Introduction

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Disclosures:

Employed by University of California, San Francisco

No conflicts of interest or commercial interests to disclose.

Brief history of care of trans youth

1950's

- Agnes Torres at UCLA
  - Presented seeking vaginoplasty to Robert Stoller's Gender Identity Clinic at UCLA in 1958
  - Described extensively by Stoller and Harold Garfinkle, PhD
  - Posed as intersex: AMAB, "testicular feminization" at adolescence. Described as female bodied "38-25-38"
  - Had vaginoplasty in 1959 at age 19
  - 1966: Agnes admitted to Stoller taking mother's estrogen to halt puberty at age 12 and develop as female adolescent

History of trans care of youth

1960's-1980's

- Richard Green's Feminine Boy Study 1960s-1980s
  - Boys brought in by parents for exhibiting feminine behavior
  - Followed longitudinally from childhood through adolescence
  - Most identified as cisgender gay men at age 18
  - Some underwent reparative therapy (Rekers/Lovaas)
  - Participants as adults reported harm from being participants
  - Mistaken idea that trans kids overwhelmingly desist

  Backlash against trans care for adults: 1979 JHU clinic closure; 1981 CMS trans health care exclusion (reversed in 2014)

History of care of trans youth

1990's to early 2000s

- Increased visibility of trans youth but few resources
- Movement against reparative therapy (1998 APA statement)
- Start of affirming model for care for trans youth
  - Dimensions Clinic 1998 San Francisco
  - Support group for parents (Menvielle and Tuerk, JAACAP 2002)
- 1998: First published report of Dutch group on using puberty blockers on a 13 year old

History of care of trans youth

2000s to present

- Affirming care for trans youth expands in US
  - Gender Management Service (GeMS) in Boston 2007
  - UCSF 2009, now many more

  Reversal of trans health exclusions:

  2013 California; 2014 CMS

  Research supporting an affirmative model

  Expansion of support for trans kids in society and schools

  Backlash: bathroom wars, ROGD

WPATH and the Standards of Care

Wpath.org

- The World Professional Association for Transgender Health since 1979 has published clinical guidelines for the multidisciplinary care of trans people, the Standards of Care
- WPATH periodically updates the SOC by consensus of experts
- SOC 7 released in 2011
- SOC 8 due within the next year

SOC 8 process

- SOC 7 Chair Eli Coleman, PhD is editor of SOC 8
- Asa Radix, MD and Jon Arcelus, MD, PhD are co-editors
- Chapter leads were then selected
- Remainder of SOC 8 committee were selected by editors and chapter leads and approved by the WPATH Board this month
- Johns Hopkins team selected and hired to rate levels of evidence in literature
- Each chapter will publish a review and recommendations
- Draft of SOC 8 will be written
- Each member of SOC 8 committee will review document as a whole and offer revisions, towards reaching consensus
- Goal is completion in 2019 or 2020.

Proposed chapters in SOC 8

Chapter Name
Global Applicability of the Standards of Care
Terminology – Diagnostic criteria
Epidemiologic Considerations
Overview of Therapeutic Approaches
New: The role of Primary Care in Gender Health
Assessment, Support and Therapeutic Approaches of Children
NEW: Assessment, Support and Therapeutic Approaches of Adolescents with Gender Diversity/Dysphoria
New: Assessment and Therapeutic Approaches of Non-Binary
New: Assessment of Adults with Gender Variance/Dysphoria
New: Mental and Behavioural Health Conditions in Adults
Hormone Therapy for Adolescents and Adults
New: Sexual Health Across the Lifespan
Reproductive Health for Adolescents and Adults
Voice and Communication Therapy
Surgery Chapter for Adolescents and Adults
Postoperative Care and Follow-Up Chapter
Applicability of the Standards of Care to People Living in Institutional Environments
Applicability of the Standards of Care to People with Intersex Conditions
NEW: Applicability of the Standards of Care to Eunuchs
NEW: Competency, Training, Education, Ethics

The speakers

SCHONFELD MEMORIAL LECTURE: CLINICAL STRATEGIES TO ADDRESS GENDER DYSPHORIA IN TRANSGENDER YOUTH

Richard R. Pleak, MD

Zucker School of Medicine at Hofstra/Northwell

5-17-19

Disclosures

- No financial disclosures
- I will discuss FDA-approved medications for non-FDA-approved indications
- Liaison, AACAP Sexual Orientation and Gender Identity Issues Committee
- Member, Workgroup on Gender Dysphoria of the APA Council on Research and Quality Care

Thank you, ASAP!

- William A. Schonfeld award
  - 1st President of ASAP
  - Awards started in 1969
- A day devoted to TG adolescent care
  - Leading experts, mentors

Overall objective

- Longitudinal, personal perspective on psychiatric care of transgender people over 40 years
- Reflection on treatment issues and guidelines
- Best practice considerations

Personal Perspective

- Med school at Wayne State, Detroit
  - Strong education on TG care
- Residency at WPIC, Pgh
  - Very LG support, care, but TG lacking
- Fellowship at Columbia
  - to work with TG & DSD experts: Drs. Heino Meyer-Bahlburg & Anke Ehrhardt
- Clinical work & education at LIJ / Hofstra / Northwell
  - From silo work to founding Center for Transgender Care

SCENARIO A

- ✓16-1 y/o teen, AMAB
  - ✓Identified as female since age 4, transgender at age 12
  - ✓Socially transitioned at 12 with female name & clothing
  - ✓Confused but supportive family, w/ Tx since age 12
  - ✓w/ Tx, referred & started Lupron at 14 (Tanner 3)
- ✓Consistent GI as female
  - ✓Has been bullied in school
  - ✓School bathroom restrictions
  - ✓Depressed with intermittent SI
  - ✓Wishes to start estrogen

SCENARIO B

- ✓17-4 y/o teen, AFAB, Tanner 4
- ✓Identified as transgender age 14
  - ✓Socially transitioned with male name & clothing
  - ✓Started Tx age 15
  - ✓Considered “blockers”
- ✓Now is “gender questioning” x 6 months
  - ✓Started wearing typical girls’ clothes again
  - ✓Asks to be referred to w/ female name & pronouns
  - ✓Started being bullied in school
- ✓Feels confused about gender identity
  - ✓No longer requests “blockers”, considering pregnancy
- ✓C/o suicidal urges

SCENARIO C

- ✓15-9 y/o teen, AMAB
  - ✓Identified as female since 13
  - ✓Socially transitioned with female name & clothing
  - ✓Parents conflicted
  - ✓On GnRH analogue (Lupron) x 1 year (Tanner 3)
- ✓Parents report no cross-gender behavior/play/statements as child
- ✓Has Asperger's
- ✓Now reconsidering estrogen

SCENARIO D

- ✓11-3 y/o, AFAB
  - ✓Identified as male since 3
  - ✓Socially transitioned age 5 with male name & clothing
  - ✓Parents supportive, school supportive
  - ✓On GnRH analogue (Lupron) x 1 year (Tanner 2)
- ✓At age 11-0, met a peer at camp who is gender queer and now re-identifies self as gender queer
  - ✓Decided to stop Lupron
  - ✓Resumed previous female name & clothing
    - ✓"I'm not a girl or a boy and can wear whatever I want"
  - ✓Parents confused and conflicted
  - ✓School has trouble re-transitioning

Definitions

- sex / gender
  - male ← → female *continuum not dichotomy*
  - chromosomal / anatomical
  - assignment (ASAB): AMAB, AFAB
- gender identity (AKA: core gender identity)
- gender role behavior: stereotypical or cross-gender for society
- gender variant, gender nonconforming, gender diversity
- transgender, transsexual, cisgender
  - TGNC
- gender fluid, gender spectrum, gender queer, agender
- sexual orientation
- LGBT, LGBTQ, LGBTT*QQIAA…, LGBTQ+ = SGM

Renoir : Claude Renoir jouant, 1905

Gender variance / transgenderism – are they disorders?

Gender identity disorders

DSM-I&II
0

vs.

DSM-III/IIIR
GIDC, TS, GIDAANT

vs.

DSM-IV
GID

vs.

DSM-5
GI → GD

DSM-5:

- ✧dysphoria as person's own
- ✧out of sexual disorders section
- ✧post-transition specifier
- ✧can have with DSD
- ✧still is Dx of childhood

Gender variance / transgenderism – are they disorders?

ICD-11, 2019 = gender incongruence

- ✧ not psychiatric Dx
- ✧ still is Dx of childhood

Dx controversy

Homosexuality removed from DSM-II in 1973…

DSM-II & Stonewall 1969 (Stonewall 50)

APA in SF 1970

Gay is Good: Frank Kameny & Barbara Gittings

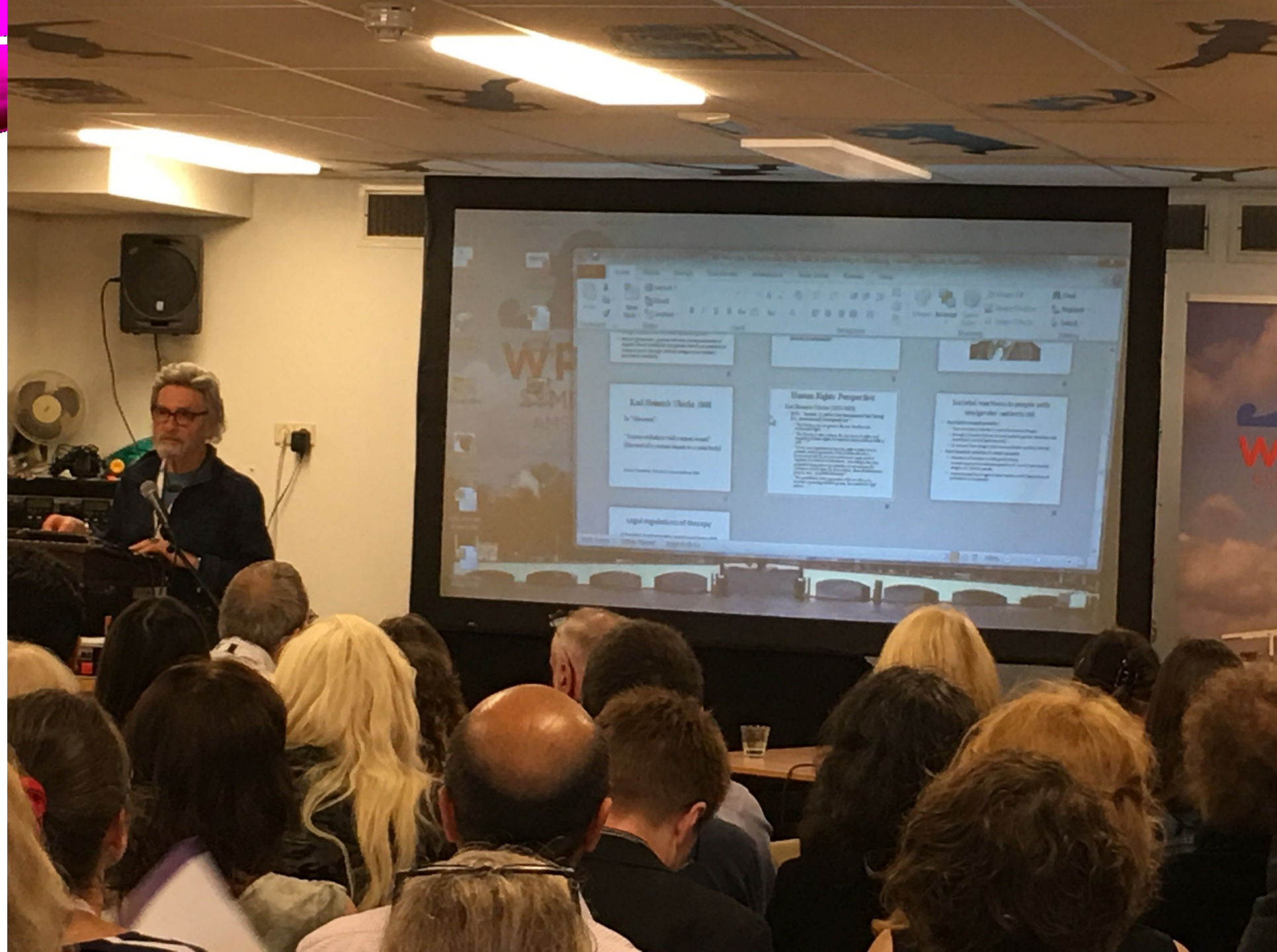
Dr. H Anonymous / John Fryer (AGLP 40)

Richard Green

1972: questioned "the premise that homosexuality is a disease or a homosexual is inferior"

Richard Green June 2016 WPATH Amsterdam

6 April 2019
Dr. Richard Green, 82, Dies; Challenged Psychiatry's View of Homosexuality

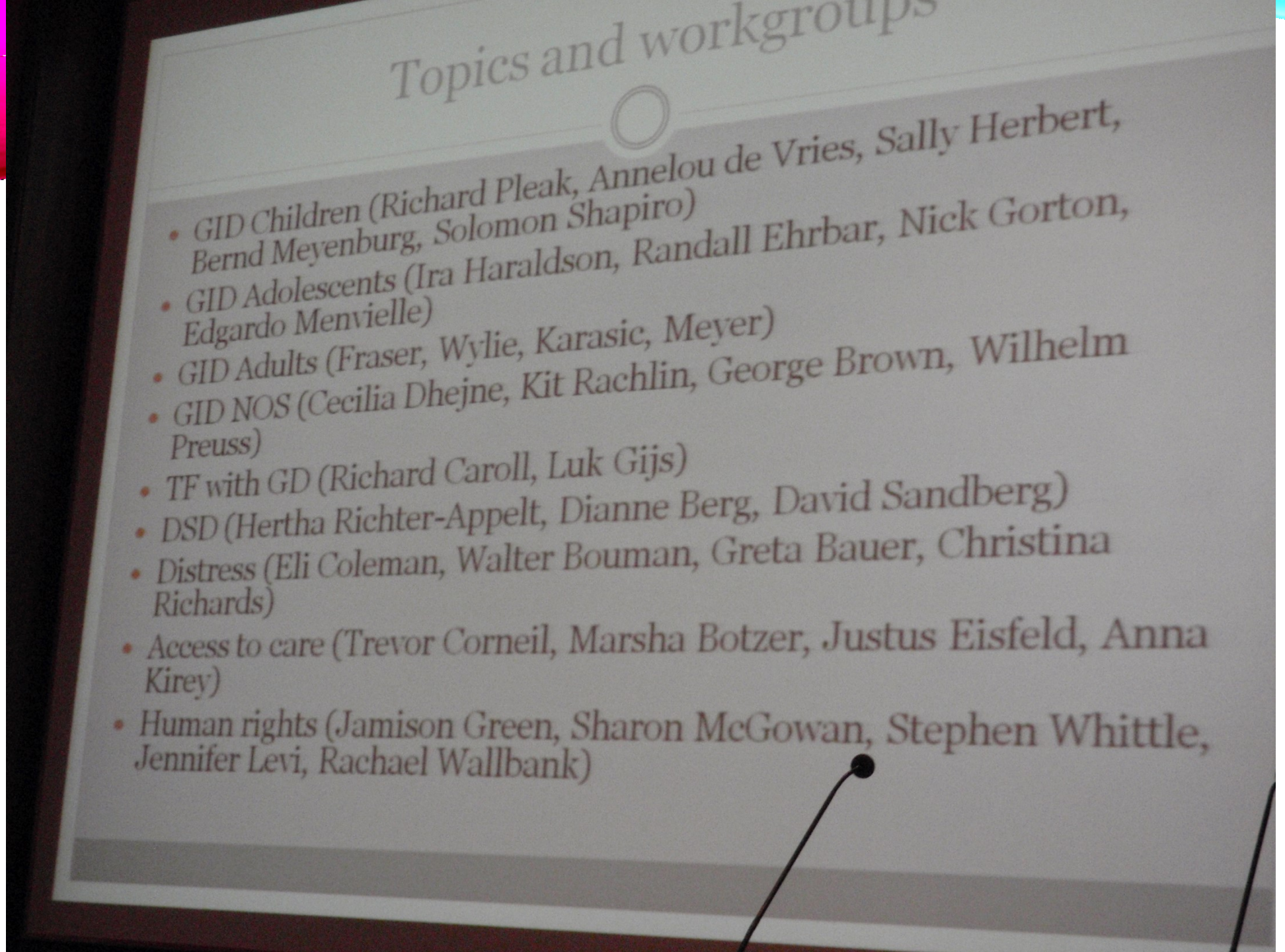


APA
San Francisco
2009

AACAP Honolulu 2009

WPATH, Oslo 2009

World Professional Association for Transgender Health


Topics and workgroups
GID Children (Richard Pleak, Annelou de Vries, Sally Herbert, Bernd Meyenburg, Solomon Shapiro)
GID Adolescents (Ira Haraldson, Randall Ehrbar, Nick Gorton, Edgardo Menvielle)
GID Adults (Fraser, Wylie, Karasic, Meyer)
GID NOS (Cecilia Dhejne, Kit Rachlin, George Brown, Wilhelm Preuss)
TF with GD (Richard Caroll, Luk Gijs)
DSD (Hertha Richter-Appelt, Dianne Berg, David Sandberg)
Distress (Eli Coleman, Walter Bouman, Greta Bauer, Christina Richards)
Access to care (Trevor Corneil, Marsha Botzer, Justus Eisfeld, Anna Kirey)
Human rights (Jamison Green, Sharon McGowan, Stephen Whittle, Jennifer Levi, Rachael Wallbank)


Pros and cons of a diagnosis
Pro
Gender variant people who experience gender dysphoria related distress can be diagnosed
A diagnosis reflects that treatment is necessary
Gives a framework for assessment
Creates greater access to care especially in countries with socialized medicine
Creates the opportunity for competent care
A name for one's experience or condition can be empowering
Facilitates research
Having a "mental disorder" doesn´t mean being mentally ill
Basis for change in identification documents
Con
Stigma and discrimination
Pathologizing
Diminishes autonomy in making personal decision about one´s body and gender expression
May push person into treatment
Places label on a child who does not experience distress
Medicalizes the "condition"

Treatment Considerations

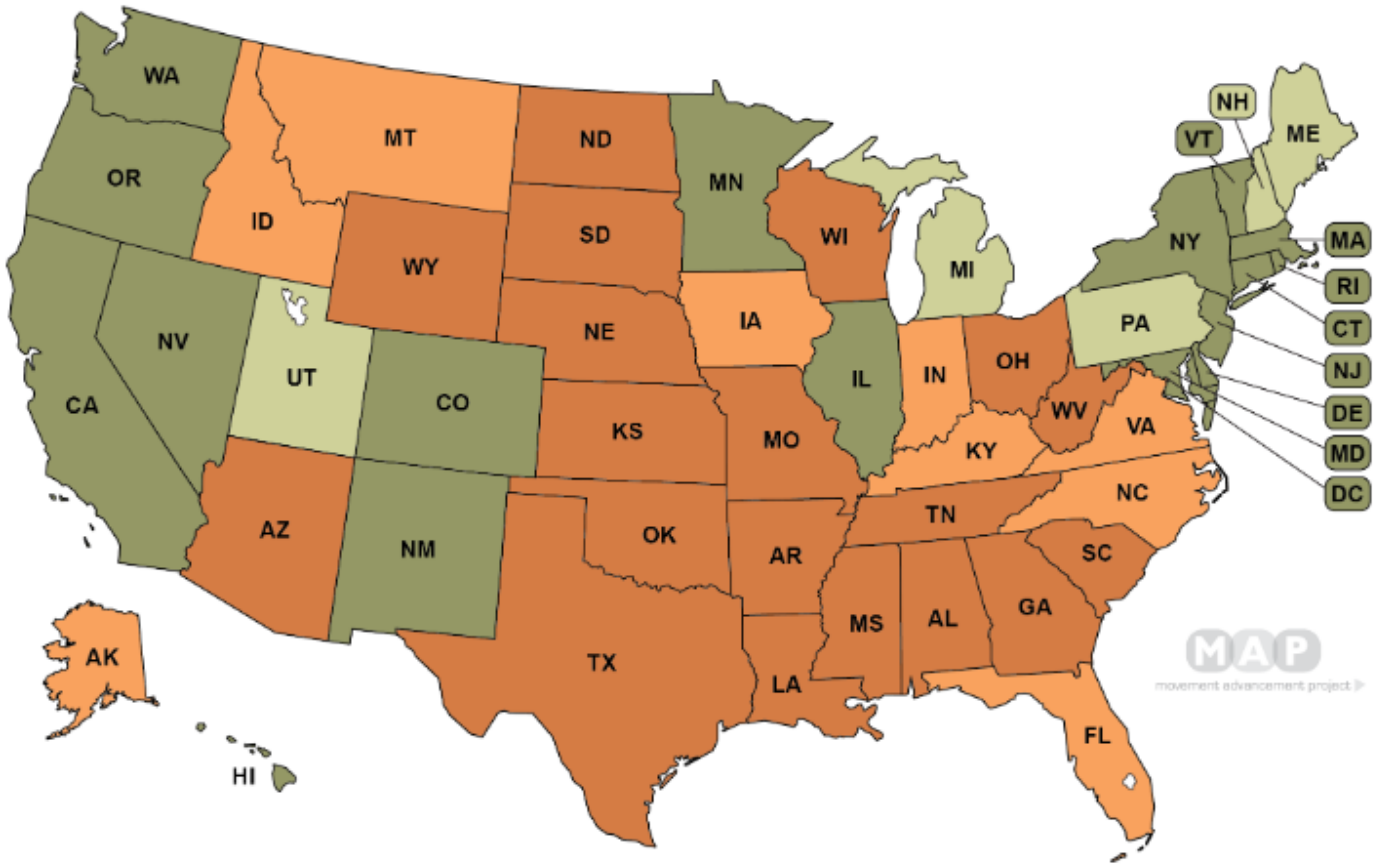
Addressing disparities in care

- IoM Report, 2011
  - Still inadequate professional training
- Joint Commission, 2012
  - ✧ Hospitals must prohibit discrimination based on sexual orientation and gender identity or expression, regardless of local law
  - ✧ Hospitals should use a transgender patient's preferred name even if not the legal name
- Obama Years: Title VII, Title IX, ACA, military
- Current POTUS, VPOTSA, & SCOTUS rollbacks

No Federal protection in the US

- → maps

OVERALL POLICY TALLY | SEXUAL ORIENTATION | GENDER IDENTITY | STATE DATA TABLE



High Gender Identity Policy Tally *(17 states + D.C.)*

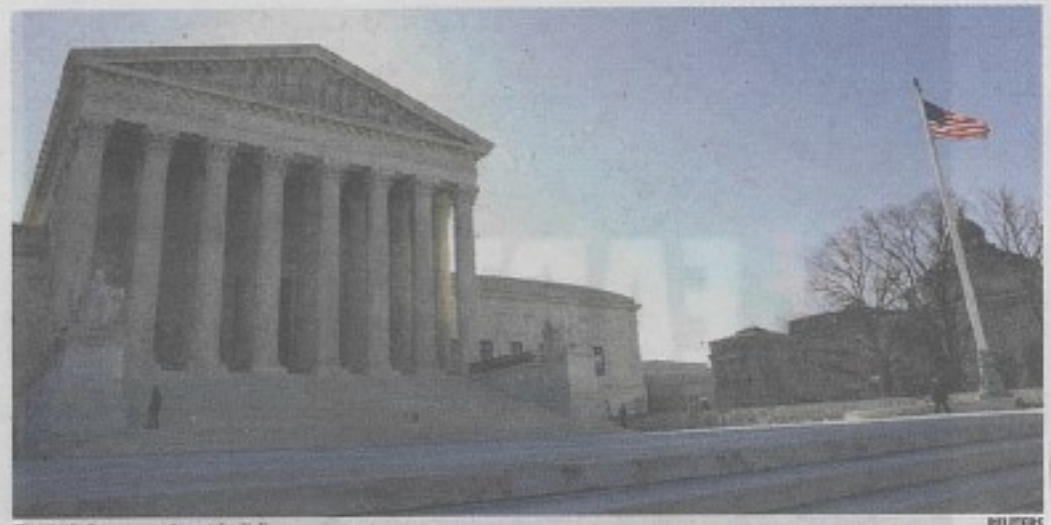
Medium Gender Identity Policy Tally *(6 states)*

Low Gender Identity Policy Tally *(8 states)*

Negative Gender Identity Policy Tally *(19 states)*

Movement Advancement Project (MAP)

Supreme Court takes up major gay, transgender job discrimination cases



The U.S. Supreme Court building. REUTERS

Trump's administration has argued that Title VII does not cover sexual orientation or gender identity.

The Supreme Court on Monday agreed to decide whether U.S. law banning workplace discrimination on the basis of sex protects gay and transgender workers, as the conservative-majority court waded into a fierce dispute involving a divisive social issue.

At issue in the high-profile legal fight is whether gay and transgender people are covered by Title VII of the Civil Rights Act of 1964, which bars employers from discriminating against employees on the basis of sex as well as race, color, national origin and religion. President Donald Trump's administration has argued that Title VII does not cover sexual orientation or gender identity.

The court, whose 5-4 conservative majority includes two Trump appointees, will take up two cases concerning gay people who have said they were fired due to their sexual orientation, one involving a New York skydiving instructor named Donald Zarda and another involving a former county child-welfare services coordinator from Georgia named Gerald Bostock.

The court also will hear a Detroit funeral home's bid to reverse a ruling that it violated federal law by firing a transgender funeral director named Aimee Stephens after Stephens revealed plans to transition from male to female.

The justices will hear arguments and issue a ruling in their next term, which starts in October.

Trump's administration reversed the approach taken under Democratic former President Barack Obama by the U.S. Equal Employment Opportunity Commission (EEOC), which enforces federal laws banning workplace discrimination.

"The American public would be shocked if the Supreme Court ruled that it's perfectly legal to fire someone because she is transgender or lesbian. That doesn't fit with American values of fair play and the idea that you should be judged on your work and not on who you are," said James Esseks, a lawyer with the American Civil Liberties Union, which represents two of the employees.

The Title VII fight marks the court's first major test on a contentious social issue since Trump's appointee Brett Kavanaugh joined it in October after a difficult Senate confirmation process.

Kavanaugh replaced retired Justice Anthony Kennedy, a conservative noted for supporting gay rights, and could provide a pivotal vote on the issue. Kennedy wrote the court's 5-4 2015 ruling legalizing gay marriage nationally, a landmark for U.S. gay rights, and its important 2003 ruling striking down laws criminalizing gay sex.

Kavanaugh's approach to gay rights is unknown, having not been involved in any major cases on the issue as an appeals court judge before becoming a justice. Trump's other Supreme Court appointee is fellow conservative Neil Gorsuch.

Trump, a Republican with strong support among evangelical Christian voters, has taken aim at gay rights and transgender rights. His Justice Department at the Supreme Court supported the right of certain businesses to refuse to serve gay people on the basis of religious objections to gay marriage.

His administration also restricted transgender service members in the military and rescinded protections regarding bathroom access for transgender students in public schools. REUTERS

Shifts in Tx over time

Coercive behavior mod → supportive, affirmative

"reparative" Tx outlawed in 16 states (NY in March 2019)

Repudiated by *AMA, APA, APA, AACAP, AAP…..*

policy statements helpful!!!

But, NARTH remains… supported by VPOTUS

endorsed by the Republican platform, 2016 election

Guidelines: *AACAP (2012), APA (2012), APA (2015),* WPATH (2011), Endocrine Society (2017)

AACAP POLICY STATEMENT: SEXUAL ORIENTATION, GENDER IDENTITY, AND CIVIL RIGHTS, 1998, 2009, 2018

- ***AACAP "rejects all public and private discrimination based on sexual orientation or gender identity of persons of any age."***
- ***AACAP "affirms the right of all people to their orientation and identity without interference or coercive interventions attempting to change sexual orientation or gender identity."***

AACAP POLICY STATEMENT: SEXUAL ORIENTATION, GENDER IDENTITY, AND CIVIL RIGHTS, 1998, 2009, 2018

- *"… "conversion therapies" should not be part of any behavioral health treatment of children and adolescents."*

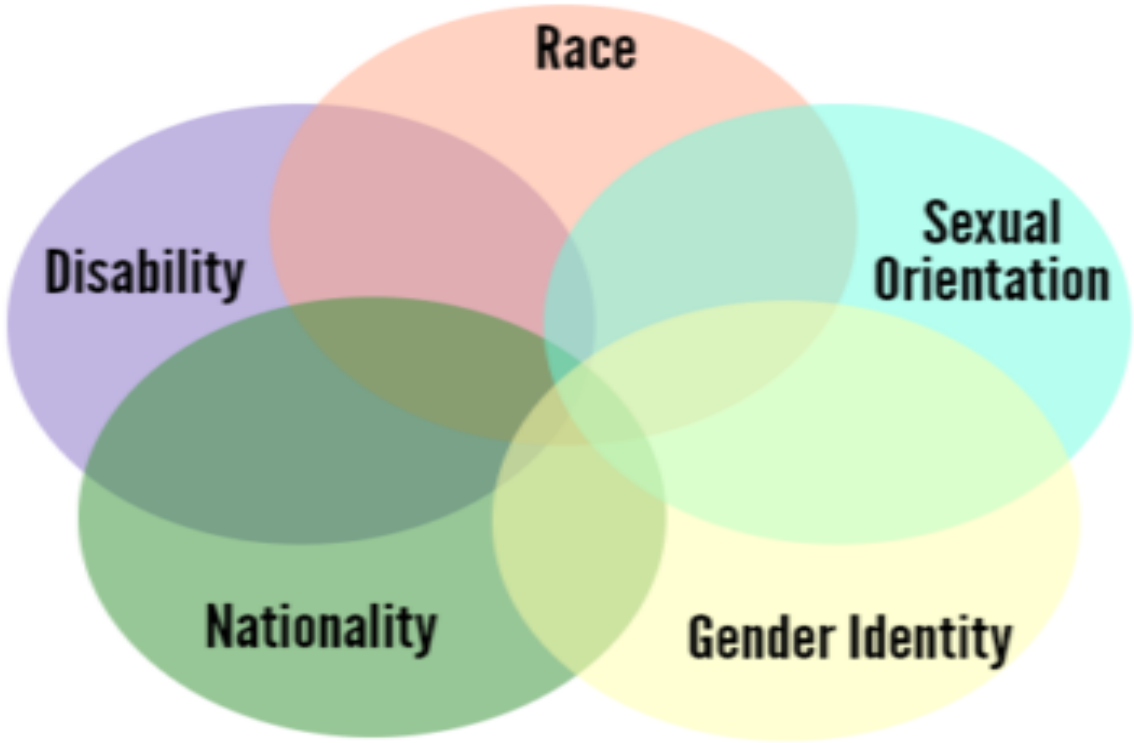
Therapeutic Considerations

Avoidance of care, difficulties finding providers

- disparities & discrimination in health care

Co-occurring morbidity/mortality

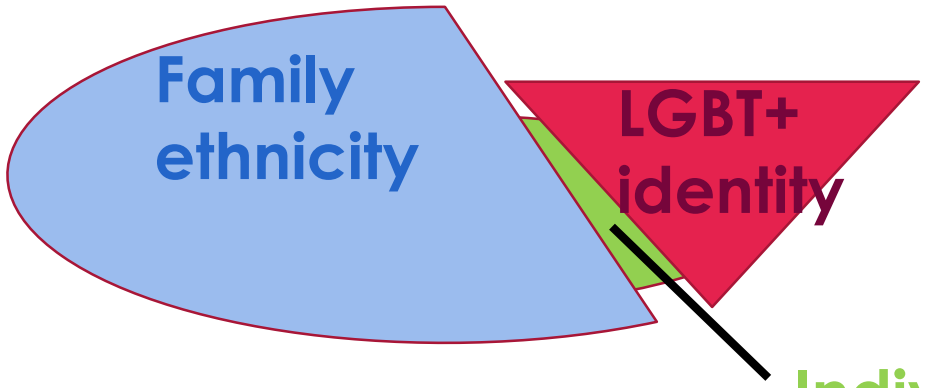
- isolation, rejection, throwaways, depression, suicidality, bullying, violence, murder
- derailed development
- marginalization & intersectionalities



Kimberlé Crenshaw

Multiply marginalized – James T. Sears

Majority population



Therapeutic Considerations

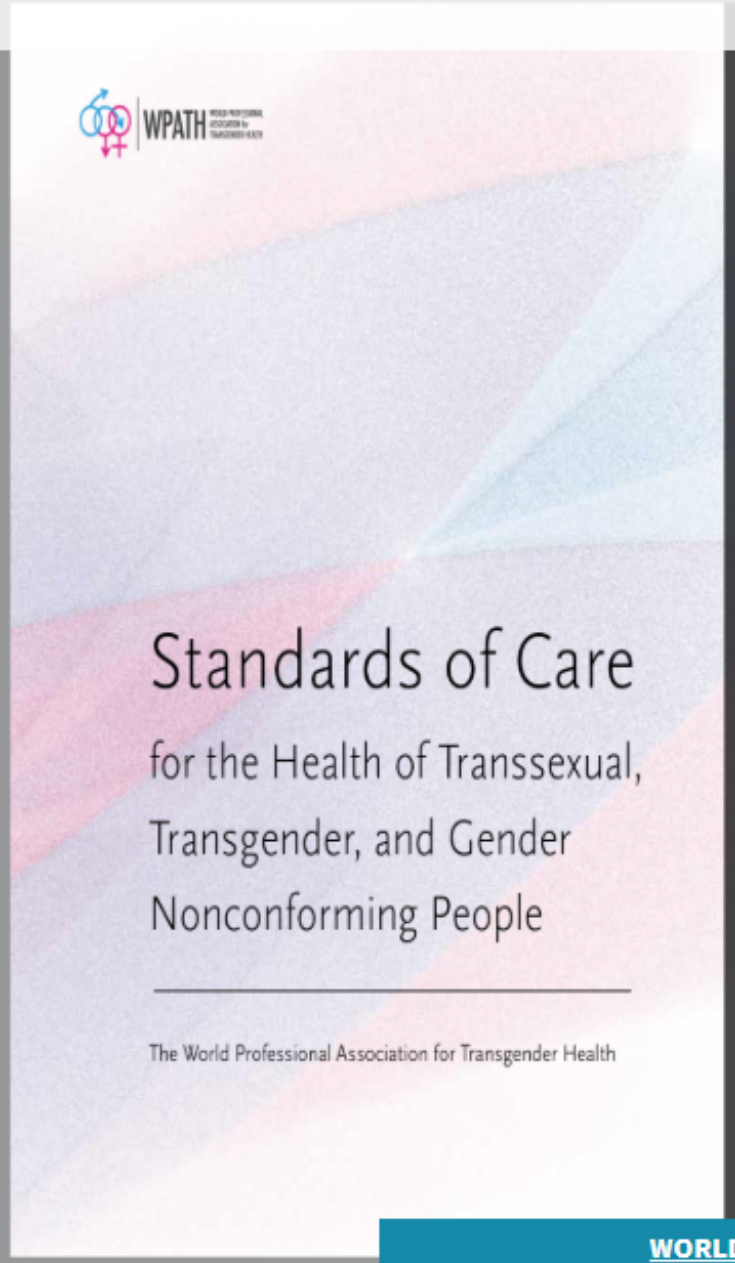
Stereotypes persist: ignoring, assumptions, etc.

- avoid ignoring "desistence" & assuming "persistence"
- embrace & support diversity of outcomes including
  - re-transitioning and not or partially transitioning

Implicit biases and internalized transphobia, homophobia

- within us, our patients, their families
- self-esteem ∝ internalized transphobia

https://implicit.harvard.edu/implicit/takeatest.html



WPATH STANDARDS OF CARE v7
Available in 18 Languages

Arabic	Chinese	Croatian
English	Finnish	French
German	Hindi	Italian
Japanese	Korean	Norwegian
Persian	Portuguese	Russian
Serbian	Spanish	Vietnamese

WPATH gratefully acknowledges the generous support of GIRES (Gender Identity Research and Education Society) of the UK, which has made our SOC translation efforts possible.

WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH
DEDICATED TO PROFESSIONAL DEVELOPMENT, SCIENCE, ETHICS AND TRANSGENDER HEALTH SINCE 1979.

Standards of Care

for the Health of Transsexual, Transgender, and Gender-Nonconforming People

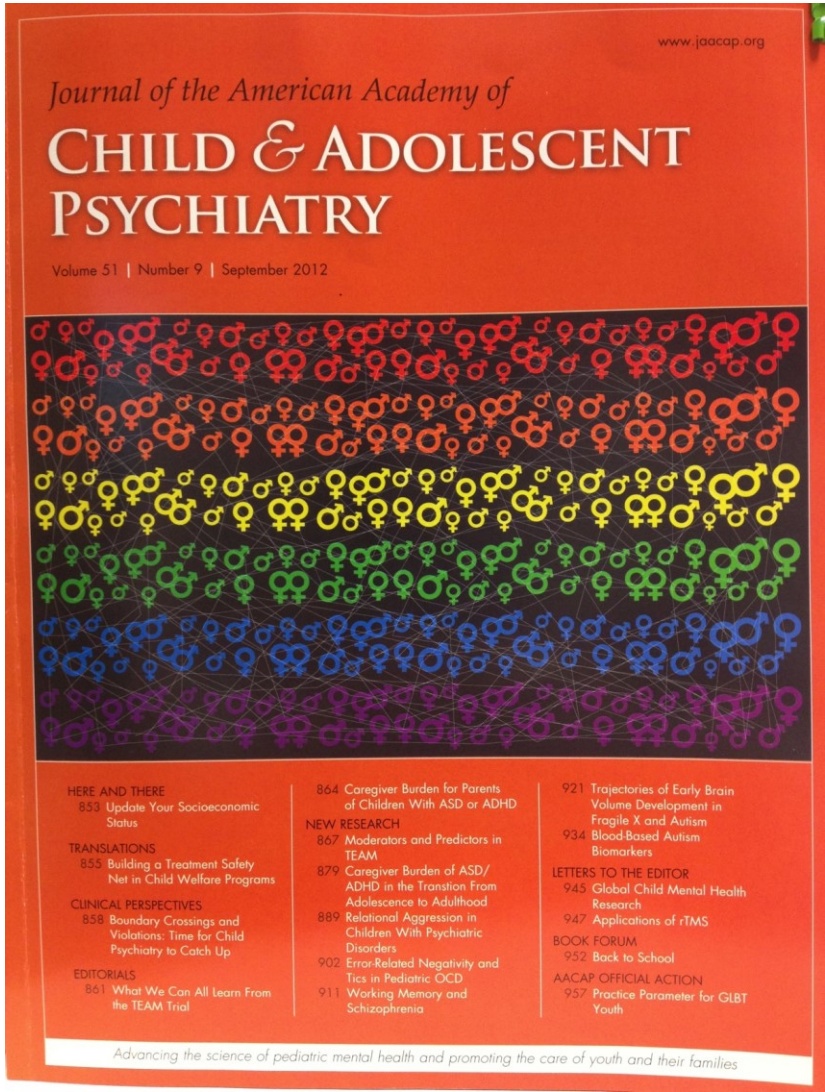
The World Professional Association for Transgender Health

SoC-7
2011
Atlanta
Emory Univ

SoC-8 *update*
2018
Buenos Aires

J Am Acad Child Adolesc Psychiatry,
September 2012

Practice parameter on gay, lesbian, or bisexual sexual orientation, gender nonconformity, and gender discordance in children and adolescents



APA GUIDELINES

None. But…

Task Force on Gender Dysphoria of the APA Council on Research and Quality Care

William Byne, Richard R. Pleak, *et al*.
Treatment of Gender Identity Disorder, *Am J Psychiatry* 2012

J Clin Endocrinol Metab, November 2017

Endocrine Treatment of Gender-Dysphoric/ Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline

Wylie C. Hembree,[1] Peggy T. Cohen-Kettenis,[2] Louis Gooren,[3] Sabine E. Hannema,[4] Walter J. Meyer,[5] M. Hassan Murad,[6] Stephen M. Rosenthal,[7] Joshua D. Safer,[8] Vin Tangpricha,[9] and Guy G. T'Sjoen,[10]

- We advise that decisions regarding the social transition of prepubertal youths with GD/gender incongruence are made with the [redacted] or another experienced professional.

- We recommend against puberty blocking and gender-affirming hormone treatment in prepubertal children with GD/gender incongruence.

J Clin Endocrinol Metab, November 2017

Endocrine Treatment of Gender-Dysphoric/ Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline

Table 5. Criteria for Gender-Affirming Hormone Therapy for Adolescents

Adolescents are eligible for GnRH agonist treatment if:

[redacted]

2. And the adolescent:
- has been informed of the effects and side effects of treatment (including potential loss of fertility if the individual subsequently continues with sex hormone treatment) and options to preserve fertility,
- has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process,

3. And a pediatric endocrinologist or other clinician experienced in pubertal assessment
- agrees with the indication for GnRH agonist treatment,
- has confirmed that puberty has started in the adolescent (Tanner stage ≥G2/B2),
- has confirmed that there are no medical contraindications to GnRH agonist treatment.

Recommendations

1. RESPECT
2. Recognize need for training
3. Recognize transference/countertransference issues & when to refer
4. Be aware of boundaries and overfamiliarities
5. Consider that GI may be fluid
6. Discuss confidentiality and maintain it
7. Ask every patient their preferred name & pronouns, ASAB, gender identity, and sexual orientation/behaviors (consider whether to document or not)
8. Address co-occurring mental health issues: caring for gender & sexual health together with mental health

PSYCHIATRIC GOALS

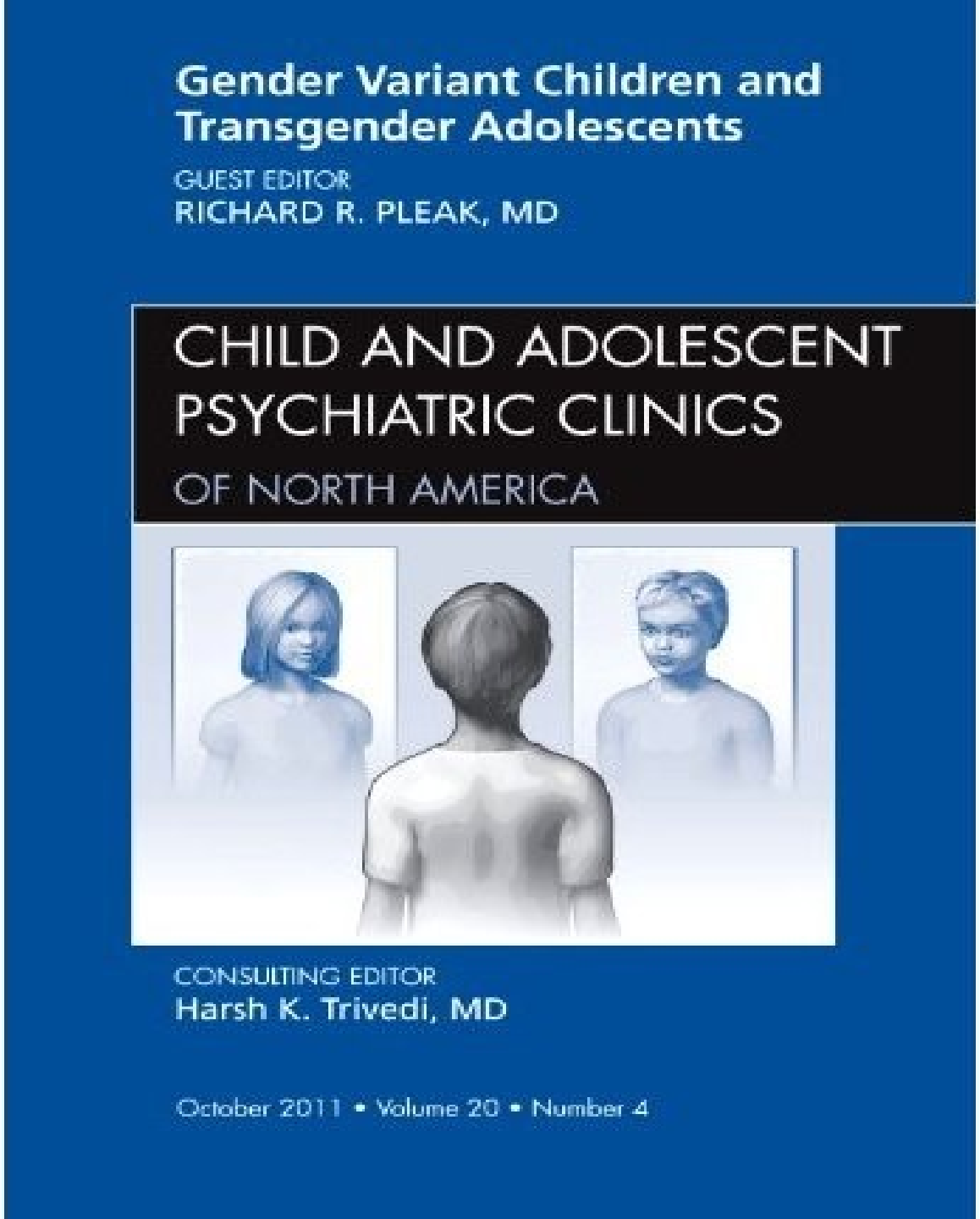
- Establishment of a healthy, positive sexual orientation and gender identity
- Programs for LGBT youth and families
- Referral and support for transitioning, hormones, surgical procedures, gender reassignment
  - Role of psychiatrists / therapists
    - discussion of all the options
    - preparing for transitioning
    - "the letter"
    - "gateopeners" *not* "gatekeepers"
  - Importance of Tx by experts in adolescence

RESILIENCE AMONG TRANSGENDER YOUTH

- Experience a wide range of abuse
- Lack of understanding by others
- More prone to mental health issues, including depression, suicidality, and trauma symptoms
- But --- majority have good outcome

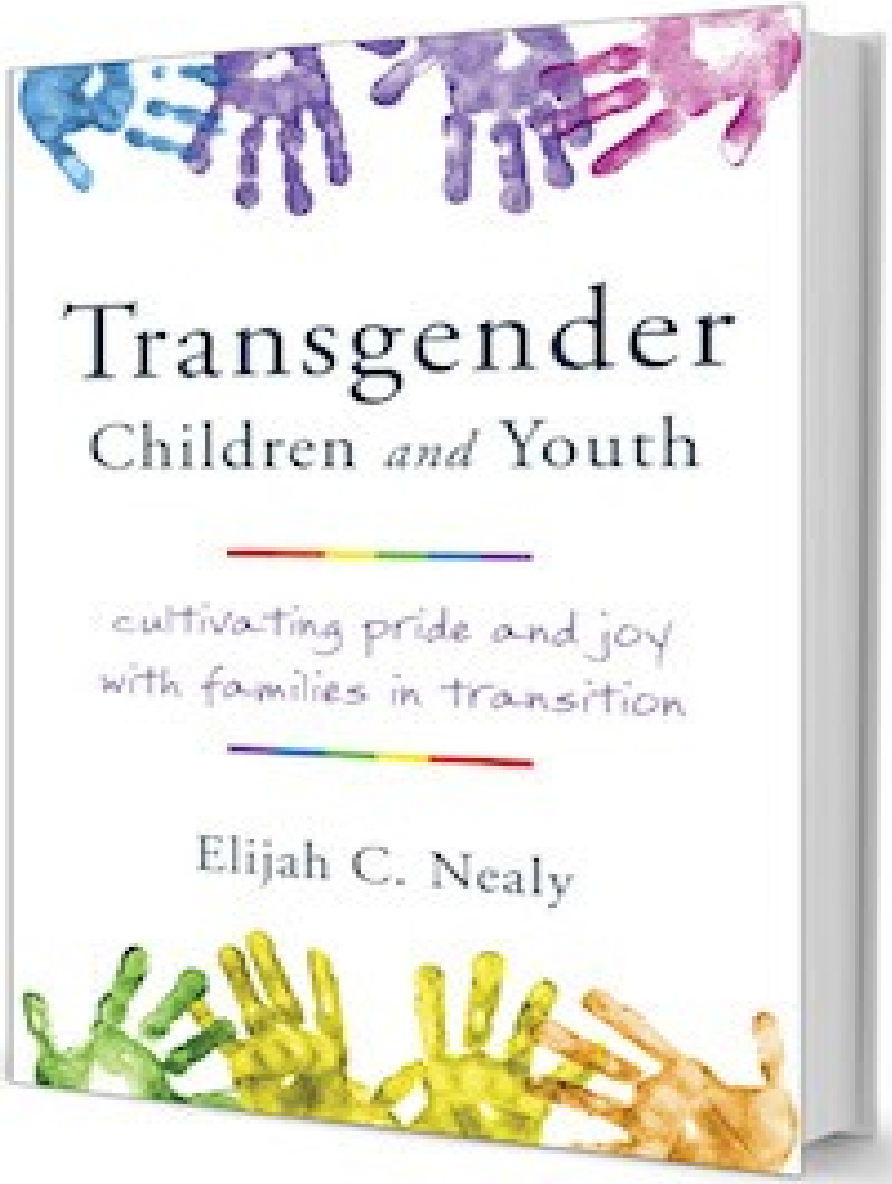
SCENARIO E

- ✓66 y/o, AFAB
  - ✓identified more as male since childhood, "butch dyke lesbian" as teenager
  - ✓confused but supportive family, w/ Tx since age 15
  - ✓identified as male & started testosterone at 25, then rejected by lesbian community
  - ✓college professor
  - ✓stopped testosterone age 62
  - ✓"It's OK if I eventually transition back to being a butch lesbian – I was more supported in that community than any other"


Gender Variant Children and Transgender Adolescents
GUEST EDITOR
RICHARD R. PLEAK, MD
CHILD AND ADOLESCENT PSYCHIATRIC CLINICS
OF NORTH AMERICA
CONSULTING EDITOR
Harsh K. Trivedi, MD
October 2011 • Volume 20 • Number 4

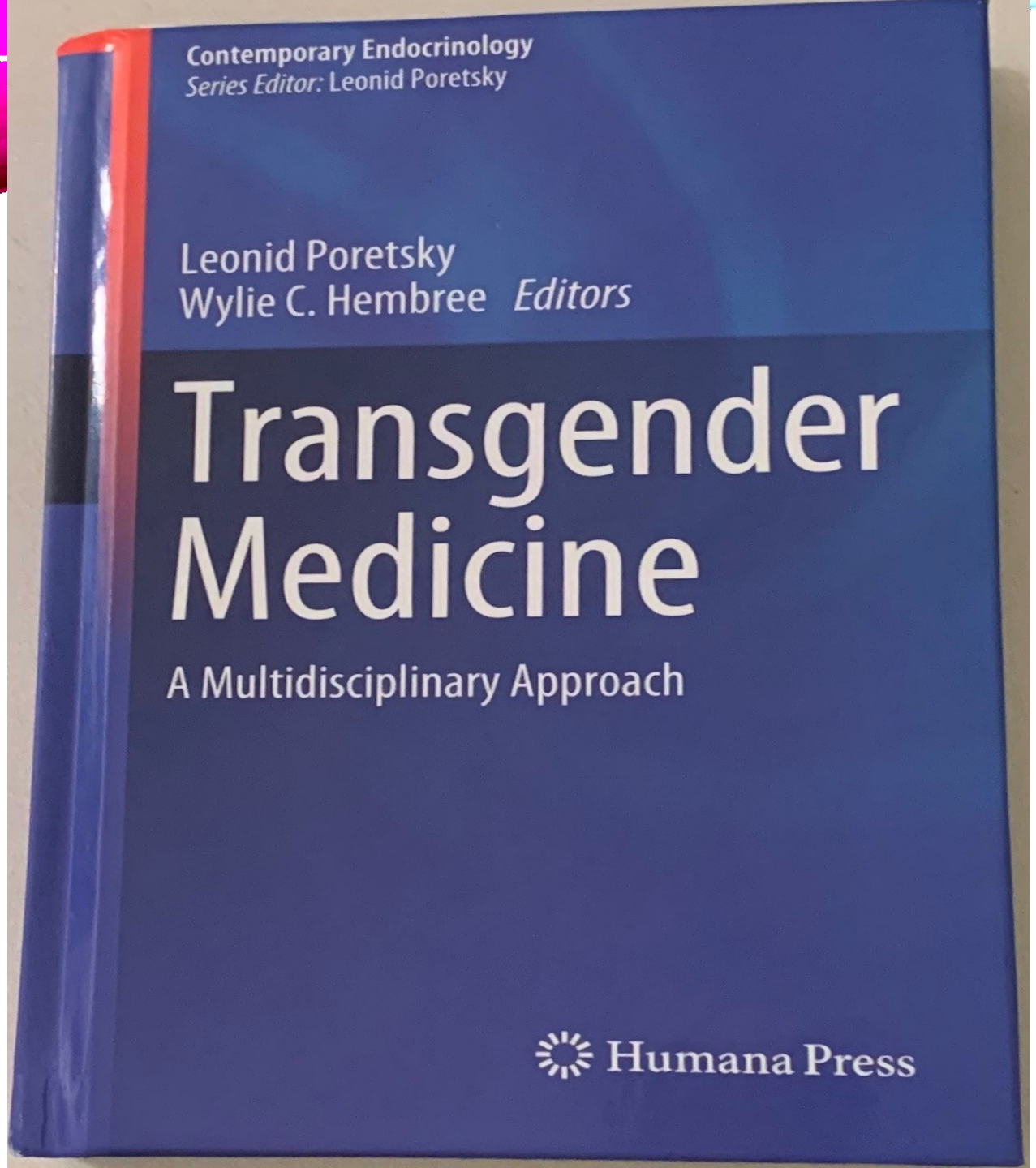
2011

2017



Book Launch and Talk

with Elijah C. Nealy


Contemporary Endocrinology
Series Editor: Leonid Poretsky
Leonid Poretsky
Wylie C. Hembree Editors
Transgender Medicine
A Multidisciplinary Approach
Humana Press

2019


I DON'T KNOW IF IM GAY, BUT I KNOW I LOVE RAINBOWS!


I DON'T KNOW
IF IM GAY, BUT I
KNOW I LOVE
RAINBOWS!

San Diego Pride 2004

2017 film by David France

Stonewall 50: LGBT Pride NYC June

Q&A

Psychotherapy with Transgender and Gender Expansive Youth

DIANE EHRENSAFT, PH.D.

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ASSOCIATE PROFESSOR OF PEDIATRICS, UCSF

CONTACT: DIANE.EHRENSAFT@UCSF.EDU

THERAPEUTIC TASK

GETTING A YOUTH'S GENDER IN FOCUS

TEMPLATE FOR GETTING A YOUTH'S GENDER IN FOCUS:

THE GENDER WEB

Each person's unique gender web weaves together

Nature

Nurture

Culture

THE THREADS IN THE GENDER WEB: NATURE, NURTURE, AND CULTURE

- Chromosomes
- Hormones
- Hormone receptors
- Gonads/Primary sex characteristics
- Secondary sex characteristics
- Brain
- Mind
- Socialization: Family, School, Religious Institutions, Community
- Culture: Values, Ethics, Laws, Theories and Practices

THE FOURTH DIMENSION OF THE GENDER WEB: TIME

Each individual alters their gender web as they weave together nature, nurture, and culture **OVER TIME**

THE GENDER WEB AND FINGERPRINTS

Like fingerprints, no two people's gender webs are exactly the same

Unlike fingerprints, gender webs are not fixed at birth. They can change over the course of a person's life

ADULTS AND THE GENDER WEB

- The gender web is each youth's personal creation
- If adults grab the threads from the youth, they mess up the youth's gender web and leave the child feeling all tangled up
- If adults facilitate the youth weaving their own personal gender web, the youth feels supported and expansive

GENDER MODALITY

- A NEW TERM INTRODUCED BY THE TRANSGENDER COMMUNITY
- SUBSTITUTE FOR DIFFERENTIATING CISGENDER AND TRANSGENDER PEOPLE INTO REIFIED BINARY CATEGORIES
- INSTEAD, EACH YOUTH HAS THEIR OWN GENDER MODALITY (CONSTRUCTION OF THEIR UNIQUE GENDER)
- OPENS THE DOOR TO GENDER INFINITIES AND NON-BINARY IDENTITIES
- ANOTHER WAY OF CONCEPTUALIZING THE GENDER WEB

Basic premises of the gender affirmative model (GAM)

Basic premises of GAM

1. Gender variations are not disorders
2. There are infinite pathways of gender
3. Cisgender is only one of many
4. Each gender pathway is positive
5. No one pathway is privileged over another

Basic premises of GAM

2. Gender presentations are diverse and varied across cultures, requiring cultural sensitivity

Basic premises of GAM

3. Gender involves interweaving of
   - Biology
   - Development and socialization
   - Culture and context

(The Gender Web)

Basic premises of GAM

4. Gender may be fluid, and can be non-binary

Basic premises of GAM

5. Gender is not fixed at a moment in time, but is a lifelong process

Basic premises of GAM

6. Co-occurring psychological issues, if present at all, are typically related to interpersonal and cultural reactions to a child, not internal pathology

Basic premises of GAM

7. Therefore, pathology more likely lies in the culture rather than in the child

Basic premises of GAM

8. Ergo: Gender may be the cure, rather than the disease

ALERT: NEW DIAGNOSIS: SGD SOCIAL GENDER DYSPHORIA

- PRESENT CONTROVERSY—SHOULD THERE BE A MENTAL HEALTH GENDER DIAGNOSIS IF GENDER DIVERISTY IS NOT A PATHOLOGY?
- DSM V GENDER DYSPHORIA: EXPERIENCE OF STRESS OR DISTRESS IN INCONGRUENCE BETWEEN DESIGNATED SEX AT BIRTH AND EXPERIENCED GENDER IDENTITY
- PERHAPS WE ARE BEING DIVERTED FROM THE REAL ISSUE, WHICH IS→
- DIAGNOSIS OF GENDER DYSPHORIA BELONGS TO THE CULTURE, NOT THE YOUTH
- NEW DIAGNOSIS: SOCIAL GENDER DYSPHORIA (SGD)
- DEFINED AS STRESS OR DISTRESS EXPERIENCED BY A CULTURE OR INDIVIDUAL WITHIN THE CULTURE WHEN EVERYTHING THEY LEARNED ABOUT GENDER IN TWO BOXES IS INCONGRUENT WITH WHAT CHILDREN (AND ADULTS) TODAY ARE DEMONSTRATING ABOUT THEIR GENDER BEING INFINITE RATHER THAN BINARY IN NATURE

THIS MEANS ……

- IT IS THE RESPONSIBILITY OF MENTAL HEALTH PROFESSIONALS TO CURE THE DISEASE BY GETTING INVOLVED IN THE COMMUNITY TO ENSURE GENDER HEALTH FOR ALL

DEFINITION of GENDER HEALTH

- A youth's opportunity to live in the gender that feels most real and/or comfortable
- A youth's ability to express gender with freedom from restriction, aspersion or rejection

Gender Microaggressions→ Gender Minority Stress

What are gender microaggressions?

- Brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative slights and insults because of gender minority status

MAIN BARRIER TO GENDER HEALTH = GENDER MINORITY STRESS

WHAT IS GENDER MINORITY STRESS?

Anxiety and distress caused by being part of a minority group and being confronted with:

1. gender-related discrimination
2. gender-related rejection
3. gender-related victimization
4. non-affirmation of gender identity
5. internalized transphobia

ESSENTIAL THERAPEUTIC TENET ABOUT GENDER

It is not for us to say, but for the youth to tell


Is it a boy or a girl?
I don't know. It can't talk yet.

THERAPEUTIC GOALS

- Facilitating authentic gender self
- Alleviating gender stress or distress
- Building Gender Resilience
- Securing Social Supports

UNDERLYING ASSUMPTION

- EVERY YOUTH IS ENTITLED TO LIVE IN THE GENDER THAT IS MOST AUTHENTIC TO THEM, A GENDER THAT DOES NOT NECESSARILY MATCH THE SEX DESIGNATED AT BIRTH OR THE CULTURE'S SOCIAL DEFINITIONS OR EXPECTIONS OF GENDER EXPRESSIONS
- i.e., "GENDER HEALTH"

ROLE OF MENTAL HEALTH

- The role of the mental health professional is to join with the youth, the family, and with allied professionals to:

*Learn about the youth's gender authentic self and the impediments to that self

*Determine if a youth's gender presentation is a symptom of something else or the youth's gender core

*Figure out next steps and take next steps

TO BE NOTED: NEXT STEPS MAY INCLUDE MAKING RECOMMENDATIONS ABOUT GENDER AFFIRMATIVE MEDICAL INTERVENTIONS

- This could include puberty blockers, hormones, or surgeries
- Very few if any other areas where mental health professional asked to weigh in on medical procedures for a child
- This part of the work involves a significant amount of advanced training—AND MAKES PROVIDERS ANXIOUS

CHALLENGE FOR THE PROVIDER

- WE'RE SUPPOSED TO LISTEN TO THE YOUTH ABOUT THEIR GENDER
- BUT HOW DO WE FIGURE OUT WHAT THEY ARE TRYING TO TELL US?

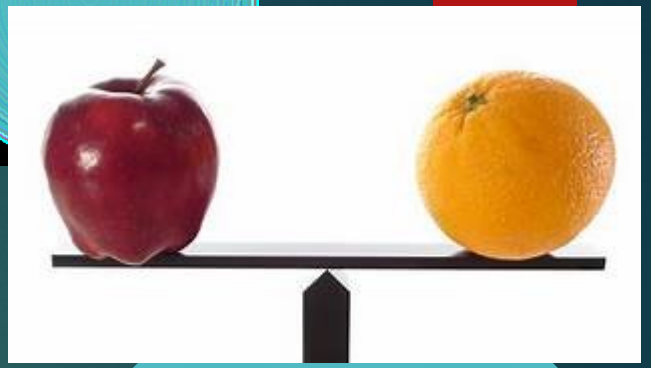
THAT QUESTION CAN MAKE A PROVIDER VERY NERVOUS

A HELPFUL TRANSLATION APP:
The fruit orchard of gender expansive youth

APPLES, ORANGES, FRUIT SALAD

- SOME YOUTH WILL BE EXPLORING OR AFFIRMING THEIR GENDER IDENTITY (APPLES)
- SOME YOUTH WILL BE EXPLORING OR AFFIRMING THEIR GENDER EXPRESSIONS (ORANGES)
- SOME YOUTH WILL BE EXPLORING OR AFFIRMING BOTH (FRUIT SALADS)

FROM WHENCE APPLES AND ORANGES?



- FROM REVIEWING THE RESEARCH ON DESISTERS AND PERSISTERS:
- PERSISTERS: YOUNG CHILDREN WHO RECEIVE A GENDER DIAGNOSIS EARLY IN LIFE AND PERSIST WITH THAT DIAGNOSIS INTO ADOLESCENCE
- DESISTERS: YOUNG CHILDREN WHO RECEIVE A GENDER DIAGNOSIS EARLY IN LIFE AND NO LONGER HAVE THAT DIAGNOSIS BY PUBERTY
- MAJORITY OF CHILDREN IN CLINICAL STUDIES HAVE PROVEN TO BE DESISTERS (most recent finding: 63%[Steensma et al., 2013])
- CONCLUSION: WAIT UNTIL ADOLESCENCE BEFORE DOING ANYTHING DRASTIC ABOUT GENDER, i.e., SOCIAL TRANSITION BECAUSE WE CAN'T KNOW BEFORE

MY RESPONSE: THIS IS MAKING NO SENSE. THESE ARE TWO DIFFERENT GROUPS OF KIDS FROM EARLY ON. WE'RE TALKING APPLES AND ORANGES.

THEN ALONG CAME THE FRUIT SALADS

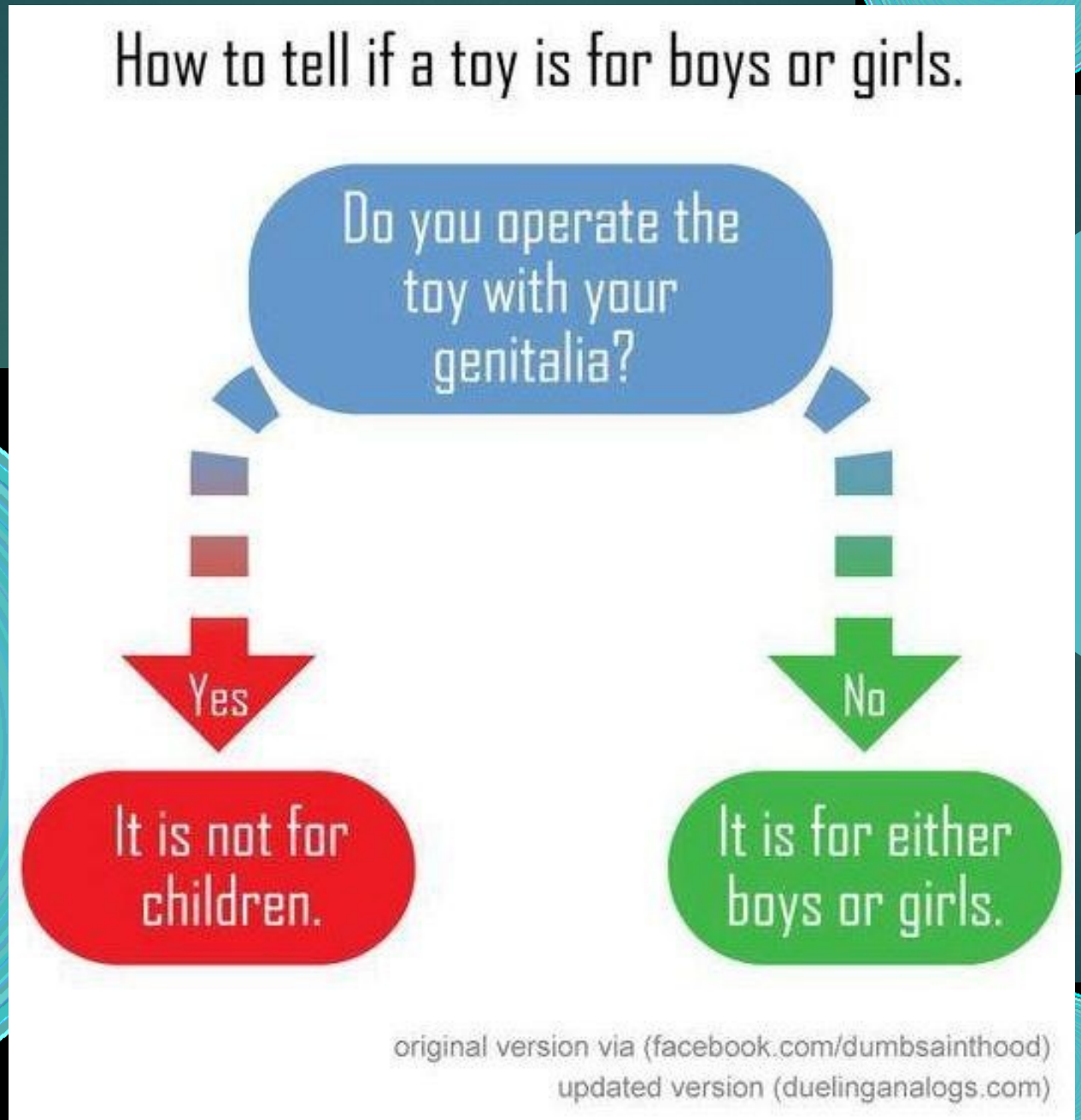
- THE PUSH CAME FROM THE YOUTH THEMSELVES, ACTIVELY CHALLENGING THE BINARY NOTIONS OF GENDER IN THOUGHT, ACTION, AND DEED

Separating Apples, Oranges, & Fruit Salads Requires Separating Gender Identity from Gender Expressions

GENDER IDENTITY: Who I know myself to be at my core—male, female, or other

GENDER EXPRESSION:: The toys I like to play with, the activities I like to do, the children I choose to play with, the clothes I like to wear, the way I like to move, and so forth

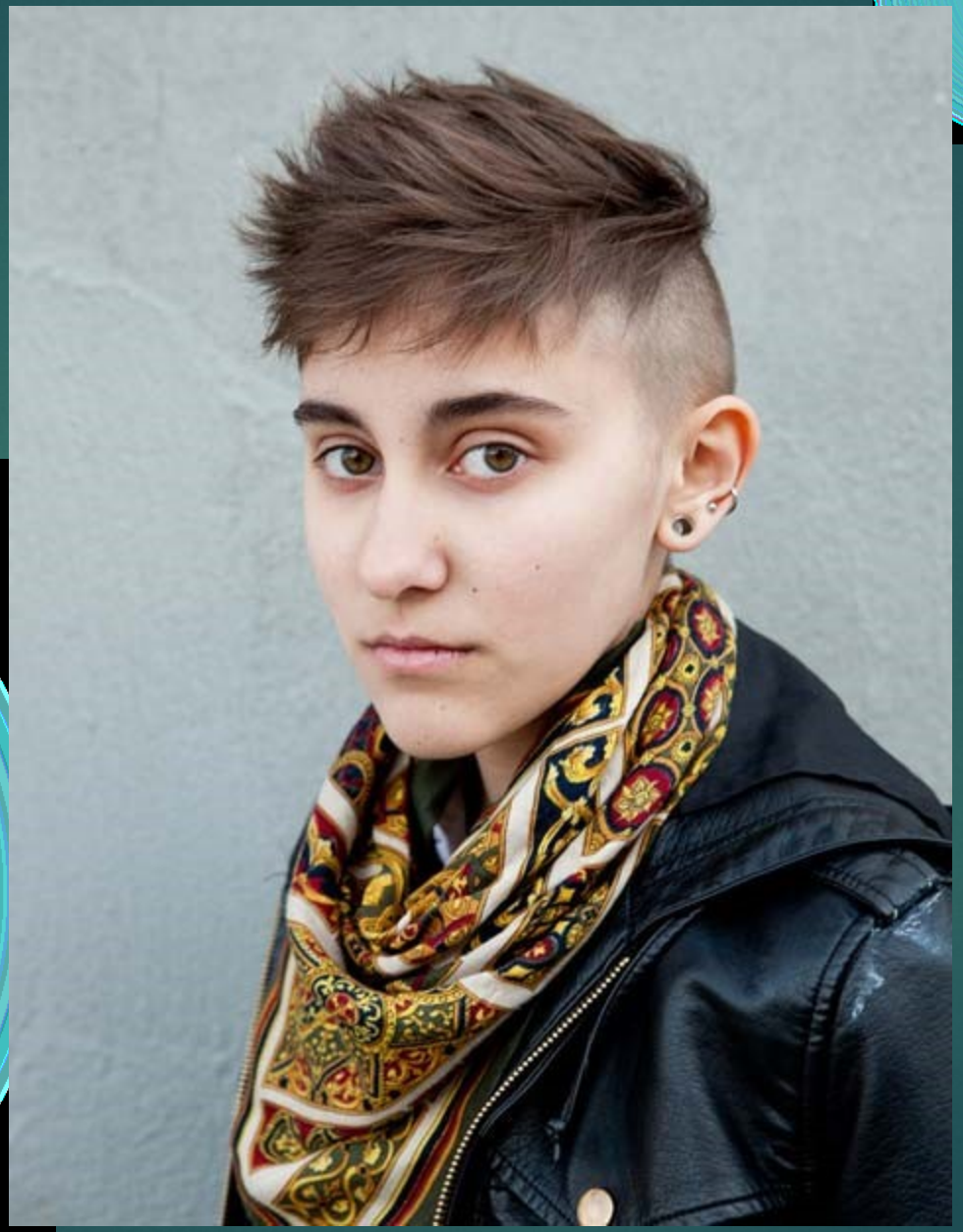
Cheat Sheet for Gender Expressions



REVISED CHEAT SHEET FOR GENDER EXPRESSIONS

APPLES

- Youth who often show up in child gender research as the "persisters"
- Cross-gender in identifications early in life; continue on the same track into and beyond puberty (Consistent, Persistent, and Insistent)
- Typically say, "I am a -------" rather than "I wish I was a ------"
- Many express body dysphoria
- Gender explorations typically don't present as child's play but serious work
- Establishing an affirmed gender identity is the main order of the day
- Nature thread of their gender web often quite strong
- Our youngest cohort of transgender people



APPLE MYTH

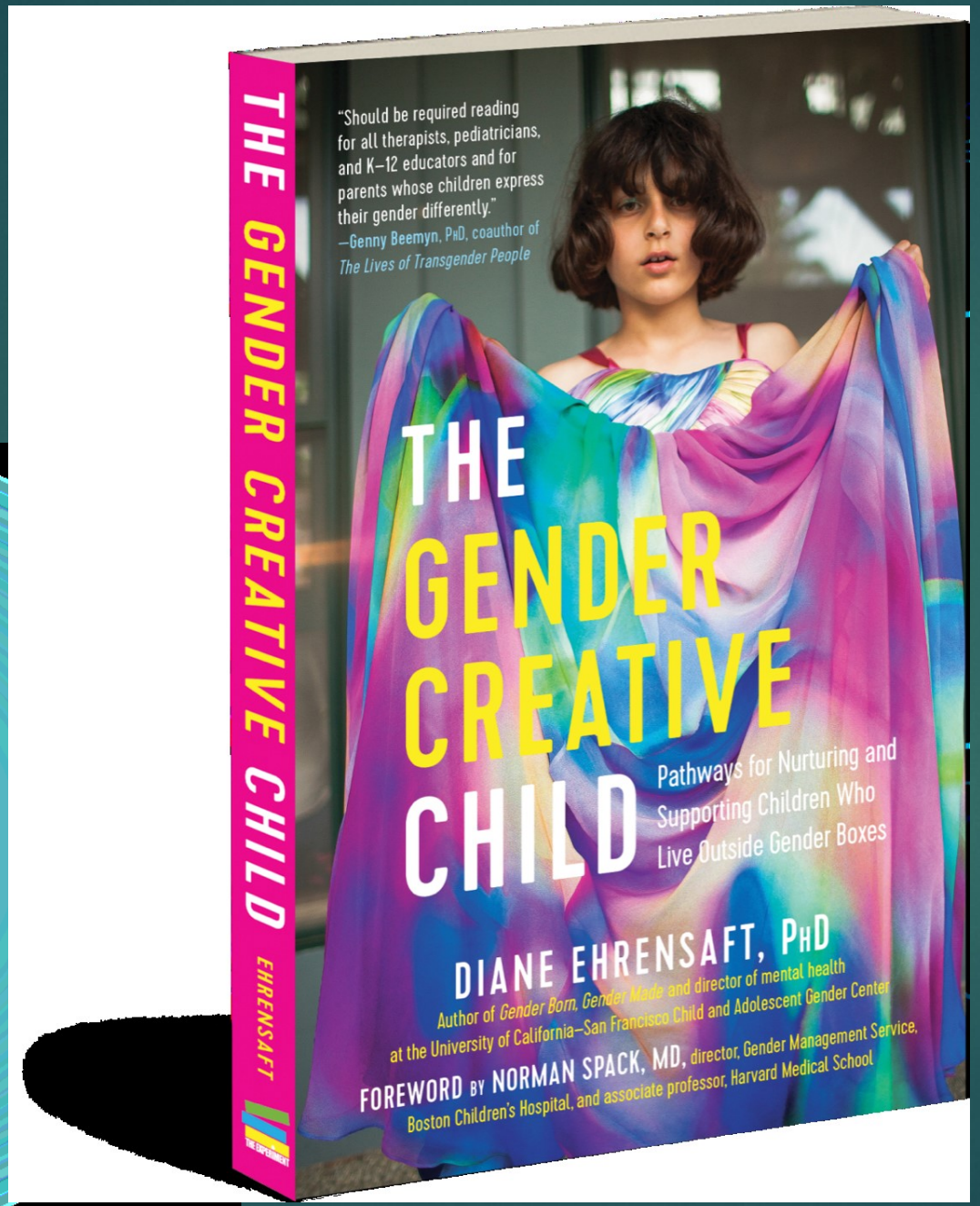
- In order to be an apple, you have to have been insistent, persistent, consistent in asserted gender identity since early childhood
- Otherwise, you don't qualify. You might even just be following a new teenage fad (AKA rapid onset gender dysphoria)

Reality: Late Harvest Apples

- A person can discover they are an apple at any point in life
- They could be two, five, fifteen, or fifty
- This is in accordance with consolidation of our gender selves being lifelong and potentially fluid process, rather than fixed at particular point in time

ORANGES

- Youth who often show up in child gender research as the "desisters"
- Gender expansive but do not repudiate their designated birth sex. May say "I wish I was a …"
- Large number of these youth will become gay or queer, exploring gender on way to discovering sexual identities
- Do not tend to repudiate their bodies, but can engage in fantasy play or ruminations about life in another body
- Explorations in realm of gender expressions rather than core gender identities
- Nature, nurture, and culture all strong threads


THE GENDER CREATIVE CHILD
EHRENSAFT
"Should be required reading for all therapists, pediatricians, and K–12 educators and for parents whose children express their gender differently."
—Genny Beemyn, PhD, coauthor of The Lives of Transgender People
THE GENDER CREATIVE CHILD
Pathways for Nurturing and Supporting Children Who Live Outside Gender Boxes
DIANE EHRENSAFT, PhD
Author of Gender Born, Gender Made and director of mental health at the University of California–San Francisco Child and Adolescent Gender Center
FOREWORD BY NORMAN SPACK, MD, director, Gender Management Service, Boston Children's Hospital, and associate professor, Harvard Medical School

FRUIT SALADS

- Tapestry of self which is neither male nor female but own creative understanding of gender, both in identities and expressions
- These youth resist gender boxes
- Often live in gender middle grounds, where no either/or but instead all and any
- = our non-binary, agender, pangender, gender fluid, gender queer youth
- Recently, culture thread of gender web shown to be strong: youth influenced by new notion of gender infinity

FROM ORANGES→ FRUIT SALADS→ APPLES

A NEW TRAJECTORY EMERGING IN ADOLESCENT EXPLORATIONS IN PSYCHOTHERAPY

Yet another trajectory

- From gay (proto-transgender) →
- transgender→
- Gender queer/non-binary

THE MENTAL HEALTH PROVIDER IN THE GENDER AFFIRMATIVE MODEL

A TRANSLATOR A MIRROR AN EAR

THERAPY ROAD MAP: UNCOVERING THE TRUE GENDER SELF, FALSE GENDER SELF,& GENDER CREATIVITY

- **True Gender Self**: One's authentic internal gender identity and expressions
- **False Gender Self**: One's gender presentation developed to protect the true gender self or to comply with the social environment's expectations, rules or guidelines about gender
- **Gender Creativity**: The weaving together of a unique and authentic gender self based on core feelings and chosen gender expressions

BACK TO THE CHALLENGE: FINDING THE YOUTH IN TRANSLATION

- If you listen, they will tell you who they are.
- But how do we know what they are saying?

TRANSLATION POSSIBLE WHEN…

- We pay attention not to just what youth say, but what they do—or not do
- We learn to suspend ourselves in a state of not knowing and stay there
- We are not in a hurry, yet ready to move fast if we recognize an urgency
- We clear our ears of our own gender wax so we can hear what youth are telling us rather than what we want them to say (countertransference)

TRANSLATION TOOLS
(with psychoanalysis as our friend)

- Listening
- Mirroring*
- Play
- Interpretation
- Suspension in state of not knowing
- Monitoring personal experiences that may distort your gender vision (countertransference)
- Cultural sensitivity
- Collaborative work with parents, family, community

MIRRORING = THERAPEUTIC KINGPIN

- Best thing any provider can do is fashion yourself as a full-length intersubjective mirror:
  - No child wants to look in the mirror and discover they are invisible
  - No child wants to look in the mirror and discover a distorted image
  - Greatest gift you can give a transgender/gender expansive child or youth: actively reflect back to them an authentic and positive image of who they are—through words, actions, feelings, ability to translate, willingness to provide treatment

CLINICAL CHALLENGE: WHAT IF IT'S GENDER AND SOMETHING ELSE?

- Gender as a solution to another life problem
- Gender as a symptom of an underlying disorder
- Gender as a signal of disordered parenting or socialization
- Gender *and* a separate psychological issue
- Gender as an obsessive phase of an autism spectrum disorder
- Goal remains the same: get youth's authentic gender in focus

Double helix rainbow kids

YOUTH WHO FALL ON BOTH SPECTRA:

GENDER

AUTISM

DATA ON DOUBLE HELIX RAINBOW KIDS

- Studies are showing significant co-occurrence of autism and gender dysphoria

- Findings from clinical study of children and adolescents Gender Identity Clinic of the VU University Medical Centre in Amsterdam:
  1. Incidence of ASD in this sample was 7.8% (n = 16)
  2. = 10x higher than prevalence of 0.6–1% of ASD in general population in Netherlands

  (de Vries et al., J Autism Dev Disord 40:930–936 2010)

- **Subsequent studies have found a clinical diagnosis of ASD occurring in 6.3%-13.3% of gender-referred youth across clinics.**

NOTE TO SELF ABOUT DOUBLE HELIX RAINBOW KIDS

- GENDER EXPLORATIONS MAY NOT SHOW UP UNTIL PUBERTY WHEN BODY CHANGES ALERT YOUTH TO GENDER
- YOUTH MAY EXPERIENCE GENDER AND THEIR GENDER SELVES FROM A NEURODIVERSE PERSPECTIVE
- IT IS NOT FOR US TO IMPOSE OUR SENSIBILITIES ABOUT GENDER ON THEM, IF WE HAPPEN TO BE NEUROTYPICAL
- INSTEAD, BEHOOVES US TO LEARN THEIR GENDER LANGUAGE & HONOR THEIR OWN PATHWAYS IN CONSOLIDATING AN AUTHENTIC GENDER SELF

MYTH ABOUT GENDER SPECIALISTS

- We rubber stamp whatever a youth tells us about their gender.*

*Some think it's our political agenda to make youth transgender (fake news)

REALITY: WE ARE NEITHER RUBBER STAMPERS NOR PUSHERS WE ARE FACILITATORS

- WE LISTEN WITH AN EAR TO FINDING OUT WHAT A YOUTH'S GENDER IS AND THEN PROVIDE THEM ALL THE NUTRIENTS THEY NEED TO LIVE AUTHENTICALLY IN THAT GENDER
- IT COULD TAKE A DAY; IT COULD TAKE YEARS

MONKEY WRENCH IN OPTIMAL CARE FOR TRANSGENDER AND GENDER EXPANSIVE YOUTH

MADE UP DIAGNOSIS: RAPID ONSET GENDER DYSPHORIA

BAD SCIENCE FROM WHICH ROGD GOT MUSCLE

- Littman L. Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. *PLoS ONE*. 2018; 13(8): e0202330

1. SKEWED SAMPLE
2. REPRESENTING PARENTS' REPORTS AS CHILDREN'S REALITY
3. CREATING A PSEUDO-DIAGNOSIS OF ROGD
4. ASKING PARENTS TO RATE THEIR CHILDREN ON A MENTAL HEALTH DIAGNOSTIC SCALE
5. MISREPRESENTING THE ROLES AND FUNCTIONS OF THE GENDER AFFIRMATIVE MENTAL HEALTH SPECIALIST AS RUBBER STAMPERS

INTENDED AND UNINTENDED CONSEQUENCES OF ROGD RESEARCH

- ENERGIZED COMMUNITY OF DOUBTING PARENTS AND ANTI-GENDER AFFIRMATIVE PROFESSIONALS
- THREATENED TO ROB YOUTH OF THEIR VOICES AND MESS UP THEIR GENDER WEB
- CREATED A BROOHAHA IN THE ACADEMIC COMMUNITY
- →BROWN RETRACTING LITTMAN'S ARTICLE AND PRINTING A CORRECTED VERSION

HOW TO UNDERSTAND THE RESPONSES

- PUBLIC: SGD-- SOCIAL GENDER DYSPHORIA
- PARENTS: "ROPD"--RAPID ONSET PARENT DISCOVERY
- TRANS COMMUNITY AND GENDER AFFIRMATIVE PRACTITONERS: "ROAD"--RAPID ONSET ACTIVIST DEMYSTIFICATION

DISPELLING MYTHS ABOUT ADOLESCENT GENDER CARE

- Gender affirmative practitioners are NOT rubber stampers
- Gender affirmative practitioners DO NOT have a political agenda
- Gender affirmative practitioners recognize that adolescence = time of exploration and experimentation
- SOGD is NOT a diagnosis
- Gender is not static. Moving to a new gender modality or back to an old one is simply gender evolution. Not to worry

THANK YOU

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- Durwood, L., McLaughlin, K.A., & Olson, K.R. (2017). Mental health and self-worth in socially transitioned transgender youth. *Journal of the American Academy of Child and Adolescent Psychiatry*, 56:116–123. e2
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- Keo-Meier, C. & Ehrensaft, D. (2018). *The Gender Affirmative Model*. Washington, D.C. American Psychological Association Publications
- Turban, J.L. & Ehrensaft, D. (2017). Research Review: Gender identity in youth: treatment paradigms and controversies. *Journal of Child Psychology and Psychiatry*, doi:10.1111/jcpp.12833

CARING FOR TRANS/GENDER DIVERSE YOUTH IN RURAL SETTINGS

Lessons learned on the frontier of New Mexico

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No disclosures

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OBJECTIVES

- What does rural look like?
- What are challenges specific to rural settings for transgender youth?
- What are strengths specific to rural settings for transgender youth?
- From clinical to systems-based, what are some creative ways to mitigate challenges and bolster strengths?
- What are some ethical conundrums found in rural mental health care?

WHAT IS RURAL/UNDERSERVED?

- Whatever is not urban (based on population density and development “footprint”)
- Over 97% of US territory is considered rural
- 20% of the US population lives in rural settings
- Vast differences based on
  - Geographic region
  - Culture
  - Economics
  - Legal protections
- Undeserved area versus
- Underserved population

FUNDAMENTAL RURAL BARRIERS

- Roads, physical distance, limited infrastructure
- Poverty, lack of jobs, lack of insurance coverage
- Lack of internet access, cell phone reception/service
- Low number of providers
- Higher age of provider - retirement, up-to-date practices
- High turnover of providers and staff
  - “The loss of the champion”
- Slow diffusion of best practices
- Funding streams specific to counties/populations
- Language barriers

Douthit N, Kiv S, Dwolatzky T, Biswas S. (2015). Exposing some important barriers to health care access in the rural USA.Public Health.129(6):611-20

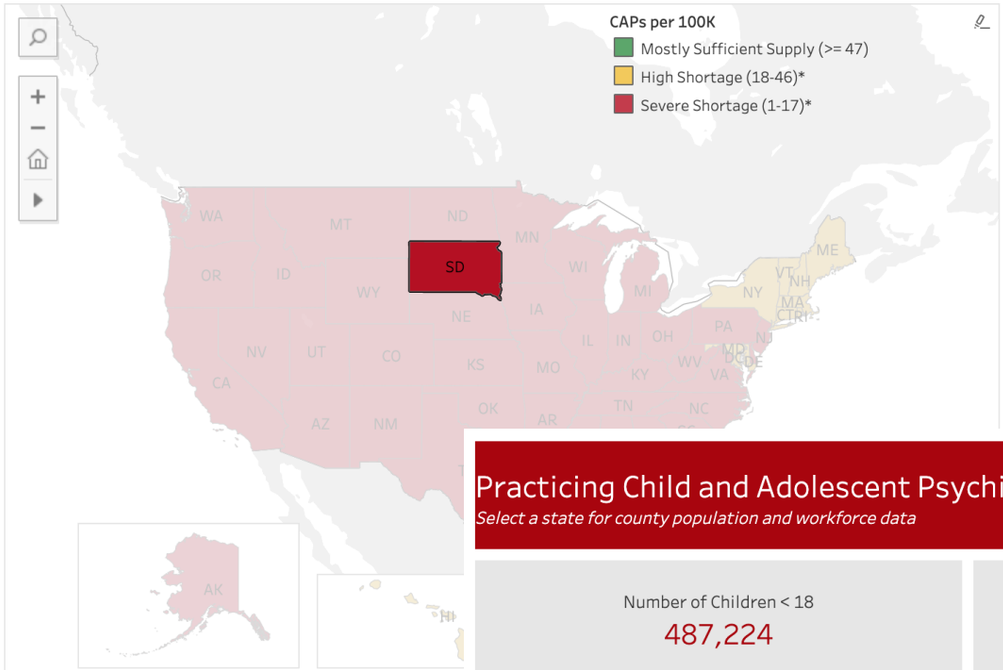
Practicing Child and Adolescent Psychiatrists

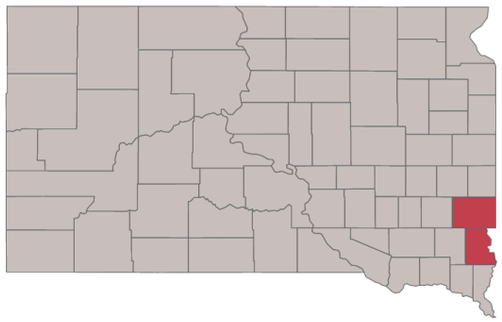
Select a state for county population and workforce data

South Dakota

** Hover for Data Source*

Number of Children < 18	Total CAPs	Number of CAPs/100K	Avg. CAP Age
212,617	3	1	49





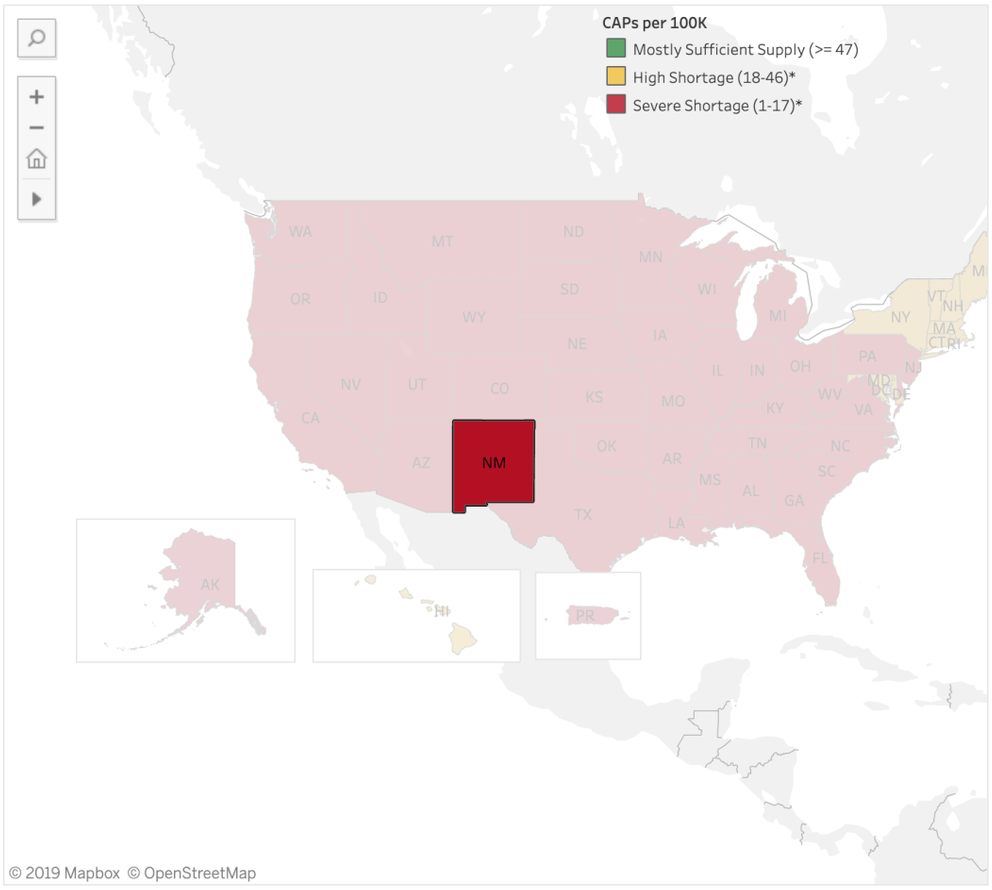
Practicing Child and Adolescent Psychiatrists

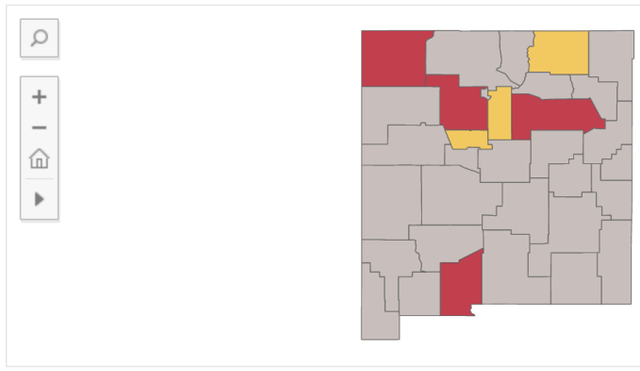
Select a state for county population and workforce data

New Mexico

** Hover for Data Source*

Number of Children < 18	Total CAPs	Number of CAPs/100K	Avg. CAP Age
487,224	68	14	55





CAPs per 100K

High Shortage (18-46)*
Severe Shortage (1-17)*
No CAPs

County	Pop. < 18	Number of CAPs
Bernalillo County	154,701	48
Catron County	556	0
Chaves County	17,783	0
Cibola County	6,666	0
Colfax County	2,386	1
Curry County	13,601	0
De Baca County	227	0

RURAL IMPACTS ON HEALTH

- Increased infant mortality
- Increased at-risk health behaviors
- Increased injury, accidents
- Increased suicide rates (men, children)
- Higher rates of obesity, diabetes, heart disease
- Decreased rate of preventative services
- Decreased health literacy
- Decreased trust of healthcare providers

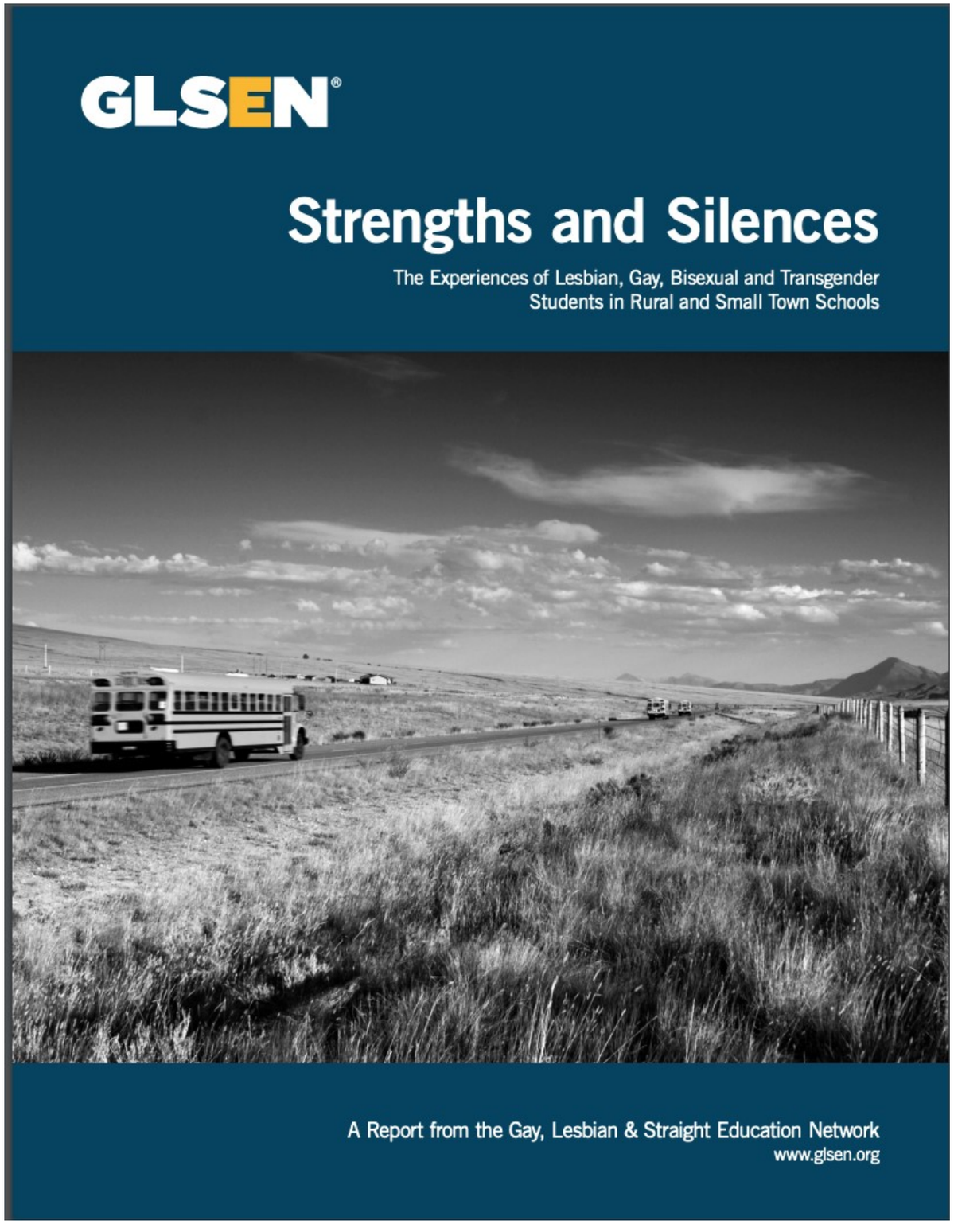
DOES SIZE MATTER?

- Size
  - Physical number of resources = less options
  - Less people = less supports
  - Privacy
  - Infrastructure, jobs, economics
- Climate
  - Local laws/protections
  - Culture of local businesses, places of worship
  - Medical and mental health care culture - what if the only gig in town is a religious organization with trans exclusions?
  - Visibility and community
  - Proximity to urban area

THE GREAT INTERSECTION

- Transgender youth are already underserved
  - Survey of small group of TGD youth/guardians in **Seattle**
    - **Lack of providers who know what they are doing**
    - Inconsistent protocols followed
    - Uncoordinated care
      - Delays in starting puberty blockers/hormones
      - Insurance exclusions
- Trans youth social and health disparities
- Higher rates of depression, anxiety, trauma, substance use
- More intersectional identities - more experiences of social/health disparities

Gridley, SJ., et. al. (2016)Youth and caregiver perspectives on barriers to gender-affirming health care for transgender youth. J Adolesc Health. 59(3):254-261.



RURAL = RISK

- Higher rates of
  - Feeling unsafe
  - Bullying/harassment
  - Missed school days
- Less
  - Staff support from school
  - Supportive peers
  - LGBTQ student resources
  - School harassment policies

Palmer, N. A., Kosciw, J. G., & Bartkiewicz, M. J. (2012).

Strengths and Silences: The Experiences of Lesbian, Gay, Bisexual and Transgender Students in Rural and Small Town Schools. New York: GLSEN

INDIVIDUAL RURAL YOUTH CONCERNS

- Privacy and impacts on family system
- Poverty and lack of insurance
- Limited resources (community centers, support groups)
- Regional culture
- Lack of access to media/internet
- Distance and poor infrastructure
- Lack of visible LGBT-specific communities/Lower number of visible or out peers/adults; lack of mentorship
- Loss of school, home and community without alternative options
- Trauma history with no long-term providers
- Gatekeeping practices that limit care to “specialists”

Knutson, D., Martyr, M.A., Mitchell, T.A., Arthur, T., Koch, J.M. 2018. Recommendations from transgender healthcare consumers in rural areas. Transgender Health. 3(1): 109-

ALL THE POSSIBLE INTERVENTIONS

- Individual
- Family of origin or choice support**
- Child protective services, legal system
- Healthcare system
  - Care delivery system
  - Care coverage
  - Education of workforce
- Education system**

CLINICAL ISSUES IN PRACTICE

- Pros/Cons of “specialty” gender practice in rural care
  - Deferred responsibility of other providers onto you
  - Promotion of stigma and marginalization
  - Risk missing other mental health needs of the youth
  - Trusted/known in the community
  - People will reach out for consultation/training
  - Youth feeling safer with an experienced clinician
- Confidentiality considerations
  - Where is the practice? Should you practice in or out of the community?
  - Are you known in the community for working only with TGD people?
  - Do staff/employees know each other or related to patients - clear confidentiality guidelines in your practice

CLINICAL ISSUES IN PRACTICE

- Transportation
  - Flexible hour and/or creation of drop-in day to keep appointments flexible
  - Phone sessions? Video sessions? Guardians via phone?
  - Peers/families supporting each other for transportation
  - Medical transport
  - Make visits count
- Length of care/sustainability
  - How long do you plan on serving this community?
  - The longer you stay, the more people you know, the more networks you make, the more resources flow and connect
  - If you're planning on leaving, what's the plan?

CLINICAL ISSUES IN PRACTICE

- Coordinating care
  - Helps all clinicians stay on the same page
  - Helps maintain consistency in care protocols followed for each youth
- BEST
  - Working within primary care, pediatricians office
  - PCMH model
- Care within the same system
- Care in different systems
- Benefits of rural
  - Most people know you and have your number
  - Quick interpersonal communications, care coordination and consultations
  - Easy networking to find resources
- Meeting the care community
  - Show up
  - Listen
  - Engage, then listen some more

CLINICAL ISSUES IN PRACTICE

- Burnout
  - No one person can do it all
  - Narcissism and sainthood and the pitfalls of both
  - Don’t assume it’s all on you - don’t make clinical moves as a hero without thinking through it first (is it in the best interest of you or the patient?)
  - What’s on you? What’s unmovable? What can be mitigated? What cannot?
  - Delegate! Find your allies in other systems beyond your own
  - Don’t duplicate services
  - Before acting, always ask - how will this be sustainable?
  - Try to not work alone - try to at least have case management, if not individual/family therapists
  - Case management
  - Case management
  - Case management

MENTAL HEALTH ASSESSMENT IN RURAL SETTINGS

- Not enough clinicians to do them
- MH clinicians disagree about the nature of the assessment
  - We have a MH collaborative to talk it out
  - The majority of the assessment is about what possible risks in the rural setting the youth may face and how to mitigate those
  - Other major issue in assessment is guardian approval/consent
- Many youth stared on hormone therapy without assessment
- **Clinical intakes done by BH - serves as the "assessment"**
  - **Triage for MH care as clinical indicated**
  - **Slow things down as clinically indicated**
- General protocol seen in New Mexico
  - Seen by pediatrician, endocrinologist, family practice
  - Screened for mental health
  - Referred as clinically indicated
    - Sometimes care held due to concerns
    - Sometimes care moved forward while also pending MH
- If something goes awry, don't panic, just start where the youth is at

ETHICAL ISSUES IN PRACTICE

- Should you connect youth you know to each other?
- Multiple roles/relationships (research story)
- Supporting transition even when it leads to bad social outcomes, worsening mental health issues
- Should you prescribe blockers, hormones?
- Harm reduction
- Being a member of the community
- Not being a member of the community
- Hearing about patients in other contexts (story)
- Boundaries (story of invite to Pueblo)
- Fertility services and lack thereof

INDIVIDUAL CLINICAL CONCERNS

- Coming out/confidentiality
  - During social or physical transition
  - During dating or sexual activity
  - In different settings or contexts - home, school, etc
  - Coming out about sexuality as well!
- Rural specific
  - Limited pool of social supports
  - Most people familiar with each other
  - Risk of being outed by dating/sexual partner
  - Limited options for alternatives in housing, places of worship, education
  - Guardians and siblings impacted a great deal as well
  - Family members, friends working in the the youth's healthcare, education, legal system
  - Youth living as "stealth"

WAYS TO DEAL

- Plan before hand if possible
  - What are the youth's goals? Stealth? Out to some? Out to all?
  - When, to whom, how?
  - Try to find one youth ally in each environment; what are some alternative social pools?
  - Identify strengths/supports and areas that need to be bolstered
  - Rely on any "cultural" ally you can find to help breech religious or other cultural barriers
  - Review confidentiality policies at local school, healthcare system with the youth
- Address sibling and guardian concerns
  - Sibling's impact at school, at home?
  - Guardians' impact at employment, place of worship, with extended family
  - Have family sessions to problem solve
  - Allies in the workforce, unanticipated religious allies
- Dating
  - What dating pool will the youth access and what risks do each incur? (apps? online?)
  - Plan before hand if possible
  - Addressing sexual violence in small communities

INDIVIDUAL CLINICAL CONCERNS

- Risk assessment
  - Immediate safety concerns, exposure to violence, sex trafficking
  - Use of street-purchased hormones, sharing injections needles
  - Substance use
  - Sex exchange work
  - Risk of being ousted from home, community, education system
- Strength assessment
  - Hopes, dreams, goals, aspirations
    - Motivational interviewing for health behaviors
    - Use strengths towards these goals
- Any supports in any areas (home, school, etc) - get creative
- Don’t just try to link to trans community - link to other intersectional strengths and communities (diversify options; story)
- Intersectional identities and strengths/communities associated with these
- Youth-lead solutions to perceived barriers and risks

INDIVIDUAL CLINICAL CONCERNS

- Harm reduction plans
  - Extended family supports or non-family of origin supports
  - Safe injection/needle sharing practices
  - Anticipated trauma flares and how to handle them
- Helping a youth think through the pros/cons of being an advocate or mentor in their community
  - Story: sometimes a policy win for many can hurt the individual involved
- Education options
  - Home-schooling
  - GED
  - Charter schools

BUILDING TRUST

- Low trust of medical systems, clinicians
  - Gatekeeping
  - Lack of knowledge
  - High turnover
  - Trauma history
- You don’t know what you don’t know
  - Listen - don’t assume challenges; hear out the strengths as well
  - Find the “elders” in the TGD community
  - Liaison with youth community centers to help build trust
  - If there is someone doling out hormones on the street, try to gain trust of this person and encourage into care - rest will follow
- Involve community voices in your care service
  - Youth-lead patient advisory counsels
  - Family-focussed community supports

PROVIDERS

- Not enough
  - Rely on care partners (clinical pharmacists, NPs/PAs)
  - Speciality to step-down care with open-end collaboration
  - What do to when you have one medical provider in the whole State?
  - Providers don’t advertise for fear of being overwhelmed or ostracized
  - Use of mental health trainees
- High staffing tuner over
  - Yearly required online and/or in-person cultural trainings
- Sustainability
  - Do not have a specialty service rely on one champion
  - Try not to practice without case management and/or peer support workers - clinicians cannot do it all
- Vet all referrals (urology story)

EDUCATING PROVIDERS

- LGBTQ mental health collaboratives
  - Case consultations
  - Article/research reviews
  - Expert lectures
  - Getting on the same page about care protocols
- Mentoring
  - Fenway through ECHO
  - 1:1 mentoring
  - Consultation with national gender centers
- National experts can help assuage fears
- Provide standardized form letters for prior auths, referrals
- Grand rounds, CME/CEU education talks
- Target training sites for social work, master-level clinicians, psychology and psychiatry trainees
- Share your materials

PROJECT ECHO

- Project ECHO (Extension for Community Healthcare Outcomes) – community education, mentoring, formation of long-term education and integrated teams
- Endocrine and HIV ECHO
  - Serving New Mexico clinicians for consultation on TGD youth cases
- HIV ECHO
- Fenway is using UNM's ECHO model for longitudinal training

HEALTH SYSTEM

- Maxed out systems already!
  - Think before starting services about the who/what/when/why
  - White Paper to help show structural direction of services, appropriate funding streams
- Time/staffing limitations for training
  - Send key person in each health system area for yearly training
  - Key person can dissipate up-to-date knowledge to entire team
- Mobile services
- Care collaboratives
  - All on the same page with care protocols
  - All know each other, can do quick consults

HEALTH SYSTEMS

- Insurance coverage
  - Network
  - Prior auth person can save clinicians from burnout
  - Establish a paper trail of individual cases to build case for coverages for all
  - Get insurances up-to-date on standards of care - don’t be afraid to call, call again, call again some more
    - “Domino effect”
- Funding
  - Collaborate on grant streams - don’t compete
  - Ensure what populations/geographical areas the grant covers
  - What after grand funding ends??

EDUCATION SYSTEM

- 1:1 advocacy or collaboration with individual person at a school
  - Remember: champions are good for as long as they are around
  - Find sustainable options and ensure your champion is mentoring others
  - LGBTQ adults in rural education face their own battles too (story about my error)
  - Safe Zone training
- **Health educators to run GSAs, perform HIV and Hep C, sex and health ed**
- Advocate for youth to change school districts and resources to do so, as indicated
- Intervention with individual school's policy, administration
- Advocacy or intervention with the school board or district policies
  - Districts often copy each other - find one district to set up a model policy and often the others will follow
- Find state GLSEN chapter to help review and or support State-based student protections
- Work with national-based organizations to help promote State-based policy changes for TGD students
  - Title IX can help support systems to change

TGD YOUTH EMPOW

- Transgender Resource Center of New Mexico
  - Family and youth support groups, education
  - Needle exchange
  - Safe lockers to store goods during the daytime
  - Links to clinicians in the area
  - Rapid HIV, hep C testing
  - Coordination of care with Truman, DOH
  - Limited on-site medical services
  - On-site therapy services
- Teen NMPower
  - Youth support group
  - HIV prevention for LGBTQ youth
  - Lavender Prom
- Santa Fe Mountain Center
  - Intersectional identity empowerment for Native Youth
  - Day camp for transgender youth
  - Harm reduction
  - Training for MH providers
- Community based participatory research
- Peer support workers

TAKE AWAY POINTS

- Be part of the community - doesn’t have to be LGBTQ-related, but you need to know your community, key players, systemic-issues with infrastructure and medical delivery
- Sometimes, it is who you know
- Listen
- See what’s already being done - can you augment, support, change, grow, add?
- Change can happen in small or big ways - any effort for change is enough
- Don’t work alone, in spirit or clinical practice
- Think before acting and consider sustainability in all you do
- Empower youth by including them in the questions and answers
- Rely on a youth’s and rural area’s intersectional cultural strengths

QUESTIONS?

Working with Families of Transgender/Gender Expansive Youth

Shawn V. Giammattei, PhD
American Society for Adolescent Psychiatry
San Francisco, CA
May 17th, 2019

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No Disclosures

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American Family Therapy Academy,
Association of Family Therapists of NCA,
World Professional Association for Transgender Health
Mind the Gap – CAGC – UCSF Beniof

Objectives

- *The importance of families in this work*
- *The experiences of family members are and what might they need from us*
- *The potential intersections of identity and diverse contexts that may impact these families*
- *How bias and stigma create disparities and lead to risks for these families*
- *Initial management strategies for gender affirming care with families*
- *Facilitating decision making processes around medical interventions*
- *Tactics that build resilience*

Common Roles I Find Myself In

How I situate myself with families

- ***Collaborator in living authentically***

- ***Gender Health Evaluator / Letter Writer***
- ***Gender Educator/Advocate***
- ***Family / Individual / Couple / Group Therapist***
- ***Gender Coach***

Why Work with Families?

- *When a transgender/gender expansive (TGE) youth transitions, their family has to transition as well*
- *Family members may experience confusion, fear, anger and grief at the process and may need help navigating this*
- *Families may need to navigate real and perceived losses*
- *Reduce trauma and homelessness*
- *Build resilience*

The Importance of Family

- **Cannot be understated**
  - *Risks factors for youth increase exponentially when families are not accepting*
  - *Each move away from rejecting their teen and toward tolerance improves their well-being, health, and educational success*

(Ryan et al., 2009; Ryan et al., 2010, Travers et al, 2012, Watson et al, 2016).

The Impact of Rejecting Families

- ***Youth who grew up in highly rejecting families***
  - *consistently experienced lower self-esteem*
  - *increased mental health problems such as anxiety, depression, suicidality & self harm*
  - *were more isolated*
  - *felt more hopeless about their lives*
  - *were more likely to drop out of school*

(Ryan et al., 2009; Ryan et al., 2010, Travers et al, 2012, Watson et al, 2016).

The Impact of Rejecting Families

- **Data show that queer youth growing up in rejecting families are nearly**
  - *6 times as likely to report high levels of depression in young adulthood*
  - *8 times as likely to have attempted suicide compared to young adults who grew up in accepting families.*
  - *3 times likely to be using illegal drugs*
  - *and 3+ times as likely to be at high risk for HIV and other sexually transmitted diseases*

(Ryan et al., 2009; Ryan et al., 2010, Travers et al, 2012, Watson et al, 2016).

First Steps in Understanding Families

- ***Do not demonize or pathologize:***
  - *Parents generally want their child to be happy and healthy in who they are*
  - *they want them to be safe from harm*
  - *Most parents, even rejecting parents want what is best for their children and can come to a place of tolerance, if not acceptance.*

- ***Start where they are:***
  - *Parents need to explore their own notions of gender and how these are supposed to be performed given their culture, etc.*
  - *Validate and appreciate what they are trying to do*

- ***Regardless of where they start, families usually shift and change over time***

- ***Parents/Caregivers/Family members have a process:***
  - *Some are in denial or believe binary notions of gender are the only truth*
  - *They may experience a period of conflict*
  - *Mourning*
    - *Grieve assumptions & hopes*
  - *Embracing the child they have*
  - *Coming out to others*
  - *Advocating for their child*

Reasons Families Seek Help

- *Worried about their child's mental health*
- *Not sure what to do (or not do) in order to change or support their child's behavior/identity*
- *Confused and want help to understand their child's authentic identity*
- *Need advocacy and advice about transitioning at school or in extracurricular activities such as sports teams*
- *Looking for professional support as they move forward with actualizing their child's identity*

Family
Who Does that Include?

- Parents / Caregivers
- Siblings
- Grandparents
- Aunts, Uncles, Cousins, Extended family
- Families of choice
  - Friends
- Community Organizations
  - Schools
  - Churches & religious leaders
  - Parent organizations

Systemic Work May Involve

- *Helping caregivers and TGE youth discover/understand the child's authentic gender*
- *Plan steps for actualizing this authentic gender*
- *Work with siblings*
- *Help parents and child learn skills to deal with discrimination and bullying*

Systemic Work May Involve

- *Psychoeducation*
  - *gender identity/expression*
  - *Social, medical, and legal transitions*
- *Advocating with other institutions like schools, doctors, communities.*
- *Helping families navigate disclosure and dealing with school records*
- *Connecting families with other families*
- *Connecting children with other gender expansive children*

Early Family Reactions

- ***Even for the gender affirming families, it is common for them to wrestle with difficult feelings***
  - fear for the TGE child's safety,
  - disappointment
  - anxiety
  - embarrassment
  - blame
  - confusion
  - anger
  - concern
  - denial
  - self-blame
  - shame

Grief and Loss

When transitioning becomes a reality

- *Direct loss*
  - *where they feel like they are losing their child*
- *Ambiguous loss*
  - *where the loss is indistinct and confusing*
- *Both can lead to the experience of grief*
  - *Parents/Caregivers who hold an affirming stance may feel guilt for these feelings*

TGE Youth of Color: Family/Community

- ***Communities of color are not more transphobic than white communities.***
- ***Experiences of Family Rejection***
  - *lack accurate information around gender and sexuality*
  - *may also be rooted in fear.*
  - *reflection on the larger racial minority community*
  - *or increase the family's experiences of discrimination and oppression in the world.*
  - *Acculturation conflict*
- ***transgender youth of color sometimes delay their coming out***
  - *Less likely to come out to parents than White TGE youth*

Conservative/Religious Communities

- *Often hold binary and heteronormative notions around gender & sexuality*
- *Often hold parents accountable to properly gender their child*
- *Families may lose their community if they support their child*
- *May risk loss of employment or housing*
- *May have a crisis of faith in the process of supporting their child*
- *Experience a loss of privilege*

Beginning Tasks

- *Establishing Authenticity*
- *Psychoeducation about gender identity/ sexuality, gender dysphoria, etc.*
- *Helping youth and their parents get on the same page or come to an understanding*
- *Making sure all family members are addressed in this process*
- *Evaluating readiness for social/medical treatment*
- *Planning next steps*

Usually Starts with Coming Out

- ***Parents and teens are often at very different developmental stages when a teen comes out***
  - *Children often are in a hurry to actualize their authentic selves*
    - *Many have been living with the discrepancy for years and have done extensive research*
  - *Parents may be completely blindsided by the news and want to slow things down*
    - *The news may seem like it came out of nowhere and they fear it is due to peer pressure and a permissive society*

Initial Parent/Caregiver Consult

- ***Explore why they have sought your services and their goals in working with you***
  - *This will tell you quite a bit about how they feel about their child's gender identity and expression*
  - *Will also let you know the role they expect you to take*
- ***Interview parents for child's history of gender expansive behavior***
  - *evaluate parents' comfort with gender non-conformity*
  - *It is very important to understand and validate parent/caregiver's stance, even if you disagree.*

Parent Support & Attunement

- *Be very careful not to alienate parents, as they may discontinue the therapy*
- *Help parents understand the things they say and do that may be hurtful to their child and encourage them not to share such thoughts and feelings directly with their child*
- *It will be difficult to help TGE youth if you are unable to establish a loving and trusting rapport with parents*
  - *It requires valuing their challenges and strengths as parents.*

(Coolhart, 2018)

Which Family Members to Include?

- ***Where are the parents/caregivers/siblings on this journey?***
  - *Separate sessions with parents followed by sessions with the youth alone are necessary if the parents' emotions are intense and potentially harmful to the child*
  - *If the child needs support to share honestly with their parents, it also would be good to see them separately at first to help them build skills*
  - *If there is good communication and family members are generally supportive, working with the whole family can be very helpful*

Family Togetherness: Bridging the Gap

- *Help parents listen to their child's gender narratives and their needs*
  - *Help keep their fears from blocking their ability to hear their child*
- *Help adolescents share what they need with their parents.*
- *Explore the pros and cons of all the options together*
- *Come up with solutions and next steps*

Special Considerations with Parents

- *Parents may want to jump to a solution too fast*
  - *It is very difficult to sit with ambiguity*
  - *It makes things feel unsafe and confusing*
  - *Flight into health*
- *Be mindful of splits between parents or a parent who is turmoil about this.*
- *Special considerations with divorced families*
  - *Gender expression can become a custody battle*
  - *Parent who insists child remain gender normative may often retain custody.*

Considering Transitions

- ***Tasks to navigate***
  - *Creating a gender team*
  - *Navigating Schools, teachers, neighbors, other parents, bullies*
  - *Safety and protecting child*
  - *Coming out - extended family, coworkers, & friends*
  - *Decision making around medical interventions*

Decision Making Around Gender Affirming Medical Interventions

- *Common themes around hormones and blockers*
- *Issues around surgeries*
- *Fertility discussions*
- *There are no neutral options*
- *Navigating insurance companies and gatekeepers*

Other Difficult Topics

- *Lots of confusion about youth not engaging in "normal" activities*
- *Unrealistic expectations*
- *Difficulty knowing where to set limits because of fear of self harm or suicidality*
- *Sexuality & Dating*
- *College and launching*

Resilience Building: Community Support

- *Parent support groups*
  - *In person*
  - *online*
- *Multi-family groups*
- *Advocacy groups*
- *Participation in community events*
- *Educating spiritual leaders and places of worship to support families of TGE youth*

Building Resilience

- ***Recognizing that it takes courage to announce to the world that you, your child, or your sibling is transgender or gender expansive***

- ***Resilience is enhanced as the child and family acquire a sense of pride in their identity***
  - *For trans youth of color, this includes developing pride in each aspect of their identity— both race and gender*
  - *When one's identity is strengthened and becomes more salient, anxiety symptoms decrease*
  - *For parents it is moving beyond tolerance and acceptance to a place where they see the value and positive impact of having a TGE child and the TGE child experiences love and nurturing because of who they are.*

(Budge, Adelson, & Howard, 2013; Bouris et al., 2010; Liu & Mustanski, 2012; Needham & Austin, 2010; Mustanski, Newcomb, & Garofalo, 2011; Ryan et al., 2010; Simons et al., 2013; Singh & McKleroy, 2011; Woodford, Paceley, Kulick, and Hong, 2015)

Building Resilience

- ***Social support is a strong facilitator of resilience among transgender adolescents and their families***
  - *supportive and accepting friends*
  - *access to trans-friendly groups and activities,*
  - *When transgender youth come out, surrounded by love and acceptance, stressors and concomitant risk factors generally diminish.*

- ***Growing up in accepting families reduces risk factors and increases physical and emotional well-being***

(Budge, Adelson, & Howard, 2013; Bouris et al., 2010; Liu & Mustanski, 2012; Needham & Austin, 2010; Mustanski, Newcomb, & Garofalo, 2011; Ryan et al., 2010; Simons et al., 2013; Singh & McKleroy, 2011; Woodford, Paceley, Kulick, and Hong, 2015)

Questions?

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MEDICAL INTERVENTIONS FOR TRANSGENDER YOUTH

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DISCLOSURE

- I have been a consultant to Endo Pharmaceuticals, Inc.
- All Rx to be discussed: "Off-label" for Gender Dysphoric Youth

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OBJECTIVES:

- Review epidemiology of transgender adolescents
- Review current treatment models: Outcomes and potential adverse effects
- Understand gaps in knowledge, barriers to care, priorities for research

Percent of Individuals Who Identify as Transgender by Age in U.S.

Age Group (yr)	%
13-17	0.7* (1/140)
18-24	0.7**
25-64	0.6**
≥ 65	0.5**

* 150,000 youth (13-17 yr)

** 1.4 million adults (≥ 18 yr)

State-level, population based surveys/ CDC surveys, The Williams Institute, UCLA School of Law, 2017

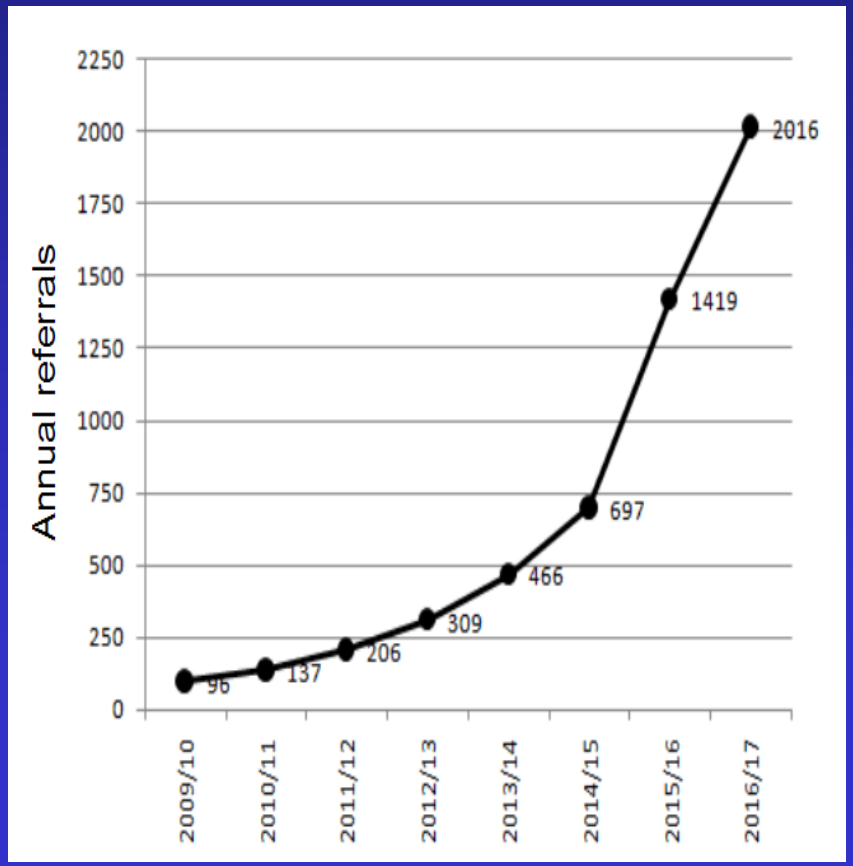
Prevalence of Transgender and Gender Nonconforming (GNC) Youth: A Population-Based Study

- Minnesota Student Survey (2016)
- N = 80,929
  - Students in 9th, 11th grades
  - Self-reported Gender Identity
  - Transgender and GNC
    - N = 2,168 (2.7%)

Rider GN et al. Pediatrics, 2018

TSUNAMI OF NEW REFERRALS TO GENDER CLINICS ACROSS THE WORLD

- **Example: Tavistock Gender Identity Development Service (U.K.)**
  - **96 -> 2016 annual referrals from 2009-2017**



INVERSION IN SEX RATIO IN GENDER DYSPHORIC ADOLESCENTS

- Amsterdam
  - 1989-2005: Assigned M : Assigned F: 1.41 : 1
  - 2006-2013: Assigned M : Assigned F: 1 : 1.72
- Toronto
  - Before 2006: Assigned M : Assigned F: 2.11 : 1
  - 2006-2013: Assigned M : Assigned F: 1 : 1.76
- Boston (2012)
  - Assigned M : Assigned F 1 : 1.26
- Los Angeles (2015)
  - Assigned M : Assigned F 1 : 1.06
- Indianapolis (2016)
  - Assigned M : Assigned F 1 : 1.38

Aitken M et al. J Sex Med, 2015
Spack N et al. Pediatrics, 2012
Olson J et al. J Adolesc Health, 2015
Chen M et al. J Adolesc Health, 2016

QUESTIONS:

- What is the natural history of transgender/ Gender dysphoria in children & adolescents?
- How should such patients be managed?

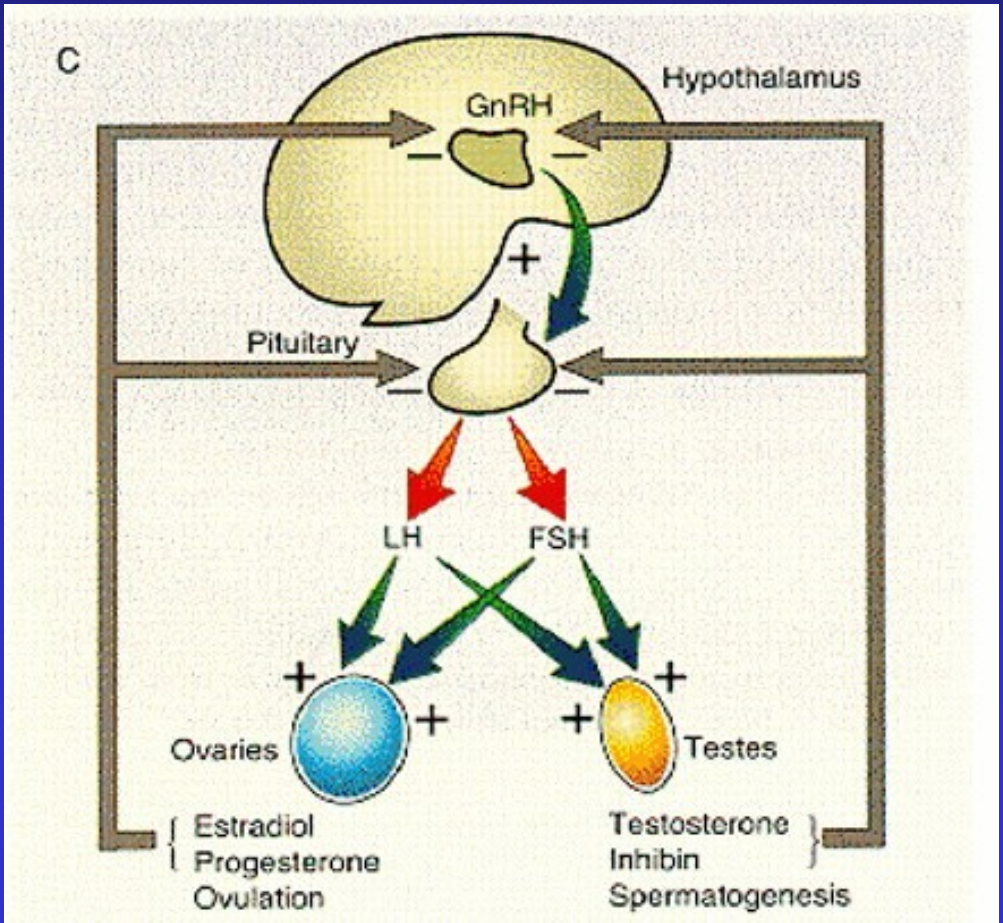
Children & Adolescents with GD: Natural History

- Gender Dysphoria persisting into early puberty:
  - Likely transgender as adult!

Management of Adolescents with GD Historical Perspectives:

- Amsterdam VU University Med Ctr
- Pubertal suppression with GnRH agonists (GnRHa)
  - Tanner 2
  - Gender dysphoria from early childhood
  - ↑ Gender dysphoria with pubertal onset

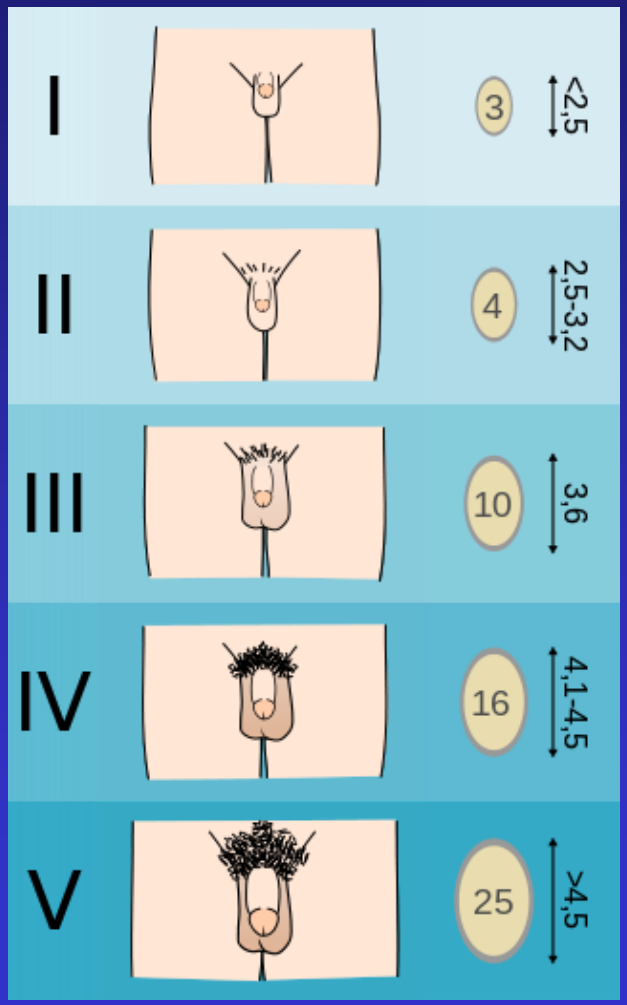
Puberty: Reactivation of Hypothalamic-Pituitary-Gonadal Axis

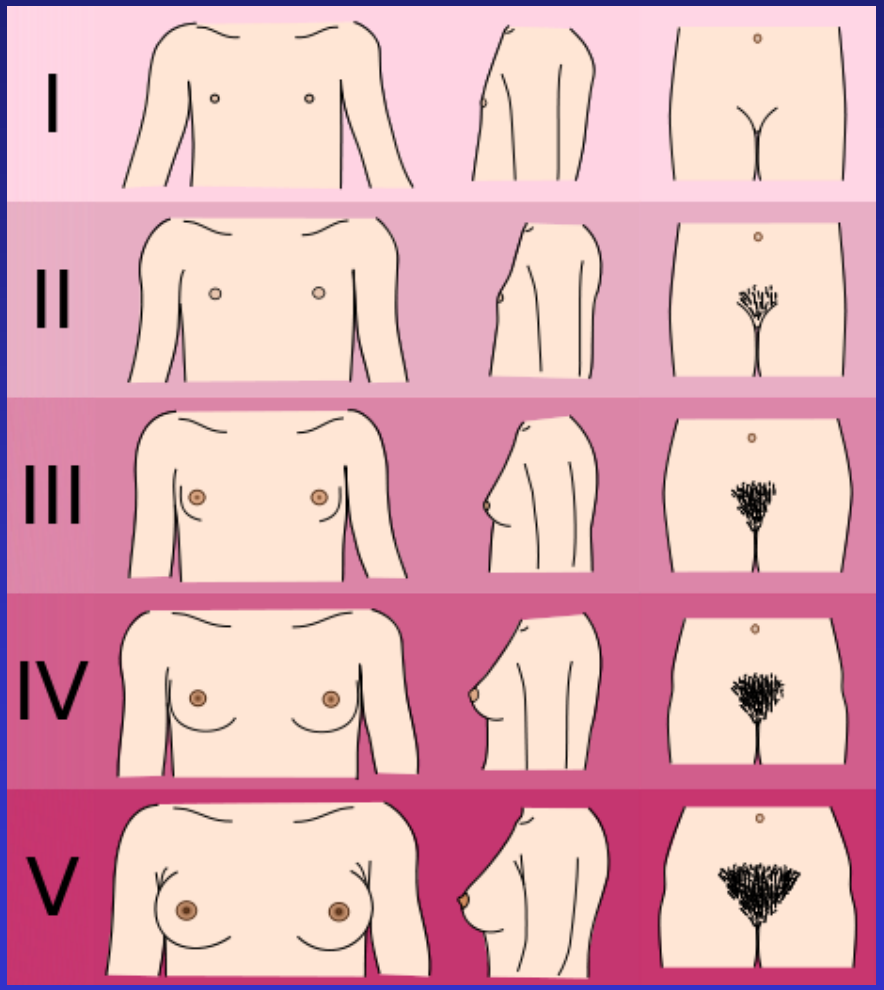


Adrenarche

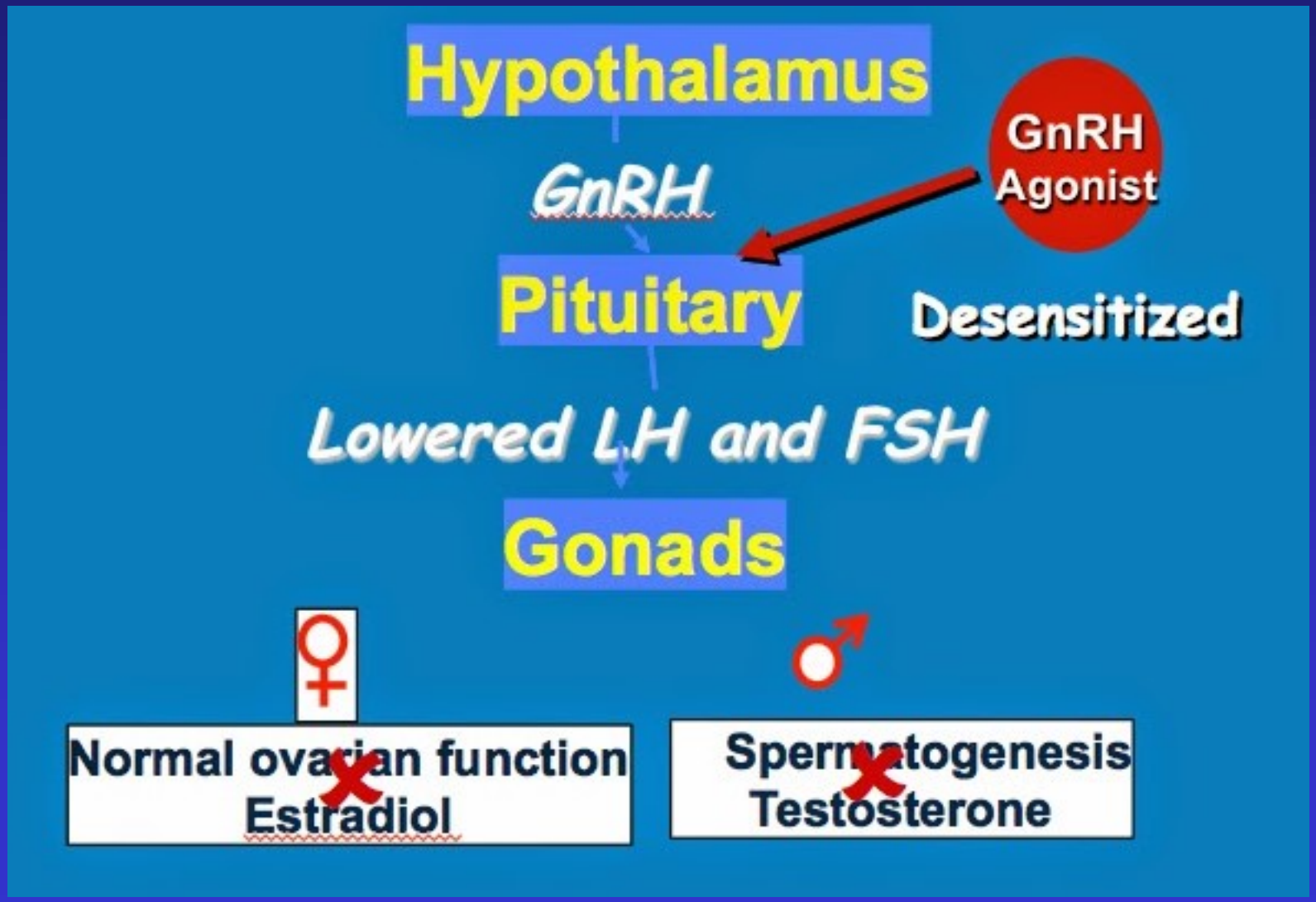
- **Independent of puberty, but temporally related**
  - Represents poorly understood maturation of adrenal cortex zona reticularis
  - Enhanced secretion of DHEA, DHEA(S), at 5-6 yr of age
  - Clinical manifestations approximately 1-2 yr later: pubic hair, axillary odor / hair

Sexual Maturity Rating: Tanner Staging





GnRH agonists: Mechanism of Action



GnRH Agonists in Gender Dysphoric Youth: Expected Benefits

- "Buys time"
- Prevents experiencing puberty of undesired sex
- Fully reversible

- Once puberty completed, can only be incompletely reversed-- Difficult to "blend"
  - MTF: Low voice, Adam's apple, masculine facial features
  - FTM: Breast development

GnRH Agonists

- **Histrelin Acetate SC Implant**
  - **Supprelin LA 50 mg SC**
  - **Duration: 1-2 years**

- **Leuprolide Acetate IM Injections**
  - **1-month**
  - **3-month**
  - **6-month**

"Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline"

Prior Pediatric/ Adolescent Recommendations:

- Dx GD made by mental health professional
- Medical providers ensure patients understand consequences of hormone suppression & cross-sex hormone Rx prior to Rx
- Suppression of pubertal hormones with GnRH agonist only after early puberty has been reached
- Initiate cross-sex hormone Rx at "about" age of 16 yr
- Defer surgery until at least 18 yr of age

Hembree WC et al. J Clin Endocrinol Metab 94:3132-3154, 2009

"Dutch protocol": 6 yr Follow-Up

- N= 55 (22 MTF, 33 FTM)
- Protocol
  - Puberty blockers (Avg. 14.8 yr at start of Rx)
  - Cross Sex Hormones (CSH) (Avg. 16.7 yr at start of Rx)
  - "Gender Reassignment Surgery" (Avg. age 20.7 yr)
- Mental Health Outcomes
  - 1 yr pre-blockers, T 0 for CSH, 1 yr post-surgery
  - Results
    - Gender Dysphoria: Resolved
    - Psychological functioning: Generally improved
    - "Well being" $\geq$ vs. same age young adults from general population
    - No patients reported regret at any phase of protocol

De Vries ALC et al. Pediatrics, 2014

GnRH Agonists in Gender Dysphoric Youth: Potential Adverse Effects

- Bone mass, growth
- Brain
- Fertility
- Other

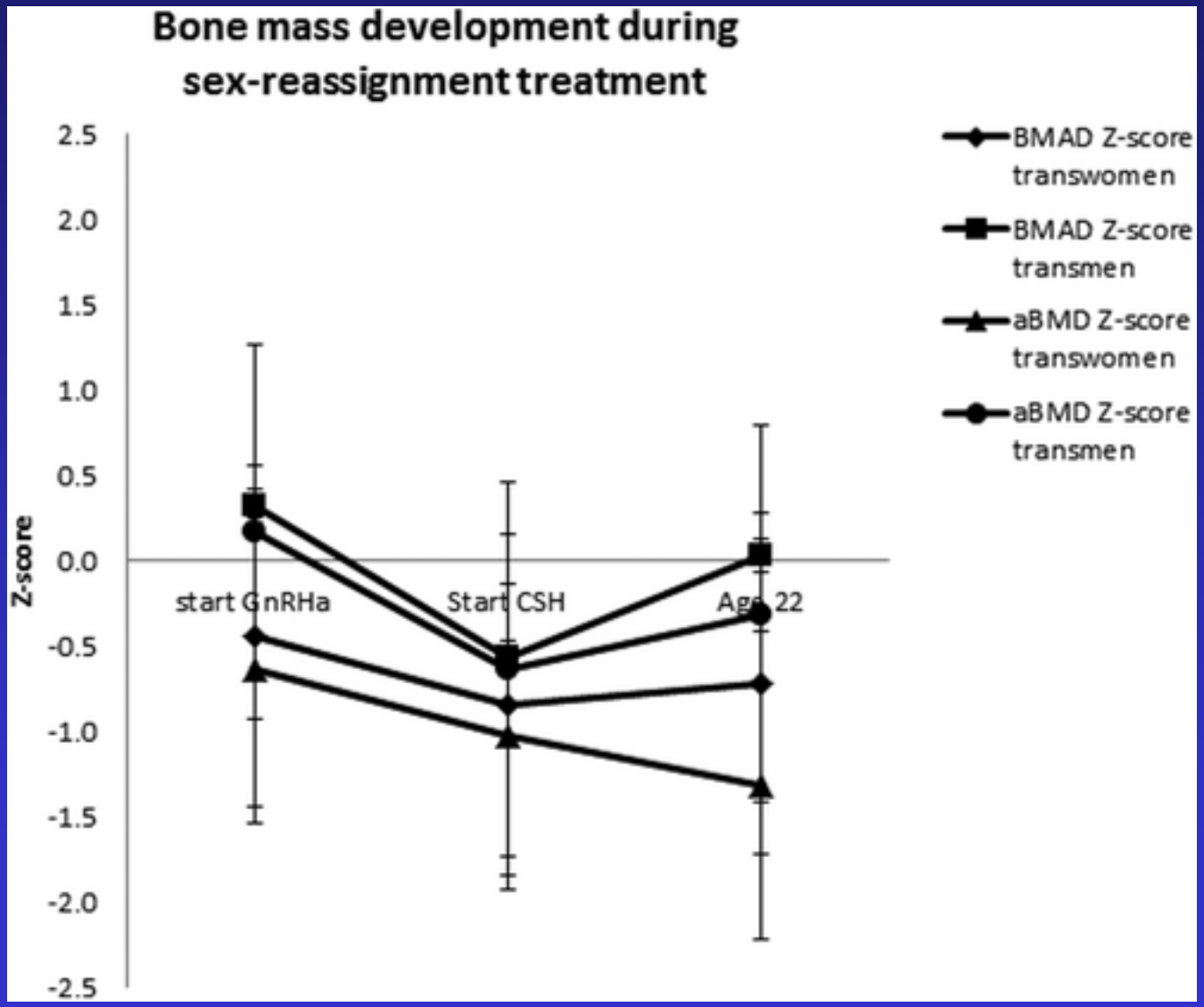
Bone and Puberty

- Peak bone mass achieved during puberty and young adulthood

- Pubertal suppression/ prolonged hypogonadism:

  Risk for ↓ BMD

"Dutch Protocol": 6 yr Follow-Up Bone Mineral Density: Lumbar Spine



Klink D et al. JCEM, 2015

"Dutch Protocol": Bone Mineral Density: 6 yr Follow-Up

- **Potential study limitations:**
  - Relatively small "N" (34: 15 MTF, 19 FTM)
  - ? Relatively low hormone dosage during initial CSH Rx
  - No data on other factors influencing bone mass
    - —Dietary calcium intake
    - —Vitamin D levels
    - —Weight-bearing exercise

Klink D et al. JCEM, 2015

Bone Mineral Density (BMD) in FTM Transsexual Adolescent Rx'd with GnRH agonist & Cross-Sex Steroids: 22-Yr Follw-Up

- Began GnRH agonist at 13.7 yr (Tanner 3)
  - —Triptorelin 3.75 mg IM q 4 wk
- Began Testosterone at 18.6 yr
  - —100 mg IM q 2 wk x 6 mo
  - —250 mg IM q 2-3 wk
- Stopped GnRH agonist at 18.6 yr
- BMD: DEXA (Lumbar Spine, Femoral Neck, Total Body) at age 35 yr
  - —Within normal range for both sexes

Cohen-Kettenis PT et al. Arch Sex Behav, 2011

GnRH Agonists & Brain Effects in Gender Dysphoric Youth

- Does GnRHa effect "Executive Functioning"?
  - —Working memory
  - —Reasoning
  - —Problem solving
  - —Planning and execution
  - Pre-frontal activation
  - Significant development during puberty
- Study
  - MTF (N = 18): Rx'd (8), 1.6 +/- 1 (SD) yr
  - FTM (N = 22): Rx'd (12), 1.6 +/- 1 (SD) yr
- Results
  - No detrimental effect on Executive functioning

Staphorsius AS et al. Psychoneuroendocrinology 56:190—199, 2015

GnRHa: Effect on White Matter Microstructure & Global IQ in MTF Adolescent: Case Report

- **MRI**
  - Diffusion Tensor Imaging
  - Fractional Anisotropy (FA)
    - » White Matter Microstructure axonal organization
- **Global IQ**
- **FA:** ↑ in select areas (sup frontal gyrus; pre-central gyrus) in male Puberty
- **Study:** MTF: Tanner 2; GnRHa (leuprolide) x 28 mo.
- **Results:**
  - FA: ←→ vs. expected ↑ in male puberty
  - Global IQ: Slight ↓ (9 pts) in "Operational Memory"

Schneider MA et al. Frontiers in Human Neuroscience, 2017

FERTILITY PRESERVATION

- Transgender/ Gender Diverse individuals
  - —Preservation of fertility:
    - » Desired option!
- Importance of counseling all transgender/ gender diverse people on implications for fertility before any hormonal interventions
  - —Pubertal blockers
  - —Gender-affirming ("cross-sex" hormones)

GnRH Agonists & Fertility in Gender Dysphoric Youth

- Blocking puberty at Tanner 2
  - Compromised oocyte maturation
  - Compromised spermatogenesis
- Parental dilemmas
- Preservation of fertility: limited options
  - Ovarian or testicular tissue cryopreservation; stem cell work

FERTILITY PRESERVATION

- **Options for Late Pubertal/ Post-Pubertal persons**
  - —Sperm banking or testicular tissue cryopreservation
  - —Oocyte (ovarian stimulation), embryo or ovarian tissue cryopreservation

    (eggs: "flash frozen" (vitrification)

  Similar to options for adults undergoing gonado-toxic cancer therapies or who elect fertility for other reasons
- **Optimal: Before starting gender affirming hormonal Rx!**

FERTILITY PRESERVATION

- **Study of Transmen who experienced pregnanacy**
  - Cross-sectional, on-line survey
  - N = 41
    - Average age of conception: 28
    - Use of T before pregnancy
      - N = 25 (61%)
        - N = 6 (24%) had unplanned pregnancy
        - 80% resumed menses within 6 months of stopping T
        - 72% conceived within 6 months of stopping T (N = 5 while still amenorrheic)

Light AD et al. Obstet Gynecol 124:1120-1127, 2014

FERTILITY PRESERVATION

- Cost Considerations
  - Sperm banking/testing: $1,000 + annual storage fee ($275-$500)
  - Oocyte / embryo cryopreservation: $10,000 + annual storage fee
  - Egg thaw, fertilization, and embryo transfer: $5,000
  - IVF with egg donation $25,000 per cycle
  - Gestational surrogacy: $80,000-$130,000

FERTILITY PRESERVATION

- Family Building Options
  - Pregnancy
  - Adoption
  - Foster
  - Blended family

FERTILITY PRESERVATION

- Recent Studies
  - Low Fertility Preservation (FP) utilization among transgender youth
    - —Nahata, et al., 2017, *J Adolesc Health*
    - —Chen et al., 2017, *J Adoles Health*
      - » Barriers to FP:
        - » Cost
        - » Invasiveness of procedures
        - » Desire not to delay medical transition

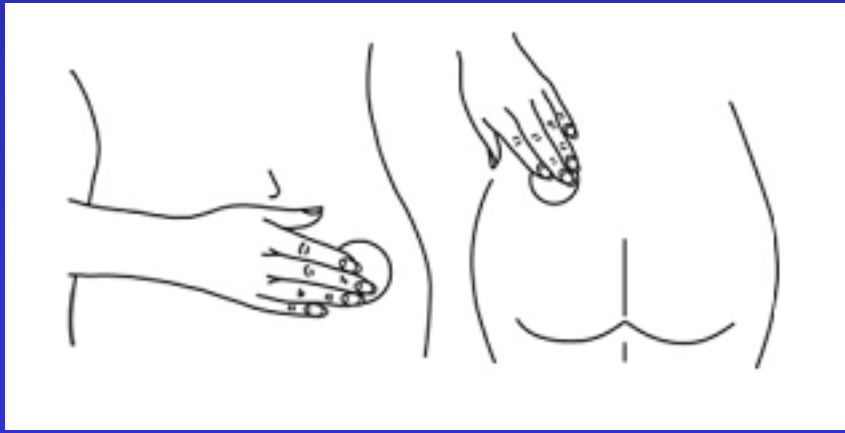
GnRH Agonists & Gender Dysphoric Youth: Other Potential Adverse Effects

- For Trans Females (AMAB)
  - Blocked at Tanner 2
    - Infantile penis and scrotum
      - » Potential concerns re adequacy of phallic/ scrotal tissue for feminizing genital surgery
        - » Creation of vulva and vagina

- **Male to Female Hormone Therapy**

Estrogen: 17 β estradiol

Transdermal



Oral or sublingual

Also: Parenteral estradiol (valerate or cypionate)

Estrogen: Expected Effects

Effect	Onset	Maximum
Breast Growth	3-6 m	2-3 y
Redistribution Body Fat	3-6 m	2-3 y
Decrease muscle mass	3-6 m	1-2 y
Skin softening/decrease oil	3-6 m	unknown
Decreased libido	1-3 m	3-6 m
Decreased spontaneous erections	1-3 m	3-6 m
Decreased testicular volume	3-6 m	2-3 y
Decreased sperm production	unknown	> 3 y
Decreased terminal hair growth	6-12 m	> 3 y
Reduced fertility	variable	unknown

Modified from Hembree WC et al. J Clin Endocrinol Metab, 2017

Estrogen: Potential Adverse Effects

- Increased risk for thromboembolic disease*
- Elevated prolactin
- Growth plate closure
- Headache

*Highest risk with supra-physiologic levels or synthetic estrogens (e.g. ethinyl estradiol)

Male to Female Hormone Rx

- In addition to Estrogen
  - Need agent to ↓ Testosterone production or action
    - GnRH agonist
    - Spironolactone (100-300 mg/d) (Monitor K+ q 3 mo, then q 1 yr)
    - Cyproterone acetate: Not avail. in US

What about Progesterone?

- Anecdotal
  - Improved
    - Breast development
    - Mood
    - Libido
- No published definitive studies

- **Female to Male Hormone Therapy**

Testosterone: Rx Options

- **Testosterone IM/ SC**
  Weekly injections
- **Androderm (patch)**
- **AndroGel**
- **Pellets**

Testosterone: Expected Effects

Effect	Onset	Maximum
Menses stop	2-6 m	N/A
Acne/ skin oiliness	1-6 m	1-2 y
Fat redistribution	1-6 m	2-5 y
Clitoral enlargement	3-6 m	1-2 y (3.5-6 cm)
Vaginal atrophy	3-6 m	1-2 y
Deepening voice/ adam's apple	6-12 m	1-2 y (irreversible)
Facial/body hair growth	6-12 m	4-5 y
Scalp hair loss	6-12 m	Irreversible
Libido changes	variable	variable
Mood changes	variable	Variable
Reduced fertility	variable	unknown

Modified from Hembree WC et al. J Clin Endocrinol Metab, 2017

Testosterone: Potential Adverse Effects*

- Polycythemia
- Dyslipidemia
- Acne
- Hypertension
- Unclear impact on fertility
- Mood lability

*Highest risk with supra-physiologic levels

Cross-Sex Hormones and Metabolic Parameters in Gender Dysphoric Adolescents

- N = 116 (72 FTM; 44 MTF)
  - Age: 13-25 yr
  - Followed > 6 mo
- Rx
  - 17 β-Estradiol: Oral, IM, TD
  - Testosterone: SC, weekly
- Results
  - Post E2: No Abnl. BMI, BP, Hb/Hct, LFTs, lipids, renal fx, prolactin,
  - Post T: ↑ Hb/Hct, BMI ↓ HDL
    No Abnl. BP, LFTs, renal fx, A1c

Jarin J et al. Pediatrics, 2017

Cross-Sex Hormones: Risk of Acute Cardiovascular Events

- **Large Cohort Study**
  - 1972-2015
  - 2517 Transwomen (Mean age 30 yr); mean f/u 9 yr
  - 1358 Transmen (Mean age 23 yr); mean f/u 8.1 yr
- **Results**
  - Transwomen:
    - Higher adjusted incidence of stroke, (VTE) vs. reference women and men
      - VTE risk less with 17 beta-estradiol
    - Higher incidence of MI vs. reference women (Not reference men)
  - Transmen
    - Higher risk of MI vs. reference women (Not reference men)
- **Limitations**
  - No adjustment for psychosocial stressors, smoking

Nota NM, et al. Circulation, 2019

Endocrine Treatment of Gender-Dysphoric/ Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline

Wylie C. Hembree (chair), Peggy T. Cohen-Kettenis, Louis Gooren, Sabine E. Hannema, Walter J. Meyer, M. Hassan Murad, Stephen M. Rosenthal, Joshua D. Safer, Vin Tangpricha, Guy G. T'Sjoen

J Clin Endocrinol Metab 102 (11):1-35, 2017

"Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline"

New Pediatric/ Adolescent Recommendations (Summary):

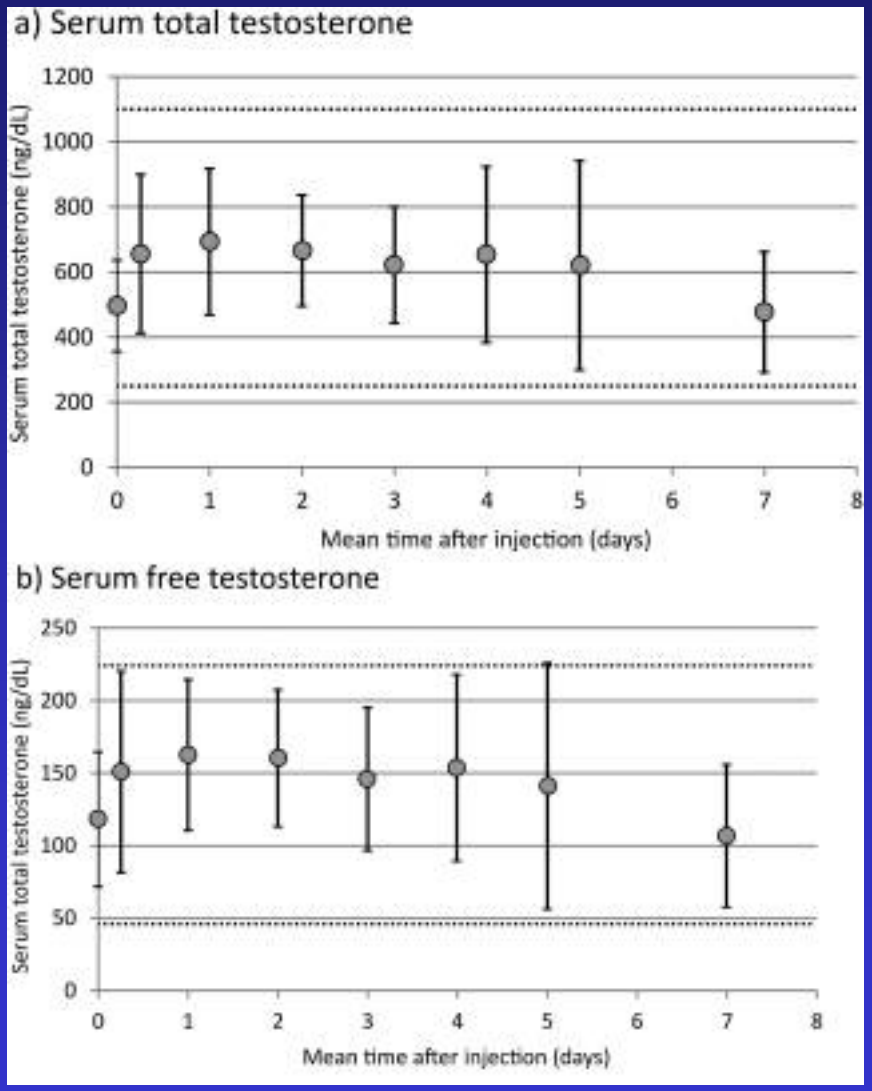
- Recognition that there may be compelling reasons to start cross-sex hormones prior to age 16 years in some GD/Gender Incongruent adolescents
  - Potential risks to bone health with prolonged hypogonadism
  - Potential risks to mental health if pubertal development is markedly out of sync with peers
- Pubertal induction schemes using transdermal estradiol or subcutaneous testosterone
- Inclusion of pubertal induction schemes for post-pubertal adolescents, resembling adult protocols
- More targeted lab surveillance during pubertal suppression and pubertal induction

SC TESTOSTERONE (T): Effective & Preferred to IM in FTM Adults

- N = 63 FTM adults (> 18 yr)
  - N = 53: Premenopausal
  - N = 22: Orig. Rx IM
  - SC T: 25g, 5/8" needle
  - Measured T post 4th consec. dose
- Results
  - 51/53: amenorrhea
  - NI serum T in all pt (median dose 75/80 mg/wk)
  - 22/22: Preference for SC

Spratt DI et al. J Clin Endrocrinol Metab, 2017

SC TESTOSTERONE (T): Serum Total and Free-T over 1 Wk Rx Cycle



N = 11 FTM adults, Age 18-50

Stable dose T > 2 mo Prior to study

McFarland J et al. JES, 2017

Areas of Uncertainty, Controversies, Barriers to Care

- **Limited safety/ efficacy data**
  - —No data with blockers in pt < 12 yr
  - —No data with cross-sex hormones in pt < 16 yr
  - —No RCTs (likely not feasible or ethical)
  - —Need for prospective, long-term outcomes studies
- **Limited access to Rx**
  - —Off-label
  - —Expensive
  - —Often denied by insurance companies
- **Limited access to care**
  - —Relatively few clinical programs
  - —Lack of training
  - —Prejudice/ misunderstanding

Management of Adolescents with GD GnRHa: Further Thoughts

- Non-intervention is not a "neutral" option
- "In dubio abstine" may be harmful!
- Importance of "Team Approach"
  - Need for adequate support for patients/ families

Child and Adolescent Gender Center: UCSF / Community Collaborative

- Integrated care provided by multi-disciplinary team
  - Mental Health Professionals
    - Diagnostic assessment
    - Psychotherapy/ counseling
    - Support groups
  - Pediatric Endocrinologists/ Adolescent Med/ Primary Care
    - Pubertal suppression
    - Cross-sex hormone Rx
    - Surveillance for desired and adverse effects
  - Advocacy Professionals
    - School training: gender inclusive campuses & cultures
    - Trainings with other organizations working with children & youth
    - Legal & other forms of advocacy
- Platform for Research

National Institutes of Health (NIH)/NICHD
The Impact of Early Medical Treatment of Transgender Youth (2015-2020)
Gender Nonconformity in Prepubescent Children: A Longitudinal Study (2019-2024)

- Multi-Center Network
  - Benioff Children's Hospital/ UCSF
  - Boston Children's Hospital/ Harvard
  - Children's Hospital LA/ USC
  - Lurie Children's Hospital Chicago/ Northwestern

R01HD082554 (08/01/2015 - 06/30/2020): National Institutes of Health (NIH)

The Impact of Early Medical Treatment of Transgender Youth

- Enrollment complete: N = 391
  - Early Pubertal Cohort (Blockers)
    - —N = 90
  - Late Pubertal/ Post Pubertal Cohort (Cross-Sex Hormones)
    - —N = 301

$5.7 MILLION IN TAXPAYER FUNDS FOR STUDY TO JUSTIFY STERILIZING CHILDREN WHO ARE GENDER CONFUSED

TONY PERKINS' WASHINGTON UPDATE

Taxpayer-funded Study Pushes Dangerous Agenda

September 20, 2018

For progressive activists, nothing can stand in the way of their agenda -- not even the health and well-being of children.

In a disturbing report from Breitbart, it was revealed that liberal activists embedded within the National Institutes of Health (NIH) are currently carrying out a taxpayer-funded study

Acknowledgements

- Children's & Adolescent Gender Center (CAGC) Colleagues
  - Diane Ehrensaft, PhD
    - Psychologist/ Gender Specialist
    - Mental Health Director, CAGC
  - Erica Anderson, PhD
    - Psychologist/ Gender Specialist
  - Joel Baum, MS
    - Director, Education & Training, Gender Spectrum
    - Director of Education & Advocacy, CAGC
  - Asaf Orr, JD
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  - Ben Geilhufe, LPCC
  - JT Huynh, BA

Thank You!

American Society for Adolescent Psychiatry

Working with Schools to Accommodate Trans Youth

May 17, 2019

San Francisco, CA

gender spectrum®

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Gender Spectrum

Director, Education and Advocacy
Child and Adolescent Gender Center
UCSF-Benioff Children's Hospital

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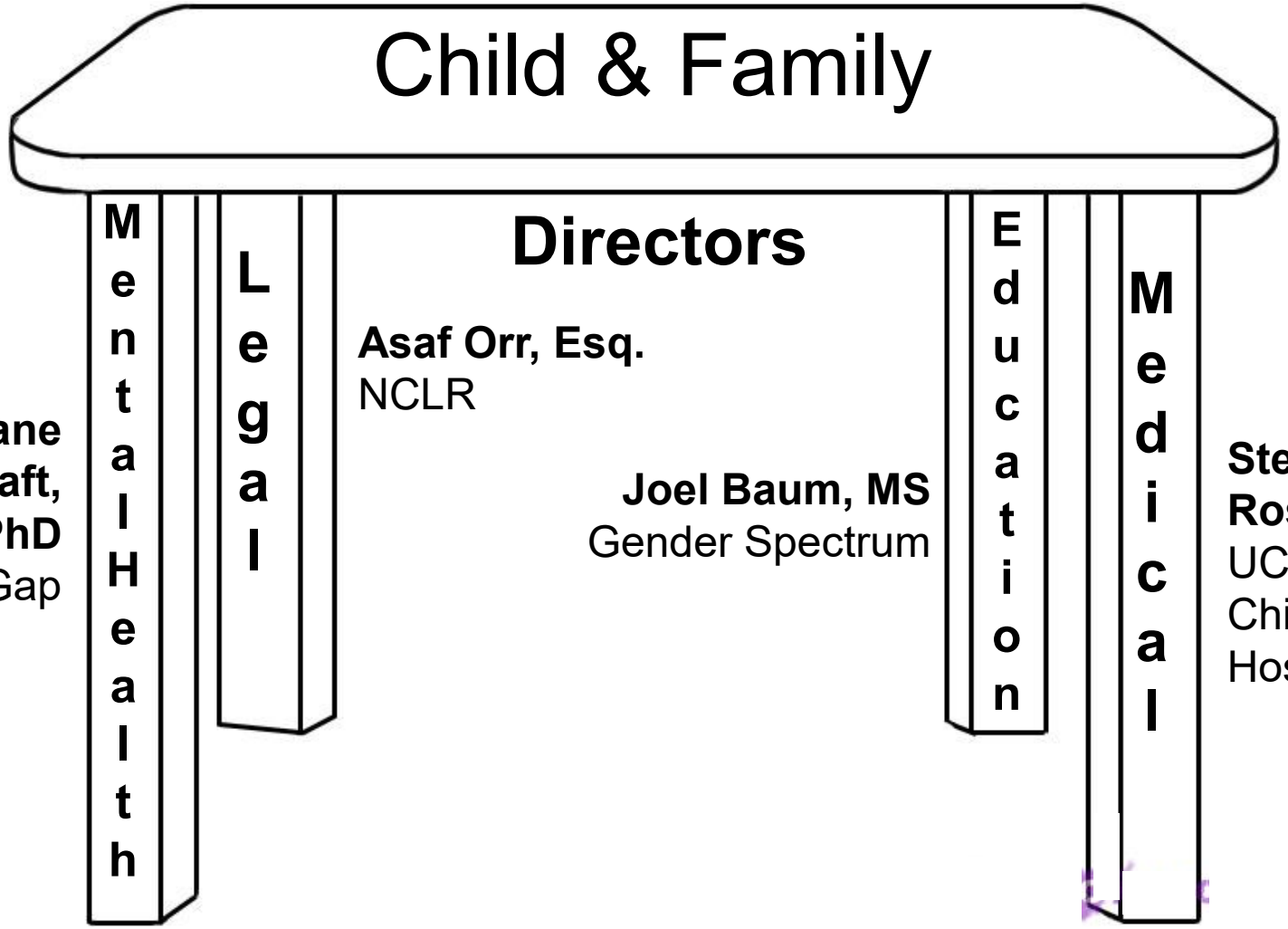
Child and Adolescent Gender Center



Diane Ehrensaft, PhD
Mind the Gap

Asaf Orr, Esq.
NCLR

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Gender Spectrum

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UCSF-Benioff Children's Hospital

gender spectrum®

Gender Spectrum Mission

To create a gender-inclusive world for all children and youth

Enacting our Mission…

- Gender Discourse
- Family/Caregiver Support
- Gender Spectrum Conference and Professionals' Symposium

July 19 – 21

St. Mary's College of CA

Enacting our Mission…

- Gender Discourse
- Family/Caregiver Support
- Gender Spectrum Conference
- Education and Training

Education and Training

- Pre-K – 12+ across the United States
- Public, private and parochial
- Urban, rural and suburban
- Leadership and staff training
- Parent and community education coaching
- Classroom practice consultation and coaching
- Resources

Gender Inclusive Schools

When someone with the authority of a teacher describes the world and you are not in it, there is a moment of psychic disequilibrium, as if you looked into a mirror and saw nothing.

— Adrienne Rich

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Gender Inclusive Schools Ask:

How are we accounting for the gender diversity of all of our students?

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Today…

- Some guiding principles
- A glimpse at the legal landscape…
- Overview of Gender Support and Communication Plans
- Questions and comments

Key Principles

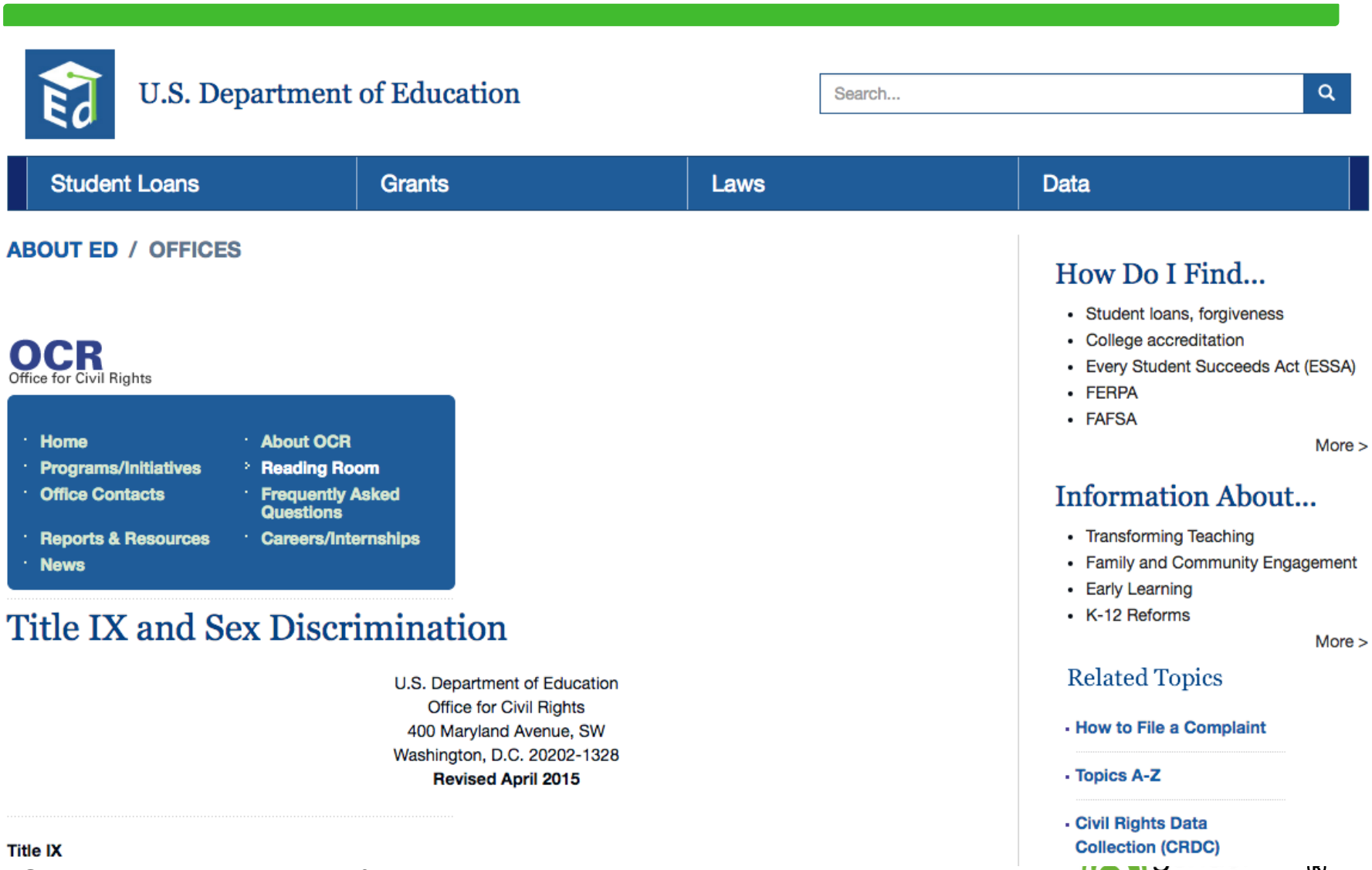
- Working and trusting as a team
- Speaking to educators' "higher selves"
- Do your homework
- Leave plenty of time for things to get done
- Learn from others
- The Law: May compel, isn't compelling

A few words about the law…

Federal: Title IX

- Prohibit sex discrimination in educational programs and activities operated by recipients of Federal financial assistance.

Enforcement



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- Frequently Asked Questions
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Title IX and Sex Discrimination

U.S. Department of Education
Office for Civil Rights
400 Maryland Avenue, SW
Washington, D.C. 20202-1328
Revised April 2015

Title IX

How Do I Find...

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- Transforming Teaching
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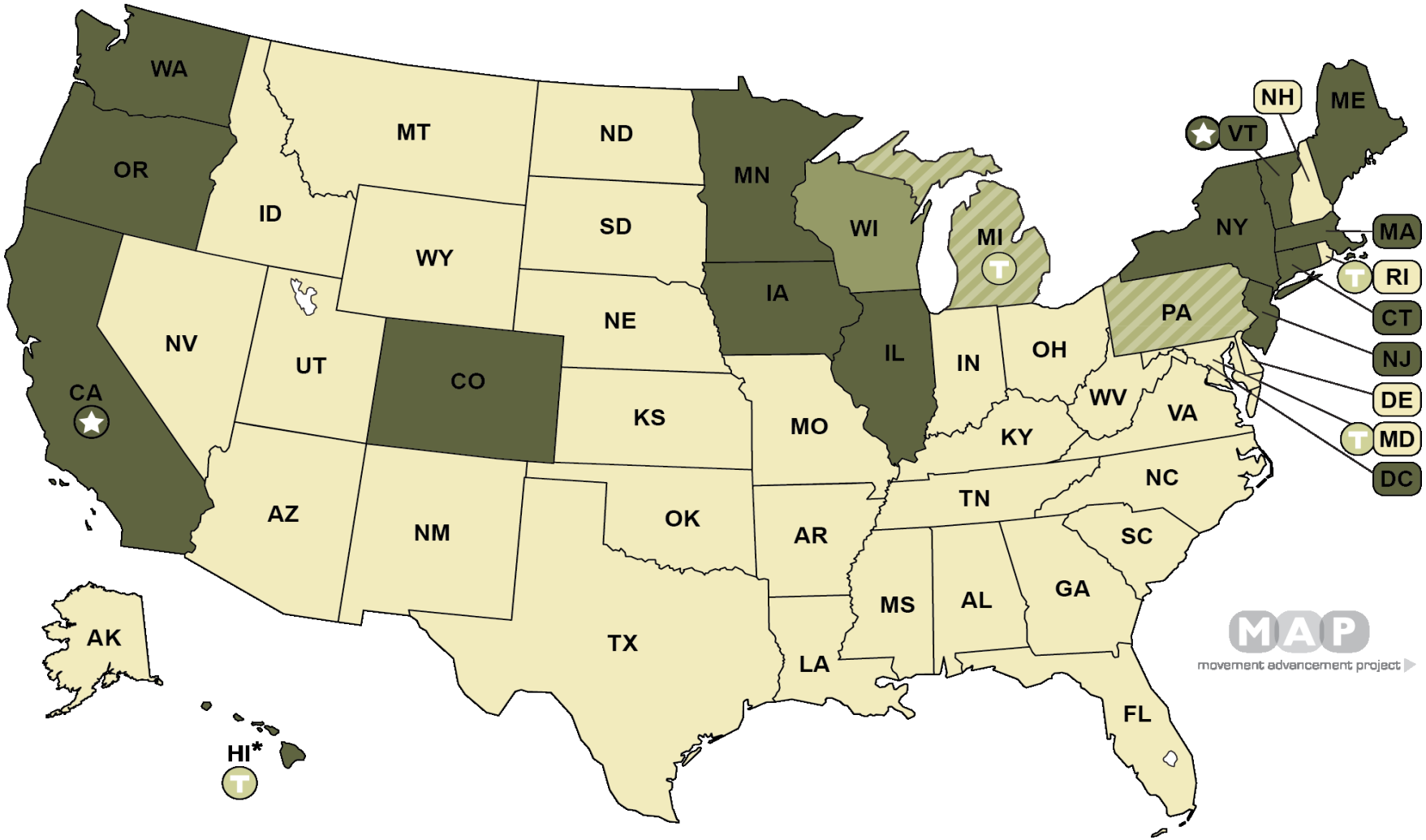
Related Topics

- How to File a Complaint
- Topics A-Z
- Civil Rights Data Collection (CRDC)

http://www.lgbtmap.org/equality-maps/safe_school_laws



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California State Anti Discrimination Policy

Education Code § 200

Protected categories:

- Disability, **gender**, nationality, race or ethnicity, religion, sexual orientation

Education Code § 210.7

"Gender" means **sex**, and includes a person's **gender identity** and **gender expression**.

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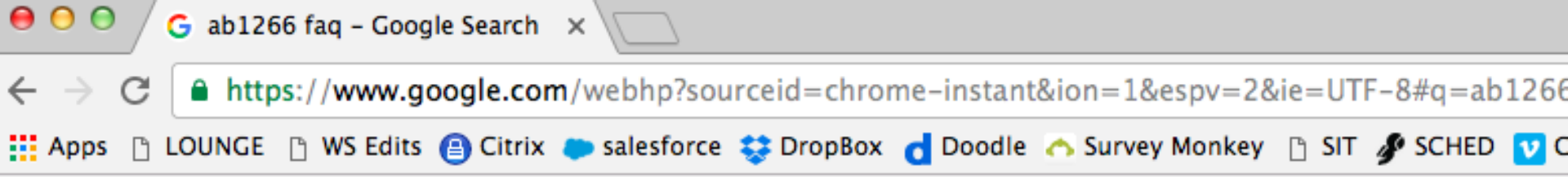
School Success and Opportunity Act

- “AB1266”
- Requires that pupils be permitted to participate in sex-segregated school programs, activities, and use facilities consistent with their gender identity, without respect to the gender listed in a pupil’s records.



Frequently Asked Questions

School Success and Opportunity Act (Assembly Bill 1266) Frequently Asked Questions.

Consistent with our mission to provide a world-class education for all students, from early childhood to adulthood, the California Department of Education issues the following Frequently Asked Questions (FAQs) in an effort to (a) foster an educational environment that is safe and free from discrimination for all students, regardless of sex, sexual orientation, gender identity, or gender expression, and (b) assist school districts with understanding and implementing policy changes related to AB 1266 and transgender student privacy, facility use, and participation in school athletic competitions.

These FAQs are provided to promote the goals of reducing the stigmatization of and improving the educational integration of transgender and gender nonconforming students, maintaining the privacy of all students, and supporting healthy communication between educators, students, and parents to further the successful educational development and well-being of every student.

1. **What is Assembly Bill (AB) 1266?**

   AB 1266, also known as the "School Success and Opportunity Act," was introduced by Assemblyman Tom Ammiano on February 22, 2013. It requires that pupils be permitted to participate in sex-segregated school programs, activities, and use facilities consistent with their gender identity, without respect to the gender listed in a pupil's records. AB 1266 was approved by Governor Brown on August 12, 2013.

   According to Assemblyman Ammiano, "This bill is needed to ensure that transgender students are protected and have the same opportunities to participate and succeed as all other students." "AB 1266 clarifies California's student nondiscrimination laws by specifying that all students in K-12 schools must be permitted to participate in school programs, activities, and facilities in accordance with the student's gender identity."

School Board: Policies and ARs

- Anti-discrimination policies must include language protecting students based on sex, gender identity and gender expression
- Anti-bullying policies
- Uniform Complaint Procedures

Live Oak ESD
Board Policy
Nondiscrimination/Harassment

BP 5145.3
Students

The Governing Board desires to
access and opportunities in the d
services, and activities. The Bo
discrimination, harassment, intir
actual or *perceived* race, color, a
identification, age, religion, mar
orientation, gender, gender ident
characteristics; or association wi
perceived characteristics.

*This policy shall apply to all act
within a district school. (Educ*

(cf. 0410 - Nondiscrimination in
(cf. 5131 - Conduct)
(cf. 5131.2 - Bullying)
(cf. 5137 - Positive School Clim
(cf. 5145.9 - Hate-Motivated Be
(cf. 5146 - Married/Pregnant/Pa
(cf. 6164.6 - Identification and F

*Unlawful discrimination, includ
includes physical, verbal, nonve
above. Unlawful discriminatio
the prohibited conduct is so seve
participate in or benefit from an
threatening, hostile, or offensive
unreasonably interfering with a
a student's educational opportun*

*Unlawful discrimination also in
categories above with respect to
or activities or the provision or*

The Board also prohibits any for
*the filing or investigation of a co
Retaliation complaints shall be i*

New Live Oak ESD
Administrative Regulation
Nondiscrimination/Harassment

AR 5145.3
Students

The district desi
coordinating the
Title IX of the E
Title II of the A
answer inquiries
serve as the com
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age, religion, ma
gender, gender i
of one or more
these actual or p
at: (Education

Director of Stud
984-1 Bostwick
(831)475-6333
jciervo@losd.ca

(cf. 1312.1 - Co
(cf. 1312.3 - Un

Measures to Pre

To prevent unla
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Live Oak School District

ENSURING EQUITY AND NONDISCRIMINATION FOR TRANSGENDER AND GENDER NON CONFORMING STUDENTS

A Reference Guide

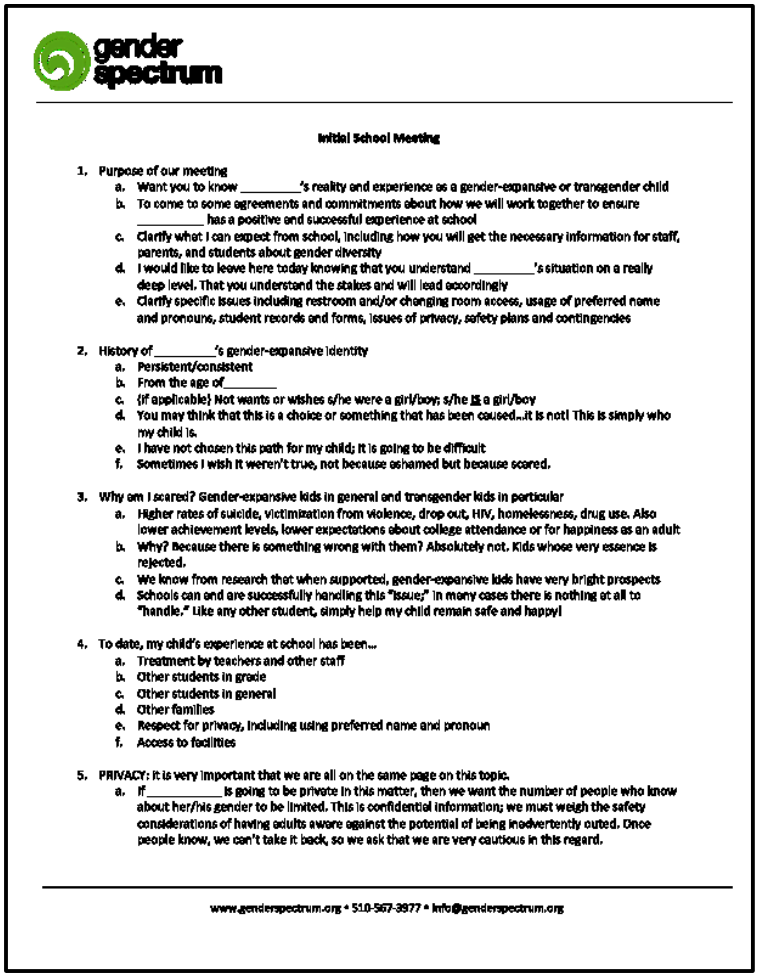
PURPOSE:
California Education Code (Ed Code) Section 220 and Board policy 0410 and BP 5145.3 require that all programs, activities, and employment practices should be conducted without discrimination based on actual or perceived sex, sexual orientation, or gender identity and

A few final words about the law…

- Legal protections are great, but should be the last card you play!
- Institutions and individuals are rarely compelled to act because it is the law
- If they do comply, it is often done grudgingly and inauthentically

Failing to plan = Planning to fail

Initial School Meeting



gender spectrum

Initial School Meeting

1. Purpose of our meeting
   a. Want you to know _____'s reality and experience as a gender-expansive or transgender child
   b. To come to some agreements and commitments about how we will work together to ensure _____ has a positive and successful experience at school
   c. Clarify what I can expect from school, including how you will get the necessary information for staff, parents, and students about gender diversity
   d. I would like to leave here today knowing that you understand _____'s situation on a really deep level. That you understand the stakes and will lead accordingly
   e. Clarify specific issues including restroom and/or changing room access, usage of preferred name and pronouns, student records and forms, issues of privacy, safety plans and contingencies

2. History of _____'s gender-expansive identity
   a. Persistent/consistent
   b. From the age of_____
   c. (If applicable) Not wants or wishes s/he were a girl/boy; s/he IS a girl/boy
   d. You may think that this is a choice or something that has been caused…it is not! This is simply who my child is.
   e. I have not chosen this path for my child; it is going to be difficult
   f. Sometimes I wish it weren't true, not because ashamed but because scared.

3. Why am I scared? Gender-expansive kids in general and transgender kids in particular
   a. Higher rates of suicide, victimization from violence, drop out, HIV, homelessness, drug use. Also lower achievement levels, lower expectations about college attendance or for happiness as an adult
   b. Why? Because there is something wrong with them? Absolutely not. Kids whose very essence is rejected.
   c. We know from research that when supported, gender-expansive kids have very bright prospects
   d. Schools can and are successfully handling this "issue;" in many cases there is nothing at all to "handle." Like any other student, simply help my child remain safe and happy!

4. To date, my child's experience at school has been…
   a. Treatment by teachers and other staff
   b. Other students in grade
   c. Other students in general
   d. Other families
   e. Respect for privacy, including using preferred name and pronoun
   f. Access to facilities

5. PRIVACY: It is very important that we are all on the same page on this topic.
   a. If _____ is going to be private in this matter, then we want the number of people who know about her/his gender to be limited. This is confidential information; we must weigh the safety considerations of having adults aware against the potential of being inadvertently outed. Once people know, we can't take it back, so we ask that we are very cautious in this regard.

www.genderspectrum.org • 510-567-3977 • info@genderspectrum.org

- Purpose
- History of gender
- Your concerns
- Experiences at school
- Privacy
- Requests

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Some General Thoughts

- Come to this meeting assuming that you will be working together **as a team** in support of your child's success. Remember: hopefully you will soon be thinking much more about reading and writing and much less about gender! You want to establish a positive relationship with your school.

Some General Thoughts

- Strongly consider attending this initial meeting without an advocate; you can always bring one later. School leaders can feel defensive if they feel blindsided by a “third party.”

Some General Thoughts

- Don’t have child attend initial meeting, and think carefully if and when it would be appropriate for your child to attend, especially if they are in primary grades

Some General Thoughts

- Specify expectations about privacy for the meeting itself; who will be there? You do not want to show up and meet a panel of adults before you have had a chance to specify your expectations about your child and family's privacy.

Some General Thoughts

- Stay calm, document and follow-up

Planning for Success!

- Gender Support Plan
- Gender Communication Plan

Creating Gender Support Plans

gender spectrum

– Confidential –

Gender Support Plan

The purpose of this document is to create shared understandings about the ways in which the student's authentic gender will be accounted for and supported at school. School staff, caregivers and the student should work together to complete this document. Ideally, each will spend time completing the various sections to the best of their ability and then come together to review sections and confirm shared agreements about using the plan. Please note that there is a separate document to plan for a student formally communicating information about a change in their gender status at school.

School/District _____ Today's Date _____
Name Student Uses: _____ Name on Birth Certificate: _____
Student's Gender Identity _____ Assigned Sex at Birth _____ Student Grade Level _____
Date of Birth _____ Sibling(s)/Grade(s) _____/____ _____/____
Parent(s), Guardian(s), or Caregiver(s) /relation to student
_____/_____ _____/_____
_____/_____ _____/_____
Meeting participants: _____

PARENT/GUARDIAN INVOLVEMENT

Guardians aware of student's gender status? Yes/No Level of Support: (none) 1 2 3 4 5 6 7 8 9 10 (High)

If support level is low what considerations must be accounted for in implementing this plan? _____

CONFIDENTIALITY, PRIVACY AND DISCLOSURE

How public or private will information about this student's gender be (check all that apply)?

____ District staff will be aware (Superintendent, Student Support Services, District Psychologist, etc.)
Specify the adult staff members:

____ Site level leadership/administration will know (Principal, head of school, counselor, etc.)
Specify the adult staff members:

____ Teachers and/or other school staff will know
Specify the adult staff members:

____ Student will not be openly "out," but some students are aware of the student's gender
Specify the students:

____ Student is open with others (adults and peers) about gender

____ Other – describe: _____

If the student has asserted a degree of privacy, what steps will be taken if that privacy is compromised, or is believed to have been compromised? _____

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Purpose of the Gender Support Plan

- Create **shared understanding** between student, school staff, and when appropriate, caregivers, about how the student's gender-related needs will be accounted for at school
- **Co-constructed** by a team of individuals committed to the student's success at school
- Broken into **specific sections** that comprise the student's day-to-day life at the school

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Gender Support Plans

- Anticipate possible scenarios
  - Breaking things down
- Prioritize student safety
- Recognize unique nature of each student's experience
- Maximize conditions for success

Trade-offs!

Sections of the Gender Support Plan

- Forming the Gender Support Team (GST)
- **Privacy: Confidentiality and Disclosure**
- Student Safety
- Privacy: Names, Pronouns and Student Records
- Use of Facilities
- Extracurricular Activities
- Additional Considerations
- Taking Action and Monitoring

Forming the Gender Support Team

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– Confidential –

Gender Support Plan

The purpose of this document is to create shared understandings about the ways in which the student's authentic gender will be accounted for and supported at school. School staff, caregivers and the student should work together to complete this document. Ideally, each will spend time completing the various sections to the best of their ability and then come together to review sections and confirm shared agreements about using the plan. Please note that there is a separate document to plan for a student formally communicating information about a change in their gender status at school.

School/District _____ Today's Date _____

Name Student Uses: _____ Name on Birth Certificate: _____

Student's Gender Identity _____ Assigned Sex at Birth _____ Student Grade Level _____

Date of Birth _____ Sibling(s)/Grade(s) _____ / _____ _____ /_____

Parent(s), Guardian(s), or Caregiver(s) /relation to student

_____ /_____ _____ / _____

_____ /_____ _____ /_____

Meeting participants: _____

PARENT/GUARDIAN INVOLVEMENT

Guardians aware of student's gender status? Yes/No Level of Support: (none) 1 2 3 4 5 6 7 8 9 10 (High)

If support level is low what considerations must be accounted for in implementing this plan? _____

_____

_____

Forming the Gender Support Team

Possible Members of the GST

- Parents/Caregivers (?)
- Student (?)
- School Leadership
- School Nurses
- Counseling Staff
- Teachers/other staff working directly with child
- Mental Health Providers
- Supporting Organizations

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Forming the Gender Support Team

- Level of parental affirmation-->involvement
- Degree of privacy with family important

Privacy: Confidentiality and Disclosure

PRIVACY: CONFIDENTIALITY AND DISCLOSURE

How public or private will information about this student's gender be (check all that apply)?

____ District staff will be aware (Superintendent, Student Support Services, District Psychologist, etc.)
Specify the adult staff members:

____ Site level leadership/administration will know (Principal, head of school, counselor, etc.)
Specify the adult staff members:

____ Teachers and/or other school staff will know
Specify the adult staff members:

____ Student will not be openly "out," but some students are aware of the student's gender
Specify the students:

____ Student is open with others (adults and peers) about gender

____ Other – describe:_____

_____

If the student has asserted a degree of privacy, what steps will be taken if that privacy is compromised, or is believed to have been compromised? _____

_____

_____

_____

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Privacy may not be an option

Confidentiality, Privacy and Disclosure

Maintaining Privacy

- Want to be known as just another student
- It's no one else's business
- No need for enduring a public sharing
- Fear of harassment and mistreatment

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Confidentiality, Privacy and Disclosure

Being Public

- Positive assertion of identity
- No need to worry about having privacy compromised
- Empowerment and affirmation

Confidentiality, Privacy and Disclosure

How to Decide?

- May not be a choice—student may live in community where they were known previously
- If privacy is an option, then important to recognize that you can't "unshare"
- Seek input from other families
- Work with organizations like Gender Spectrum

Confidentiality, Privacy and Disclosure

The School's Role

- Regardless of level of privacy, implications for school
- If privacy asserted, responsible to help maintain it and avoid compromising it
- If public, responsible to ensure student's safety and respect student privacy by not discussing the child's gender
- Must have contingency plans

Student Safety

STUDENT SAFETY

Who will be the student's "go to adult" on campus?_____

If this person is not available, what should student do?_____

What, if any, will be the process for periodically checking in with the student and/or family?_____

_____

What are expectations in the event the student is feeling unsafe and how will student signal their need for help:

During class_____

On the yard_____

In the halls_____

Other_____

Other safety concerns/questions:_____

_____

_____

What should the student's parents do if they are concerned about how others are treating their child at school?

_____

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Student Safety

- Identifying a “go to” adult and back-up
- Signaling need for support?
- Frequency of check-ins?
- How will caregivers share any concerns about safety issues at school?
- Work with Gender Support Team!

Privacy: Names and Pronouns

PRIVACY: NAMES, PRONOUNS AND STUDENT RECORDS

Name/gender marker are listed on the student's identity documents _____ _____

Name/gender marker entered into the Student Information System_____ _____

Name to be used when referring to the student_____Pronouns _____

Is there a process/form for changing the student's name in the SIS? _____ How is accessed/used?

_____

_____

If not, what adjustments can be made to protect this student's privacy (see below)?_____

_____

_____

Who will be the point person at school for ensuring these adjustments are made and communicated as needed?

_____

How will instances be handled in which the incorrect name or pronoun are used by staff members? _____

_____

By students? _____

_____

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Names and Pronouns

- Degree of privacy is crucial factor here
- Easiest approach: Change the student's name and gender markers in the student information system
- More difficult approach: not changing in system and trying to anticipate ALL situations where student's name will show up
- Almost impossible and can be devastating for student

Names and Pronouns

- Permanent Pupil Records: maintain a hard copy of the students birth certificate and other identifying materials (such as pictures from cumulative file) under lock and key in principal's or other office
- Meeting data reporting responsibilities:
  - Change for purposes of reporting and change back
  - Risk audit finding and explain
- Must weigh violating student's privacy and its impact versus not meeting bureaucratic requirement

Names and Pronouns

- Caregiver(s) not supportive: school must account for the students privacy as they work with adults in student's life
- Most likely means name will remain as listed on birth certificate in order to avoid violating students privacy with parents
- Mistakes: honest versus deliberate

Use of Facilities

USE OF FACILITIES

Student will use the following bathroom(s) on campus_____

Student will change clothes in the following place(s)_____

If student/parent have questions/concerns about facilities, who should they contact?_____

What are the expectations regarding the use of facilities for any class trips?_____

_____

What are the expectations regarding rooming for any overnight trips?_____

_____

Are there any questions or concerns about the student's access to facilities?_____

_____

_____

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Use of Facilities

- Ensuring shared understanding as a team
- Ideally, student can declare what they need and the request is honored
- If not, then important to at least demonstrate understanding why this is such an important issue
- Strategize together to allow student access
- Ultimately, if not allowed, student/family will determine what steps they wish to take

Extra-Curricular Activities

EXTRA CURRICULAR ACTIVITIES

In what extra-curricular programs or activities will the student be participating (sports, theater, clubs, etc)?

_____

_____

What steps will be necessary for supporting the student there?_____

_____

_____

Does the student participate in an after-school program?_____

What steps will be necessary for supporting the student there?_____

_____

_____

Questions/Notes: _____

_____

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Extra-Curricular Activities

- School-sponsored activities: plan should extend into these as well
- After school programs: important to establish plan with these as well, either by inviting them to GSP meeting or setting up a separate meeting

Additional Considerations?

OTHER CONSIDERATIONS

Does the student have any sibling(s) at school?_____Factors to be considered regarding sibling's needs?

_____

_____

_____

Does the school have a dress code? _____ How will this be handled?_____

_____

_____

Are there lessons, units, content or other activities coming up this year to consider (growth and development, swim unit, social justice units, name projects, dance instruction, Pride events, school dances etc.)?_____

_____

_____

_____

Are there any specific social dynamics with other students, families or staff members that need to be discussed or accounted for?_____

_____

_____

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Additional Considerations?

- Social dynamics with other students or families?
- Siblings?
- Dress code?
- Specific activities?
  - Sex education
  - Swim units
  - School trips?

Monitoring

NEXT STEPS: SUPPORT PLAN REVIEW AND REVISION

How will this plan be monitored over time?_____

_____

What will be the process should the student, family, or school wish to revisit any aspects of the plan (or seek additions to the plan)?_____

_____

What are specific follow-ups or action items emerging from this meeting and who is responsible for them?

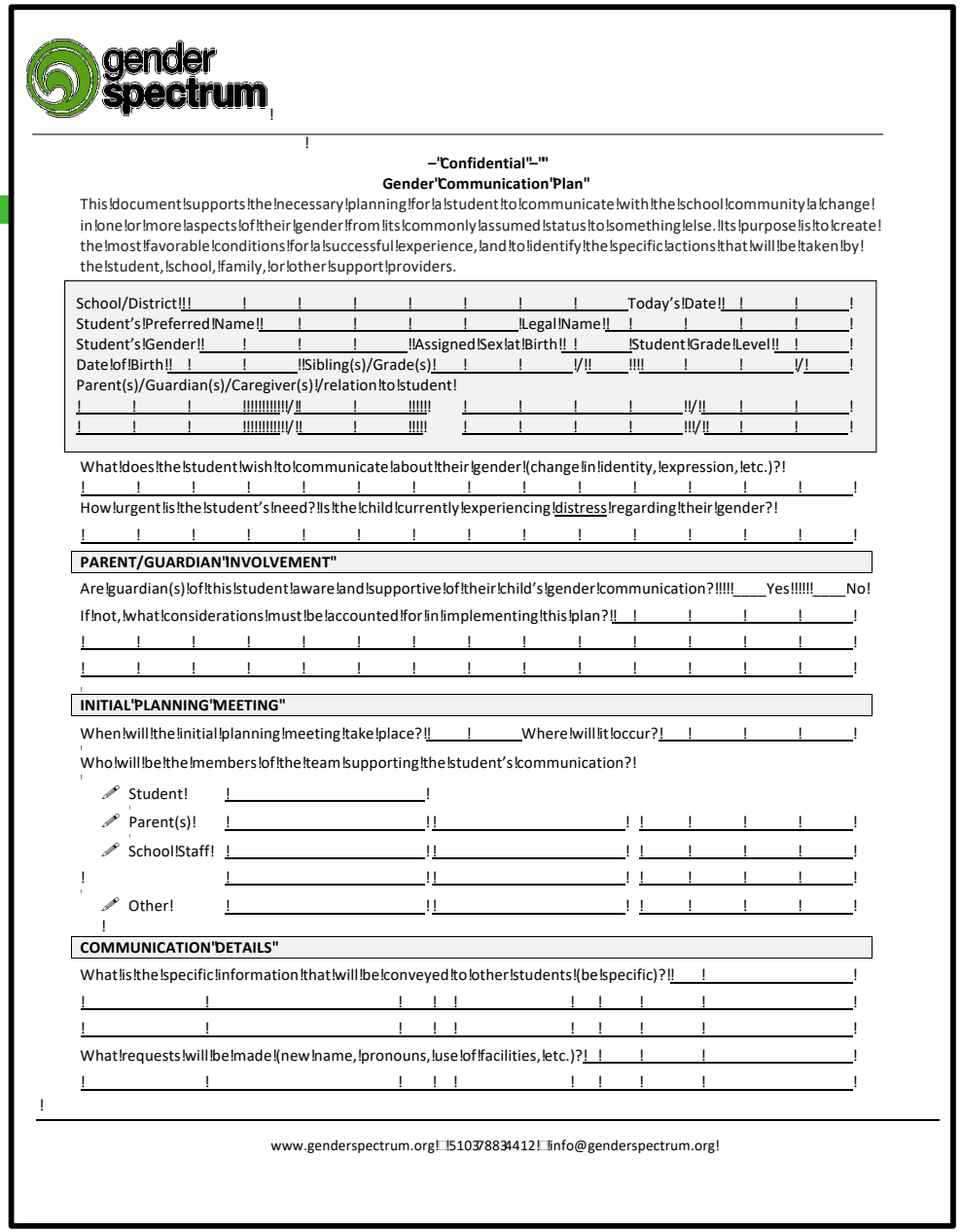
Action Item	Who?	When?

Date/Time of next meeting or check-in_____ Location _____

Communicating a Change in Gender Status

- "Transition" **PUBLIC PROCESS** of socially aligning one's gender with the internal sense of self.
  - **changes in name or pronouns**
  - a more aligned **gender expression**
  - **use of facilities**
  - **participation** in activities
  - **social interactions**
- M**oment(s) in time** in which this takes place

Gender Communication Plans



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–"Confidential"–"

Gender"Communication"Plan"

This!document!supports!the!necessary!planning!for!a!student!to!communicate!with!the!school!community!a!change!in!one!or!more!aspects!of!their!gender!from!its!commonly!assumed!status!to!something!else.!Its!purpose!is!to!create!the!most!favorable!conditions!for!a!successful!experience,!and!to!identify!the!specific!actions!that!will!be!taken!by!the!student,!school,!family,!or!other!support!providers.

School/District!!_____!_____!_____!_____!_____!_____!_____!_____Today's!Date!!_____!_____!_____!

Student's!Preferred!Name!!_____!_____!_____!_____!_____!Legal!Name!!_____!_____!_____!_____!

Student's!Gender!!_____!_____!_____!_____!!Assigned!Sex!at!Birth!!_____!_____!Student!Grade!Level!!_____!_____!

Date!of!Birth!!_____!_____!_____!!Sibling(s)/Grade(s)!_____!_____!_____!/!!_____!!!!_____!_____!_____!/!_____!

Parent(s)/Guardian(s)/Caregiver(s)!/relation!to!student!

_____!_____!_____!_____!!!!!!!!!!!!/!!_____!_____!!!!!!_____!_____!_____!_____!_____!!/!!_____!_____!_____!

_____!_____!_____!_____!!!!!!!!!!!!/!!_____!_____!!!!!!_____!_____!_____!_____!_____!!!/!!_____!_____!_____!

What!does!the!student!wish!to!communicate!about!their!gender!(change!in!identity,!expression,!etc.)?!

_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!

How!urgent!is!the!student's!need?!Is!the!child!currently!experiencing!distress!regarding!their!gender?!

_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!

PARENT/GUARDIAN"INVOLVEMENT"

Are!guardian(s)!of!this!student!aware!and!supportive!of!their!child's!gender!communication?!!!!!!____Yes!!!!!!____No!

If!not,!what!considerations!must!be!accounted!for!in!implementing!this!plan?!!_____!_____!_____!_____!_____!_____!

_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!

_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!

INITIAL"PLANNING"MEETING"

When!will!the!initial!planning!meeting!take!place?!!_____!_____Where!will!it!occur?!_____!_____!_____!_____!_____!

Who!will!be!the!members!of!the!team!supporting!the!student's!communication?!

- Student!_____!_____!
- Parent(s)!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!
- School!Staff!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!
- Other!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!

COMMUNICATION"DETAILS"

What!is!the!specific!information!that!will!be!conveyed!to!other!students!(be!specific)?!!_____!_____!

_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!

_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!

What!requests!will!be!made!(new!name,!pronouns,!use!of!facilities,!etc.)?!_____!_____!_____!_____!

_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!_____!

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Most positive in schools where…

- being yourself is ok and honored!
- adults set the tone
- the question is “How?” and not “If”
- gender inclusive practice is intentional

Forming the Team

INITIAL PLANNING MEETING

When will the initial planning meeting take place? _____ Where will it occur? _____

Who will be the members of the team supporting the student's transition?

- ☐ Student _____
- ☐ Parent(s) _____ _____ _____
- ☐ School Staff _____ _____ _____
  _____ _____ _____
- ☐ Other _____ _____ _____

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Specifics of the “Moment(s)”

COMMUNICATION DETAILS

What is the specific information that will be conveyed to other students (be specific)? _____

_____

_____

What requests will be made (new name, pronouns, use of facilities, etc.)?_____

_____

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Specifics of Communication “Moment”

If you could close your eyes and imagine this going perfectly, what would it look like?

Lesson Title: Gender in 3-D/*Be Who You Are*

Goals:

- To reinforce the non-binary nature of gender as a spectrum
- To introduce the idea that gender is about the things we like and do (expression) and the things we feel (identity) along with the body we are born with (biology/sex)
- To share the story *Be Who You Are* as an example of a transgender child's feelings and experiences

Objectives:

- Students will recognize that gender has three different aspects: biology, expression and identity
- Students will identify different ways to show respect and acceptance to a child who is transgender

Time required: 30 - 40 minutes

Materials:

- Whiteboard or chart paper and pens
- *Be Who You Are*, by Jennifer Carr

Activities

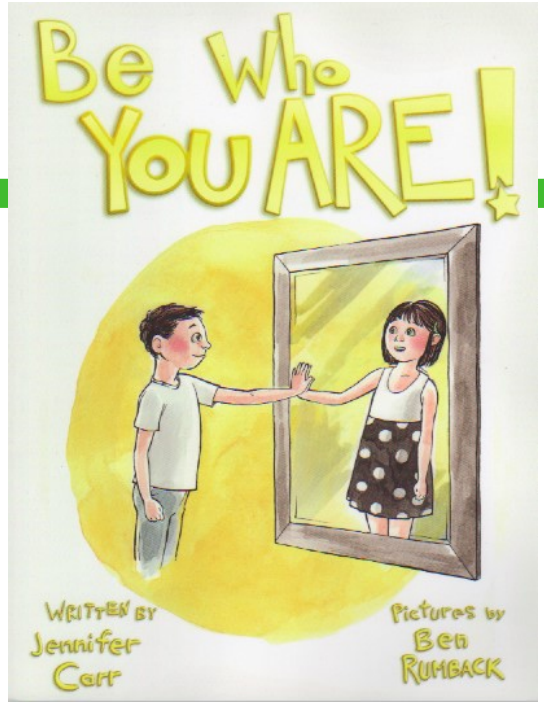
Introduction

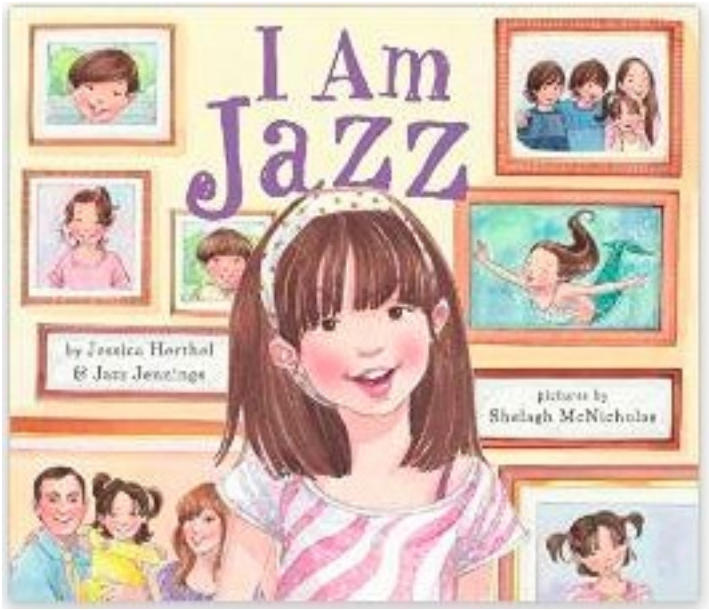
a. Ask, "Has anyone heard the word 'gender' before?" Gender is about being a boy, or a girl, or maybe even something else. ***!***
b. We're going to spend a few minutes today learning about what gender is and how each of us has a gender that is uniquely our own! Than we are going to read a story about a child who is learning about her own gender and trying to help everyone else know who she really is.***!***

What is Gender? (15 - 20 minutes)

a. What is Gender?

i. Begin by mentioning that a lot of times gender gets talked about as being about boys and girls, and the body they were born with. It turns out that this is not the whole story; it is a lot more interesting than that.
ii. Explain to students that gender is not just about bodies, but it is really about three things: our bodies (gender biology), how we dress and act (gender expression), and how we feel inside (gender identity). You will be creating a diagram like the one below.





Backwards Mapping

Training for School Staff

Will there be specific training about this student's gender with school staff?____ When? _

Who will be conducting the training? _____ What will be the content of the training?

_____

_____

Questions/Notes: _____

_____

_____

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Backwards Mapping

KEY DECISIONS PRIOR TO STUDENT'S COMMUNICATION

Communications with Other Families

Will any sort of information be shared with other families about the student's gender? _____

With whom: ____ Families in child's grade ____ Whole School ____Other (specify)_____

Who will be responsible for creating this? _____ When will it be sent? _____

How will it be distributed? _____

What specific information will be shared*? _____

_____

_____

_____

Questions/Notes: _____

_____

* see sample letters

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Backwards Mapping

Parent Information Night About Gender Diversity

Will there be specific training for school community members?_____ When? _____

Who'll conduct it? _____Will it reference the student's gender?_____

What will be the content of the training? _____

_____

_____

Questions/Notes: _____

_____

Class Meeting with Parents

Will there be any meeting with the families of the student's peers?_____ When?_____

Who will lead the meeting?_____ Who will be attending the meeting?_____

What will be the purpose for this meeting? _____

_____

_____

Backwards Mapping

Identifying and Enlisting Parent Allies

Are there any parents/adults in the community you would like to enlist in support of the child's communication?

If so, who?_____

When will you speak with them?_____ What will be your request? _____

_____

Questions/Notes: _____

_____

Identifying and Enlisting Peer Allies

Are there other students you would like to enlist in support of the child's communication?_____

If so, who?_____

When will they be spoken with?_____ What requests will be made? _____

_____

_____

Questions/Notes: _____

Backwards Mapping

Siblings

Does the student have any siblings at the school?____What needs to be considered for them?

Training in their classroom(s)? _____ Emotional Support?_____

_____

_____

Questions/Notes: _____

_____

_____

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Backwards Mapping

TIMELINE

Which of the following will take place in relation to this student's gender communication, and when will it occur and who will be responsible for making it happen?

Activity	Date	Lead
❑ Initial Planning Meeting		
❑ Lessons/Activities with Other Students		
❑ Communications with Other Families		
❑ Training for School Staff		
❑ Parent Information Night About Gender Diversity		
❑ Class Meeting with Parents		
❑ Identifying and Enlisting Parent Allies		
❑ Identifying and Enlisting Peer Allies		

What are the specific follow-ups or action items emerging from this meeting and who is responsible for them?

Action Item	Who?	When?

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Questions and Comments?

For More Information

Professional Development

Information

Resources

Consultation

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MENTAL HEALTH CARE WITH EMERGING ADULTS

Eric Yarbrough, MD

OVERVIEW

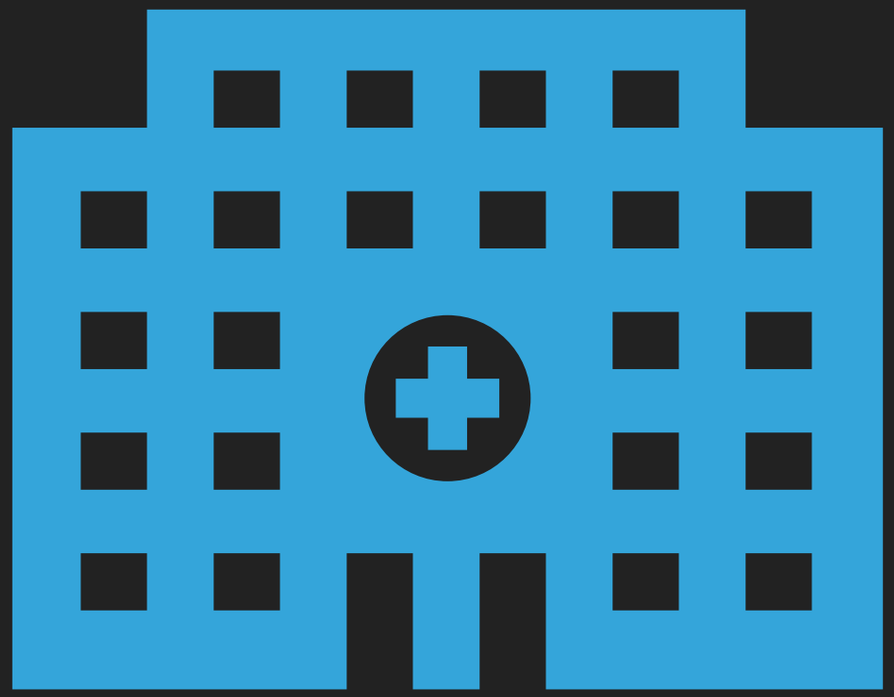
- Disclosures
- Evaluation
- Symptoms
- Diagnosis
- Interventions

DISCLOSURES

- PERSONAL EXPERIENCE WORKING WITH TGNB/TGNC PEOPLE
- MY VIEWS MAY DIFFER FROM OTHERS
- WPATH STANDARDS OF CARE
- AGLP: THE ASSOCIATION OF LGBTQ PSYCHIATRISTS
- CALLEN-LORDE COMMUNITY HEALTH CENTER
- GMHC (GAY MEN'S HEALTH CRISIS)
- WHAT YOU LEARN IS APPLICABLE TO ALL PATIENTS

EVALUATION

- WHAT BRINGS A YOUNG ADULT TO SEE A PSYCHIATRIST?
  - PSYCHIATRIC SYMPTOMS
  - GENDER DYSPHORIA
  - FAMILY INTERVENTION



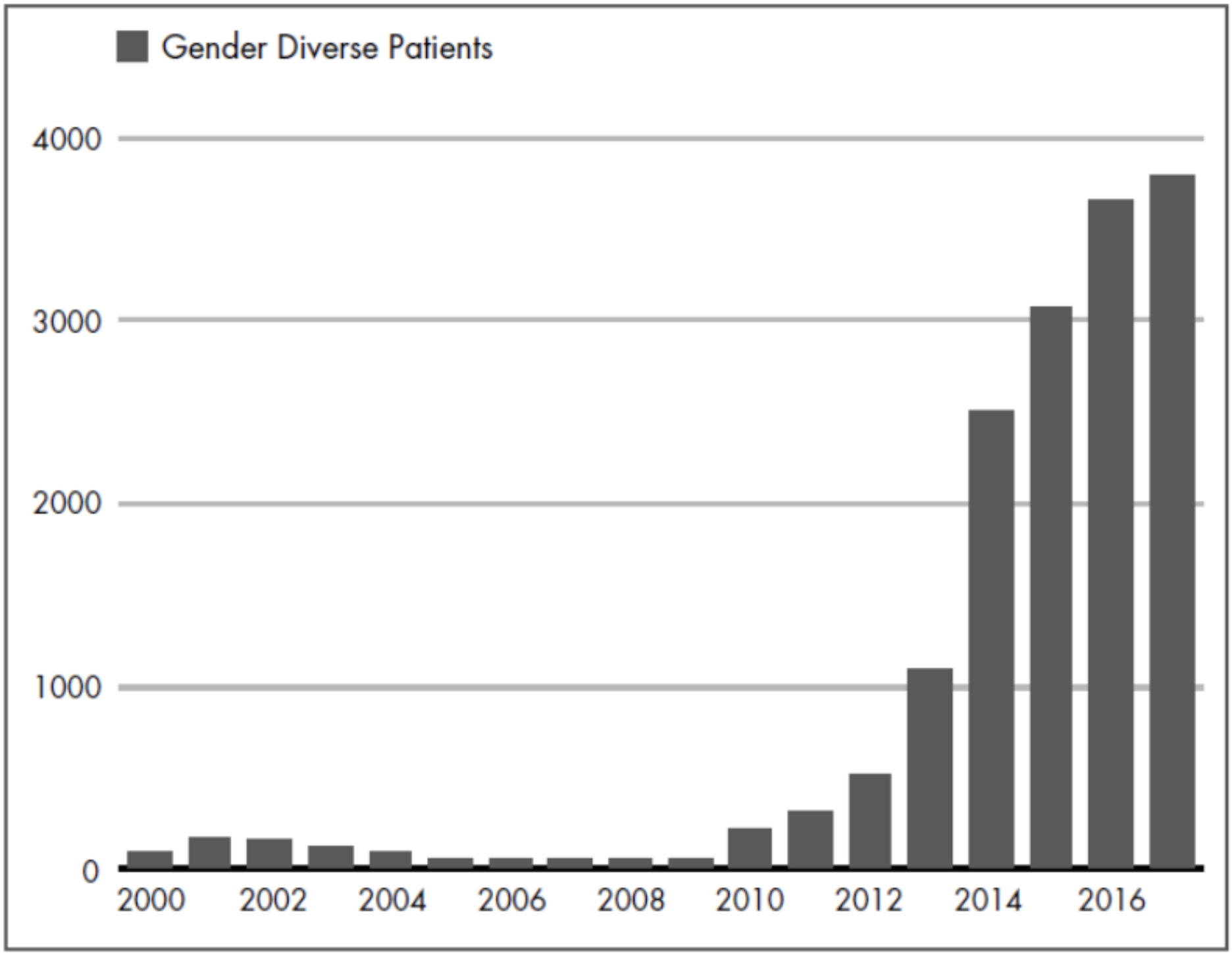
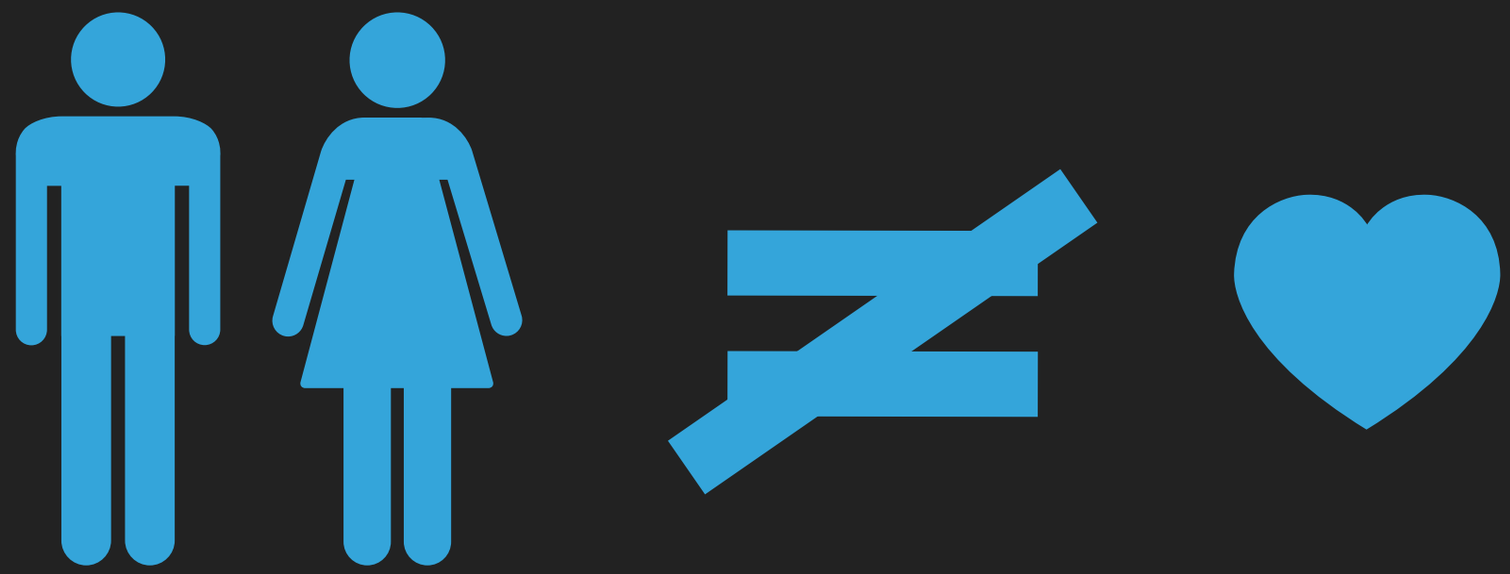


FIGURE 4–1. Increase in number of transgender patients at Callen-Lorde Community Health Center from 2000 to 2017.

Source. P. Carneiro, personal communication, January 9, 2018.

TRANSITION IS NOT UNIDIRECTIONAL

GENDER IS NOT ORIENTATION



MENTAL HEALTH SYMPTOMS

- DEPRESSION
- ANXIETY
- SUBSTANCE USE
- SUICIDAL IDEATION
- SUICIDE ATTEMPTS

THE QUESTION OF DIAGNOSIS

- GENDER DYSPHORIA
- PLURALITY
- PERSONALITY DISORDER
- PSYCHOSIS

- GENDER DYSPHORIA IN ADOLESCENTS AND ADULTS 302.85 (F64.0)
  A. A MARKED INCONGRUENCE BETWEEN ONE'S EXPERIENCED/EXPRESSED GENDER AND ASSIGNED GENDER, OF AT LEAST 6 MONTHS' DURATION, AS MANIFESTED BY AT LEAST TWO OF THE FOLLOWING:
    A MARKED INCONGRUENCE BETWEEN ONE'S EXPERIENCED/EXPRESSED GENDER AND PRIMARY AND/OR SECONDARY SEX CHARACTERISTICS (OR IN YOUNG ADOLESCENTS, THE ANTICIPATED SECONDARY SEX CHARACTERISTICS).
    A STRONG DESIRE TO BE RID OF ONE'S PRIMARY AND/OR SECONDARY SEX CHARACTERISTICS BECAUSE OF A MARKED INCONGRUENCE WITH ONE'S EXPERIENCED/EXPRESSED GENDER (OR IN YOUNG ADOLESCENTS, A DESIRE TO PREVENT THE DEVELOPMENT OF THE ANTICIPATED SECONDARY SEX CHARACTERISTICS).
    A STRONG DESIRE FOR THE PRIMARY AND/OR SECONDARY SEX CHARACTERISTICS OF THE OTHER GENDER.
    A STRONG DESIRE TO BE OF THE OTHER GENDER (OR SOME ALTERNATIVE GENDER DIFFERENT FROM ONE'S ASSIGNED GENDER).
    A STRONG DESIRE TO BE TREATED AS THE OTHER GENDER (OR SOME ALTERNATIVE GENDER DIFFERENT FROM ONE'S ASSIGNED GENDER).
    A STRONG CONVICTION THAT ONE HAS THE TYPICAL FEELINGS AND REACTIONS OF THE OTHER GENDER (OR SOME ALTERNATIVE GENDER DIFFERENT FROM ONE'S ASSIGNED GENDER).
  B. THE CONDITION IS ASSOCIATED WITH CLINICALLY SIGNIFICANT DISTRESS OR IMPAIRMENT IN SOCIAL, OCCUPATIONAL, OR OTHER IMPORTANT AREAS OF FUNCTIONING.

THEMES IN MENTAL HEALTH

- WHERE AM I ON THE SPECTRUM?
- WHAT ARE THE PROS AND CONS OF HORMONES AND SURGERY?
- CAN YOU GIVE ME HORMONES?
- CAN YOU HELP ME FIND A DOCTOR?
- CAN YOU WRITE ME A LETTER?
- CAN YOU TALK TO MY FAMILY?
- HOW DO I FIND WORK?
- HOW DO I FIND LOVE?
- WHAT DO I DO NOW?

LETTER WRITING IS A CAPACITY EVALUATION

LETTER FOR SURGERY:
5/17/2019

PATIENT NAME:
PATIENT DOB:

DEAR DR. X,

[NAME OF PATIENT] IS A PATIENT OF MINE SINCE [DATE OF FIRST VISIT]. I AM WRITING THIS LETTER IN SUPPORT OF [NAME OF PATIENT] UNDERGOING [TYPE THE NAME OF THE SURGERY]
[METOIDIOPLASTY/VAGINOPLASTY/PHALLOPLASTY/HYSTERECTOMY/OOPHORECTOMY/ORCHIECTOMY/BILATERAL REDUCTION MAMMOPLASTY WITH CHEST RECONSTRUCTION/ BREAST AUGMENTATION].

[NAME OF PATIENT] EXPERIENCES PERSISTENT GENDER DYSPHORIA, AND I AM IN SUPPORT OF THIS GENDER-CONFIRMING SURGERY AS THE NEXT STEP IN THEIR TRANSITION PROCESS. IN ORDER TO RECEIVE GENDER-AFFIRMING HORMONE TREATMENT [NAME OF PATIENT] WAS DETERMINED TO HAVE CAPACITY TO MAKE INFORMED CONSENT.

[PLEASE PROVIDE RELEVANT PSYCHIATRIC HISTORY HERE INCLUDING DIAGNOSIS, RECENT HOSPITALIZATIONS OR SUICIDE ATTEMPTS, WHETHER THEIR SYMPTOMS ARE WELL CONTROLLED, AND WHY THE CLIENT IS READY FOR SURGERY AT THIS TIME IN YOUR OPINION]

THEIR CURRENT MEDICAL HORMONE REGIMEN INCLUDES [INSERT CURRENTLY PRESCRIBED HORMONE] WHICH THEY HAVE BEEN TAKING SINCE [INSERT HORMONE START DATE].
OR
THEY ARE CURRENTLY NOT TAKING HORMONES BECAUSE THEY ARE CONTRAINDICATED BY THE DIAGNOSIS OF [INSERT DIAGNOSIS].

PLEASE CALL ME AT (111) 111-1111 WITH ANY QUESTIONS OR TO ARRANGE FOLLOW-UP CARE.
SINCERELY,
[NAME OF PROVIDER]
[LICENSE NUMBER]