACHES

One of the real supports for any new therapy is an outcome analysis. Because of the controversial nature of sex reassignment surgery, this type of analysis has been very important. Almost all of the outcome studies in this area have been retrospective.

One of the first studies to examine the post-treatment psychosocial outcomes of transsexual patients was done in 1979 at Johns Hopkins University School of Medicine and Hospital (USA) (J. K. Meyer & Reter, 1979). This study focused on patients' occupational, educational, marital, and domiciliary stability. The results revealed several significant changes with treatment. These changes were not seen as positive; rather, they showed that many individuals who had entered the treatment program were no better off or were worse off in many measures after participation in the program. These findings resulted in closure of the treatment program at that hospital/medical school (Abramowitz, 1986).

Subsequently, a significant number of health professionals called for a standard for eligibility for sex reassignment surgery. This led to the formulation of the original *Standards of Care* of the Harry Benjamin International Gender Dysphoria Association (now WPATH) in 1979.

In 1981, Pauly published results from a large retrospective study of people who had undergone sex reassignment surgery. Participants in that study had much better outcomes: Among 83 FtM patients, 80.7% had a satisfactory outcome (i.e., patient self report of "improved social and emotional adjustment"), 6.0% unsatisfactory. Among 283 MtF patients, 71.4% had a satisfactory outcome, 8.1% unsatisfactory. This study included patients who were treated before the publication and use of the *Standards of Care*.

Since the *Standards of Care* have been in place, there has been a steady increase in patient satisfaction and decrease in dissatisfaction with the outcome of sex reassignment surgery. Studies conducted after 1996 focused on patients who were treated according to the *Standards of Care*. The findings of Rehman and colleagues (1999) and Krege and colleagues (2001) are typical of this body of work; none of the patients in these studies regretted having had surgery, and most reported being satisfied with the cosmetic and functional results of the surgery. Even patients who develop severe surgical complications seldom regret having undergone surgery. Quality of surgical results is one of the best predictors of the overall outcome of sex reassignment (Lawrence, 2003). The vast majority of follow-up studies have shown an undeniable beneficial effect of sex reassignment surgery on postoperative outcomes such as subjective well being, cosmesis, and sexual function (De Cuypere et al., 2005; Garaffa, Christopher, & Ralph, 2010; Klein & Gorzalka, 2009), although the specific magnitude of benefit is uncertain from

the currently available evidence. One study (Emory, Cole, Avery, Meyer, & Meyer, 2003) even showed improvement in patient income.

One troubling report (Newfield et al., 2006) documented lower scores on quality of life (measured with the SF-36) for FtM patients than for the general population. A weakness of that study is that it recruited its 384 participants by a general email rather than a systematic approach, and the degree and type of treatment were not recorded. Study participants who were taking testosterone had typically being doing so for less than 5 years. Reported quality of life was higher for patients who had undergone breast/chest surgery than for those who had not ($p<.001$). (A similar analysis was not done for genital surgery.) In other work, Kuhn and colleagues (2009) used the King's Health Questionnaire to assess the quality of life of 55 transsexual patients at 15 years after surgery. Scores were compared to those of 20 healthy female control patients who had undergone abdominal/pelvic surgery in the past. Quality of life scores for transsexual patients were the same or better than those of control patients for some subscales (emotions, sleep, incontinence, symptom severity, and role limitation), but worse in other domains (general health, physical limitation, and personal limitation).

Two long-term observational studies, both retrospective, compared the mortality and psychiatric morbidity of transsexual adults to those of general population samples (Asscheman et al., 2011; Dhejne et al., 2011). An analysis of data from the Swedish National Board of Health and Welfare information registry found that individuals who had received sex reassignment surgery (191 MtF and 133 FtM) had significantly higher rates of mortality, suicide, suicidal behavior, and psychiatric morbidity than those for a nontranssexual control group matched on age, immigrant status, prior psychiatric morbidity, and birth sex (Dhejne et al., 2011). Similarly, a study in the Netherlands reported a higher total mortality rate, including incidence of suicide, in both pre- and post-surgery transsexual patients (966 MtF and 365 MtF) than in the general population of that country (Asscheman et al., 2011). Neither of these studies questioned the efficacy of sex reassignment; indeed, both lacked an adequate comparison group of transsexuals who either did not receive treatment or who received treatment other than genital surgery. Moreover, transsexual people in these studies were treated as far back as the 1970s. However, these findings do emphasize the need to have good long-term psychological and psychiatric care available for this population. More studies are needed that focus on the outcomes of current assessment and treatment approaches for gender dysphoria.

It is difficult to determine the effectiveness of hormones alone in the relief of gender dysphoria. Most studies evaluating the effectiveness of masculinizing/feminizing hormone therapy on gender dysphoria have been conducted with patients who have also undergone sex reassignment surgery. Favorable effects of therapies that included both hormones and surgery were reported in a comprehensive review of over 3000 patients in 79 studies (mostly observational) conducted between 1961 and 1991 (Eldh, Berg, & Gustafsson, 1997; Gijs & Brewaeys, 2007; Murad et al., 2010; Pfäfflin & Junge, 1998). Patients operated on after 1986 did better than those before 1986; this reflects significant improvement in surgical complications (Eldh et al., 1997). Most patients have reported improved psychosocial outcomes, ranging between 87% for MtF patients and 97% for FtM patients (Green & Fleming, 1990).

Similar improvements were found in a Swedish study in which "almost all patients were satisfied with sex reassignment at 5 years, and 86% were assessed by clinicians at follow-up as stable or improved in global functioning" (Johansson, Sundbom, Höjerback, & Bodlund, 2010). Weaknesses of these earlier studies are their retrospective design and use of different criteria to evaluate outcomes.

A prospective study conducted in the Netherlands evaluated 325 consecutive adult and adolescent subjects seeking sex reassignment (Smith, Van Goozen, Kuiper, & Cohen-Kettenis, 2005). Patients who underwent sex reassignment therapy (both hormonal and surgical intervention) showed improvements in their mean gender dysphoria scores, measured by the Utrecht Gender Dysphoria Scale. Scores for body dissatisfaction and psychological function also improved in most categories. Fewer than 2% of patients expressed regret after therapy. This is the largest prospective study to affirm the results from retrospective studies that a combination of hormone therapy and surgery improves gender dysphoria and other areas of psychosocial functioning. There is a need for further research on the effects of hormone therapy without surgery, and without the goal of maximum physical feminization or masculinization.

Overall, studies have been reporting a steady improvement in outcomes as the field becomes more advanced. Outcome research has mainly focused on the outcome of sex reassignment surgery. In current practice there is a range of identity, role, and physical adaptations that could use additional follow-up or outcome research (Institute of Medicine, 2011).

APPENDIX E

DEVELOPMENT PROCESS FOR THE *STANDARDS OF CARE,* VERSION 7

The process of developing *Standards of Care, Version 7* began when an initial *SOC* "work group" was established in 2006. Members were invited to examine specific sections of *SOC, Version 6*. For each section, they were asked to review the relevant literature, identify where research was lacking and needed, and recommend potential revisions to the *SOC* as warranted by new evidence. Invited papers were submitted by the following authors: Aaron Devor, Walter Bockting, George Brown, Michael Brownstein, Peggy Cohen-Kettenis, Griet DeCuypere, Petra DeSutter, Jamie Feldman, Lin Fraser, Arlene Istar Lev, Stephen Levine, Walter Meyer, Heino Meyer-Bahlburg, Stan Monstrey, Loren Schechter, Mick van Trotsenburg, Sam Winter, and Ken Zucker. Some of these authors chose to add co-authors to assist them in their task.

Initial drafts of these papers were due June 1, 2007. Most were completed by September 2007, with the rest completed by the end of 2007. These manuscripts were then submitted to the *International*

Journal of Transgenderism (IJT). Each underwent the regular *IJT* peer review process. The final papers were published in Volume 11 (1–4) in 2009, making them available for discussion and debate.

After these articles were published, an *SOC* Revision Committee was established by the WPATH Board of Directors in 2010. The Revision Committee was first charged with debating and discussing the *IJT* background papers through a Google website. A subgroup of the Revision Committee was appointed by the Board of Directors to serve as the Writing Group. This group was charged with preparing the first draft of *SOC, Version 7* and continuing to work on revisions for consideration by the broader Revision Committee. The Board also appointed an International Advisory Group of transsexual, transgender, and gender-nonconforming individuals to give input on the revision.

A technical writer was hired to (1) review all of the recommendations for revision—both the original recommendations as outlined in the *IJT* articles and additional recommendations that emanated from the online discussion—and (2) create a survey to solicit further input on these potential revisions. From the survey results, the Writing Group was able to discern where these experts stood in terms of areas of agreement and areas in need of more discussion and debate. The technical writer then (3) created a very rough first draft of *SOC, Version 7* for the Writing Group to consider and build on.

The Writing Group met on March 4 and 5, 2011 in a face-to-face expert consultation meeting. They reviewed all recommended changes and debated and came to consensus on various controversial areas. Decisions were made based on the best available science and expert consensus. These decisions were incorporated into the draft, and additional sections were written by the Writing Group with the assistance of the technical writer.

The draft that emerged from the consultation meeting was then circulated among the Writing Group and finalized with the help of the technical writer. Once this initial draft was finalized, it was circulated among the broader *SOC* Revision Committee and the International Advisory Group. Discussion was opened up on the Google website and a conference call was held to resolve issues. Feedback from these groups was considered by the Writing Group, who then made further revisions. Two additional drafts were created and posted on the Google website for consideration by the broader *SOC* Revision Committee and the International Advisory Group. Upon completion of these three iterations of review and revision, the final document was presented to the WPATH Board of Directors for approval. The Board of Directors approved this version on September 14, 2011.

Funding

The *Standards of Care* revision process was made possible through a generous grant from the Tawani Foundation and a gift from an anonymous donor. These funds supported the following:

1. Costs of a professional technical writer;

2. Process of soliciting international input on proposed changes from gender identity professionals and the transgender community;

3. Working meeting of the Writing Group;

4. Process of gathering additional feedback and arriving at final expert consensus from the professional and transgender communities, the *Standards of Care, Version 7,* Revision Committee, and WPATH Board of Directors;

5. Costs of printing and distributing *Standards of Care, Version 7,* and posting a free downloadable copy on the WPATH website;

6. Plenary session to launch the *Standards of Care, Version 7,* at the 2011 WPATH Biennial Symposium in Atlanta, Georgia, USA.

Members of the *Standards of Care* Revision Committee†

Eli Coleman, PhD (USA)* - Committee chair
Richard Adler, PhD (USA)
Walter Bockting, PhD (USA)*
Marsha Botzer, MA (USA)*
George Brown, MD (USA)
Peggy Cohen-Kettenis, PhD (Netherlands)*
Griet DeCuypere, MD (Belgium)*
Aaron Devor, PhD (Canada)
Randall Ehrbar, PsyD (USA)
Randi Ettner, PhD (USA)
Evan Eyler, MD (USA)
Jamie Feldman, MD, PhD (USA)*
Lin Fraser, EdD (USA)*
Rob Garofalo, MD, MPH (USA)
Jamison Green, PhD, MFA (USA)*
Dan Karasic, MD (USA)
Gail Knudson, MD (Canada)*
Arlene Istar Lev, LCSW-R (USA)
Gal Mayer, MD (USA)
Walter Meyer, MD (USA)*
Heino Meyer-Bahlburg, Dr. rer.nat. (USA)
Stan Monstrey, MD, PhD (Belgium)*
Blaine Paxton Hall, MHS-CL, PA-C (USA)
Friedmann Pfäfflin, MD, PhD (Germany)
Katherine Rachlin, PhD (USA)
Bean Robinson, PhD (USA)
Loren Schechter, MD (USA)
Vin Tangpricha, MD, PhD (USA)
Mick van Trotsenburg, MD (Netherlands)
Anne Vitale, PhD (USA)
Sam Winter, PhD (Hong Kong)
Stephen Whittle, OBE (UK)
Kevan Wylie, MB, MD (UK)
Ken Zucker, PhD (Canada)

---

* Writing Group member.
† All members of the *Standards of Care, Version 7 Revision Committee* donated their time to work on this revision.

International Advisory Group Selection Committee

Walter Bockting, PhD (USA)
Marsha Botzer, MA (USA)
Aaron Devor, PhD (Canada)
Randall Ehrbar, PsyD (USA)
Evan Eyler, MD (USA)
Jamison Green, PhD, MFA (USA)
Blaine Paxton Hall, MHS-CL, PA-C (USA)

International Advisory Group

Tamara Adrian, LGBT Rights Venezuela (Venezuela)
Craig Andrews, FtM Australia (Australia)
Christine Burns, MBE, Plain Sense Ltd (UK)
Naomi Fontanos, Society for Transsexual Women's Rights in the Phillipines (Phillipines)
Tone Marie Hansen, Harry Benjamin Resource Center (Norway)
Rupert Raj, Sherbourne Health Center (Canada)
Masae Torai, FtM Japan (Japan)
Kelley Winters, GID Reform Advocates (USA)

Technical Writer

Anne Marie Weber-Main, PhD (USA)

Editorial Assistance

Heidi Fall (USA)

ZSQUAREDESIGN LLC | MPLS, MN

ISBN XXX-X-XXX-XXXXX-X

FPO FPO

X XXXXXX XXXXXX

VERIFICATION

STATE OF TEXAS §

TRAVIS COUNTY §

Before me the undersigned notary, on this day personally appeared Maddy R. Dwertman, the affiant, whose identity is known to me. After I administered an oath, affiant testified as follows:

1. My name is Maddy (Madeleine) R. Dwertman. I am over the age of 18 years, of sound mind, and capable of making this verification. I am co-counsel of record for Plaintiffs/Appellees Jane and John Doe, individually and as parents and next friends of Mary Doe, a minor, and Plaintiff/Appellee Dr. Megan Mooney (collectively "Plaintiffs" or "Appellees") in *Jane Doe, et al. v. Gregory Abbott, et al.,* Cause No. D-1-GN-22-000977, pending before the 201st Judicial District Court in Travis County, Texas ("District Court Case"). I am also co-counsel of record for Plaintiffs/Appellees in this appeal. I have personal knowledge of the proceedings and the pleadings and other papers on file in the District Court Case and in this case.

2. Appendices A through G in the foregoing Appendix to Appellees' Emergency Motion for Temporary Injunctive Relief Pursuant to Rule 29.3 are true and correct copies of filings and orders in the underlying District Court Case. Additionally, Appendix H is a true and correct copy of excerpts of the Reporter's

Record of the March 11, 2022 hearing in the District Court on Plaintiffs' Application for Temporary Injunction that counsel for Plaintiffs/Appellees requested, paid for and received from the court reporters who transcribed that hearing.

FURTHER AFFIANT SAYETH NOT.

Maddy (Madeleine) R. Dwertman

Subscribed and sworn to before me by Maddy (Madeleine) R. Dwertman, on this 16th day of March 2022.

Notary Public, State of Texas

Name: Stephanie Orrias

Commission Expires: 11/27/22

Automated Certificate of eService

This automated certificate of service was created by the efiling system. The filer served this document via email generated by the efiling system on the date and to the persons listed below. The rules governing certificates of service have not changed. Filers must still provide a certificate of service that complies with all applicable rules.

Shelly Skeen
Bar No. 24010511
sskeenlaw@gmail.com
Envelope ID: 62686046
Status as of 3/17/2022 11:01 AM CST

Case Contacts

Name	BarNumber	Email	TimestampSubmitted	Status
Ryan Kercher		ryan.kercher@oag.texas.gov	3/16/2022 10:44:47 PM	SENT
Kath Xu		kxu@aclu.org	3/16/2022 10:44:47 PM	SENT
Anjana Samant		asamant@aclu.org	3/16/2022 10:44:47 PM	SENT
Shelly Skeen		sskeen@lambdalegal.org	3/16/2022 10:44:47 PM	SENT
Nicholas Guillory		nguillory@lambdalegal.org	3/16/2022 10:44:47 PM	SENT
James Esseks		jesseks@aclu.org	3/16/2022 10:44:47 PM	SENT
Chase Strangio		cstrangio@aclu.org	3/16/2022 10:44:47 PM	SENT
Camilla Taylor		ctaylor@lambdalegal.org	3/16/2022 10:44:47 PM	SENT
Karen Loewy		kloewy@lambdalegal.org	3/16/2022 10:44:47 PM	SENT
Currey Cook		ccook@lambdalegal.org	3/16/2022 10:44:47 PM	SENT
Omar Gonzalez-Pagan		ogonzalez-pagan@lambdalegal.org	3/16/2022 10:44:47 PM	SENT
Savannah Kumar	24120098	skumar@aclutx.org	3/16/2022 10:44:47 PM	SENT
Andre Segura	24107112	asegura@aclutx.org	3/16/2022 10:44:47 PM	SENT
Shelly L. Skeen	24010511	slskeen@gmail.com	3/16/2022 10:44:47 PM	SENT
Brian Klosterboer	24107833	bklosterboer@aclutx.org	3/16/2022 10:44:47 PM	SENT
Brandt Roessler	24127923	brandt.roessler@bakerbotts.com	3/16/2022 10:44:47 PM	SENT
Derek Raymond McDonald	786101	derek.mcdonald@bakerbotts.com	3/16/2022 10:44:47 PM	SENT
David Goode	24106014	david.goode@bakerbotts.com	3/16/2022 10:44:47 PM	SENT
Madeleine Dwertman	24092371	maddy.dwertman@bakerbotts.com	3/16/2022 10:44:47 PM	SENT
Paul Castillo	24049461	pcastillo@lambdalegal.org	3/16/2022 10:44:47 PM	SENT
Courtney Corbello	24097533	courtney.corbello@oag.texas.gov	3/16/2022 10:44:47 PM	SENT