

REVIEWS

How Young Is Too Young: Ethical Concerns in Genital Surgery of the Transgender MTF Adolescent

Christine Milrod, PhD

Southern California Transgender Counseling, Los Angeles, CA, USA

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ABSTRACT

Introduction. During the last decade, the age of youths presenting for gender confirmation has steadily fallen. Transgender adolescents are being treated with gonadotropin-releasing hormone analogues and subsequently cross-sex hormones at early or midpuberty, with genital surgery as the presumed final step in treatment for female-affirmed (male-to-female) individuals. Despite the minimum age of 18 as eligibility to undergo irreversible procedures, anecdotal reports show that vaginoplasties of female-affirmed patients under 18 have been performed by surgeons, thereby contravening the World Professional Association for Transgender Health Standards of Care.

Aim. The purpose of this article is (i) to provide a review of salient factors regarding genital surgery in transgender adolescents; (ii) to review various ethical protocols for determining maturity in gender dysphoric individuals under 18; and (iii) to present a new systematic set of ethical principles largely derived from the surgical management of youths with disorders of sex development and adapted to the needs of transitioning adolescents.

Methods. A literature review of the topic was performed. Ethical guidelines derived from applied treatment protocols of children with disorders of sex development were written.

Main Outcome Measure. Progressing from the current state of ethical standards and clinical assumptions, a new development of ethical guidelines for genital surgery in the female-affirmed transgender adolescent was created.

Results. There were no controlled studies of vaginoplasties performed on female-affirmed adolescents under 18 years of age. A new set of ethical guidelines was created in order to support treatment professionals in their decision making process.

Conclusions. Professionals across disciplines treating female-affirmed adolescents can utilize the proposed ethical guidelines to facilitate decision making on a case-by-case basis in order to protect both patients and practitioners. These guidelines may also be used in support of more open discussions and disclosures of surgical results that could further the advancement of treatment in this emerging population. **Milrod C. How young is too young: Ethical concerns in genital surgery of the transgender MTF adolescent. J Sex Med 2014;11:338–346.**

Key Words. Adolescent; Ethical Concerns; Gender Dysphoria; Genital Surgery; MTF; Transgender

During the last decade, the age of gender dysphoric youths presenting for affirmative gender treatment in the United States and Europe has steadily fallen, sometimes to preteen or prepubertal age ranges. Accompanied by mostly supportive parents who seek information and advice rather than deterrence or aversive treatment, ever younger transgender children and adolescents are able to explore transitioning in both private practice settings and at clinics dedicated to the treatment of gender identity issues. Gender dysphoria

among children and teenagers has also become a frequent part of human interest stories in mainstream media where well-known television journalists often lend their support to programs exploring the various stages of transition of both male-to-female (male-to-female) and female-affirmed (male-to-female [MTF]) transgender children. One such female-affirmed child has been the subject of several documentary segments broadcast on various television networks in the United States [1,2]. First filmed at age five and subsequently as an

11-year-old girl, her life is examined in details that include physician visits for puberty hormone blockers, interviews regarding dating and boys, and a final commentary on the fact that she must wait until the age of 18 to have genital surgery. In Europe, a German-born teenager had gender-confirming genital surgery at the age of 16 in 2009 and became known as the youngest female-affirmed patient in the world to undergo the procedure for reasons of gender dysphoria [3]. In the academic literature, Winter [4] has reported on several Thai transgender women who began hormone treatments at the inception of puberty, with one MTF adolescent undergoing genital surgery at 15.5 years of age. With the increased visibility of transitioning teens in the worldwide media as well as in follow-up studies of adolescents transitioning with the help of gonadotropin-releasing hormone (GnRH) analogues and gonadal steroids, references to genital surgery are being made as a matter of course and as a final step in the transitioning process [5–12].

The most recent World Professional Association for Transgender Health (WPATH) Standards of Care version 7 presents eligibility and readiness criteria for transitioning adolescents in which irreversible interventions (i.e., genital surgeries) are not recommended until the adolescent has “reached the legal age of majority in a given country” [13]. The document specifies that the age criterion should not be seen as an indication for “active intervention,” only as an age threshold. Although the Standards of Care recognize that the legal age of majority varies from nation to nation, the age of majority is currently 18 in both the United States and Germany; hence, the procedure performed on a 16-year old girl was clearly not in accordance with the WPATH Standards of Care—neither the current nor the previous version, valid during 2005–2011. In addition, anecdotal reports and personal communication with surgeons in the United States who wish to remain anonymous confirm that genital surgeries in female-affirmed patients under 18 have been performed, thereby contravening the Standards of Care and thus prompting physicians, therapists, and other clinical professionals who otherwise adhere to the WPATH criteria to maintain official silence in the matter. From a treatment perspective, this is no surprise—if social transitioning and administration of hormones are sliding toward younger ages, the request for surgical procedures among younger individuals will follow. The current Standards of Care provide some flexibility in the minimum age

requirement for chest reconstruction in male-affirmed adolescents, even though it could be argued that this procedure is practically irreversible. For female-affirmed teenagers, however, the irreversibility of genital surgery becomes a dilemma that offers no simple solution other than waiting until the age of 18, unless therapists and medical professionals act upon the rationale in the final paragraph concerning adolescents in the standards, namely to avoid the risk of prolonging gender dysphoria. Understandably, there are many stakeholders in the debate concerning transitioning in children and adolescents in general. Opinions range from the possibility of doing harm when doing nothing [5,11] to favoring “the treatment plan that involves less extensive surgery or none at all” [14]. Meanwhile, a surgeon or a therapist confronted with an emotionally impacted teenaged girl who feels different from her peers and who wants nothing more than gender-congruent genitals is often at loss in terms of adherence or departure from the Standards of Care—is it optimal to gratify the patient’s wishes or to withhold treatment in the name of ethical compliance? For those professionals who choose to approve and provide the requested procedure, there are no easy answers or a clearly delineated pathway to decision making. Contrary to the vast amount of available ethical principles in the surgical management of children with disorders of sex development (DSD), there are no guidelines in the literature or in the ethical standards that assist the physician or mental health professional in the decision to approve genital surgery in transgender adolescents under 18 years of age. The practitioner, whether solo or in a team, must rely mainly on clinical impressions, the therapeutic relationship, and the personal conviction that the decision to proceed with surgery is the right one. To assist these practitioners with more concrete points of support in the evaluative process, this article will provide a review of salient factors regarding genital surgery in transgender adolescents; current ethical protocols for determining maturity in gender dysphoric individuals under 18 will be reviewed, and a systematic set of ethical principles largely derived from the surgical management of youths with DSD and adapted to the needs of transitioning adolescents will be presented.

Factors Influencing Adolescents to Seek Genital Surgery

In order to understand the transitioning adolescent’s desire for genital congruence, it is helpful

to review the various issues that arise during the trajectory of transition, particularly among those who begin their social transition at prepubertal or early pubertal ages. As increasing rates of girls and boys move toward hormone blockers and subsequently gonadal steroids, the concept of living full-time as an early teen in the affirmed gender is no longer considered rare or unusual. For adolescents whose entire puberty is experienced in their corrective gender, it is a realistic possibility to live outwardly in gender congruence without disclosing the birth sex to peers. Holman and Goldberg [15] suggest that the transitioning individual's decision to refrain from any disclosures is not because of embarrassment or shame but rather a concern about the response from others; or, it may simply be a reflection of the adolescent's desire to keep this information completely private. As genital surgery is not recommended prior to age 18, there is always a risk that peer interactions will uncover the individual's transgender status. Giordano [16] points out that when this happens to someone living with atypical genitals, his or her story is no longer private—it assumes public connotations of which the subject no longer has control. Goffman's [17] theory of stigma applies to the transitioning adolescent in that the potentially "discreditable" individual repeatedly must prove the affirmed gender to others who subsequently impose their interpretation and placement of the person within the binary gender system. If the individual is found by others to be lacking or unable to reproduce an adequately gendered identity, including the possession of gender congruent genitals, he or she fails to manage the stigma and becomes "discredited." In addition, repeated disclosures and accommodation to other people's gender norms can reproduce the stigma and further propel the individual toward feelings of shame and inadequacy.

The literature contains ample evidence of transgender adolescents being harassed or victimized in schools because of their gender status [7,9,15,18–24]. Gender variant children and teens report peer victimization that includes name calling, being insulted, or physically threatened. Gender identity and sexual orientation are often conflated in victimization that includes being injured with weapons, being punched, raped, or otherwise assaulted. For some transgender teens, bullying or cyberharassment (i.e., being targeted by cameras or smartphones that spread malicious, demeaning, or threatening texts and images) occurs on a regular basis. Transgender students report being victimized at higher levels than

cisgendered gay/lesbian/bisexual (GLB) youth, with female-affirmed individuals encountering the highest levels of victimization related to their gender expression. Even if there have been accommodations made such as official antiharassment measures or open discussions of gender inclusivity in the individual's school, peer violence can still occur. Sequelae for these teens include a decrease in self-esteem, depression, anxiety, drug abuse, self-injurious behavior, and wanting to leave school altogether for safety concerns. In fact, transgender students often seek transfer into more accepting or alternative schools that may offer safer and more affirming conditions for lesbian/gay/bisexual/transgender (LBGT) youth. Predictably, transgender adolescents experience less harassment in the context of passing, which means that as long as their birth sex is not disclosed, victimization may remain nil. Nevertheless, the potential loss of a social network or being excluded from peer groups can make the passing individual secretive in friendships and guarded when meeting new people in order to maintain privacy regarding the genital incongruence [18–20,22–24].

But there is another influential factor that drives the female adolescent's wish for genital congruence that does not include any violence at all—the desire for romance and dating [25,26]. Much like female-affirmed transitioning adults, transgender teenagers who experience puberty with atypical genitals often find the exploration of sexual self-pleasuring, romantic relationships, and engaging in physical contact with a romantic partner extremely difficult, if not impossible. The avoidance of any such activities until the age of 18 may cause a delay in healthy, age-appropriate emotional development because of dysphoria or discomfort with incongruent genitals. In addition, the longer the wait for surgical intervention, the higher the level of frustration and impatience, particularly among girls in their midteens who begin to observe some of their cisgendered female peers engage in romantic or sexual relationships without these obvious constraints. It is often because of this emerging intensely negative feeling state expressed in the patient that surgeons and clinicians wrestle with the principle of harm reduction against existing ethical protocols and rationale for delaying the procedure. Harm reduction as a justification for treatment has been widely acknowledged among clinicians, with the vast majority endorsing medical intervention during early puberty to prevent psychological suffering and potentially costly and more invasive treatments in

later adulthood [6,13,16,26–28]. Additionally, Giordano [29] asserts that any type of age-related restrictions to treatment should be eliminated and that healthcare professionals may open themselves to legal challenges if they refuse to provide care.

Current Ethical Standards and Protocols

It is the official standard of WPATH to defer genital surgery until the transitioning individual has reached 18 years of age. This position is also shared by The Endocrine Society, a worldwide organization dedicated to the education and practice advancement of endocrinology. In 2009, the Clinical Guidelines Subcommittee of the Society appointed a task force to formulate evidence-based recommendations for the diagnosis and treatment of transgender individuals [30]. By using the GRADE system (Grading of Recommendations, Assessment, Development and Evaluation), members of this and various other European endocrinological societies jointly issued a summary of recommendations concerning the treatment of adolescents, in which they suggested that surgery be deferred until the individual has reached the age of 18. In terms of grading, the recommendation itself is acknowledged by the Endocrine Society as “weak” and the quality of evidence “very low.” This is mainly because the evidence comes from unsystematic observations provided by the panelists whose principal source of evidentiary contributions consists of opinions, values, and preferences, with remarks subsumed under “suggestions.” In addition, “weak” recommendations ultimately require a deeper evaluation of the transitioning individual’s circumstances and preferences in order to make a decision. Despite this recommendation, the Endocrine Society does acknowledge that 16-year-olds are legal adults in many countries and are mature enough to make medical decisions of some complex cognitive ability. Such is the case in the Netherlands, where adolescents from 16 years of age are legally competent to make treatment choices, independent of parental consent [5]. Nevertheless, the policy of Dutch clinics treating transgender teens is that genital surgery should not be performed before the age of 18. A review of the available literature by Dutch clinicians shows that although there is agreement as to emotional maturity representing a better criterion than age alone, there is a perceived lack of objective criteria in assessing readiness for genital surgery in adolescents [10]. An approved candidate for surgery is an 18-year-old who has

been living in the affirmed gender since the age of 16 or earlier. It is recognized that some adolescents who undergo early hormonal treatments find it “increasingly confusing” that they retain the genitals of their birth sex, and that therapists should be instrumental in helping said teenagers realize “a balanced view of the short- and long-term costs and benefits of gender transition” (p. 89). Correspondingly, there is “international consensus that the risks of early surgical intervention far outweigh the potential benefits in virtually all cases” (p. 92), although no additional citations or references are provided to support this specific statement. This notwithstanding, Dutch outcome studies of late adolescents/young adults who have undergone irreversible procedures 1–4 years before follow-up have evidenced psychologically normative functioning and a high satisfaction rate with no regrets among both genders postsurgery [11,12,31].

One of the disadvantages in adolescent girls who have been treated with GnRH analogues at an early age is the possibility of insufficient skin for penile inversion vaginoplasty. Several authors refer to autologous skin grafting from donor sites, tissue expanders, or the use of sigmoid colon tissue as viable solutions to this problem [5,8,16,32,33]. For teenagers who begin gonadal treatment during midpuberty or later, this may not be a concern as there is generally enough tissue available for the construction of a neovagina. However, the main rationale for delaying genital surgery in adolescents can be found in references to possible postoperative regret. As there are no available data of transgender minors who have been offered genital surgery but who have changed their minds or experienced postoperative regret, the burden of differentiating between gender variant children who grow up to request gender transition and those who retain their natal gender identity falls first and foremost on clinicians and their subjective decisions. Surgeons rely primarily on mental health professionals who perform diagnostic and therapeutic assessments and who provide letters of recommendation for genital surgery; thus, there is a genuine expression of fear among clinicians in making the wrong diagnosis based on the fact that young people often experiment with gender role behavior as a consequence of normative identity development and perhaps more so when the adolescent is gender variant. Even if the clinician deems the youth to be mature and expressing a definitive intent to transition, there simply may not be a sufficient understanding or life awareness to consent to irreversible treatment. Early expla-

nations of treatment options and limitations are recommended in order to divest the child or teen of any belief that surgery is a simple and uncomplicated procedure that will resolve all problems of transition. Thus, by imposing the 18-year age threshold for irreversible genital procedures, the available ethical standards aim to balance the suffering of the waiting adolescent with avoiding the risk of postsurgery regret [6,7,12,14,15,26,28].

Informed Consent

It is a worldwide recognized legal principle that young children possess a limited capacity to make decisions regarding their own health treatment. Most adolescents also have limited or no legal ability to provide informed consent. Drescher and Byne [9] note that the majority of postindustrialized nations do not have a standardized, universal legal system for the accommodation of gender transitions. In addition, there is a lack of randomized, controlled studies that provide definitive recommendations for treatment options. Thus, best evidence available is characterized as “expert opinion,” which is influenced by prevailing cultural belief systems and theoretical orientations. Clinicians are often consulted as expert witnesses in judiciary settings, and in some countries, the courts will rely overwhelmingly on expert testimony. In the United States, parents or legal guardians are generally those who can make decisions on behalf of their minor children as the courts assume that parents know what is best for their child [34]. In some U.S. jurisdictions, the “mature minor doctrine” enables minors who obtain a court order to emancipate and consent to medical treatment. However, genital surgery is costly, and the likelihood that an emancipated minor is able to sustain such fees on her own is rather remote; hence, there is an *a priori* assumption of parental approval and consent. The mature minor legislation has some bearing on the issue of the adolescent’s understanding of informed consent to a variety of procedures and treatments. In California, a minor of any age can consent to abortion, youths above 12 years of age may consent to treatment for sexually transmitted infections, and at 15, emancipated minors can consent to any medical procedures. The courts will ultimately ascertain that the petitioner is sufficiently mature and well informed, and also aware of the potential consequences of consenting to treatment. However, this is not the case for the entire country as requirements of consent are subject to state law, for example, youths in

Kansas are not permitted to consent to any gender-affirming medical treatment whatsoever [21,26]. Conversely, the Infants Act of British Columbia, Canada does allow for providing gender-affirming treatment but not genital surgery to those under 19 without parental consent, if the practitioner is convinced that treatment is in the best interest of the adolescent who in turn must understand the benefits and risks of the requested intervention and thereby provide informed consent [15,35]. Recently, the Family Court of Australia issued a judgment allowing minors with parental consent to begin gonadal treatment without a court order [36]; in the case of genital surgeries, however, a child may not consent, and court authorization must be sought [28]. In the United Kingdom, the so-called Gillick case in 1986 established that a minor under 16 years of age is competent and can provide consent to medical treatment if she has the adequate understanding and intelligence required for the capacity to make such decisions. The “Gillick competence” is considered a landmark case for having established adolescent autonomy in British health care; however, demonstrating competence actually demands greater or further requirements than those of an adult in a similar situation. In practice, surgical treatment of genitals in female-affirmed transgender adolescents is not initiated prior to age 18 in the United Kingdom [29,37,38].

In order to be valid, consent should be fully informed, competently given, and uncoerced. For transgender individuals no matter what their age, coercion is largely a nonissue as there are no reports in the literature of children being induced or forced to transition. Giordano [16,29] asks if fully informed consent can be ever be given for irreversible procedures, as no surgeon can guarantee an exact outcome. If genital surgery was so fraught with risk that no “sane” individual would consent, then the procedure would not be provided to anyone at all. The adolescent as well as the adult are on equal footing in this matter (i.e., the individual receives the most complete information possible, and based on the understanding thereof, consent is given). Thus, Giordano points out the discrepancy in treating adolescents with gender variance differently from their cisgendered counterparts who can consent to equally irreversible medical procedures without parental permission and receive them. In addition, contemporary empirical studies demonstrate that minors under 18 are capable of providing informed consent. In a review of the literature concerning the psychology

of the consenting adolescent, Newman [39] suggests that 15- to 16-year-olds demonstrate a capacity to provide consent based on having reached the developmental milestone of capacity for logical and abstract thought. Shield [26] also argues that adolescents can provide voluntary informed consent by the age of 14 and cites “The Rule of Sevens,” often employed by the courts:

A minor younger than 7 years old is presumed to lack capacity to consent; a minor between the ages of 7 and 14 bears a rebuttable presumption of lack of capacity; and a minor between the ages of 14 and 21 enjoys a rebuttable presumption of capacity. (p. 405)

Meanwhile, surgeons and other treatment professionals often weigh the best interest of their adolescent patients against the responsibility of performing an irreversible procedure and its sequelae over which they do not always have complete control. Moreover, the litigious climate in the United States and the tenuous but theoretical probability of a lawsuit by an adult who may have consented to vaginoplasty as a teen but experienced postsurgical regret years later could prompt surgeons to defer procedures until the individual has reached legal age. Another possible deterrence factor among surgeons may be an awareness of the eugenics movement in the United States and Europe during the early to mid-20th century, in which gonadectomies were performed on various groups of physically healthy young women without patient consent [40,41]. Giordano [16] readily acknowledges that physicians are not obligated to perform procedures upon request, but counters that practitioners need to consider that ethics are superseded by moral responsibility—“it is a mistake to believe that omitting to treat is a morally neutral option” (p. 266).

Ethical Principles Derived from the Surgical Management of Children with DSD

A paradoxical relationship exists between female-affirmed teens on hormones who desire genital surgery but must wait until legal age and adolescents diagnosed with DSD who fight against surgical procedures that have been imposed on them since early childhood. In the former case, practitioners are left with few documented guidelines other than presumed consensus; in the latter, there exists a considerable amount of literature on the ethical and surgical management of children with DSD. Despite the inherent paradox between these two populations, there is a point at which ethics

concerning surgical procedures in children with atypical genitalia intersect with ethical issues of surgery in transgender teens. This vector contributes to a core of generalizable principles that can be used to the practitioner’s advantage in decision making and also to create accepted standards of practice. Based on the ethical principles of managing DSD in children by Gillam, Hewitt, and Warne [42,43] as well as the recommendations of the Department of Health of Victoria, Australia [44] and the Consensus Statement for Management of Intersex Disorders [34], a systematic framework is provided to assist physicians and mental health practitioners in the absence of specific directives beyond the best interest of the adolescent.

Principles for Decisions Concerning Genital Surgery of the Adolescent

1. The Principle of Psychological Support and Education

The adolescent and parent(s) or guardian(s) should be given psychological support as well as a complete disclosure of the benefits, risks, options, and alternative treatments to the requested procedure. The irreversibility of the procedure and its effect on reproductive options should be explained by the clinician, despite the likelihood that the adolescent has consented to earlier gonadal treatment that may have already impacted fertility. There should be ample time and opportunity for discussion of emotional issues related to any type of pressure the adolescent may feel, either to hurry or defer the surgery because of peer interactions, potential disclosures, or physically intimate situations arising in her social network or personal relationships. It is also important that there is emotional support available if the surgery is postponed because of lack of adequate scrotal or penile tissue, extended time needed for permanent pubic hair removal, problems with tissue expanders, etc. Generally, this phase of treatment falls upon the therapist-clinician who often acts as a bridge between the patient, other mental health professionals, and the surgeon. In effect, the therapist becomes an advocate for the adolescent and should thus be a resource of information about the procedure, its risks, benefits, and postoperative care. The therapist should maintain a discourse that is free from social stereotypes and should avoid imposing any specific ideas of gender during the course of treatment [14,26,45–47].

2. The Principle of Medical Management

The surgeon is responsible for providing full disclosure and explanation of the surgical procedure as well as conducting a physical evaluation and explaining postoperative management to the patient and her parent(s). Because of the additional constraints of performing genital surgeries on adolescents who may need tissue grafts and/or tissue expanders, only surgeons with documented experience of gender-affirming surgeries and training in urology, gynecology, and/or plastic surgery should perform the procedure. The surgeon should make efforts to be available to the patient, her parent(s), and the therapist, should unexpected physical issues arise for the patient during the months of preparation time before the procedure. Should the surgeon defer or decline to do the procedure for any reason, a reasonable explanation and further referrals should be provided in direct communication with the patient and her parent(s).

3. The Principle of Risk

Assessment of physical risk to the adolescent falls within the domain of the surgeon and the physician who provides the patient with hormones and general medical care. These professionals should assess the degree of physical harm in terms of loss of life, damage to organs, or other deleterious physical sequelae of the procedure, as well as the likelihood of such damage occurring because of the procedure. In addition, the remedy or measures used to mitigate the physical risks should be assessed on their own merits, as should delaying or deferring surgery until the patient turns 18, in order to reduce the magnitude and probability of physical risk. Any such deferment should be included in the category of psychosocial risk to the patient, who holds the reasonable expectation that the treatment team acts in her best interest. The therapist–clinician will most likely be the primary professional to assess psychosocial risks such as the patient’s feelings of social isolation, physical safety concerns, or emotional difficulties in both peer and romantic relations because of having atypical genitalia. Family values and the specific sociocultural milieu of the adolescent may make a difference in the perception of psychosocial risk; although many clinicians in modern societies agree on the benefits of evolving romantic interactions as the foundation of healthy psychosexual relations in later adulthood, there may be restrictions imposed by the parents or the patient’s culture that would not consider a delay or

deferment as contrary to the best interest of the adolescent.

4. The Principle of Human and Legal Rights

There should be no ambiguity in terms of the adolescent having provided full, free, and informed consent to the procedure. All members of the treatment team—generally the psychotherapist, the endocrinologist or family physician responsible for hormone management, and the surgeon—should be in complete agreement that the adolescent, as a layperson of sound mind, has understood the surgical procedure in terms of risks, benefits, and alternative options with the same degree of competence as someone 18 years of age or older. Despite the adolescent’s status as a minor, she should be provided the right to privacy and final consent with regard to her physical being, treatment records, and consent to photographs or other images stored according to applicable privacy laws. Decisions regarding her general health care should provide the adolescent with the same equality and rights as any other patient in treatment for a physical condition despite the official diagnostic classification of gender dysphoria as a mental disorder.

Conclusion

According to the expert advisory group that provided the recommendations for management of infants and children with DSD to the Department of Health in Victoria, Australia [44], the criteria for application of principles of treatment ethics should be the following:

- a) robust—all sets of principles should be considered in all cases;
- b) transparent—the application of all principles to decisions made should be documented;
- c) consistent—all the principles should be considered for all cases. (p. 7)

In order to assist practitioners accordingly with the application of these or any other proposed treatment principles on a case-by-case basis, it would behoove the WPATH and other professional associations to provide additional guidelines unique to the surgical concerns of minors beyond the limited information that exists within the current version of the Standards of Care until such time that said standards may reflect a permanent change. The absence of additional guidelines will not stop genital surgeries of female-affirmed adolescent minors; in fact, the rate of such procedures

will likely continue to increase but without the benefit of open discussion and disclosure of results that could further the advancement of surgical treatment in this emerging population.

Corresponding Author: Christine Milrod, PhD, Southern California Transgender Counseling, Los Angeles, CA 90048, USA. Tel: +1 310 281-9658; E-mail: info@transgencounseling.com

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Statement of Authorship

Category 1

(a) Conception and Design

Christine Milrod

(b) Acquisition of Data

Christine Milrod

(c) Analysis and Interpretation of Data

Christine Milrod

Category 2

(a) Drafting the Article

Christine Milrod

(b) Revising It for Intellectual Content

Christine Milrod

Category 3

(a) Final Approval of the Completed Article

Christine Milrod

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