Standards of Care, Draft Revision, 2026

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Based on Revised draft (1/90) approved by: The majority of the membership of the Harry Benjamin International Gender Dysphoria Association, Inc.

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1. Introduction [original]

As of the beginning of 1979, an undocumentable estimate of the number of adult Americans hormonally and surgically sex-reassigned ranged from 3,000 to 6,000. Also undocumentable is the estimate that between 30,000 and 60,000 USA citizens consider themselves to be valid candidates for sex reassignment. World estimates are not available. As of mid-1978, approximately 40 centers in the Western hemisphere offered surgical sex reassignment to persons having a multiplicity of behavioral diagnoses applied under a multiplicity of criteria.

In recent decades, the demand for sex reassignment has increased as have the number and variety of possible psychological, hormonal and surgical treatments. The rationale upon which such treatments are offered have become more and more complex. Varied philosophies of appropriate care have been suggested by various professionals identified as experts on the topic of gender identity. However, until the present [document], no statement of the standard of care to be offered to gender dysphoric patients (sex reassignment applicants) has received official sanction by any identifiable professional group. The present document is designed to fill that void.

[Since the original, WPATH, an organization that replaced the original, has offered several revisions that have increased the scope of this document far beyond its original intent. While the number of people seeking sex reassignment has continued to grow, the Standards of Care has increasingly become diluted and ignored. The present document is an attempt to restate the original intent and to update the criteria to more clearly define those it intends to serve.]

2. Statement of Purpose

The following is an explicit statement of the appropriate standards of care to be offered to applicants for hormonal and surgical sex reassignment.

3. Definitions

3.1 Standard of care.
The standards of care, as listed below, are minimal requirements and are not to be construed as optimal standards of care. It is recommended that professionals involved in the management of sex reassignment cases use the following as minimal criteria for the evaluation of their work. It should be noted that some experts on gender identity recommend that the time parameters listed below should be doubled or tripled. It is recommended that the reasons for any exceptions to these standards, in the management of any individual case, be very carefully documented. Professional opinions differ regarding the permissibility of , and the circumstances warranting, any such exception.

3.2 Hormonal sex reassignment.
Hormonal sex reassignment refers to the administration of androgens to genotypic and phenotypic females, and the administration of estrogens and/or progesterones to genotypic and phenotypic males, for the purpose of effecting somatic changes in order for the patient to more closely approximate the physical appearance of the genotypically other sex. Hormonal sex-reassignment does not refer to the administration of hormones for the purpose of medical care and or research conducted for the treatment or study of non-gender dysphoric medical conditions (e.g., aplastic anemia, impotence, cancer, etc.)

3.3 Surgical sex reassignment.
Genital surgical sex reassignment refers to surgery of the genitalia and/or breasts performed for the purpose of altering the morphology in order to approximate the physical appearance of the genetically other sex in persons diagnosed as gender dysphoric. Such surgical procedures as mastectomy, reduction mammoplasty, augmentation mammoplasty, castration, orchidectomy, penectomy, vaginoplasty, hysterectomy, salpingectomy, vaginectomy, oophorectomy and phalloplasty in the absence of any diagnosable birth defect or other medically defined

pathology, except gender dysphoria, are included in this category labeled surgical sex reassignment.

Non-Genital surgical sex reassignment refers to any and all other surgical procedures of non-genital, or non-breast sites (nose, throat, chin, cheeks, hips, etc.) conducted for the purpose of effecting a more masculine appearance in a genetic female or for the purpose of effecting a more feminine appearance in a genetic male, in the absence of identifiable pathology which would warrant such surgery regardless of the patient's genetic sex (facial injuries, hermaphroditism, etc.).

3.4 Gender Incongruence.

Gender incongruence is the reported mismatch between the genetic foundation and physical appearance and herein refers a person that demonstrates dysfunction with societal role expectations and distress with their sex of birth and who asserts a gender identity different from their sex of birth. Gender incongruence, therefore, is the primary working diagnosis applied to any and all persons requesting surgical and hormonal sex reassignment.

3.5 Gender Dysphoria.

Gender Dysphoria herein refers to that a psychological state of distress whereby a person demonstrates social dysfunction and emotional and who requests hormonal and surgical sex reassignment. Gender dysphoria, herein, does not refer to cases of infant sex reassignment or reannouncement. Gender dysphoria, therefore, is the primary symptom of distress to any and all persons requesting surgical and hormonal sex reassignment.

3.6 Clinical Behavioral Scientist.

Possession of an academic degree in a behavioral science does not necessarily attest to the possession of sufficient training or competence to conduct psychotherapy, psychological counseling, nor diagnosis of gender identity problems. Persons recommending sex reassignment surgery or hormone therapy should have documented training and experience in the diagnosis and treatment of a broad range of psychologic conditions. Licensure or certification as a psychological therapist or counselor does not necessarily attest to competence in gender identity problems. Persons recommending sex reassignment surgery or hormone therapy should have the documented training and experience to diagnose and treat a broad range of sexual conditions. Certification in sex therapy or counseling does not necessarily attest to competence in the diagnosis and treatment of gender identity conditions or disorders. Persons recommending sex reassignment surgery or hormone therapy should have proven competence in general psychotherapy, sex therapy, and gender counseling/therapy.

Any and all recommendations for sex reassignment surgery and hormone therapy should be made only by clinical behavioral scientists possessing the following minimal documentable credentials and expertise:

3.6.1.
A minimum of a master's degree in clinical behavioral science, granted by an institution of education accredited by a national or regional accrediting board.

3.6.2.
One recommendation of the two required for sex reassignment surgery, must be made by a person possessing a doctoral degree (e.g., Ph.D., Ed.D., D.Sc., D.S.W., Psy.D., or M.D.) in a clinical behavioral science, granted by an institution of education accredited by a national or regional accrediting board.

3.6.3.
Demonstrated competence in psychotherapy as indicated by a license to practice medicine, psychology, clinical social work, marriage and family counseling, or social psychotherapy, etc., granted by the state of residence. In states where no such appropriate license board exists, persons recommending sex reassignment surgery or hormone therapy should have been certified by a nationally known and reputable association, based on education and experience criteria, and, preferably, some form of testing (and not simply on membership received for dues paid) as an accredited or certified therapist/counselor (e.g. American Board of Psychiatry and Neurology, Diploma in Psychology from the American Board of Professional Psychologists, Certified Clinical Social Workers, American Association of Marriage and Family Therapists, American Professional Guidance Association, etc.).

3.6.4.
Demonstrated specialized competence in sex therapy and theory as indicated by documentable training and supervised clinical experience in sex therapy (in some states professional licensure requires training in human sexuality; also, persons should have approximately the training and experience as required for certification as a sex Therapist or Sex Counselor by the American Association of Sex Educators, Counselors and Therapists, or as required for membership in the Society for Sex Therapy and Research). Continuing education in human sexuality and sex therapy should also be demonstrable.

3.6.5.
Demonstrated and specialized competence in therapy, counseling, and diagnosis of gender identity disorders as documentable by training and supervised clinical experience, along with continuing education. The behavioral scientists recommending sex reassignment surgery and hormone therapy and the physician and surgeon(s) who accept those recommendations share responsibility for certifying that the recommendations are made based on competency indicators as described above.

4. Principles and Standards

Introduction

4.1.1. Principle 1.
Hormonal and surgical sex reassignment is extensive in its effects, is invasive to the integrity of the human body, has effects and consequences which are not, or are not readily, reversible, and may be requested by persons experiencing short-termed delusions or beliefs which may later be changed and reversed.

4.1.2. Principle 2
Hormonal and surgical sex reassignment are procedures requiring justification and are not of such minor consequence as to be performed on an elective basis.

4.1.3. Principle 3.
Published and unpublished case histories are known in which the decision to undergo hormonal and surgical sex reassignment was, after the fact, regretted and the final result of such procedures proved to be psychologically debilitating to the patients.

4.1.4 Standard 1.
2Hormonal and/or surgical sex reassignment on demand (i.e., justified simply because the patient has requested such procedures) is contraindicated. It is herein declared to be professionally improper to conduct, offer, administer or perform hormonal sex reassignment and/or surgical sex reassignment without careful evaluation of the patient's reasons for requesting such services and evaluation of the beliefs and attitudes upon which such reasons are based.

4.2.1. Principle 4.
The analysis or evaluation of reasons, motives, attitudes, purposes, etc., requires skills not usually associated with the professional training of persons other than clinical behavioral scientists.

4.2.2. Principle 5.
Hormonal and/or surgical sex reassignment is performed for the purpose of improving the quality of life as subsequently experienced and such experiences are most properly studied and evaluated by the clinical behavioral scientist.

4.2.3. Principle 6.
Hormonal and surgical sex reassignment are usually offered to persons, in part, because a psychiatric/psychologic diagnosis of transsexualism (see DSM-III, section 302.5x), or some related diagnosis, has been made. Such diagnoses are properly made only by clinical behavioral scientists.

4.2.4. Principle 7.
Clinical behavioral scientists, in deciding to make the recommendation in favor of hormonal and/or surgical sex reassignment share the moral

responsibility for that decision with the physician and/or surgeon who accepts that recommendation.

4.2.5. Standard 2.
Hormonal and surgical (genital and breast) sex reassignment must be preceded by a firm written recommendation for such procedures made by a clinical behavioral scientist who can justify making such a recommendation by appeal to training or professional experience in dealing with sexual disorders, especially the disorders of gender identity and role.

4.3.1. Principle 8.
The clinical behavior scientist's recommendation for hormonal and/or surgical sex reassignment should, in part, be based upon an evaluation of how well the patient fits the diagnostic criteria for transsexualism as listed in the DSM-III-R category 302.50 to wit:

A. Persistent discomfort and sense of inappropriateness about one's sex at birth.
B. Persistent preoccupation for at least two years with getting rid of one's primary and secondary sex characteristics and acquiring the sex characteristics of the other sex.
C. The patient has reached puberty.

This definition of transsexualism is herein interpreted not to exclude persons who meet the above criteria but who otherwise may, on the basis of their past behavioral histories, be conceptualized and classified as transvestites and/or effeminate male homosexuals or masculine female homosexuals in the presence of pre-puberty gender identity distress.

4.3.2. Principle 9.
The intersexed patient (with a documented hormonal or genetic abnormality) should first be treated by procedures commonly accepted as appropriate for such medical conditions.

4.3.3. Principle 10.
The patient having a psychiatric diagnosis (i.e., schizophrenia) in addition to a diagnosis of transsexualism should first be treated by procedures commonly accepted as appropriate for such non-transsexual psychiatric diagnoses.

4.3.4. Standard 3.
Hormonal and surgical sex reassignment may be made available to intersexed patients and to patients having non-transsexual psychiatric/psychologic diagnoses if the patient and therapist have fulfilled the requirements of the herein listed standards; if the patient can be reasonably expected to be habilitated or rehabilitated, in part, by such hormonal and surgical sex reassignment procedures; and if all other commonly accepted therapeutic approaches to such intersexed or nontranssexual psychiatrically/psychologically diagnosed patients have been either attempted, or considered for use prior to the decision not to

use such alternative therapies. The diagnosis of schizophrenia, therefore, does not necessarily preclude surgical and hormonal sex reassignment.

HORMONAL SEX REASSIGNMENT

4.4.1. Principle 11.
Hormonal sex reassignment is both therapeutic and diagnostic in that the patient requesting such therapy either reports satisfaction or dissatisfaction regarding the results of such therapy.

4.4.2. Principle 12.
Hormonal sex reassignment may have some irreversible effects (infertility, hair growth, voice deepening and clitoral enlargement in the female-to-male patient and infertility and breast growth in the male-to-female patient) and, therefore, such therapy must be offered only under guidelines proposed in the present standards.

4.4.3. Principal 13.
Hormonal sex reassignment should precede surgical sex reassignment as its effects (Patient satisfaction or dissatisfaction) may indicate or contraindicate later surgical sex reassignment.

4.4.4. Standard 4.
The initiation of hormonal sex reassignment shall be preceded by recommendation for such hormonal therapy, made by a clinical behavioral scientist.

4.5.1. Principle 14.
The administration of androgens to females and of estrogens and/or progesterones to males may lead to mild or serious health-threatening complications.

4.5.2. Principle 15.
Persons who are in poor physical health, or who have identifiable abnormalities in blood chemistry, may be at above average risk to develop complications should they receive hormonal medication.

4.5.3 Standard 5.
The physician prescribing hormonal medication to a person for the purpose of effecting hormonal sex reassignment must warn the patient of possible negative complications which may arise and that physician should also make available to the patient (or refer the patient to a facility offering) monitoring of relevant blood chemistries and routine physical examinations including, but not limited to, the measurement of SGPT in persons receiving testosterone and the measurement of SGPT, bilirubin, triglycerides and fasting glucose in persons receiving estrogens.

4.6.1. Principle 16.
The diagnostic evidence for transsexualism (see 4.3.1. above) requires that the clinical behavioral scientist have knowledge, independent of the patient's verbal claim, that the dysphoria, discomfort, sense of inappropriateness and wish to be rid of one's own genitals, have existed for at least two years and have a history of pre-puberty dysphoria. This evidence may be obtained by interview of the patient's appointed informant (friend or relative) or it may be obtained by the fact that the clinical behavioral scientist has professionally known the patient for an extended period of time.

4.6.2 Standard 6.
The clinical behavioral scientist making the recommendation in favor of hormonal sex reassignment shall have known the patient in a psychotherapeutic relationship for at least 6 months prior to making said recommendation.

Surgical Sex Reassignment

(Genital and/or Breast)

4.7.1. Principle 17.
Peer review is a commonly accepted procedure in most branches of science and is used primarily to ensure maximal efficiency and correctness of scientific decisions and procedures.

4.7.2. Principle 18.
Clinical behavioral scientists must often rely on possibly unreliable or invalid sources of information (patients' verbal reports or the verbal reports of the patients' families and friends) in making clinical decisions and in judging whether or not a patient has fulfilled the requirements of the herein listed standards.

4.7.3. Principle 19.
Clinical behavioral scientists given the burden of deciding who to recommend for hormonal and surgical sex reassignment and for whom to refuse such recommendations are subject to extreme social pressure and possible manipulation as to create an atmosphere in which charges of laxity, favoritism, sexism, financial gain, etc., may be made.

4.7.4 Principle 20.
A plethora of theories exist regarding the etiology of gender dysphoria and the purposes or goals of hormonal and/or surgical sex reassignment such that the clinical behavioral scientist making the decision to recommend such reassignment for a patient does not enjoy the comfort or security of knowing that his or her decision would be supported by the majority of his or her peers.

4.7.5. Standard 7.
The clinical behavior scientist recommending that a patient applicant receive surgical (genital and breast) sex reassignment must obtain peer review, in the format of a clinical behavioral scientist peer who will personally examine the patient applicant, on at least four occasions over a two-month period, and who will, in writing state that he or she concurs with the decision of the original clinical behavioral scientist. Peer review (a second opinion) is not required for hormonal sex reassignment. Non-genital and breast surgical sex reassignment does not require the recommendation of a behavioral scientist. At least one of the two behavioral scientists making the favorable recommendation for surgical (genital and breast) sex reassignment must be a doctoral level clinical behavioral scientist.

4.8.1. Standard 8.
The clinical behavioral scientist making the primary recommendation in favor of genital (surgical) sex reassignment shall have known the patient in a psychotherapeutic relationship for at least 12 months prior to making said recommendation. That clinical behavioral scientist should have access to the results of psychometric testing (including IQ testing of the patient) when such testing is clinically indicated.

4.9.1. Standard 9.
Genital sex reassignment shall be preceded by a period of at least 24 months during which time the patient lives full time in the social role of the genetically other sex.

4.10.1. Principle 21.
Genital surgical sex reassignment includes the invasion of, and the alteration of, the genitourinary tract. Undiagnosed pre-existing genitourinary disorders may complicate later genital surgical sex reassignment.

4.10.2. Standard 10.
Prior to genital surgical sex reassignment a urological examination should be conducted for the purpose of identifying and perhaps treating abnormalities of the genitourinary tract.

4.11.1. Standard 11.
The physician administering or performing surgical (genital) sex reassignment is guilty of professional misconduct if he or she does not receive written recommendations in favor of such procedures from at least two clinical behavioral scientists; at least one of which is a doctoral level clinical behavioral scientist and one of whom has known the patient in a professional relationship for at least 12 months.

MISCELLANEOUS

4.12.1. Principle 22.
The care and treatment of sex reassignment applicants or patients often causes special problems for the professional offering such care and treatment. These special problems include, but are not limited to, the need for the professional to cooperate with education of the public to justify his or her work, the need to document the case history perhaps more completely than is customary in general patient care, the need to respond to multiple, nonpaying, service applicants and the need to be receptive and responsible to the extra demands for services and assistance often made by sex reassignment applicants as compared to other patient groups.

4.12.2. Principle 23.
Sex reassignment applicants often have need for post-therapy (psychologic, hormonal and surgical) follow-up care for which they are unable or unwilling to pay.

4.12.3. Principle 24.
Sex reassignment applicants often are in a financial status which does not permit them to pay excessive professional fees.

4.12.4. Standard 12.
It is unethical for professionals to charge sex reassignment applicants "whatever the traffic will bear" or excessive fees far beyond the normal fees charged for similar services by the professional. It is permissible to charge sex reassignment applicants for services in advance of the tendering of such services even if such an advance fee arrangement is not typical of the professional's practice. It is permissible to charge patients, in advance, for expected services such as post-therapy follow-up care and/or counseling. It is unethical to charge patients for services which are essentially research, and which services do not directly benefit the patient.

4.13.1. Principle 25.
Sex reassignment applicants often experience social, legal and financial discrimination not known, at present, to be prohibited by federal or state law.

4.13.1. Principle 26.
Sex reassignment applicants often must conduct formal and semiformal legal proceedings (i.e., in-court appearances against insurance companies or in pursuit of having legal documents changed to reflect their new sexual and gender status, etc.).

4.13.3. Principle 27.
Sex reassignment applicants, in pursuit of what are assumed to be their civil rights as citizens, are often in need of assistance (in the form of

copies of records, letters of endorsement, court testimony, etc.) from the professionals involved in their case.

4.13.4. Standard 13.
It is permissible for a professional to charge only the normal fee for services needed by a patient in pursuit of his or her civil rights. Fees should not be charged for services for which, for other patient groups, such fees are not normally charged.

4.14.1. Principle 28.
Hormonal and surgical sex reassignment has been demonstrated to be a rehabilitative or habilitative, experience for properly selected adult patients.

4.14.2. Principle 29.
Hormonal and surgical sex reassignment are procedures which must be requested by, and performed only with the agreement of, the patient having informed consent. Sex reannouncement or sex reassignment procedures conducted on infantile or early childhood intersexed patients are common medical practices and are not included in or affected by the present discussion.

Sex reassignment applicants often, in their pursuit of sex reassignment, believe that hormonal and surgical sex reassignment have fewer risks than such procedures are known to have.

4.14.4. Standard 14.
Surgical sex reassignment may be conducted of administered only to persons obtaining their legal majority (as defined by state law) or to persons declared by the courts as legal adults (emancipated minors).

4.15.1. Standard 15.
Hormonal and surgical sex reassignments should be conducted or administered only after the patient applicant has received full and complete explanations, preferably in writing, in words understood by the patient applicant, of all risks inherent in the requested procedures.

4.16.1. Principle 31.
Gender dysphoric sex reassignment applicants and patients enjoy the same rights to medical privacy as does any other patient group.

4.16.2. Standard 16.
The privacy of the medical record of the sex reassignment patient shall be safeguarded according to procedures in use to safeguard the privacy of any other patient group.

5. Explication

5.1
Prior to the initiation of hormonal sex reassignment:

5.1.1.
The patient must demonstrate that the sense of discomfort with the self and the urge to rid the self of the genitalia and the wish to live in the genetically other sex role have existed for at least 2 years and demonstrate pre-puberty dysphoria or sex role non-conformity.

5.1.2.
The patient must be known to a clinical behavioral scientist for at least 6 months and that clinical behavioral scientist must endorse the patient's request for hormone therapy.

5.1.3.
Prospective patients should receive a complete physical examination which includes, but is not limited to, the measurement of SGPT in persons to receive testosterone and the measurement of SGPT, bilirubin, triglycerides and fasting glucose in persons to receive estrogens.

5.2.
Prior to initiation of genital or breast sex reassignment (Penectomy, orchidectomy, castration, vaginoplasty, mastectomy, hysterectomy, oophorectomy, salpingectomy, vaginectomy, phalloplasty, reduction mammoplasty, breast amputation):

5.2.1. See 5.1.1. above.

5.2.2.
The patient must be known to the clinical behavioral scientist for at least 12 months and that clinical behavioral scientist must endorse the patient's request for genital surgical reassignment.

5.2.3.
The patient must be evaluated at least four times over a two-month period by a clinical behavioral scientist other than the clinical behavioral scientist specified in 5.2.2. above and that second clinical behavioral scientist must endorse the patient's request for genital sex reassignment. At least one of the clinical behavioral scientists making the recommendation for genital sex reassignment must be a doctoral level clinical behavioral scientist.

5.2.4
The patient must have been successfully living in the genetically other sex role for at least two years.

5.3
During and after services are provided:

5.3.1
The patient's right to privacy should be honored.

5.3.2.
The patient must be charged only appropriate fees, and these fees may be levied in advance of services.