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Gender-affirming care for the adolescent patient

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Abstract: Over the past decade, the number of children and adolescents who identify as transgender and/or gender diverse has increased. It is essential for clinicians to have the knowledge and resources to effectively care for these patients, identify associated risks (such as sexually transmitted infections, unplanned pregnancy, depression, anxiety, and increased suicide risk) as well as to understand hormone therapy to help patients achieve desired expression of the gender with which they identify.

People who identify as lesbian, gay, bisexual, transgender, queer, intersex, asexual, two-spirit, and/or other minority sexual and gender identities (LGBTQIA2+) are among vulnerable populations that are underserved by the healthcare system. The number of people identifying as transgender, gender diverse, or something outside the gender binary (that is, man or woman; boy or girl) has significantly increased over the past decade.[1] The term "transgender," regardless of whether one identifies as man, woman, or other, encompasses many gender-variant descriptions and expressions.[2] Those who identify as transgender may consider the use of hormones and/or gender-affirming procedures and surgeries to aid in their physical selves' alignment with their gender identity. Other sexual and gender minorities may choose not to alter their bodies with hormones or surgery but simply identify as something

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other than the gender binary identity assigned to them at birth.

Similarly, the number of children who identify under the LGBTQIA2+ umbrella has steadily increased over the past decade (to 8%).[1,3,4] Nearly one in five people who identify as transgender is between ages 13 and 17 years; this age group therefore comprises about 18% of the transgender community, up from 10% previously. Approximately 1.4% of the US population ages 13 to 17 years, or 300,000 high school-aged individuals, identifies as transgender, as compared with 0.5% of their adult counterparts. Moreover, it is estimated that between 2.5% and 8.4% of children and adolescents identify as gender diverse worldwide.[4]

Some children identify as transgender as early as age 3 or 4 years. It has been theorized that, by age 7 years, children typically have internalized the idea of gender constancy, or the concept that their gender is, for the most part, unchangeable. Gender and child development theories continue to evolve. However, the imposition of the concept of gender constancy can be particularly problematic for children who identify as transgender, though some individuals may not question their sexual orientation and/or gender identity until later in life. For youth who identify as gender diverse, however, the consequence of failing to address gender incongruence can lead to increased rates of depression, anxiety, negative self-image, and suicidal ideation.[5] Gender incongruence is the incompatibility between one's self-identification in terms of gender and the gender that traditionally corresponded to the sex assigned to them at birth. Gender incongruence is sometimes used synonymously with gender dysphoria, although dysphoria more specifically describes the psychological and physical distress that some individuals experience when their self-identified gender does not align with their physical body.[6] Not all transgender or gender nonbinary individuals experience gender dysphoria. A term that is no longer used is "gender identity disorder."[7] Terminology relating to gender identity is outlined in *Table 1*.

Due to the lack of clinical education and knowledge regarding the appropriate and affirming care of this population of patients, the specific healthcare needs of gender-diverse people frequently go unmet.[11,12] LGBTQIA2+ youth are especially vulnerable to substance use disorder, sexually transmitted infections, mental health disorders (anxiety, depression, and increased rates of suicidal ideation), and bullying.[13] It is imperative that clinicians know and understand the variation that exists among this diverse population of patients as well as the available resources and appropriate plans of care that serve to support patients who identify as gender diverse. Studies have demonstrated disparities in care for gender-diverse patients, leading to untreated chronic health issues. When clinicians are not well educated on the specific needs of this population, patients are unable to access life-saving care such as hormone therapy, surgery, and mental health services.[14] Primary care prevention, routine screening, and health promotion should be offered to gender-diverse patients in the same way that they would be offered to any other patient.[15]

In 2023, the American Academy of Pediatrics (AAP) reviewed and reaffirmed in a news release its previous policy statement, published in 2018, on caring for gender-diverse youth.[16] The AAP's recommendations include ensuring access to "comprehensive, gender-affirming, and developmentally appropriate" care for gender-diverse youth; offering support to family and friends; supporting insurance plans that cover transition-related care, including medical, psychological, and surgical interventions; and the use of chosen pronouns, stored in electronic health record (EHR) systems. The AAP also endorses healthcare professionals and organizations' advocacy for policies and laws that protect gender-diverse youth from discrimination. Organizational policy structures need to be implemented or updated to meet the needs of this growing population of patients and to prevent discrimination, stigma, and lack of access to care. Microaggressions and discrimination due to cisnormativity and cisgenderism may occur if clinicians are either unaware of their personal biases or if they intentionally create an atmosphere of disrespect toward and mistreatment of patients.[17]

Creating an affirmative environment

Well-meaning staff may inadvertently demonstrate insensitivity in their effort to be inclusive, or they may blatantly disrespect the gender-diverse patient due to their own lack of knowledge of working with this population. Patients and their families may overhear staff conversations that are inappropriate, causing these individuals to feel uncomfortable or unwelcome. Such incidents can compromise patients' sense of safety. It is important for clinicians and staff to gain the trust of patients and their families to ensure accessibility of their care. Appropriate training and education of all office staff who interact with patients,

Table 1. Terminology[8-10]

Term	Description
Agender	Describes a person who does not identify or align with any particular gender or who identifies as genderless
Cisgender	Describes a person whose gender identity aligns with their sex assigned at birth
Cisgenderism	Ideology that aims to delegitimize, pathologize, or deny self-identified gender identities
Cisnormativity	Ideology that assumes that all persons are cisgender
Gender binary	The traditional societal classification of two fixed genders: boy or girl; man or woman
Gender diverse	Describes a person whose gender identity, role, or expression differs from the cultural norm of the gender binary (boy or girl; man or woman)
Gender nonconforming	Describes a person whose gender expression does not align with societal expectations of the binary boy/man or girl/woman or a person who self-describes as transgender
Genderfluid	Describes a person whose gender is not fixed
Genderqueer	Describes an individual whose gender identity is something other than the binary of boy/man or girl/woman and who may incorporate gender identities outside of the societal norm; similar to nonbinary
Intersex	Describes a person who is born with one or more types of reproductive organs, genitals, chromosomes, and/or secondary sex characteristics that do not match the traditional expectations for either the female or male sex
LGBTQIA2+	An umbrella acronym representing many diverse minority sexual orientations and genders. Generally understood to stand for lesbian, gay, bisexual, transgender, queer, intersex, asexual, two-spirit, and/or other minority sexual and gender identities.
Misgendering	An intentional or unintentional act of addressing someone with a pronoun that does not reflect or align with their identified gender
Queer	Adjective used, in self-description or by members of the LGBTQIA2+ community, to describe a person whose sexual orientation or gender identity is not solely heterosexual or cisgender, respectively. Should never be used as a derogatory term.
Questioning	Describes a person who is exploring their sexual orientation and/or gender identity
Transgender or trans	Adjective that describes a person whose gender identity does not align with or differs from the one associated with their sex assigned at birth
Two-spirit	A culture-specific term used to describe individuals within some Indigenous, Native American, Alaska Native, and First Nations communities who have both masculine and feminine spirit and are considered sacred and spiritual leaders for this reason

particularly those who are gender diverse, should be mandated.

Intake forms should be reflective of inclusive terminology. EHR systems should accommodate gender diversity and include information on pronouns and gender identity so that patients and/or their families can preregister easily prior to the visit; moreover, the clinician should review this information and use the appropriate patient name and pronouns during appointments. It is never acceptable to use a patient's "dead name" (or the name that was given to them at birth) or to ask the patient about their dead name. It is important to recognize that clinicians may make errors and use the wrong name or pronouns. If this occurs, the clinician should simply acknowledge the error, apologize, and move on with the appointment. Such acknowledgment helps the patient to connect with and trust their clinician. Only use pronouns if the patient has identified their preferences; otherwise, it is perfectly acceptable to get the patient's attention by making eye contact or tapping their shoulder.[18] Adolescents ages 12 to 13 years and older should be allowed private, direct access to patient portals to communicate with their clinicians regarding sensitive information such as sexual orientation and gender identity with limited parental proxy access to this information. Such services promote access to care as well as help to foster a relationship and communication between patients and their clinicians.[19]

The visible use of rainbow decals, pins, flags, and other items connote provision of culturally sensitive care, as the rainbow is a universal symbol representing LGBTQIA2+ pride. Although use of this symbol may

send a positive message of support to patients, it must be done with caution. Prior to use, effective training of staff must be implemented. If the office displays, for example, a rainbow decal, then its clinicians and staff must possess the accompanying competency with relation to providing affirmative care to this patient population.

Restrooms pose an issue for transgender, nonbinary, and gender-nonconforming patients. Most public restrooms are binary (boy/man or girl/woman) and do not correspond with many people's gender identity. The US Transgender Survey revealed that 1 in 10 respondents was denied access to a restroom and 12% were verbally harassed, with smaller numbers physically or sexually assaulted, while accessing a restroom.[14] Restrooms do not necessarily require renovation to accommodate all persons. Simply changing the signage to state that the restroom is "gender inclusive" (or an equivalent) is sufficient to demonstrate that the office is a welcoming environment.

Suggested steps for the patient prior to pharmacologic therapy

Prior to initiating any pharmacologic therapy, the Pediatric Endocrine Society and the World Professional Association for Transgender Health (WPATH) both recommend that the adolescent be encouraged to transition socially.[20,21] Social transition is achieved by way of the child or adolescent's expression of their desired gender identity through clothing, hairstyles, and specification and use of chosen pronouns (*Box 1*). Chosen pronouns are used to refer to someone in a manner that reflects their personal gender identity. Misgendering occurs when a person is referred to in a way that does not match their gender identity. Misgendering can be a deliberate act—one that is based on the personal beliefs of someone who is not accepting of this population—or it can occur accidentally.

Box 1. Gender pronouns and honorifics

Gender pronouns
She/her/hers
He/him/his
They/them/theirs
Ze/Zir/Zirs
Ze/Hir/Hirs
Per/pers
Xe/xem/xyr

Titles or honorifics
Mr.
Mrs.
Miss
Ms.
Mx. (gender-neutral honorific for those who do not want to be identified by their gender or who do not identify with a specific [or any] gender)

Data from the Trevor Project demonstrate that the rate of attempted suicide among gender-diverse individuals when all of the people with whom they lived respected their chosen pronouns was 12% as compared with 21% for gender-diverse persons whose pronouns were not respected; other selected illustrative data points from the Trevor Project are outlined in *Box 2*.[8,22] It is critical that the child or adolescent, along with their chosen or biological family, approach the school team to ensure the safety of the individual who is transitioning through the identification of advocates within the school system.[25] According to the US Transgender Survey, approximately 54% of respondents who were out as transgender or believed classmates and school staff thought they were transgender reported verbal harassment, 24% reported physical assault, and 13% reported sexual assault while in school (kindergarten through 12th grade) because they were transgender, and 52% reported being prohibited from dressing in alignment with their gender identity while in school.[14]

Mental health support is important for gender-diverse youth who may be struggling with their sexual orientation and/or gender identity. They especially need support when making the decision to "come out" to family and friends. It is often necessary to have family, chosen or otherwise, participate in mental health services to learn how to support and accept the patient, particularly during their exploration phase and as they navigate the potential for transition. Mental health assessments are valuable in helping these patients to safely navigate adolescence and move into adulthood.[26] Additionally, a comprehensive mental health evaluation aids in identifying any undiagnosed, underlying, or co-occurring psychiatric disorders, which may disproportionately affect this population.[27]

Legal considerations

In the past year, a record number of anti-LGBTQIA2+ laws have been proposed or passed, particularly surrounding gender-affirming care for transgender adolescents. Currently, 19 states in the US have laws that restrict access to care for this population. Clinicians are often vulnerable to these restrictive laws, which

make providing care to transgender patients a felony in some places and ban, in some cases, patients' use of telehealth appointments with out-of-state clinicians who intend to provide medically necessary care for anyone under the age of 18 years.[3] Clinicians should be familiar with the laws regarding provision of transgender care in their individual states.

Legal transition is dependent upon the individual state's laws regarding change in gender markers. Such changes typically involve updating birth certificates, passports, and other forms of legal identification. Individuals whose physical presentation does not match their identification may experience harassment, assault, or denial of services.[14]

Initiation of puberty-suppressing hormones begins after the child or adolescent decides to transition medically with the understanding of the reversibility of the process if use of such hormones is discontinued. In addition, gender-affirming hormone therapy (GAHT), such as use of testosterone or estrogen plus an androgen inhibitor, may also be considered beginning in early adolescence.[16] Any masculinizing or feminizing surgical procedures are considered and performed after the time that the adolescent has reached the state's age of majority (or legal adulthood).

Therapies

It is imperative that any clinician who is not well versed, experienced, or comfortable in providing interventions for this population refer any LGBTQIA2+ individuals to other clinicians who can effectively deliver lifesaving and necessary services.

Use of puberty-suppressing hormones and/or GAHT is necessary in allowing the gender-diverse child or adolescent to align their body with the gender with which they identify and decrease gender incongruence. It is well documented that GAHT increases quality of life and mental health among transgender youth.[4,16,28]

Gonadotropin-releasing hormone analogues (GnRHas) inhibit release of gonadotropins, suppressing ovarian and testicular steroidogenesis and leading to cessation of puberty.[29] GnRHa therapy has been in use since the 1980s in those individuals diagnosed with central precocious puberty, but it has gained favor for use in transgender adolescents or those who wish to explore or confirm their gender identity as a means to help prevent the development of secondary sex characteristics by delaying the onset of puberty.[30] Any incongruence between gender identity and secondary sex characteristics can worsen gender dysphoria in transgender and gender-diverse youth, and the failure to suppress puberty can increase the risk of suicidal ideation while the individual explores their gender identity.[31] Suppression of puberty with GnRHa therapy is associated with increased psychological and global functioning.[32]

The use of GnRHas is recommended by both the Pediatric Endocrine Society and WPATH for those individuals who are discovering or questioning their gender identity.[20,21] Individuals must be at Tanner stage 2 or higher in their development before considering the use of puberty blockers. Tanner stage 2 occurs at approximately 11 to 12 years of age upon noticeable change in the genitals: More specifically, males see an increase in teste and penis size, whereas females develop breast buds, larger areolae, and coarse pubic hair. Puberty blockers may also be prescribed to prevent any further reproductive development such as menses, erections, and ejaculation.[7] This class of medication can be cost prohibitive for patients who are either uninsured or underinsured or for those whose insurance does not cover it.

GnRHa therapy suppresses endogenous puberty by decreasing or blocking the release of gonadotropins,

Box 2. Selected findings from the Trevor Project's national surveys[22-24]

- 41% of LGBTQ young people seriously contemplated suicide in the 12 months prior to one survey. Of transgender and nonbinary adolescents specifically, half seriously contemplated suicide.
- 48% of LGBTQ young people engaged in self-harm in the 12 months prior to one survey. Of transgender and nonbinary adolescents specifically, more than 60% engaged in self-harm.
- Those who reported having their chosen pronouns respected by people in their lives attempted suicide at a lower rate than those whose pronouns were not respected.
- Less than 40% of transgender and nonbinary young people found their home to be gender affirming.
- Transgender and nonbinary young people who attended schools that were gender affirming had lower rates of attempted suicide.
- Of LGBTQ young people who desired mental health care in the year prior to one survey, 56% were unable to get it.
- LGBTQ young people living in affirming or accepting communities reported significantly lower rates of attempting suicide than those who did not live in affirming or accepting communities.

Note: The Trevor Project uses the term "LGBTQ young people" in its most recent national survey.

thereby inhibiting the production of endogenous sex hormones that are responsible for puberty. If GnRHa therapy is discontinued, then endogenous puberty will commence or resume, albeit later than the typical chronologic age for puberty. The use of GnRHas is reversible up to the age of 16 to 18 years, at which time, depending upon the country or state in which they live, the individual is legally permitted to make their own medical decisions.[7,16] It is important to understand that undergoing puberty—entailing, for example, the onset of secondary sex characteristics such as breast growth, protrusion of the Adam's apple, and voice changes—may very well increase gender dysphoria as well as suicidal ideation for gender-diverse individuals. GnRHas are available in either injectable formulations (dosed monthly, every 3 months, or every 6 months) or as subcutaneous implants that may be effective for 1 to 2 years; however, their use is off-label for this purpose.[33]

The use of puberty-suppressing hormones is not without other considerations. Although their use is intended to halt puberty, it is important for the patient and families to understand that this therapy may ultimately result in underdeveloped genitals and lack of viable tissue in the future for gender-affirming surgeries, if the individual chooses to pursue them.[34] (For example, graft-only vaginoplasty, which allows construction of a vaginal canal, may not be possible if penile or scrotal skin is sparse; however, alternative procedures might include the use of skin grafts from other parts of the body or colon tissue to create the vaginal canal.)

The use of GAHT may also be considered, potentially in conjunction with use of puberty blockers. GAHT typically entails use of testosterone for individuals assigned female at birth who are masculinizing or estrogen plus an androgen inhibitor for individuals assigned male at birth who are feminizing.[16] A common approach is to consider initiation of these medications beginning at age 16 years; however, more studies are needed regarding use prior to age 14 years.[20] Effects of these medications vary in reversibility.[16] Any gender-diverse patient who decides to use exogenous testosterone for masculinization should be educated on the appropriate use of contraception, as testosterone is not a reliable form of birth control despite the effect of amenorrhea upon the patient's initiation of use of this hormone. It is essential that patients who elect to start hormone therapy such as with testosterone or estrogen understand fully the effects of these hormones, particularly the fact that some of the changes they induce, including deepening of the voice, male pattern baldness, breast growth, and clitoral enlargement, may not be fully reversible.[35,36]

When the individual reaches the age of majority and wishes to consider gender-affirmation surgeries, consultation with a qualified surgeon specializing in gender-affirming procedures should be sought. Types of gender-affirming surgeries are listed in *Table 2*. Significant barriers to life-saving, gender-affirming surgeries, specifically lack of insurance coverage, high cost, and lack of access, exist. Certain insurance providers consider these procedures cosmetic and therefore do not offer coverage. The out-of-pocket cost can be approximately $10,000 to $50,000 per procedure, depending on the procedure type and associated costs (hospital stay, anesthesia, travel, and after-care, among other considerations).[11]

Prior to any surgical procedure, counseling on reproductive rights such as sperm banking or egg retrieval should be discussed in view of potential future fertility. Adolescents typically do not consider these options until many years later, when they have matured enough to consider family planning. An increasing number of transmasculine and nonbinary patients are exercising their reproductive rights through the use of assisted reproductive technology. The long-term effect of testosterone on the reproductive organs requires further research.[39]

Diagnostic codes and insurance

Billing and coding for transgender-related care can be challenging, especially if gender markers on legal documents do not match an individual's insurance card. Gender dysphoria is a diagnosis found in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR),* but it is important to understand that not all gender-diverse people experience gender dysphoria. Use of the diagnostic code connected to a true diagnosis of gender dysphoria is useful when prescribing hormones or caring for gender-diverse patients. A term that is outdated and no longer considered acceptable to use is gender identity disorder, although it is often employed by clinicians who are not current with appropriate terminology for this population of patients. This term was removed from the *DSM-5* in 2013, as it implies that the gender-diverse patient is disordered. The term did not encompass the psychological distress that some

Table 2. Types of gender-affirming surgeries[11,34,37,38]

Transmasculine	Transfeminine
• Chest reconstruction (also known as "top surgery," not to be referred to as a mastectomy) • Phalloplasty (also known as "bottom surgery"): use of vaginal tissue or skin grafts to create a penis-like structure requiring internal prosthesis or external support to achieve erection • Scrotoplasty: surgical creation of a scrotum using native labial tissue or skin grafts • Metoidioplasty: surgical creation of a penis using clitoral erectile tissue • Total hysterectomy and salpingo-oophorectomy: surgical removal of uterus, fallopian tubes, ovaries, and cervix • Vaginectomy: surgical removal of all or part of the vagina; often combined with metoidioplasty • Facial masculinization surgery (cheek implants, jaw contouring with or without implants) • Urethroplasty: surgical repositioning of the urethra during bottom surgery	• Vaginoplasty: surgical creation of a vagina utilizing genital tissue • Feminizing mammoplasty (breast augmentation) • Orchiectomy: surgical removal of testicles • Cricothyroid approximation and anterior glottoplasty: voice surgery for pitch elevation • Body contouring: gluteal augmentation, abdominoplasty, liposuction • Facial feminization: mandible reconstruction • Tracheal shave • Rhinoplasty: plastic surgery to change or enhance the shape of one's nose • Cheek augmentation: lifting or augmenting cheekbones with silicone implants

gender-diverse persons experience when their gender identity does not match their body or the sex assigned to them at birth. Gender incongruence is another term that is helpful when coding for these visits, especially if the patient does not have gender dysphoria.

Conclusion

Gender-diverse people and sexual minorities experience barriers to care and may be unable to access necessary and often life-saving treatment. As more individuals identify as transgender and/or outside of the gender binary, it is imperative for clinicians to become well versed in the specific needs of each population represented under the LGBTQIA2+ umbrella. It is necessary to mitigate lack of access to care; create welcoming, gender-affirmative environments; and create networks of educated clinicians to ensure a multidisciplinary approach for helping patients to achieve their desired gender expression. Such care can only be achieved through organizational non-discrimination policies, mandated education for all personnel, incorporation of inclusive language on intake forms and in EHR systems, and provision of patient education materials on websites and in waiting areas, all of which together help to create a respectful, inclusive, gender-affirming atmosphere.[17] A great deal of online resources are available to clinicians to help create affirming environments for their patients; some include the LGBTQIA+ Health Education Center, the Trevor Project, and the LGBTQ Primary Care Toolkit. The UCSF Center for Excellence for Transgender Health and WPATH also have comprehensive resources for prescribing hormones. Finally, clinicians should attend sessions at conferences that provide education on the care of this population of patients.

REFERENCES

1. University of California, San Francisco, Center of Excellence for Transgender Health. 2021. http://transhealth.ucsf.edu.
2. Institute of Medicine (IOM). The health of lesbian, gay, bisexual, and transgender people: building a foundation for better understanding. 2011. https://nap.nationalacademies.org/catalog/13128/the-health-of-lesbian-gay-bisexual-and-transgender-people-building.
3. Herman JL, Flores AR, O'Neill KK. How many adults and youth identify as transgender in the United States? UCLA School of Law Williams Institute. 2022. https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-Pop-Update-Jun-2022.pdf.
4. Roberts C. Persistence of transgender gender identity among children and adolescents. *Pediatrics*. 2022;150(2):1-3.
5. Hajek A, König H, Buczak-Stec E, Blessmann M, Grupp K. Prevalence and determinants of depressive and anxiety symptoms among transgender people: results of a survey. *Healthcare* (Basel). 2023;11(5):705. doi:10.3390/healthcare11050705.
6. Marconi E, Monti L, Marfoli A, et al. A systematic review on gender dysphoria in adolescents and young adults: focus on suicidal and self-harming ideation and behaviours. *Child Adolesc Psychiatry Ment Health*. 2023;17(1):110. doi:10.1186/s13034-023-00654-3.
7. Butler G. Gender incongruence. *Paediatr Child Health*. 2020;30(12):407-410.
8. GLAAD. *GLAAD Media Reference Guide*. 11th ed. 2023. https://glaad.org/reference/trans-terms/.
9. Human Rights Campaign. Glossary of Terms. 2023. https://www.hrc.org/resources/glossary-of-terms.
10. PFLAG. LGBTQ+ Glossary. 2023. https://pflag.org/glossary/.
11. Tristani-Firouzi B, Veith J, Simpson A, Hoerger K, Rivera A, Agarwal CA. Preferences for and barriers to gender affirming surgeries in transgender and non-binary individuals. *Int J Transgend Health*. 2021;23(4):458-471. doi:10.1080/26895269.2021.1926391.
12. Reisner SL, Benyishay M, Stott B, Vedilago V, Almazan A, Keuroghlian AS. Gender-affirming mental health care access and utilization among rural transgender and gender diverse adults in five northeastern U.S. states. *Transgend Health*. 2022;7(3):219-229. doi:10.1089/trgh.2021.0010.

13. Aisner AJ, Zappas M, Marks A. Primary care for lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) patients. *J Nurse Pract*. 2020;16 (4):281-285.
14. US Transgender Survey. Executive Summary. 2015. www.ustranssurvey.org/reports/#2015report.
15. Zschaebitz E, Bradley A, Olson S, Casey C, Britz J. Primary care practice for gender-diverse patients using gender-affirming hormone therapy. *J Nurse Pract*. 2023;19(3). doi:10.1016/j.nurpra.2022.104526.
16. Rafferty J; Committee on Psychosocial Aspects of Child and Family Health; Committee on Adolescence; Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness. Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents [published correction appears in Pediatrics. 2023 Oct 1;152(4):]. *Pediatrics*. 2018;142(4):e20182162. doi:10.1542/peds.2018-2162
17. Kcomt L, Gorey KM, Barrett BJ, McCabe SE. Healthcare avoidance due to anticipated discrimination among transgender people: a call to create trans-affirmative environments. *SSM Popul Health*. 2020;11:100608. doi:10.1016/j.ssmph.2020.100608.
18. National LGBT Health Education Center. Providing inclusive services and care for LGBTQ people: A guide for health care staff. 2023. lgbtqiahealtheducation.org/wp-content/uploads/Providing-Inclusive-Services-and-Care-for-LGBT-People.pdf
19. Lee JA, Holland-Hall C. Patient portals for the adolescent and young adult population: benefits, risks and guidance for use. *Curr Probl Pediatr Adolesc Health Care*. 2021;51(11):101101. doi:10.1016/j.cppeds.2021.101101.
20. World Professional Association of Transgender Health (WPATH). Standards of care for the health of transgender and gender diverse people, version 8. 2022. www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644.
21. Pediatric Endocrine Society. Transgender care: Introduction to health for transgender youth. 2023. pedsendo.org/patient-resource/transgender-care/.
22. The Trevor Project. 2023 U.S. National Survey on the Mental Health of LGBTQ Young People. www.thetrevorproject.org/survey-2023/.
23. The Trevor Project. National Survey on LGBTQ Youth Mental Health 2020. www.thetrevorproject.org/survey-2020/.
24. The Trevor Project. 2022 National Survey on LGBTQ Youth Mental Health. www.thetrevorproject.org/survey-2022/.
25. Neiman T, Sieve L, Stenberg L, Molesky N, Nic Rider G. "Bridging the gap": school nurse experiences providing care for transgender and gender diverse students and their parents/guardians. *J Sch Nurs*. 2023;39(5):377-384.
26. Coyne CA, Huit TZ, Janssen A, Chen D. Supporting the mental health of transgender and gender-diverse youth. *Pediatr Ann*. 2023;52(12):e456-e461. doi:10.3928/19382359-20231016-02.
27. Klinger D, Riedl S, Zesch HE, et al. Mental health of transgender youth: a comparison of assigned female at birth and assigned male at birth individuals. *J Clin Med*. 2023;12(14):4710. doi:10.3390/jcm12144710.
28. Lopez X, Kuper LE. Large study on hormone therapy for transgender youth provides reassurance amid treatment politicization. *Nat Rev Endocrinol*. 2023;19(6):319-320. doi:10.1038/s41574-023-00824-5.
29. Guss C, Gordon CM. Pubertal blockade and subsequent gender-affirming therapy. *JAMA Netw Open*. 2022;5(11):e2239763. doi:10.1001/jamanetworkopen.2022.39763.
30. Herman J, Flores A, O'Neill K. How many adults and youth identify as transgender in the United States? Williams Institute. 2022. williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-Pop-Update-Jun-2022.pdf.
31. Rew L, Young CC, Monge M, Bogucka R. Review: Puberty blockers for transgender and gender diverse youth-a critical review of the literature. *Child Adolesc Ment Health*. 2020;26(1):3-14. doi:10.1111/camh.12437.
32. Eitel KB, Hodax JK, DiVall S, Kidd KM, Salehi P, Sequeira GM. Leuprolide acetate for puberty suppression in transgender and gender diverse youth: A comparison of subcutaneous eligard versus intramuscular lupron. *J Adolesc Health*. 2023;72(2):307-311.
33. Hobson BJ, Lett E, Hawkins LA, Swendiman RA, Nance ML, Dowshen NL. Transgender youth experiences with implantable GnRH agonists for puberty suppression. *Transgend Health*. 2022;7(4):364-368. doi:10.1089/trgh.2021.0006.
34. Li V, Demzik A, French W, Dickey A, Maddox K, Figler BD. Gender affirming graft only vaginoplasty. *Urology*. 2023;177:230. doi:10.1016/j.urology.2023.05.006.
35. UCSF Transgender Care. Information on testosterone hormone therapy. 2020. transcare.ucsf.edu/article/information-testosterone-hormone-therapy.
36. UCSF Transgender Care. Information on estrogen hormone therapy. 2020. transcare.ucsf.edu/article/information-estrogen-hormone-therapy.
37. Chang J. Gender-affirming voice surgery: Pitch elevation. *Oper Tech Otolaryngol Head Neck Surg*. 2023;34(1):63-68.
38. University of California, San Francisco, Center of Transgender Excellence for Transgender Health. 2021. transhealth.ucsf.edu.
39. Kinnear HM, Moravek MB. Reproductive capacity after gender-affirming testosterone therapy. *Hum Reprod* (Oxford, England). 2023;38(10):1872-1880. doi:10.1093/humrep/dead158.

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Gender-affirming care for the adolescent patient

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- Read the article. The test for this CE activity is to be taken online at **www.nursingcenter.com/CE/NP**. Tests can no longer be mailed or faxed.
- You'll need to create (it's free!) and log in to your personal CE Planner account before taking online tests. Your planner will keep track of all your Lippincott Professional Development online CE activities for you.
- There's only one correct answer for each question. A passing score for this test is 8 correct answers. If you pass, you can print your certificate of earned contact hours and access the answer key. If you fail, you have the option of taking the test again at no additional cost.
- For questions, contact Lippincott Professional Development: 1-800-787-8985.
- Registration deadline is March 7, 2025.

PROVIDER ACCREDITATION

Lippincott Professional Development will award 2.5 contact hours and 0.5 pharmacology contact hour for this continuing nursing education activity.

Lippincott Professional Development is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

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Payment: The registration fee for this test is $24.95.