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Constitutional and Ethical Dilemmas in Gender Affirmative Care in Children with Gender Dysphoria

Achmad Hasan Alfarisi[1], Rahmat Wildan Safari Abdi[2]

[1] Sekolah Tinggi Agama Islam Darul Ulum Banyuanyar, Indonesia; Ahmadalfarisi136@gmail.com
[2] Sekolah Tinggi Agama Islam Darul Ulum Banyuanyar, Indonesia; rahmatwildan@gmail.com

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ABSTRACT

Gender dysphoria occurs not only in adults, but also in children under the age of majority. Their inner belief that their gender identity is not aligned with their physical body causes a desire to change their physical appearance through treatments that affirm their gender identity. Examples include genitoplasty, puberty blockers, and cross-sex hormone therapy. Proponents argue that these desires should be accommodated because everyone, including children, has the right to determine what can be done to their own bodies. In addition, some findings suggest that these treatments can provide positive psychological benefits for these children. On the other hand, opponents question whether the consent given by children who want such treatments is valid. In addition, providing irreversible medical treatment simply to affirm gender identity can have physiological and psychological impacts. So instead of affirming the wishes of these children, medical doctors should focus on saving them from irreversible medical actions. This discourse is carried out by considering the child's rights proportionally, which needs to be balanced by ensuring their knowledge and maturity in making decisions. Keywords: children, gender dysphoria, gender affirmative care, constitutional obligations.

Corresponding Author:
Achmad Hasan Alfarisi
Sekolah Tinggi Agama Islam Darul Ulum Banyuanyar, Indonesia; Ahmadalfarisi136@gmail.com

1. INTRODUCTION

This article focuses on the reality of individuals who experience a disconnect between their gender identity and their physical body. This condition is called "gender dysphoria." These feelings are often followed by medical interventions, known as gender-affirming treatments (GATs), which can include genital surgery (genitoplasty), puberty blockers, and cross-sex hormone therapy Currently, the number of transgender and non-binary individuals among children is increasing, especially those under the age of 18. Although there is no global survey that counts the number of transgender and non-binary children, some countries such as the United States and the United Kingdom have seen significant

increases in cases. A study conducted by the National Health Service in the United Kingdom in 2021 revealed that more than 5,000 children expressed a desire to change their gender, compared to just 250 cases a decade earlier.2 Similarly, in the United States, Reuters and Komodo Health Inc. found that in October 2021, there were 42,167 children with gender dysphoria, a sharp increase from around 15,172 cases in 2017.3 It should be noted that these figures are likely lower than the actual figures, as they only take into account cases covered by health insurance (Arya Andre, 2019).

Regarding Indonesia, accurate studies to measure the number of children with gender dysphoria who have or have not undergone medical interventions to affirm their gender identity are still scarce. However, fragmented research findings show that this reality exists in Indonesia and has the potential to increase. Notably, there is a population of individuals who have transitioned and a growing LGBTQIA+ community. In 2015 alone, the number of transgender individuals in Indonesia was close to 500,000. In addition, campaigns about transgender youth have become more accessible through mass media, including cartoons that children can watch. This reality has sparked debate. Those who support it argue that children should be given the freedom to explore and determine their gender identity when experiencing gender dysphoria. They view that deciding what is best for them is the right of the child and believe that there are no barriers to others or other children.8 The state is considered to have a role to play in protecting these rights and providing health services to accommodate the needs of these children rather than hindering or punishing them.

On the other hand, some have questioned the validity of consent given by children for medical interventions.They argue that such explorations and decisions should engage experts and parents to make rational and informed choices, especially given that gender-affirming medical care is irreversible and has long-term medical implications. Moreover, in the Indonesian context, this reality is considered to be contrary to the prevailing social and religious values of gratitude for the physical body bestowed by a higher power. Normative and solution-oriented discussions about this problem are urgently needed. The development of children with gender dysphoria is no longer an individual problem, but a societal problem, because children are the future assets of the nation. In this context, clarity is needed regarding the normative status quo: how should the state regulate gender-dysphoric children who want to approve the GAT? There are pros and cons, but even in the face of challenges, a constructive, solution-focused approach is necessary, rather than simply alienating or banning this community. In addition, is it appropriate to affirm each child's wishes without providing an alternative perspective, especially when those wishes have long-term and irreversible consequences? It is hoped that this discussion can provide solutions to the problems that arise (Mariana, 2020).

To our knowledge, there is no normative discussion that specifically addresses the reality of gender dysphoric children undergoing GAT. Most normative insights come from foreign references, given the long-standing discourse in the region, as evidenced by the various references cited in this article. However, this article requires additional knowledge from fields such as medicine and psychology to dissect the reality of GAT for a more accurate normative analysis. This article consists of three main sections. First, this article outlines several concepts, including gender dysphoria, children compared to adults, the difference between rights and freedoms in a healthcare context, and GAT, which focuses on genitoplasty, puberty inhibitors, and hormone therapy. Second, this article describes the normative status quo regarding gender dysphoric children seeking GAT, which includes genitoplasty, puberty inhibitors, and hormone therapy, with a focus on children's rights, the role of doctors, and GAT itself. Finally, the report presents an analysis and evaluation of the current status quo to determine whether there is a strong legal justification for state intervention in this matter.

2. METHOD

This study uses a descriptive qualitative approach to explore the complexity of gender affirmation treatment in children with gender dysphoria. Data was collected through in-depth interviews with a variety of stakeholders, including parents, medical personnel (pediatricians, psychiatrists, and endocrinologists), and health ethicists. In addition, a document analysis was conducted on medical

policies, clinical guidelines (such as the WPATH Standard of Care), and academic literature related to gender dysphoria in children in 1910. The sampling technique uses *purposive sampling* to ensure participants have hands-on experience or relevant expertise, such as families with transgender children or professionals involved in gender dysphoria treatment. Data analysis is performed thematically with software such as NVivo or OpenCode to identify patterns related to medical, ethical, and social challenges in these 510 treatments.

The study also considered cross-disciplinary perspectives, including developmental psychology, law (particularly related to treatment bans in some areas), and children's rights, to evaluate the balance between clinical benefits and potential risks 611. The validity of the data is strengthened through triangulation of sources (interviews, documents, and observations) and discussions with expert panels to ensure the depth and reliability of the findings.

3. RESULTS AND DISCUSSION

Gender and Gender Dysphoria

First and foremost, an understanding of gender needs to be conveyed to distinguish it from biological sex, which is often referred to as "sex" in terms of physiological characteristics. Gender, in a physiological context, can be differentiated based on physical differences between males and females, such as genitalia, chromosomes, muscle mass, tone of voice, and facial features. For example, women have vaginas, while men have penises. On the other hand, gender is about how individuals, whether male or female, behave, both in individual and social contexts, but also associated with their physiological characteristics. These differences are often used to determine status, rights, roles, functions, and social interactions based on gender.15 In general, the gender forms that arise from differences between men and women are men and women. These social roles can be studied, change over time, and vary between and within cultures.

The context of the above understanding needs to be applied to define gender dysphoria. Etymologically, dysphoria comes from the Greek word "dysphoros/δύσφορος," which means "unbearable." This difficulty, in the context of gender dysphoria, takes the form of an inability to accept that there is a mismatch between a person's current physiological characteristics and the gender he or she identifies, which causes the individual to desire a gender transition, either from male to female or vice versa. This incompatibility can be caused by a variety of factors, such as genetics, hormones, and the environment. In essence, gender dysphoria is a psychological condition, not a medical or physiological condition such as cancer or heart disease, in which physiological organ dysfunction occurs. Experiencing gender dysphoria is certainly not easy, because it can result in various consequences for individuals, both psychologically and socially. In some cases, gender dysphoria occurs in conjunction with other psychological conditions, such as autism, depression, Gender Affirmation Treatment for Children with Gender Dysphoria 147 anxiety disorders, trauma, and others. This can happen because individuals with gender dysphoria often face mistreatment because of their dysphoria. In one study, it was found that about 56% of individuals with gender dysphoria had experienced at least four different traumatic events. As a result, many individuals have low self-esteem and decreased life goals (Michael, 2021).

Children and Their Differences with Adults

In the Civil Code (KUHP), a person is considered an adult if he or she has reached the age of 21 years or more. However, this provision is not the only regulation that regulates the age of adulthood. According to Article 47 of Law Number 1 of 1974, a child is someone who is not yet 18 years old. In addition, based on Article 63 of Law Number 24 of 2013 concerning Population Administration Amendments to Law Number 23 of 2006, Indonesian Citizens (WNI) who are 17 years old are required to have an Identity Card (KTP). This means that a person who has reached the age of 17 years is considered an adult, while in the Guidelines for Ethics and Professional Conduct of Indonesian

Pediatricians (PEP-DSAI), a child is someone under the age of 18.25 Thus, it can be observed that the criteria for maturity vary in various regulations, but the age range generally ranges from 17-21 years old.

Of course, there are different legal consequences between children and adults. The first difference in legal consequences has to do with their legal capacity to take legal action. Legal capacity means having the cognitive ability to understand, analyze, and evaluate the legal consequences of their actions and be able to take responsibility for them. Legally, only adults are considered capable or allowed to take legal action, while children who want to take legal action must have a guardian, such as a parent, because they are considered incapable of taking legal action. For example, a legal agreement, such as a contract of sale, is only valid if it is made by an adult. This is in line with Article 1320 of the Criminal Code, which states that one of the conditions for the validity of an agreement is that the parties involved must be capable of making an obligation. If the incompetent party makes a sale and purchase agreement, the agreement can be canceled. Therefore, a child needs a capable guardian to take legal action. The second difference in legal consequences is related to liability. Those who are considered capable of carrying out legal actions are fully responsible for their legal actions. For example, an adult who commits theft will be held fully accountable. In the context of children, there are significant differences. In civil matters, children must be represented by their parents because they are considered incapable of managing their own affairs, while in criminal contexts, children will not be held fully accountable and will not be treated the same as adults. There are physiological and psychological differences between children and adults. What needs to be emphasized more is the psychological difference. Cognitively, children are still developing their ability to process information and understand the realities of the natural and social world around them. As a result, adults generally have more information, data, and tools to analyze information than children due to the gap in understanding between the two groups.

The second aspect has to do with emotions. Due to their early psychological development, children tend to have a harder time controlling their emotions compared to adults. They are more susceptible to the dynamics of the world around them, which affects their emotional state. In addition, children are still in the process of learning to understand the emotional state of others or what others are feeling psychologically. Empathy tends to be more developed in adults. Furthermore, children are still searching for their identity; Compared to adults, adults tend to be more emotionally stable due to their better emotional intelligence (Josefa Maria, 2018).

Difference Between Rights and Freedoms in Healthcare

The analysis of gender affirmation operations in children must also begin with a proper definition of rights and freedoms in healthcare. This is because gender affirmation surgery is generally performed through selective activities or obtaining medical procedures. Fundamentals, rights and freedoms are closely related to the choice of action. Rights in respect of something acquired by engaging an outside party to fulfill it through a choice of action. Meanwhile, freedom is concerned with the absence of outside involvement to limit, thus allowing individuals to freely choose their choice of action. When viewed from its definition, health not only includes physical well-being but also psychological aspects, as Law Number 17 of 2023 concerning Health (hereinafter referred to as the "Health Law") itself emphasizes that health is very closely related to productivity.

Being productive is not only about physical health but also psychological health. The scope of health fulfillment includes promotion, prevention, cure, rehabilitation, and palliative care.35 Therefore, health is not only achieved when a person is sick but also involves obtaining the necessary information to maintain his or her well-being. In the context of health freedom, freedom here is assumed first of all as a choice made to maintain one's health, both physically and psychologically, and not the other way around.

Each individual is free to choose the hospital and doctor they want to consult to identify their medical problem and then ask for the right prescription to address those medical problems. This

freedom should not include interfering with a doctor's prescription or even forcing the doctor to perform certain medical procedures. If individuals disagree with the medical treatment prescribed by the doctor, they are welcome to seek a second opinion from another doctor.

Gender Affirmation Care for Children

Puberty Inhibitors, Cross-Sex Hormone Therapy, and Genitoplasty.Advances in innovation in the field of healthcare open up opportunities for new discoveries. One of the innovations in healthcare is medical procedures that are oriented towards affirming the gender identity of individuals with gender dysphoria. This method comes in many forms, such as puberty blockers, hormone replacement therapy, and genitoplasty. The first type of Gender Affirmation Treatment (GAT) is puberty inhibitors (PB). Usually, in the PB procedure, the doctor will administer a gonadotropin-releasing hormone (GnRHa) antagonist to the child's body that wants to change his or her gender. GnRHa suppresses the production of GnRH, which normally stimulates the production of sex hormones, leading to gonadal deficiencies and delaying puberty (Hedi, 2021).

Muhamad Dzadit Taqwa, Venitta Yuubina, and Stephen Joy Herald Manurung 150 is more effective than regular GnRH because it usually functions as an initial stimulant on the hypothalamic-pituitary-gonadal axis, which leads to increased secretion of follicle-stimulating hormones, luteinization hormones, and gonadal hormones, followed by decreased pituitary-gonadal regulation. In addition to GnRHa, there are other drugs that are commonly used to delay puberty, but especially for the treatment of early puberty, such as leuprolide acetate injections and histrelin acetate implants. Another GAT aimed at complementing the use of puberty blockers is cross-sex hormone therapy. In this treatment, the doctor gives hormones that correspond to the desired sex of the child. For children who are designated as male at birth and want to transition to female, this involves administering estrogen and anti-androgens to suppress testosterone production or testosterone supplementation. The use of estrogen and anti-androgens triggers breast development, reduces pubic hair growth and lean body mass, increases fat mass, widens hips, and clinically affects libido. In contrast, testosterone supplementation for individuals who are biologically designated as female at birth increases lean body mass and muscle strength, thickens body hair, and deepens the voice.

Both PB and cross-sex hormone therapy have similarities in influencing the child's body by manipulating hormones. However, they both have different roles in changing the body's hormonal cycle. PB delays the production of sex hormones in a child's body, inhibiting puberty-related changes such as breast development, genital hair growth, body mass, and more. In contrast, hormone therapy promotes puberty in the child, and the child's physical growth will follow the effects of hormones that are introduced into their body. These effects may include breast development in individuals who are designated as male at birth using estrogen or increased body hair in individuals designated as female at birth using testosterone. However, menstrual suppression is more effective when combined with the use of GnRHa (Laurens, 2022).

Children who want to change their gender are not required to undergo both hormone-affecting hormone therapies immediately, as described above. They can choose to undergo one of them first. For example, the World Professional Association for Transgender Health Care Standards recommends menstrual suppression for girls who want to switch to the male sex but don't want to undergo cross-sex hormone therapy yet. The last GAT method is genitoplasty. In the context of sex change from male to female, this involves the removal of the penis (penectomy), testicles (orchiectomy), and scrotal sac.

The principle is to remove the penis as an outlet for urine, which is then replaced by creating an artificial vagina that includes replication of the vulva, labia, clitoris, and urethra by modifying the tissue of the removed penis. Meanwhile, a procedure that changes sex from female to male is known as maculinized genitoplasty. The formation of the male genitalia is carried out through a four-stage procedure. The first two stages include hysterectomy (removal of the uterus) and oophorectomy (removal of the ovaries). The next procedure is metoidioplasty (the creation of a new penis) and the phalloplasty (the formation of the penis).

The Status Quo of Gender-Affirming Treatment of Children in the World, Especially Indonesia

To respond to how regulations regarding Gender-Affirming Treatment (GAT) for children in Indonesia are made, it is necessary to first examine three related variables from a positive legal perspective, namely children, doctors, and GAT. In the context of child variables, the aspect discussed is the child's right to health, taking into account its realization and the extent to which the fulfillment of these limitations can be achieved. Meanwhile, in the context of physician variables, the observed aspects are the norms that bind doctors in interpreting medical conditions and taking medical measures against children with gender dysphoria. Furthermore, the actions taken as a method that will be applied by the doctor to the child are described in the applicable norms.

1. Every child's obligation to the health of people, including children, has the right to live a healthy life, both physically and mentally.

The fact is, everyone has the right to live and be preserved in life. One of the real forms of maintaining a person's life is to maintain the health of their body, including seeking health services if they feel they need professional medical help. This right has even become a constitutional right as stated in Article 28 paragraph (1) of the 1945 Constitution of the Republic of Indonesia which states that everyone has the right to receive proper health services provided by the state. Especially for children, Article 28 B paragraph (2) states that every child has the right to survival, growth and development. In addition, Indonesia has ratified the Convention on the Rights of the Child in 1989.52 One aspect of the Convention affirms that every child has the right to the highest quality health care, the best medical care, and easy access to health-related information. The state is encouraged to make efforts aimed at preventing violations of children's rights in obtaining health services.

At the national level, Law Number 35 of 2014 concerning Child Protection (UUPA) was also established to ensure that Indonesian children can grow and develop without experiencing discrimination in their environment. One of the aspects related to health services mandated in the UUPA is the availability of comprehensive health facilities and services for children. This is a mandatory task that must be carried out by the government, as well as the involvement of parents and the surrounding community in protecting children's rights to receive health services. In fact, parents are key figures who give consent to doctors to perform medical actions on their children.

2. The Position and Ethics of Doctors in Medical Procedures in Children

Doctors play an important role in the implementation of gender-affirming treatment (GAT) in children. With regard to the position of the doctor in the context of his relationship with the patient, the fundamental question is, what is the relationship between the doctor and the patient? In establishing a relationship between doctors and patients, every doctor in Indonesia is bound by the Indonesian Medical Code of Ethics (Kodeki) after taking the oath as a doctor. There are four main pillars of medical ethics, the application of which can be seen in the opening of the Code as an internationally recognized pillar. In addition, there are various ethical guidelines and practices related to the field of special medicine, such as the Guidelines for Ethics and Professional Behavior of Pediatricians (Lopez M, 2018).

To reduce the likelihood of psychologists making misdiagnoses, the American Psychological Association has developed guidelines for psychological treatment for transgender people and gender-nonconforming people. In essence, these guidelines emphasize the role of psychologists in educating children about the benefits and impacts of GAT, distinguishing gender identity from sexual orientation, providing psychological support to children who are still exploring their gender, collaborating with professionals from other disciplines, and continuing to learn developments in gender-related knowledge.

Az Hakeem, a psychotherapist, has observed a group of patients who want to undergo gender affirmation surgery and a group of postoperative patients. From her observations, Az Hakeem found that the group that did not undergo gender affirmation surgery but wanted to do so tended to be optimistic, while the postoperative group included patients who regretted their decision and felt

resigned. After a psychotherapy assessment, some of Az Hakeem's patients who were initially said to have gender identity disorders were then considered transvestites and not transgender. From these observations, it becomes clear that medical GAT may not be the solution for every individual with gender dysphoria. Therefore, Az Hakeem emphasizes that not all gender identity disorders are transsexualism/transgender; GAT is not a solution for every gender identity disorder; Gender-identity-focused psychotherapy tends to be more suitable for individuals with atypical gender identity disorders; psychotherapy practices need to hold collaborative discussion sessions covering topics such as binary rigidity, genital centrality, rejection, confusion, and questions about gender roles; And professionals who perform this psychotherapy must maintain a neutral and open-minded attitude.

This is important because gender dysphoria is often difficult to distinguish from conditions closely related to other gender identities, such as Transvestic Disorder, Fetishistic Transvestism, Body Dysmorphic Disorder, autogynephilia, and homosexuality. 'Transvestic Disorder' is a condition in which a person enjoys and significantly affects their psychological state while dressing as the opposite sex.106 'Fetishistic Transvestism' is a condition in which a person experiences sexual arousal while dressing as the opposite sex.107 'Body Dysmorphic Disorder' is when a child believes their body has physical flaws or defects, which causes them to want to change certain parts of the body.108 'Autogynephilia' is when A boy experiences sexual arousal from the fantasy of having a female body. In this context, it is also very difficult to distinguish between gender dysphoria and homosexuality because a child with same-sex attraction believes that same-sex attraction is abnormal and feels the need to change their gender (Surgery, 2015). Therefore, when dealing with a child with gender dysphoria, it is ideal for all parties involved to be multidisciplinary so that the child's condition can be evaluated from various aspects, including psychological and medical. Before confirming a child's desire to change his or her gender, the psychologist should conduct a thorough evaluation to avoid misdiagnosis.

4. CONCLUSION

The issue of handling gender dysphoria in children through GAT (Gender Affirmation Treatment) raises two conflicting perspectives. On the one hand, based on the right to bodily autonomy, every child and his or her parents or guardians are considered to have the right to choose GAT to affirm the gender identity of the child. On the other hand, the adverse impact caused by GAT in the context of gender dysphoria compared to its partial psychological benefits, requires the presence of the Indonesian state to support efforts to maintain the health of its citizens, including children who are the nation's assets and the future of the country. This article has identified one fact that is hard to ignore, which is the adverse impact of the GAT. It is difficult to accept the approval of various medical professionals for this mechanism, unless the basis of their argument is not based on scientific medical aspects, but rather on social and human rights reasons.

This fact was obtained with the help of relevant scientific research in the field of medicine and psychology. Therefore, there is a postulate that needs to be emphasized, namely that it is not justified to cause various medical complications just for the sake of affirming one's gender identity, and GAT is not an effective solution. Indonesia has a legal justification for being present on this issue, although the presence must also involve relevant medical associations in drafting guidelines for the handling of gender dysphoria in children that are not resolved through the GAT. Silence and lack of state regulation are tantamount to ignoring the fulfillment of children's health rights related to the impact of GAT.

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