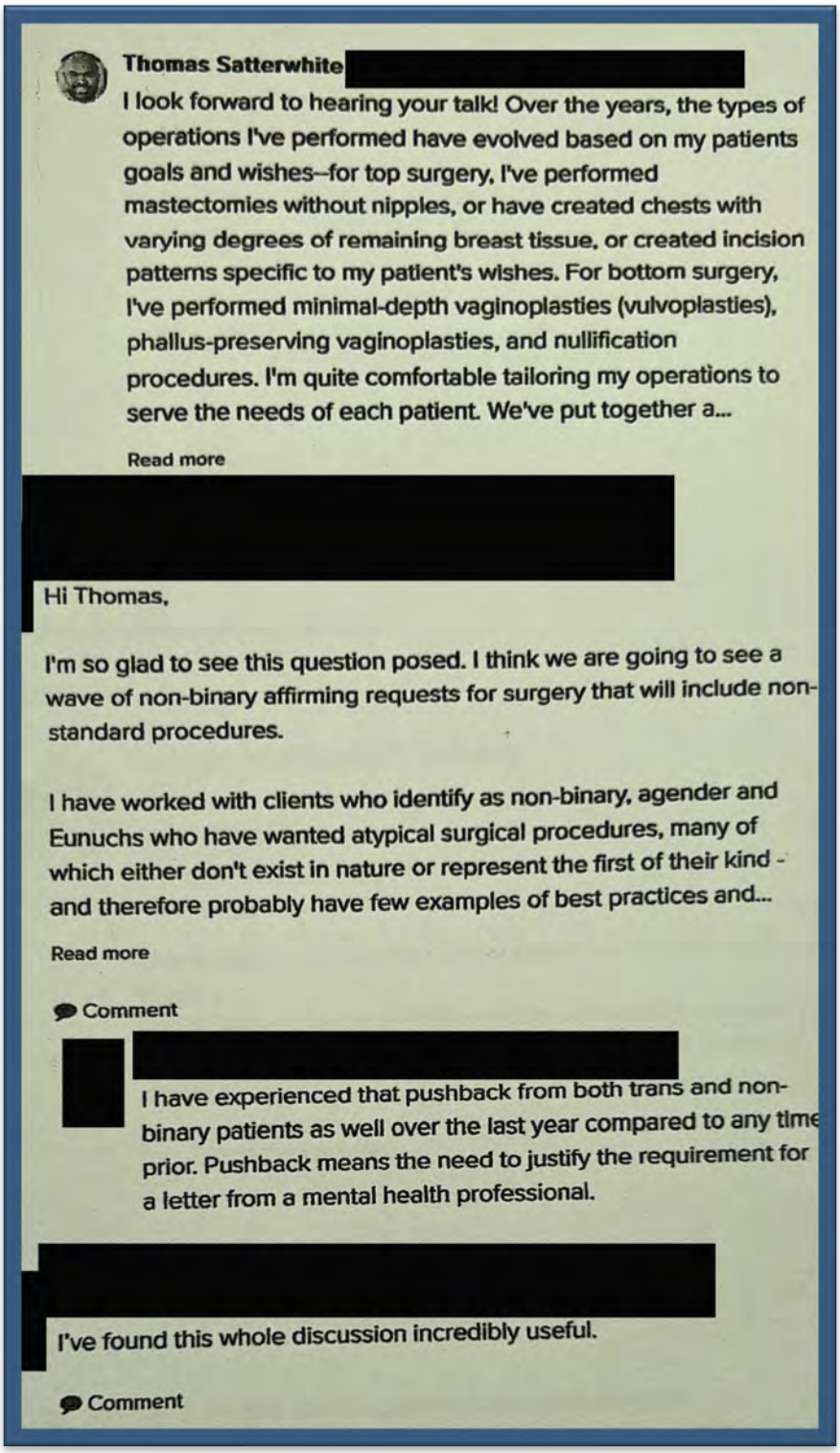


Thomas Satterwhite [redacted]

I look forward to hearing your talk! Over the years, the types of operations I've performed have evolved based on my patients goals and wishes--for top surgery, I've performed mastectomies without nipples, or have created chests with varying degrees of remaining breast tissue, or created incision patterns specific to my patient's wishes. For bottom surgery, I've performed minimal-depth vaginoplasties (vulvoplasties), phallus-preserving vaginoplasties, and nullification procedures. I'm quite comfortable tailoring my operations to serve the needs of each patient. We've put together a...

Read more

[redacted]

Hi Thomas,

I'm so glad to see this question posed. I think we are going to see a wave of non-binary affirming requests for surgery that will include non-standard procedures.

I have worked with clients who identify as non-binary, agender and Eunuchs who have wanted atypical surgical procedures, many of which either don't exist in nature or represent the first of their kind - and therefore probably have few examples of best practices and...

Read more

Comment

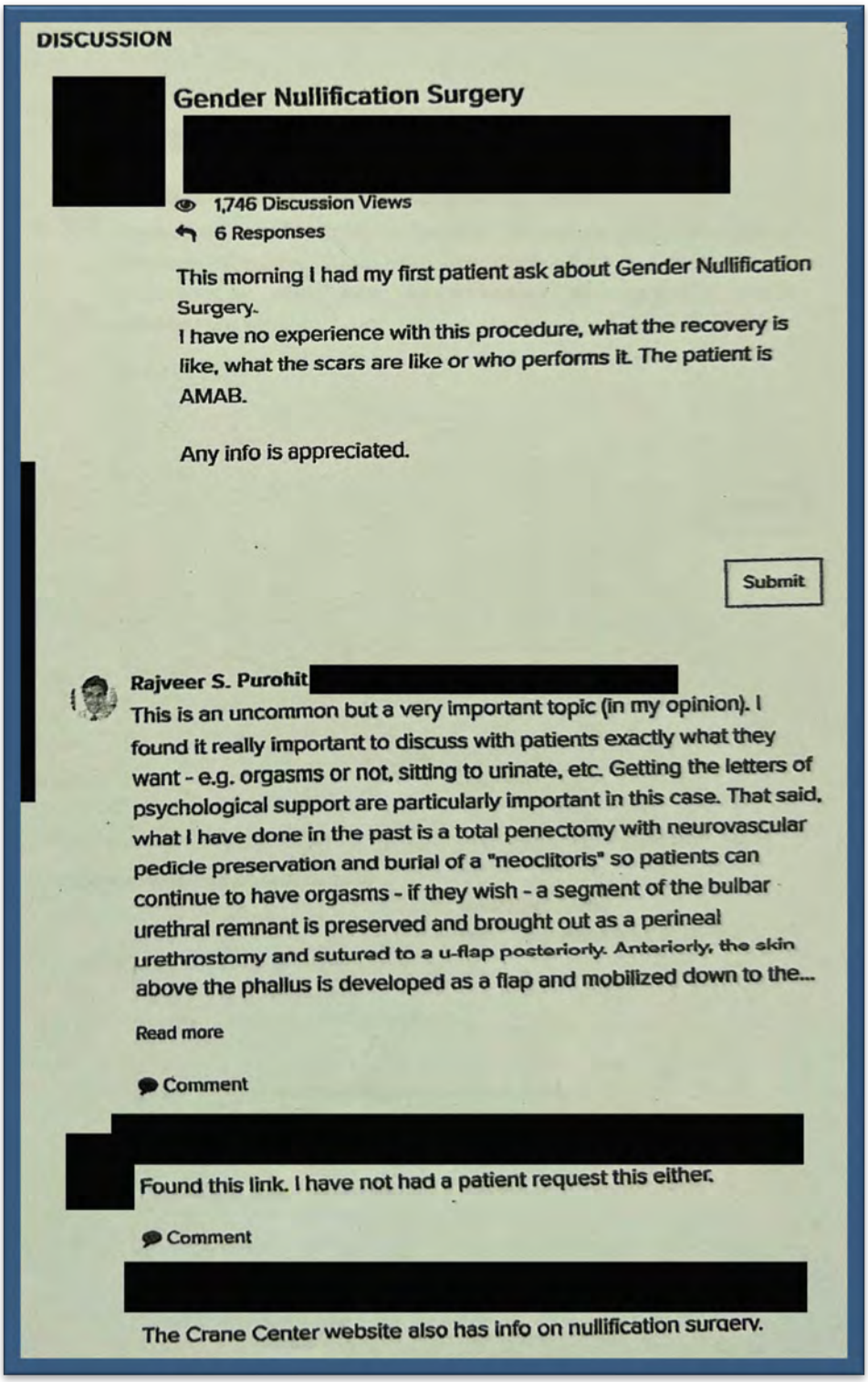
[redacted]

I have experienced that pushback from both trans and non-binary patients as well over the last year compared to any time prior. Pushback means the need to justify the requirement for a letter from a mental health professional.

[redacted]

I've found this whole discussion incredibly useful.

Comment



DISCUSSION

[redacted] Gender Nullification Surgery

[redacted]

1,746 Discussion Views

6 Responses

This morning I had my first patient ask about Gender Nullification Surgery.
I have no experience with this procedure, what the recovery is like, what the scars are like or who performs it. The patient is AMAB.

Any info is appreciated.

Submit

Rajveer S. Purohit [redacted]
This is an uncommon but a very important topic (in my opinion). I found it really important to discuss with patients exactly what they want - e.g. orgasms or not, sitting to urinate, etc. Getting the letters of psychological support are particularly important in this case. That said, what I have done in the past is a total penectomy with neurovascular pedicle preservation and burial of a "neoclitoris" so patients can continue to have orgasms - if they wish - a segment of the bulbar urethral remnant is preserved and brought out as a perineal urethrostomy and sutured to a u-flap posteriorly. Anteriorly, the skin above the phallus is developed as a flap and mobilized down to the...

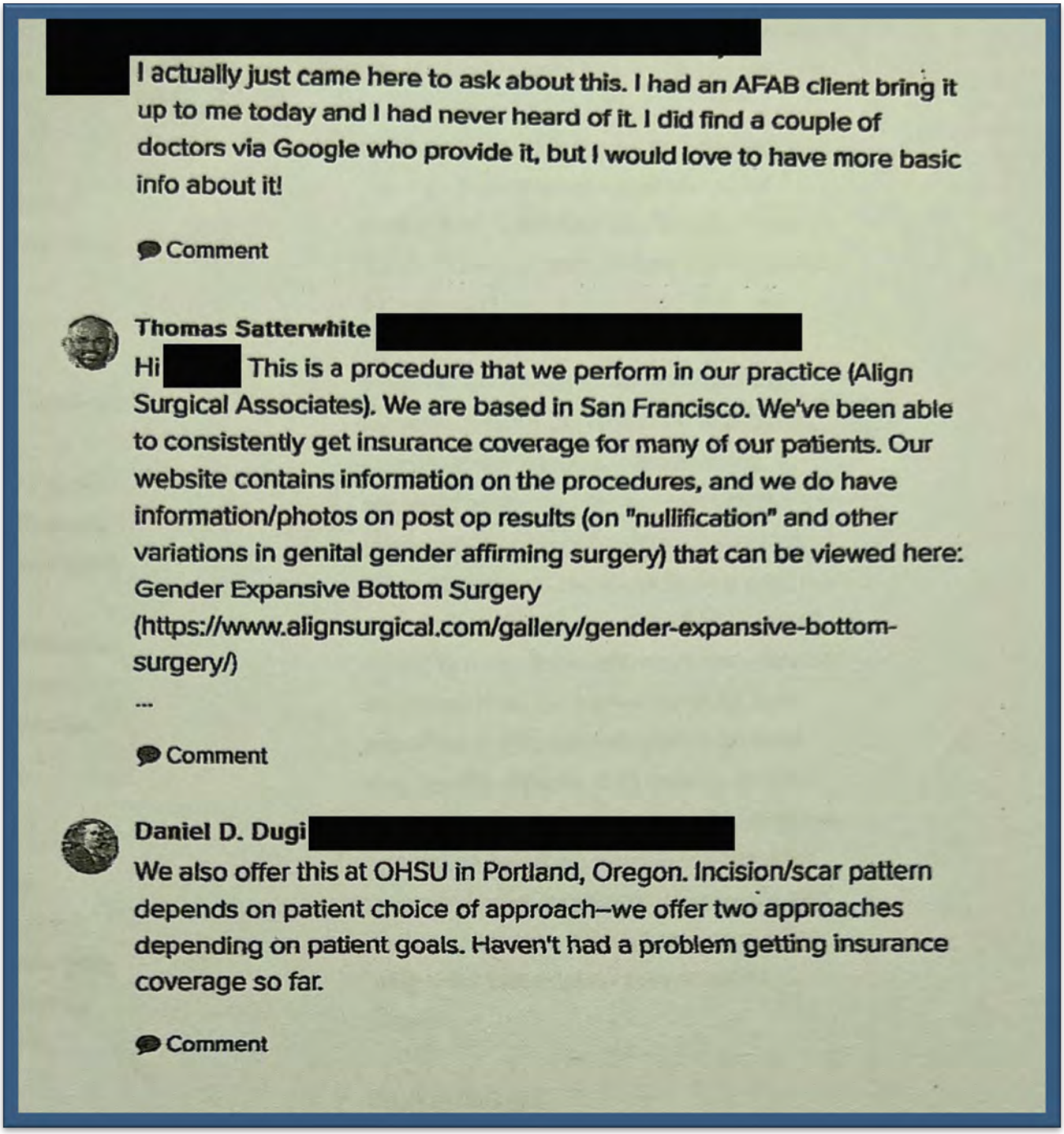
Read more

Comment

[redacted]
Found this link. I have not had a patient request this either.

Comment

[redacted]
The Crane Center website also has info on nullification surgery.



[redacted] I actually just came here to ask about this. I had an AFAB client bring it up to me today and I had never heard of it. I did find a couple of doctors via Google who provide it, but I would love to have more basic info about it!

Comment

Thomas Satterwhite [redacted]

Hi [redacted] This is a procedure that we perform in our practice (Align Surgical Associates). We are based in San Francisco. We've been able to consistently get insurance coverage for many of our patients. Our website contains information on the procedures, and we do have information/photos on post op results (on "nullification" and other variations in genital gender affirming surgery) that can be viewed here: Gender Expansive Bottom Surgery (https://www.alignsurgical.com/gallery/gender-expansive-bottom-surgery/)

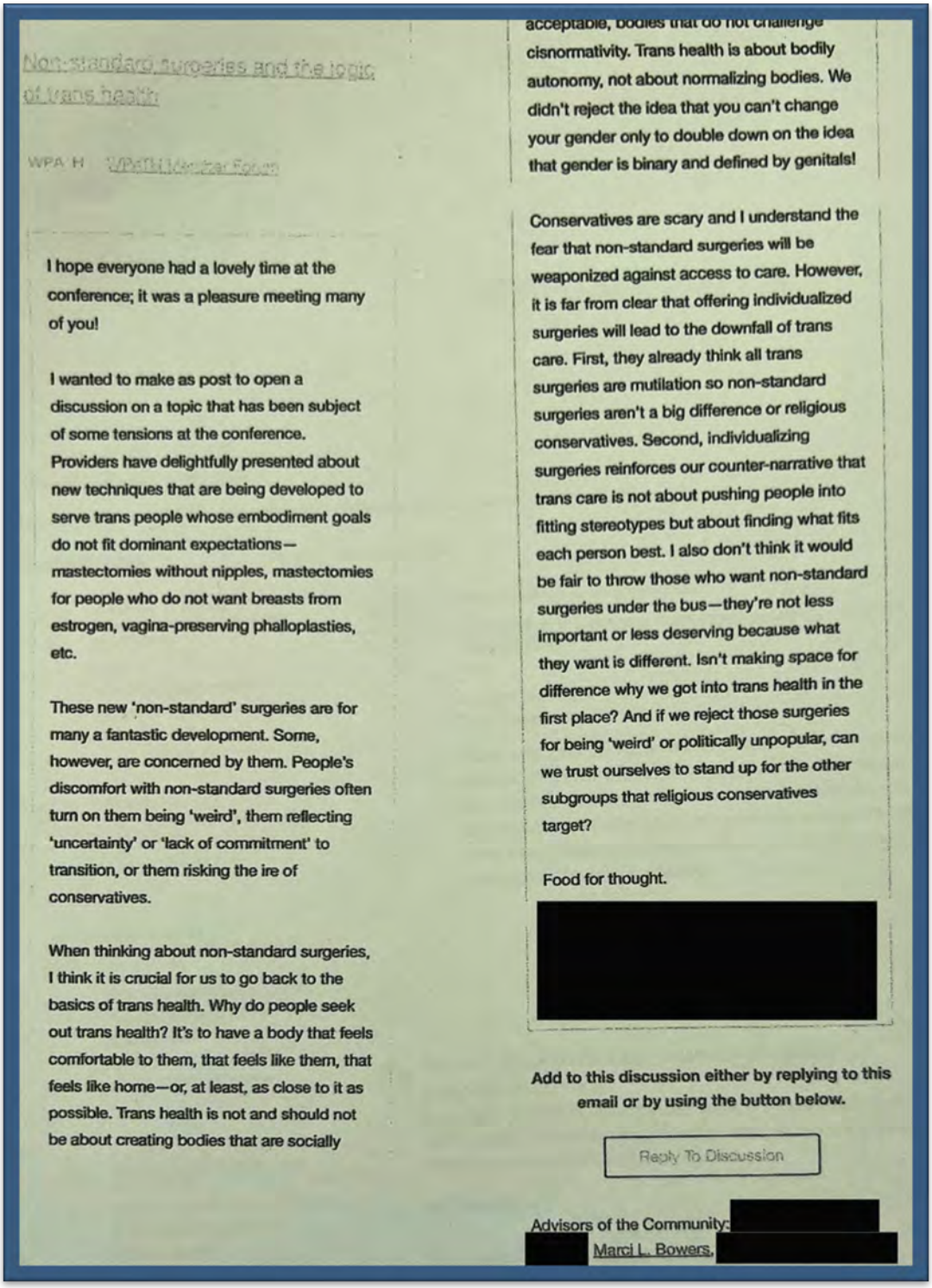
...

Comment

Daniel D. Dugi [redacted]

We also offer this at OHSU in Portland, Oregon. Incision/scar pattern depends on patient choice of approach–we offer two approaches depending on patient goals. Haven't had a problem getting insurance coverage so far.

Comment



Non-standard surgeries and the topic of trans health

WPA H [redacted] WPATH Member Forum

I hope everyone had a lovely time at the conference; it was a pleasure meeting many of you!

I wanted to make as post to open a discussion on a topic that has been subject of some tensions at the conference. Providers have delightfully presented about new techniques that are being developed to serve trans people whose embodiment goals do not fit dominant expectations—mastectomies without nipples, mastectomies for people who do not want breasts from estrogen, vagina-preserving phalloplasties, etc.

These new 'non-standard' surgeries are for many a fantastic development. Some, however, are concerned by them. People's discomfort with non-standard surgeries often turn on them being 'weird', them reflecting 'uncertainty' or 'lack of commitment' to transition, or them risking the ire of conservatives.

When thinking about non-standard surgeries, I think it is crucial for us to go back to the basics of trans health. Why do people seek out trans health? It's to have a body that feels comfortable to them, that feels like them, that feels like home—or, at least, as close to it as possible. Trans health is not and should not be about creating bodies that are socially acceptable, bodies that do not challenge cisnormativity. Trans health is about bodily autonomy, not about normalizing bodies. We didn't reject the idea that you can't change your gender only to double down on the idea that gender is binary and defined by genitals!

Conservatives are scary and I understand the fear that non-standard surgeries will be weaponized against access to care. However, it is far from clear that offering individualized surgeries will lead to the downfall of trans care. First, they already think all trans surgeries are mutilation so non-standard surgeries aren't a big difference or religious conservatives. Second, individualizing surgeries reinforces our counter-narrative that trans care is not about pushing people into fitting stereotypes but about finding what fits each person best. I also don't think it would be fair to throw those who want non-standard surgeries under the bus—they're not less important or less deserving because what they want is different. Isn't making space for difference why we got into trans health in the first place? And if we reject those surgeries for being 'weird' or politically unpopular, can we trust ourselves to stand up for the other subgroups that religious conservatives target?

Food for thought.

[redacted]

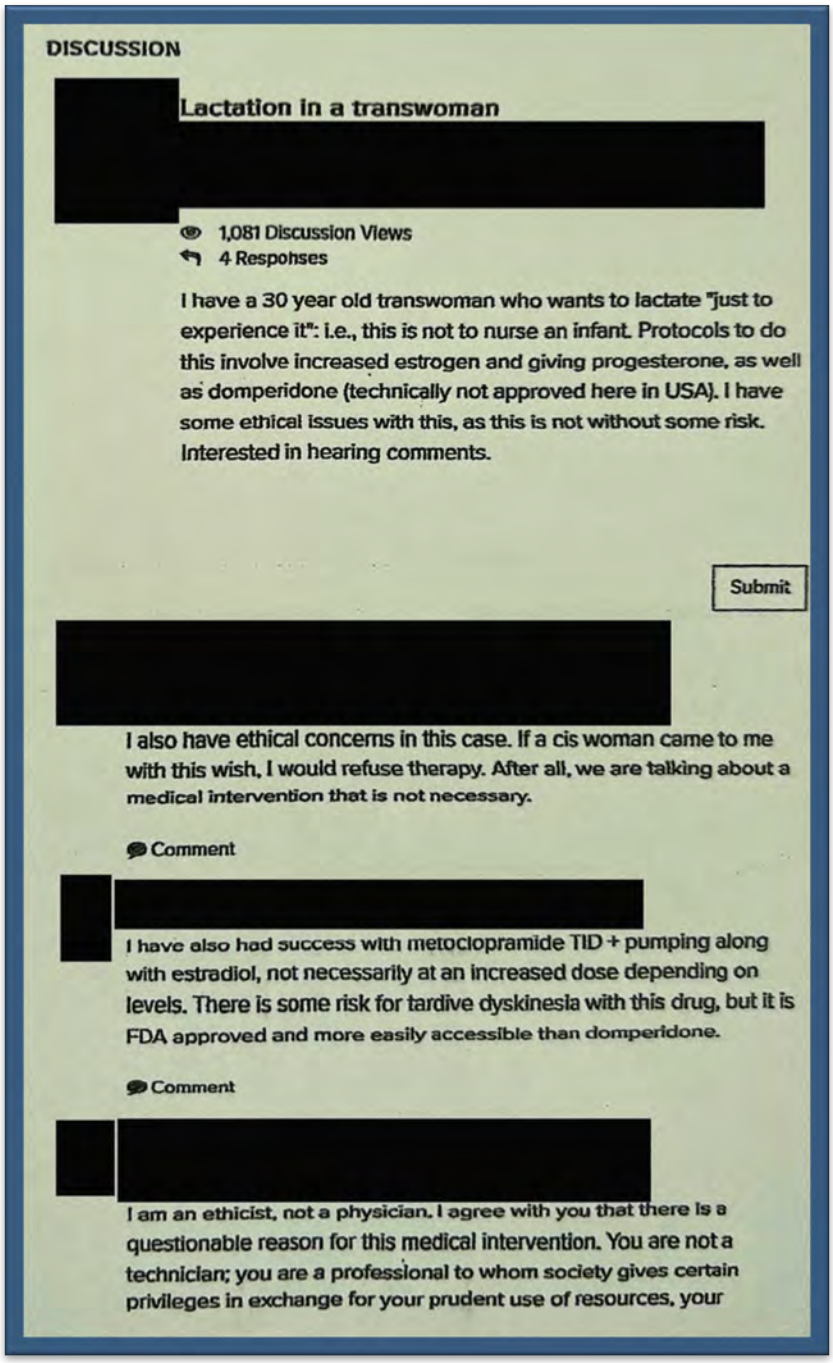
Add to this discussion either by replying to this email or by using the button below.

Reply To Discussion

Advisors of the Community: [redacted] Marci L. Bowers, [redacted]

13) LACTATION CONCERNS

a) A WPATH member discusses risk in providing a trans patient with lactation capabilities via surgery



DISCUSSION

[redacted] Lactation in a transwoman [redacted]

1,081 Discussion Views
4 Responses

I have a 30 year old transwoman who wants to lactate "just to experience it": i.e., this is not to nurse an infant. Protocols to do this involve increased estrogen and giving progesterone, as well as domperidone (technically not approved here in USA). I have some ethical issues with this, as this is not without some risk. Interested in hearing comments.

Submit

[redacted]

I also have ethical concerns in this case. If a cis woman came to me with this wish, I would refuse therapy. After all, we are talking about a medical intervention that is not necessary.

Comment

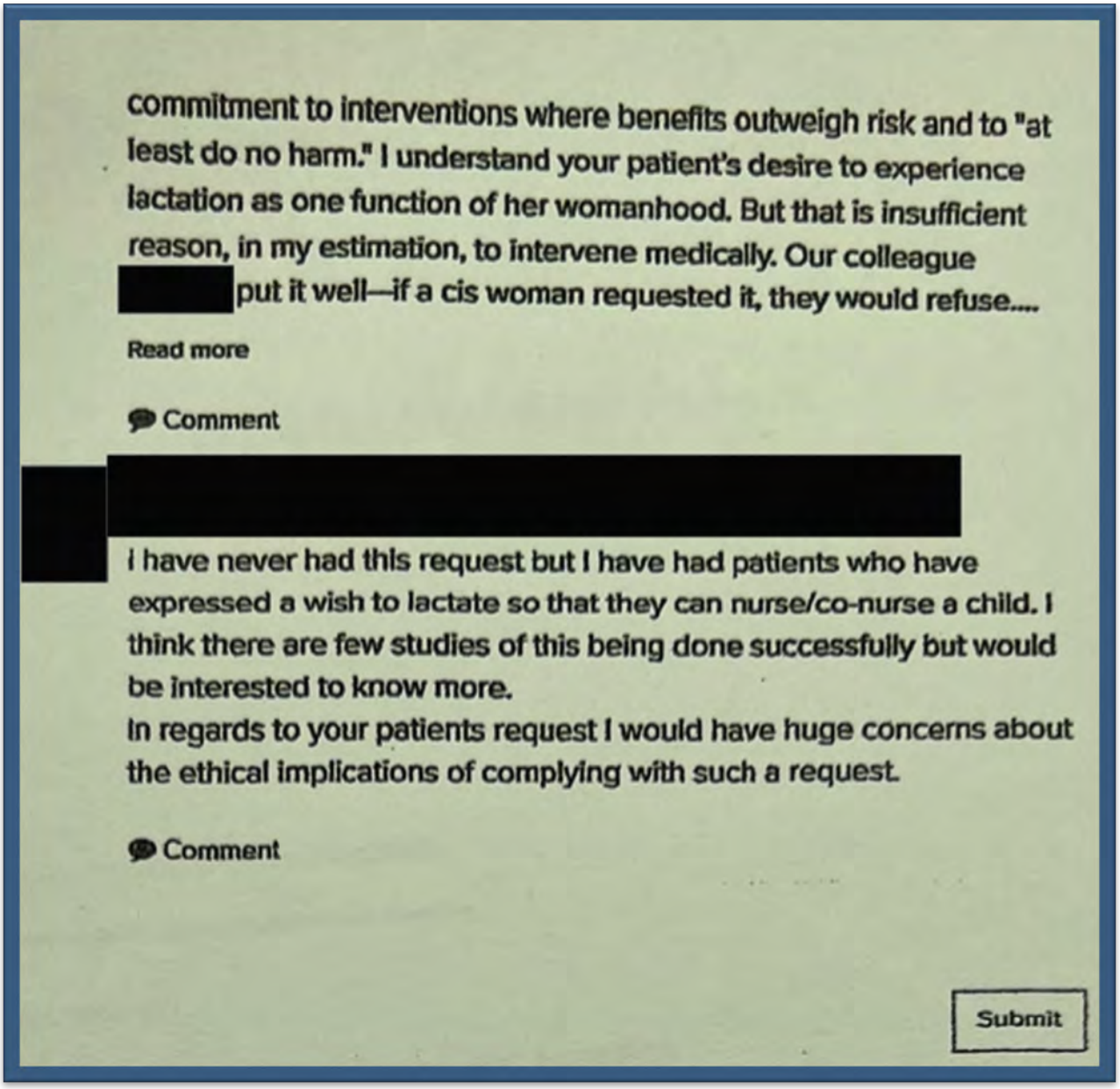
[redacted]

I have also had success with metoclopramide TID + pumping along with estradiol, not necessarily at an increased dose depending on levels. There is some risk for tardive dyskinesia with this drug, but it is FDA approved and more easily accessible than domperidone.

Comment

[redacted]

I am an ethicist, not a physician. I agree with you that there is a questionable reason for this medical intervention. You are not a technician; you are a professional to whom society gives certain privileges in exchange for your prudent use of resources, your



commitment to interventions where benefits outweigh risk and to "at least do no harm." I understand your patient's desire to experience lactation as one function of her womanhood. But that is insufficient reason, in my estimation, to intervene medically. Our colleague [redacted] put it well—if a cis woman requested it, they would refuse....

Read more

Comment

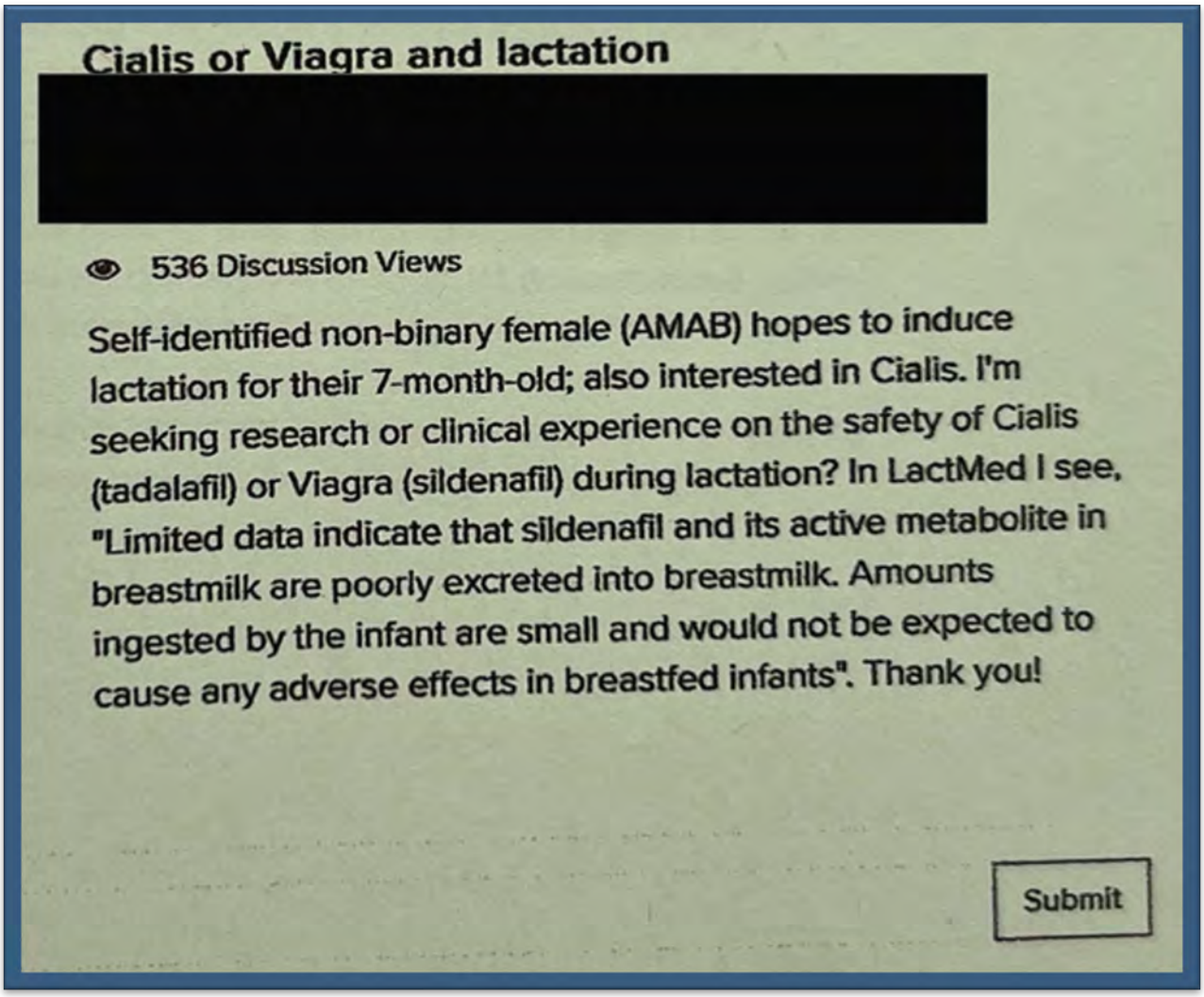
[redacted]

I have never had this request but I have had patients who have expressed a wish to lactate so that they can nurse/co-nurse a child. I think there are few studies of this being done successfully but would be interested to know more.
In regards to your patients request I would have huge concerns about the ethical implications of complying with such a request.

Comment

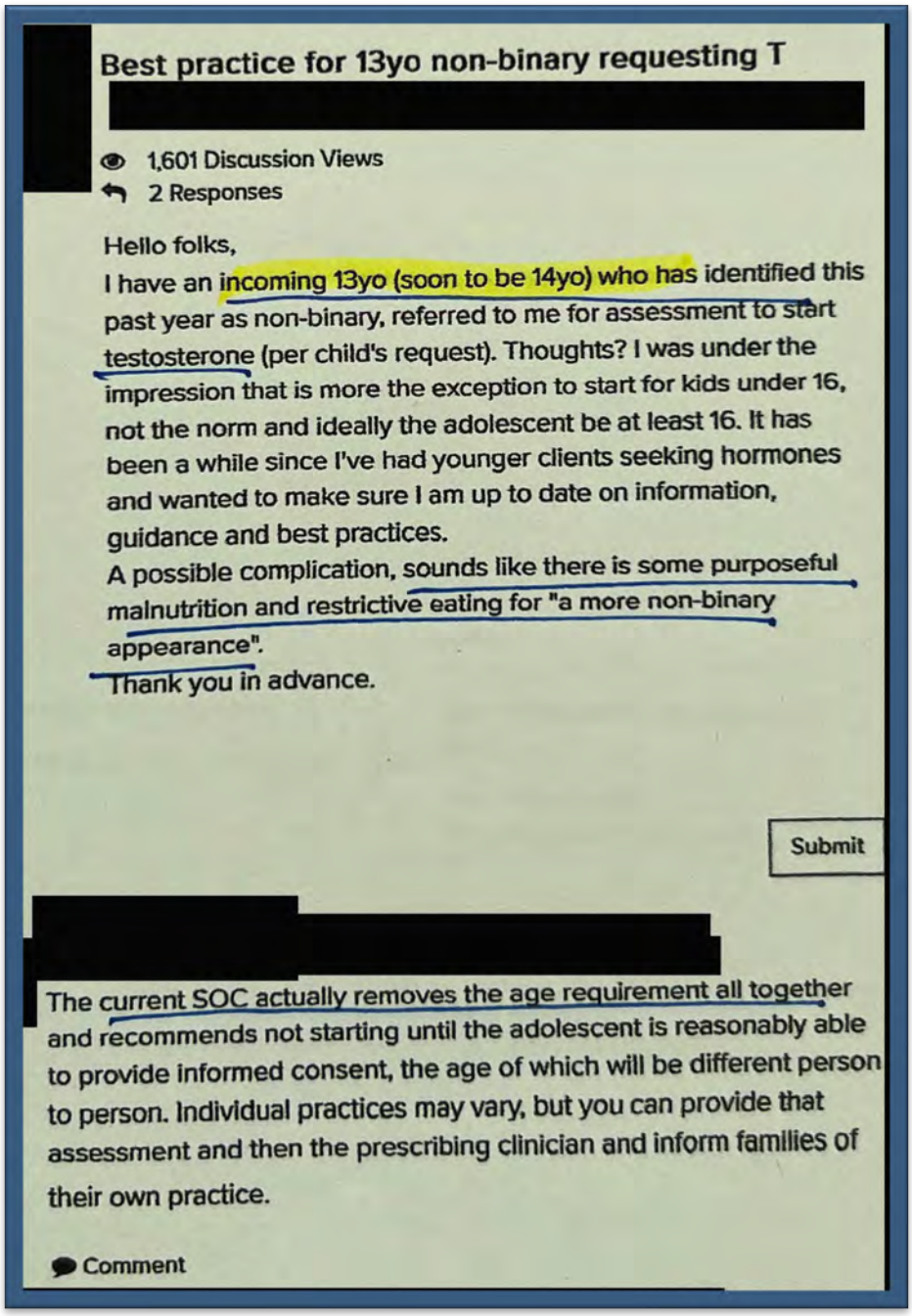
Submit

b) A nonbinary female expresses a desire to induce lactation and take Cialis



14) NON-BINARY HEALTHCARE FOR MINORS

a) WPATH members discuss a nonbinary 13-year-old patient requesting HRT



Best practice for 13yo non-binary requesting T

[redacted]

1,601 Discussion Views
2 Responses

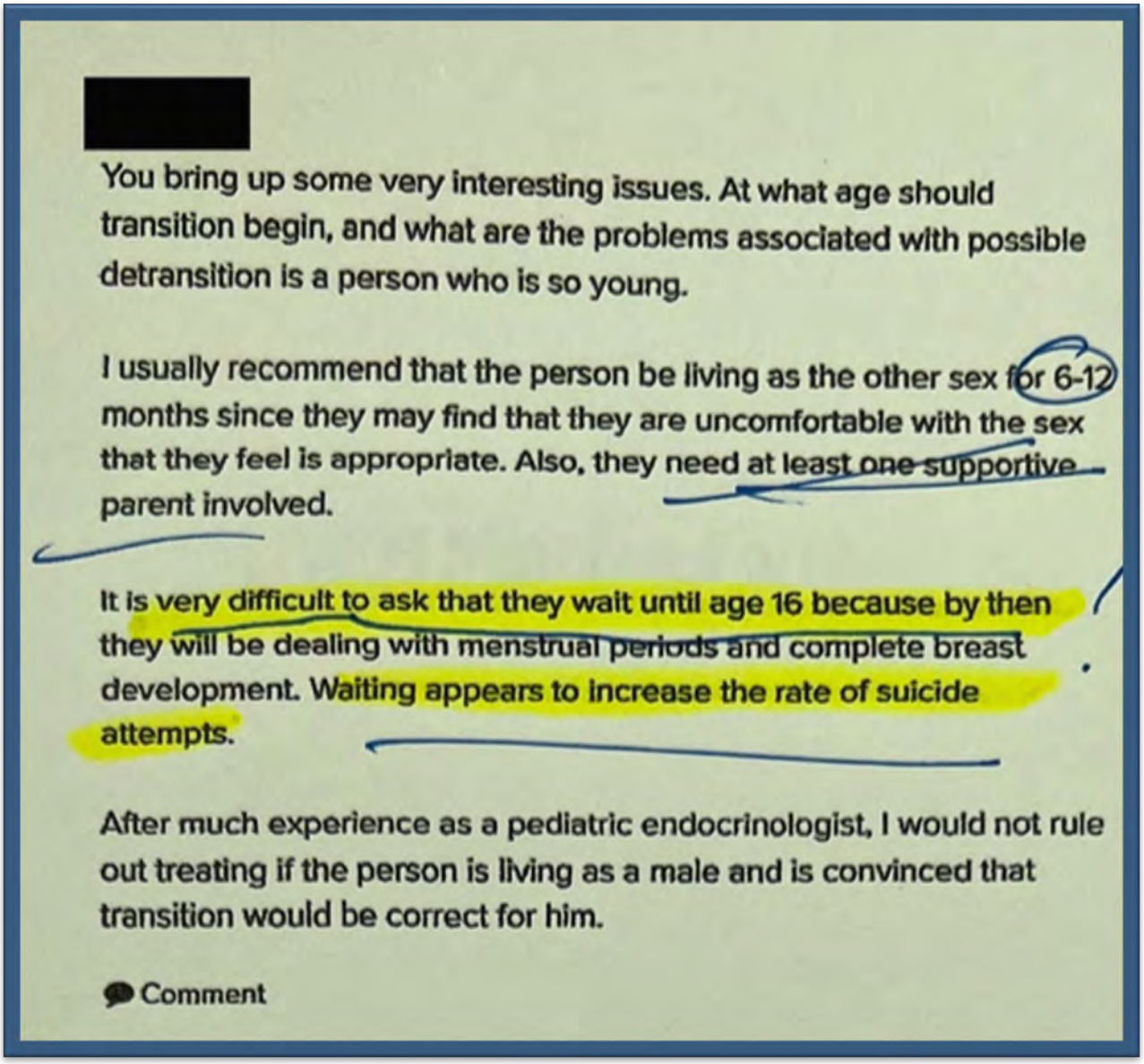
Hello folks,
I have an incoming 13yo (soon to be 14yo) who has identified this past year as non-binary, referred to me for assessment to start testosterone (per child's request). Thoughts? I was under the impression that is more the exception to start for kids under 16, not the norm and ideally the adolescent be at least 16. It has been a while since I've had younger clients seeking hormones and wanted to make sure I am up to date on information, guidance and best practices.
A possible complication, sounds like there is some purposeful malnutrition and restrictive eating for "a more non-binary appearance".
Thank you in advance.

Submit

[redacted]

The current SOC actually removes the age requirement all together and recommends not starting until the adolescent is reasonably able to provide informed consent, the age of which will be different person to person. Individual practices may vary, but you can provide that assessment and then the prescribing clinician and inform families of their own practice.

Comment



[redacted]

You bring up some very interesting issues. At what age should transition begin, and what are the problems associated with possible detransition is a person who is so young.

I usually recommend that the person be living as the other sex for 6-12 months since they may find that they are uncomfortable with the sex that they feel is appropriate. Also, they need at least one supportive parent involved.

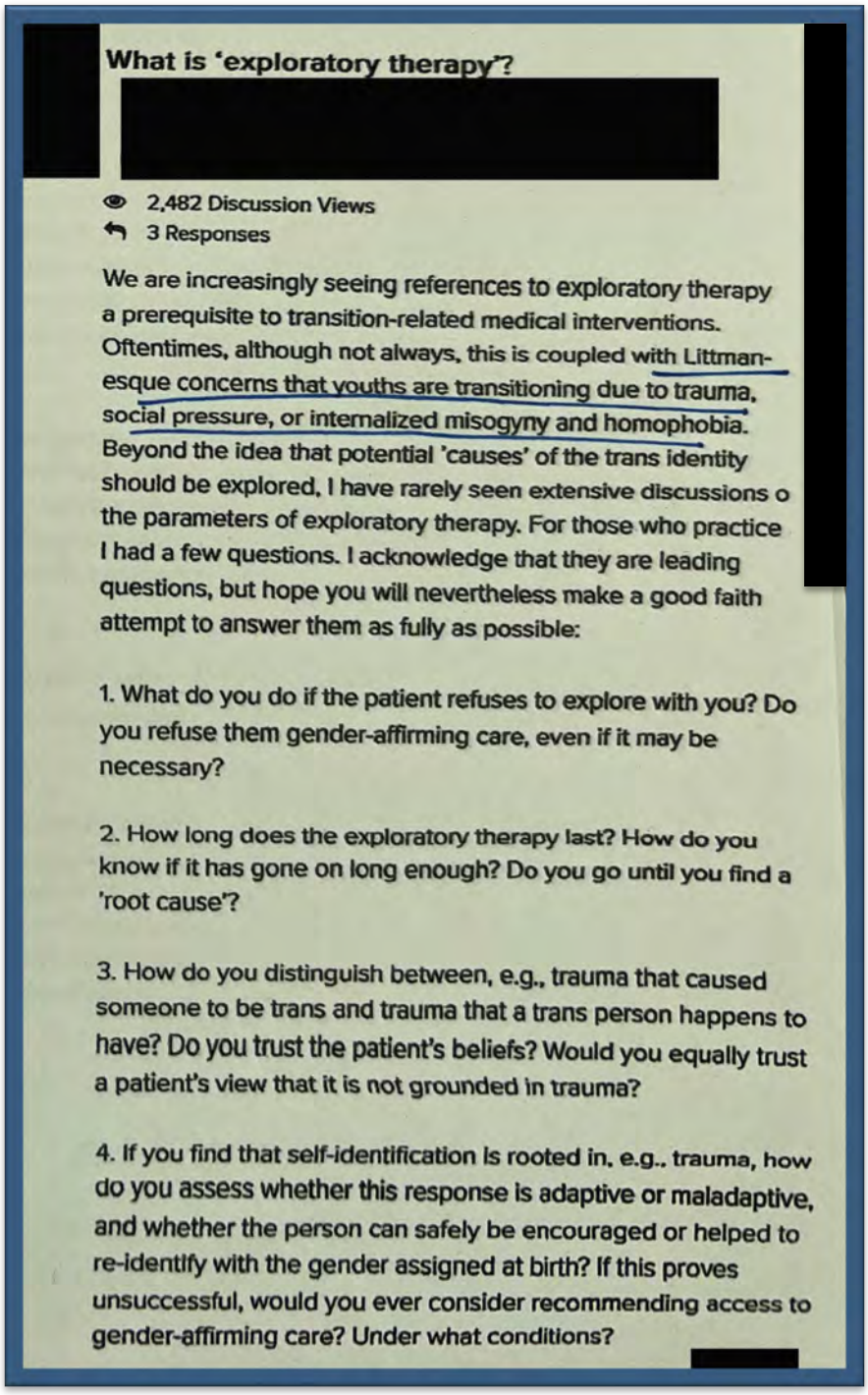
It is very difficult to ask that they wait until age 16 because by then they will be dealing with menstrual periods and complete breast development. Waiting appears to increase the rate of suicide attempts.

After much experience as a pediatric endocrinologist, I would not rule out treating if the person is living as a male and is convinced that transition would be correct for him.

Comment

15) CAUSE FOR TRANSITION AND EXPLORATORY THERAPY

a) A WPATH member questions if there is a root cause driving transition



What is 'exploratory therapy'?

[redacted]

2,482 Discussion Views
3 Responses

We are increasingly seeing references to exploratory therapy a prerequisite to transition-related medical interventions. Oftentimes, although not always, this is coupled with Littman-esque concerns that youths are transitioning due to trauma, social pressure, or internalized misogyny and homophobia. Beyond the idea that potential 'causes' of the trans identity should be explored, I have rarely seen extensive discussions o the parameters of exploratory therapy. For those who practice I had a few questions. I acknowledge that they are leading questions, but hope you will nevertheless make a good faith attempt to answer them as fully as possible:

1. What do you do if the patient refuses to explore with you? Do you refuse them gender-affirming care, even if it may be necessary?

2. How long does the exploratory therapy last? How do you know if it has gone on long enough? Do you go until you find a 'root cause'?

3. How do you distinguish between, e.g., trauma that caused someone to be trans and trauma that a trans person happens to have? Do you trust the patient's beliefs? Would you equally trust a patient's view that it is not grounded in trauma?

4. If you find that self-identification is rooted in, e.g., trauma, how do you assess whether this response is adaptive or maladaptive, and whether the person can safely be encouraged or helped to re-identify with the gender assigned at birth? If this proves unsuccessful, would you ever consider recommending access to gender-affirming care? Under what conditions?

[redacted]

5. If a patient re-identifies as cisgender, do you wind-down the therapy or do you continue at the same pace to ensure their re-identification is genuine and not a coping or adaptive response? Why or why not?

6. Relatedly, do you consider self-identification as transgender more suspect or deserving of exploration than self-identification as cisgender? Why or why not? How is this reflected in exploratory therapy?

7. Is there any evidence that exploratory therapy leads to better outcomes, however you define them, or that it can successfully identify youths who aren't 'truly trans,' youths whose identification is maladaptive, and/or youths who would be harmed by accessing gender-affirming interventions?

8. Do you believe that transition-related medical interventions such as hormones can be offered in parallel to exploratory therapy either as a means of reducing present gender dysphoria or as a way of helping the individual explore their gender and whether gender-affirming care is right for them? Do you think social and medical transition being temporary is an inherently undesirable outcome? Why or why not? Is this related to an intuition that bodies that have undergone medical transition are less desirable and should be avoided if possible?

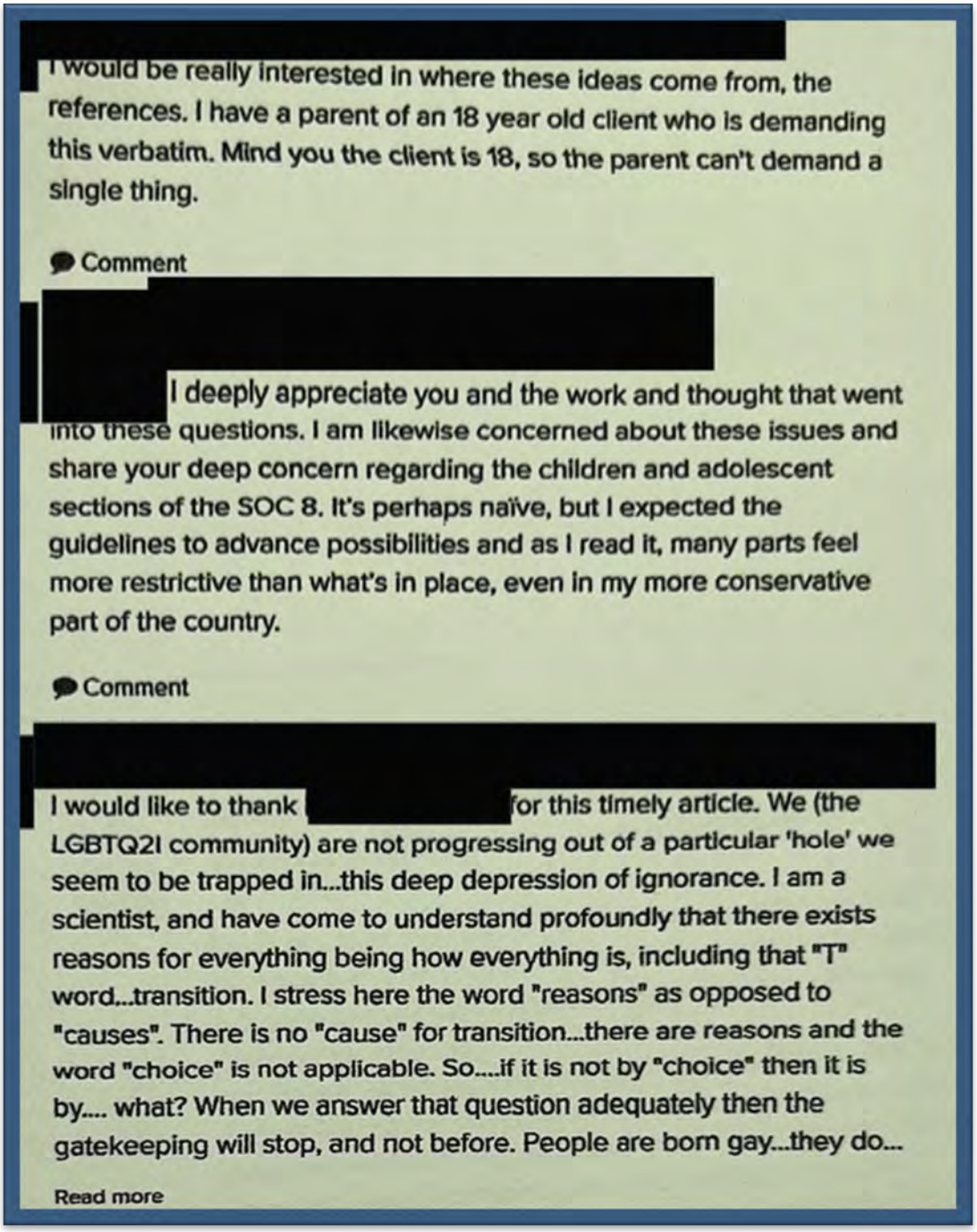
9. What do you make of the distress of the numerous youths who are 'truly' trans, who we have reasons to believe are a strong majority and will experience ongoing distress during? Based on the recent Littman study, the high end of non-disclosure of detransition to clinician is around 75% and the high end of detransition estimates is around 3%. Even assuming the correctness of these higher bound estimates, we would still have 88% of individuals not detransitioning.

9. Given your concern about precipitated and premature affirmation as a foreclosure of gender identity and exploration, what are your thoughts on encouraging puberty blockers more broadly to all questioning or even perhaps all cisgender kids? Would your answer change if we were 100% certain that puberty blockers had no long-term side effects?

10. Do you believe that such exploratory therapy can create psychological and emotional pressures to re-identify with the gender they were assigned at birth?

11. Do you believe that such exploratory therapy can create psychological and emotional pressures to lie, misrepresent, or otherwise engage in the therapy in bad faith so as to ensure access to sought interventions? Do you believe this could lead patients to suppress doubts and worries and, as a result, make less-than-informed decisions on accessing gender-affirming care?

Thank you ahead of time for your answers.



I would be really interested in where these ideas come from, the references. I have a parent of an 18 year old client who is demanding this verbatim. Mind you the client is 18, so the parent can't demand a single thing.

Comment

I deeply appreciate you and the work and thought that went into these questions. I am likewise concerned about these issues and share your deep concern regarding the children and adolescent sections of the SOC 8. It's perhaps naïve, but I expected the guidelines to advance possibilities and as I read it, many parts feel more restrictive than what's in place, even in my more conservative part of the country.

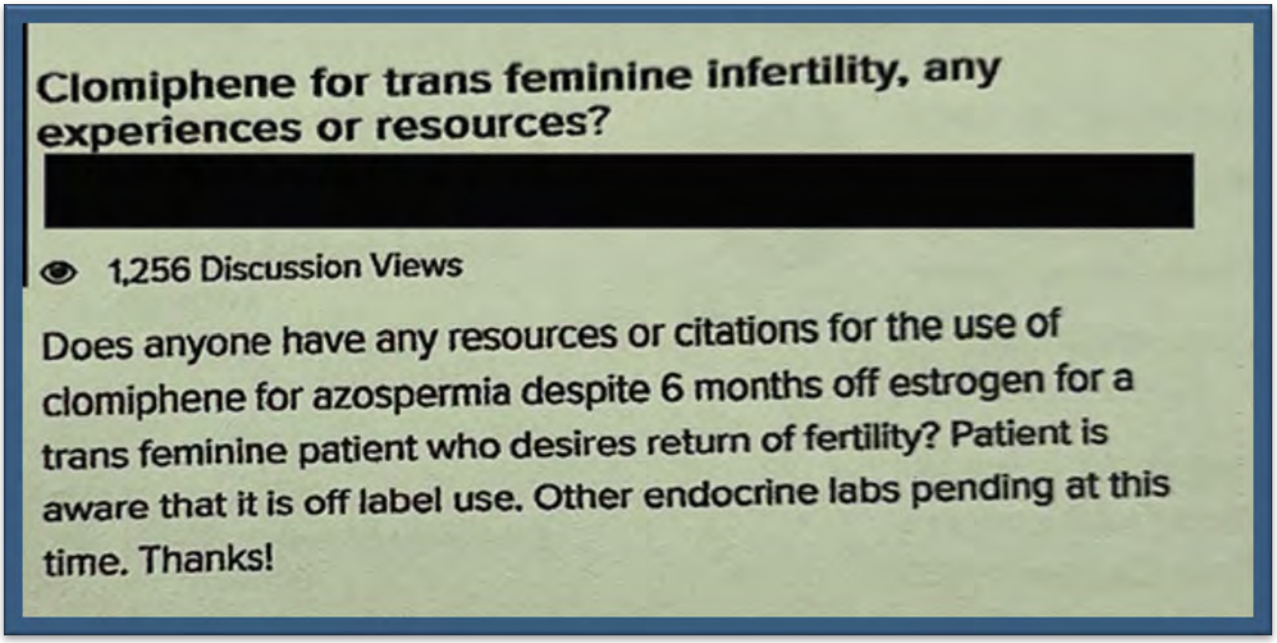
Comment

I would like to thank for this timely article. We (the LGBTQ2I community) are not progressing out of a particular 'hole' we seem to be trapped in...this deep depression of ignorance. I am a scientist, and have come to understand profoundly that there exists reasons for everything being how everything is, including that "T" word...transition. I stress here the word "reasons" as opposed to "causes". There is no "cause" for transition...there are reasons and the word "choice" is not applicable. So....if it is not by "choice" then it is by.... what? When we answer that question adequately then the gatekeeping will stop, and not before. People are born gay...they do...

Read more

16) FERTILITY ISSUES

a) A WPATH member seeks resources for infertility treatments



Clomiphene for trans feminine infertility, any experiences or resources?

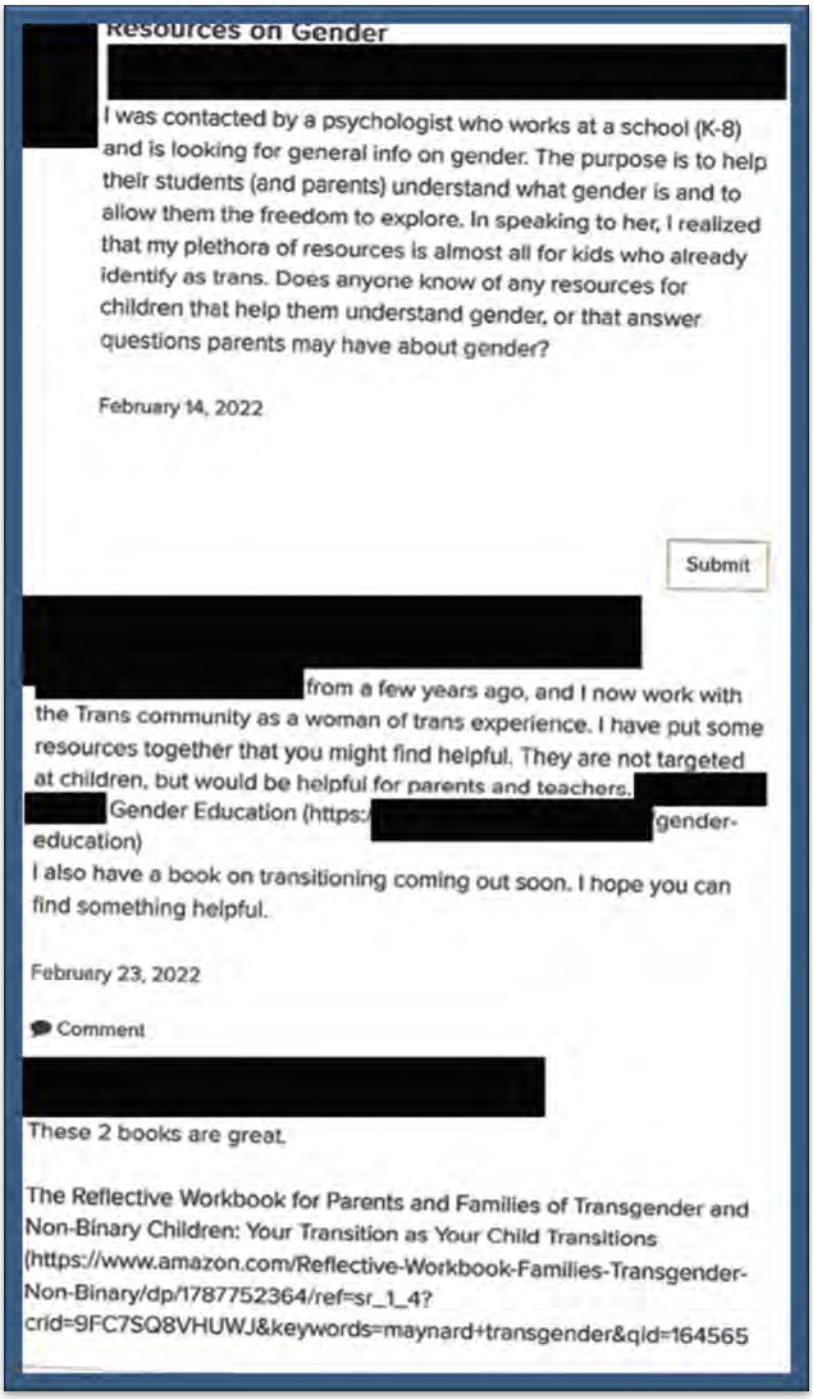
[redacted]

1,256 Discussion Views

Does anyone have any resources or citations for the use of clomiphene for azospermia despite 6 months off estrogen for a trans feminine patient who desires return of fertility? Patient is aware that it is off label use. Other endocrine labs pending at this time. Thanks!

17) RESOURCES FOR MINORS ON TRANS HEALTHCARE

a) WPATH members discuss a school psychologist searching for gender resources for students



Resources on Gender

[redacted]

I was contacted by a psychologist who works at a school (K-8) and is looking for general info on gender. The purpose is to help their students (and parents) understand what gender is and to allow them the freedom to explore. In speaking to her, I realized that my plethora of resources is almost all for kids who already identify as trans. Does anyone know of any resources for children that help them understand gender, or that answer questions parents may have about gender?

February 14, 2022

Submit

[redacted] from a few years ago, and I now work with the Trans community as a woman of trans experience. I have put some resources together that you might find helpful. They are not targeted at children, but would be helpful for parents and teachers. [redacted] Gender Education (https:/[redacted]gender-education)

I also have a book on transitioning coming out soon. I hope you can find something helpful.

February 23, 2022

Comment

[redacted]

These 2 books are great.

The Reflective Workbook for Parents and Families of Transgender and Non-Binary Children: Your Transition as Your Child Transitions (https://www.amazon.com/Reflective-Workbook-Families-Transgender-Non-Binary/dp/1787752364/ref=sr_1_4?crid=9FC7SQ8VHUWJ&keywords=maynard+transgender&qid=164565

The Reflective Workbook for Teachers and Support Staff of Trans and Non-Binary Students (https://www.amazon.com/Reflective-Workbook-Teachers-Non-Binary-Students/dp/1787752178/ref=sr_1_5?crid=9FC7SQ8VHUWJ&keywords=maynard+transgender&qid=1645653115&sprefix=maynards+transgend%2Caps%2C292&sr=8-5)

February 23, 2022

Comment

[redacted]

For teens/pre-teens, I like to use the Gender Quest workbook (https://www.amazon.com/Gender-Quest-Workbook-Exploring-Identity-ebook/dp/B018RSC3WE/ref=sr_1_1?crid=3ILMEGB0K34I3&keywords=gender+quest&qid=1645652708&s=digital-text&sprefix=gender+quest%2Cdigital-text%2C109&sr=1-1) with clients to guide our discussions. For younger children (although I don't personally work with this age group), The Gender Identity Workbook for Kids by K. Storck would be my recommendation.

February 23, 2022

Comment

[redacted]

Hi [redacted] for parents I would recommend my book, How To Understand Your Gender (https://bookshop.org/books/how-to-understand-your-gender-a-practical-guide-for-exploring-who-you-are/9781785927461). I have been told that it's a good resource for parents. It's definitely not just about trans people or trans issues but rather a guide to understanding gender for people of any gender(s). It is also suitable for high school students but not really K-8, although I know some middle-schoolers who have enjoyed it.

For K-8, I would recommend the following books:
The Big Book of LGBTQ Activities (https://us.jkp.com/collections/gender-diversity-gender-diversity-pid-906/products/the-big-book-of-lgbtq-activities)

The Every Body Book (https://us.jkp.com/collections/children-s-books-gender-diversity-pid-816/products/the-every-body-book)

The Pronoun Book (https://us.jkp.com/collections/children-s-books-gender-diversity-pid-816/products/the-pronoun-book)

For younger children, Who Are You? (https://us.jkp.com/collections/children-s-books-gender-diversity-pid-816/products/who-are-you)

I hope this is helpful!

February 23, 2022

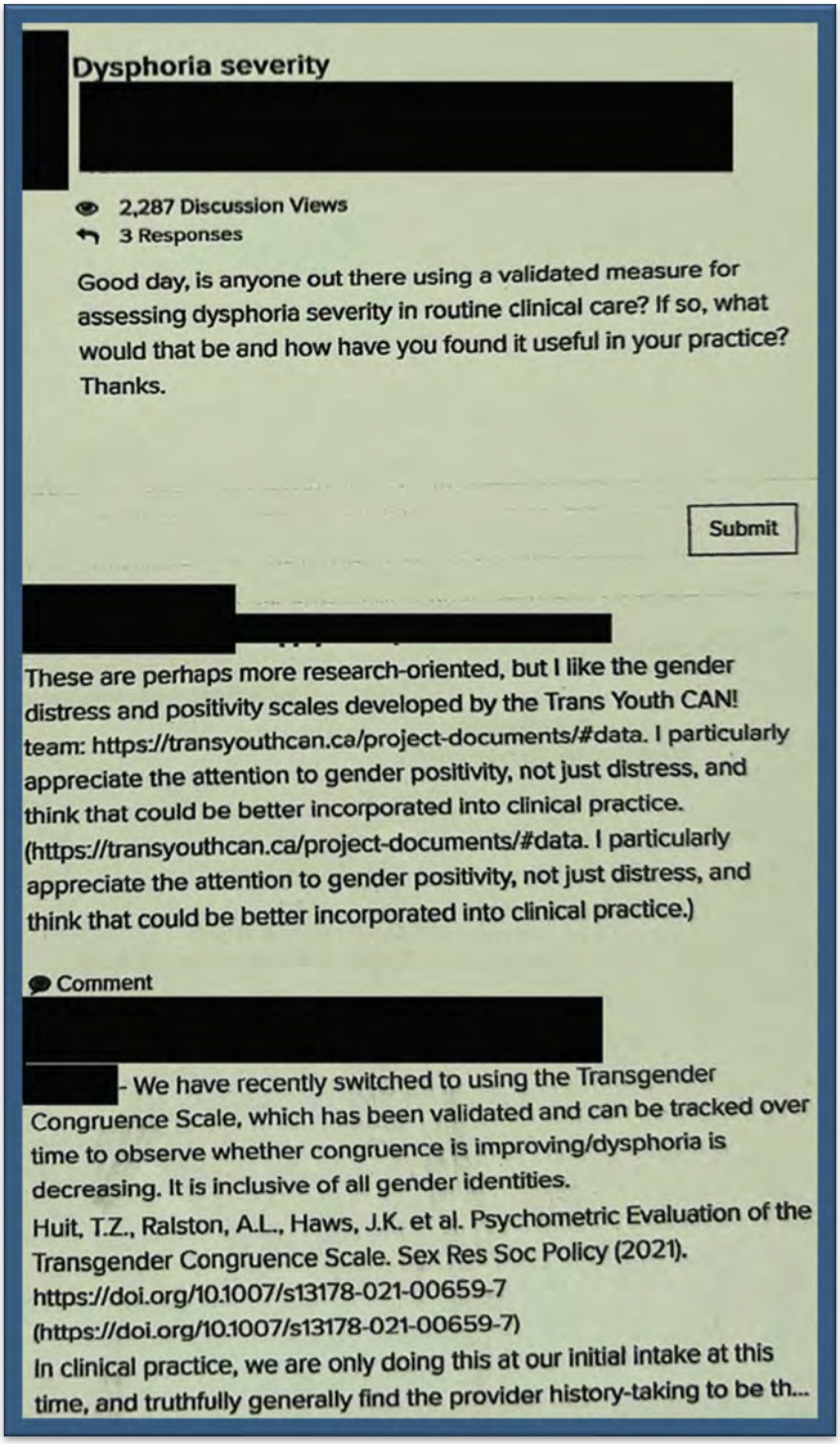
Comment

[redacted]

I just learned of this resource, which may be helpful for your needs. There's a resource page for parents and supportive adults which gives some basic info: TYFA - Parents (http://imatyfa.org/parents.html)

18) EVALUATING DYSPHORIA SEVERITY

a) WPATH members discuss finding validated measures for gender dysphoria severity



Dysphoria severity

[redacted]

2,287 Discussion Views
3 Responses

Good day, is anyone out there using a validated measure for assessing dysphoria severity in routine clinical care? If so, what would that be and how have you found it useful in your practice? Thanks.

Submit

[redacted]

These are perhaps more research-oriented, but I like the gender distress and positivity scales developed by the Trans Youth CAN! team: https://transyouthcan.ca/project-documents/#data. I particularly appreciate the attention to gender positivity, not just distress, and think that could be better incorporated into clinical practice. (https://transyouthcan.ca/project-documents/#data. I particularly appreciate the attention to gender positivity, not just distress, and think that could be better incorporated into clinical practice.)

Comment

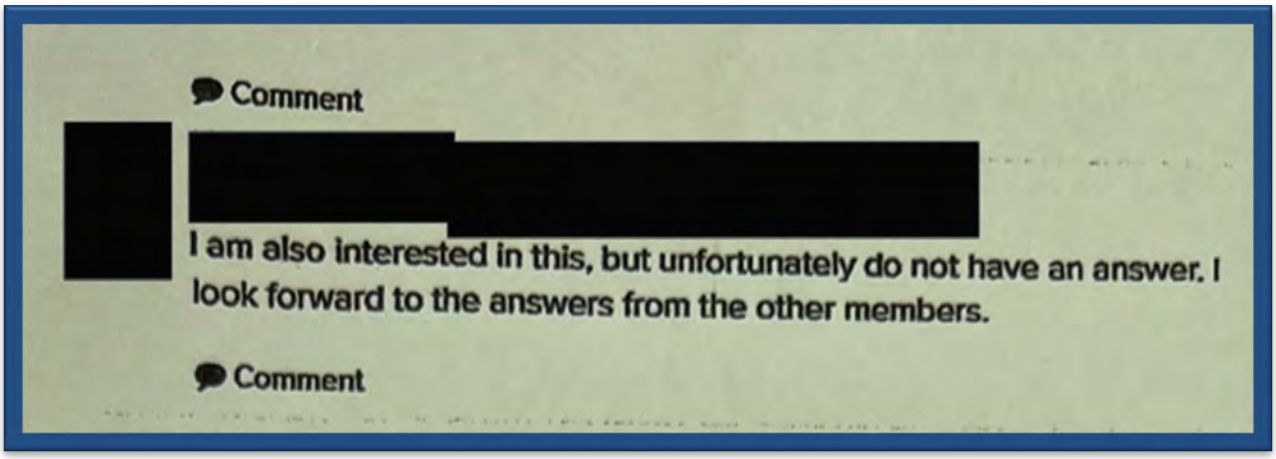
[redacted]

[redacted] - We have recently switched to using the Transgender Congruence Scale, which has been validated and can be tracked over time to observe whether congruence is improving/dysphoria is decreasing. It is inclusive of all gender identities.

Huit, T.Z., Ralston, A.L., Haws, J.K. et al. Psychometric Evaluation of the Transgender Congruence Scale. Sex Res Soc Policy (2021). https://doi.org/10.1007/s13178-021-00659-7 (https://doi.org/10.1007/s13178-021-00659-7)

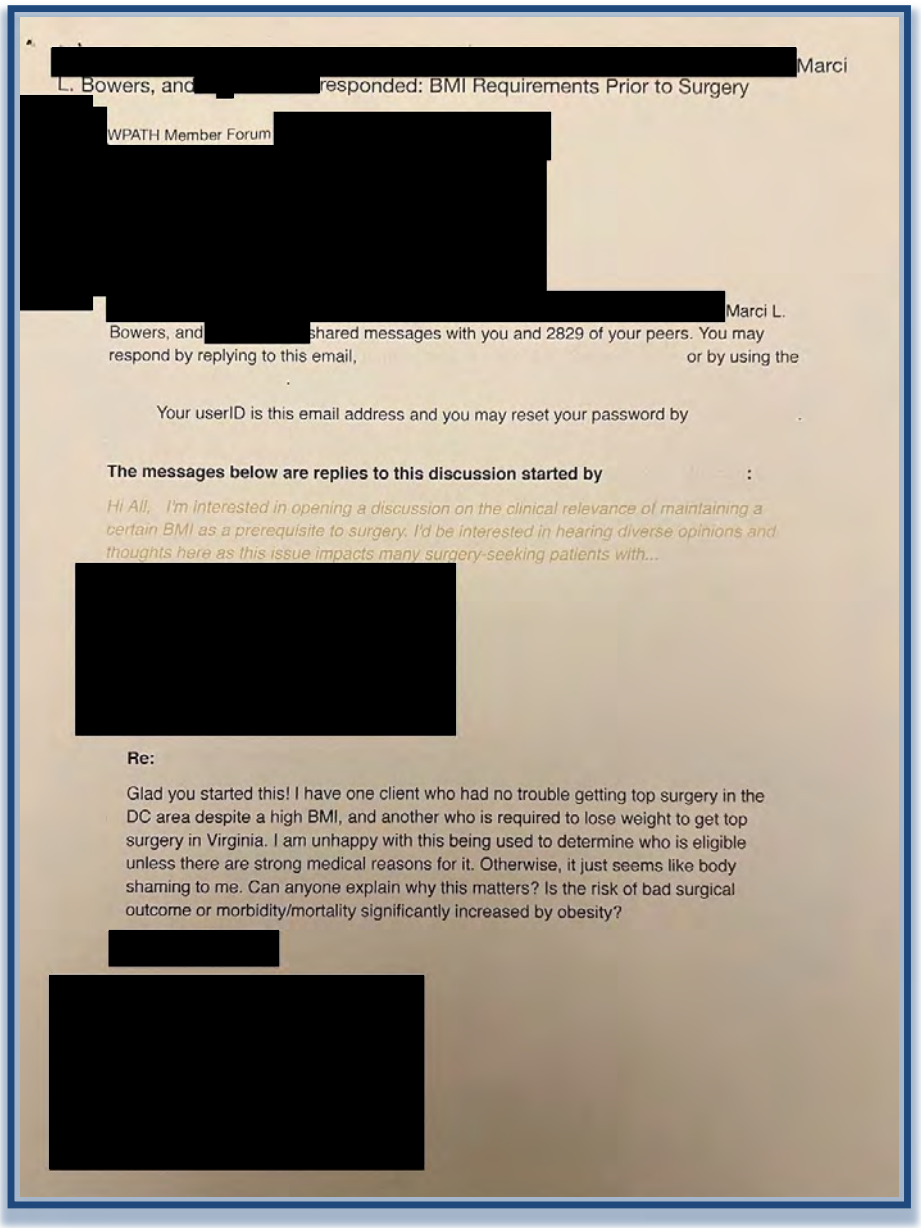
In clinical practice, we are only doing this at our initial intake at this time, and truthfully generally find the provider history-taking to be th...

b) A WPATH member expresses a lack of validated measures to determine gender dysphoria severity



19) BMI REQUIREMENTS PRIOR TO SURGERY

a) WPATH members discuss the clinical relevance of maintaining a certain BMI as a prerequisite to surgery



[redacted] Marci L. Bowers, and [redacted] responded: BMI Requirements Prior to Surgery

[redacted] WPATH Member Forum [redacted]

[redacted] Marci L. Bowers, and [redacted] shared messages with you and 2829 of your peers. You may respond by replying to this email, or by using the

Your userID is this email address and you may reset your password by

The messages below are replies to this discussion started by :

Hi All, I'm interested in opening a discussion on the clinical relevance of maintaining a certain BMI as a prerequisite to surgery. I'd be interested in hearing diverse opinions and thoughts here as this issue impacts many surgery-seeking patients with...

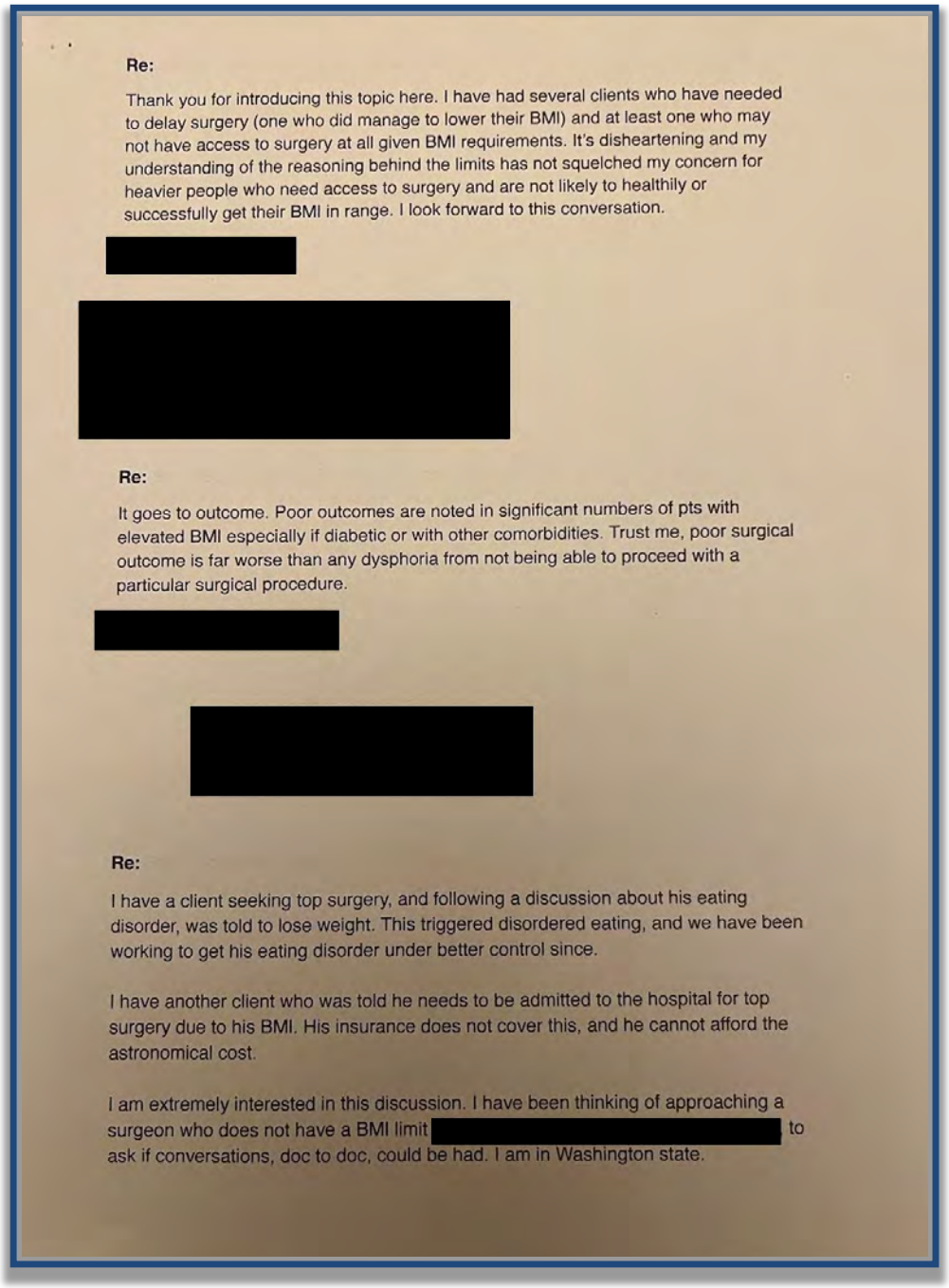
[redacted]

Re:

Glad you started this! I have one client who had no trouble getting top surgery in the DC area despite a high BMI, and another who is required to lose weight to get top surgery in Virginia. I am unhappy with this being used to determine who is eligible unless there are strong medical reasons for it. Otherwise, it just seems like body shaming to me. Can anyone explain why this matters? Is the risk of bad surgical outcome or morbidity/mortality significantly increased by obesity?

[redacted]

[redacted]



Re:

Thank you for introducing this topic here. I have had several clients who have needed to delay surgery (one who did manage to lower their BMI) and at least one who may not have access to surgery at all given BMI requirements. It's disheartening and my understanding of the reasoning behind the limits has not squelched my concern for heavier people who need access to surgery and are not likely to healthily or successfully get their BMI in range. I look forward to this conversation.

[redacted]

[redacted]

Re:

It goes to outcome. Poor outcomes are noted in significant numbers of pts with elevated BMI especially if diabetic or with other comorbidities. Trust me, poor surgical outcome is far worse than any dysphoria from not being able to proceed with a particular surgical procedure.

[redacted]

[redacted]

Re:

I have a client seeking top surgery, and following a discussion about his eating disorder, was told to lose weight. This triggered disordered eating, and we have been working to get his eating disorder under better control since.

I have another client who was told he needs to be admitted to the hospital for top surgery due to his BMI. His insurance does not cover this, and he cannot afford the astronomical cost.

I am extremely interested in this discussion. I have been thinking of approaching a surgeon who does not have a BMI limit [redacted] to ask if conversations, doc to doc, could be had. I am in Washington state.

Thank you.

[redacted]

[redacted]

Re:

My understanding for the BMI requirements is that they are clinically relevant to decrease the likelihood of post operative complications. A high (or low) BMI increases the risk for poor post surgical outcomes for ANY surgery, not just gender-affirming surgeries.

[redacted]

Transgender Surgery, Obstetrics and Gynecology
Dr. Marci L Bowers, MD

Re:

High BMI (greater than 40) is associated with lesser outcomes, longer operative times. But we truly do try not to fat shame patients. That said, weight loss is a great thing with surgery as a carrot towards better health and surgical outcomes. I'd truly pressed, we can make it work out safely.

- Marci L. Bowers

[redacted]

Re:

The recommendations for BMI thresholds for gender affirming surgery are mostly extrapolated from other similar procedures, though overall there is little quality data regarding surgeries on patients at higher BMIs regardless of the surgery (trans or not),

due to systemic fatphobia and lack of quality care for people who are at higher BMIs. Poor health and disease is blamed on high BMI, people are told to lose weight before surgery, etc., and thus nothing is done to actually treat people at higher BMIs because the first go-to solution is to ask people to lose weight before doing anything else.

I think a great next-step toward a solution would be for surgeons who are doing surgeries on patients at higher BMIs to publish their data about the outcomes. Additionally it would be great for providers to be educated on the low success rates of sustainable weight loss and take that into account when prescribing it to patients prior to surgery, and instead try to figure out other alternatives to allow patients to have surgery safely. I don't dispute the fact that outcomes are riskier at higher BMIs, but I do dispute that it is the fault of adiiposity itself rather than weight bias influencing how patients at higher BMIs are cared for and operated on.

[redacted]

[redacted]

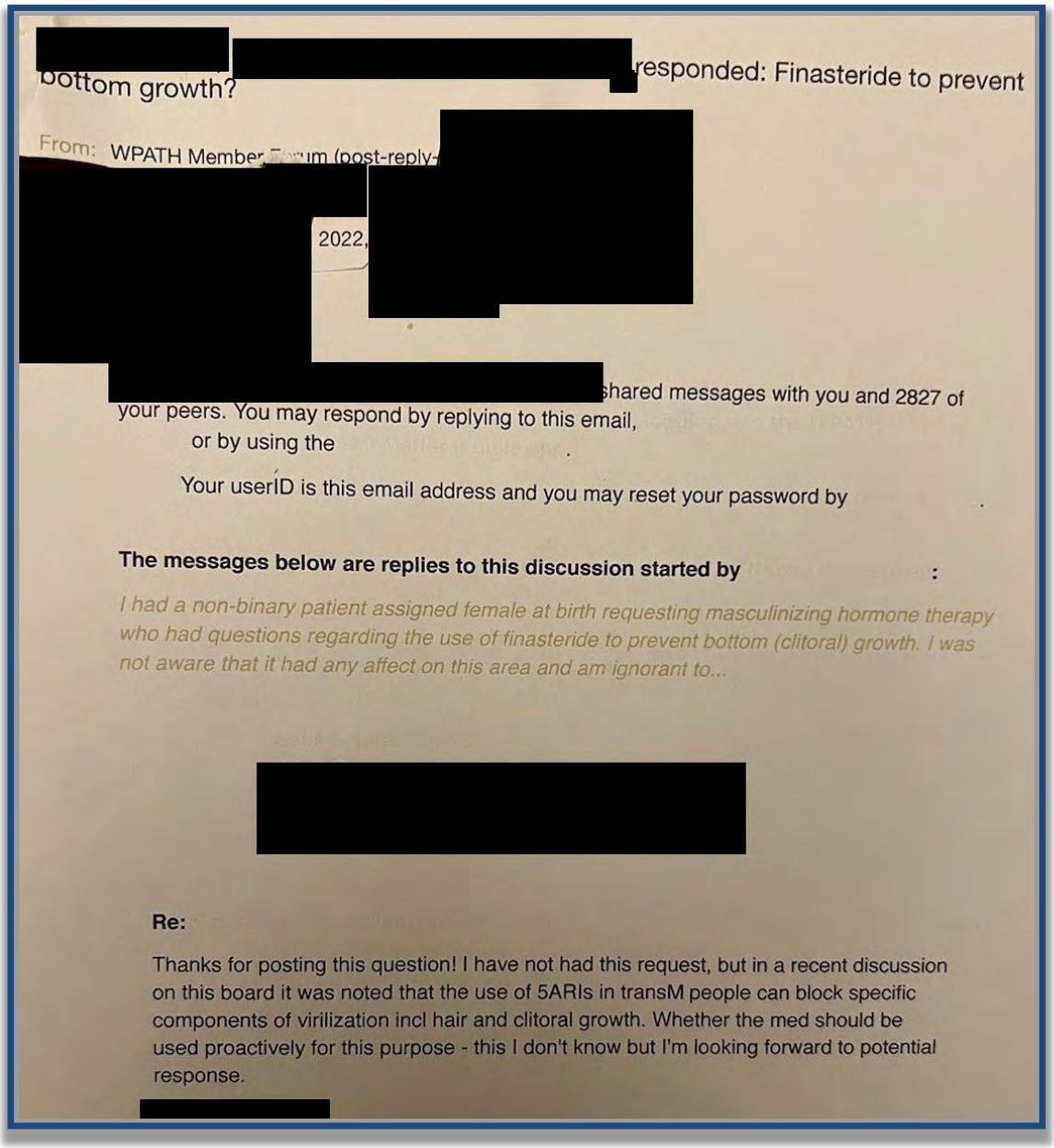
Re:

I do want to add on, I recognize that this is a systemic issue and not the fault of any individual provider. I think most people are doing the best they can with the info they have to provide safe surgeries. However that doesn't also mean positive change can't take place to allow patients at every size to have surgery safely and to learn more about how best to support patients at higher body weights without defaulting to weight loss as a first option. Like you mentioned it is also important to take into account the high prevalence of eating disorders in trans individuals and that recommending weight loss to access surgery can exacerbate this.

[redacted]

20) HORMONE COMPLICATIONS

a) WPATH members discuss the use of Finasteride to prevent bottom (clitoral) growth



[redacted] responded: Finasteride to prevent bottom growth?

From: WPATH Member [redacted]

2022, [redacted]

[redacted] shared messages with you and 2827 of your peers. You may respond by replying to this email, or by using the .

Your userID is this email address and you may reset your password by .

The messages below are replies to this discussion started by [redacted]:

I had a non-binary patient assigned female at birth requesting masculinizing hormone therapy who had questions regarding the use of finasteride to prevent bottom (clitoral) growth. I was not aware that it had any affect on this area and am ignorant to...

[redacted]

Re:

Thanks for posting this question! I have not had this request, but in a recent discussion on this board it was noted that the use of 5ARIs in transM people can block specific components of virilization incl hair and clitoral growth. Whether the med should be used proactively for this purpose - this I don't know but I'm looking forward to potential response.

[redacted]

Re:

I haven't had experience with this use of finasteride or this request in particular, but my understanding is that finasteride blocks the conversion of testosterone to dihydrotestosterone (DHT). DHT is primarily a hormone important for embryological development and in the adult cis-male is active in scalp hair follicles and prostate tissue primarily. I would guess that clitoral growth would occur to some extent in response to testosterone even in the presence of finasteride, but will be interested to hear if others have tried using it to block clitoral growth.

[redacted]

[redacted]

Re:

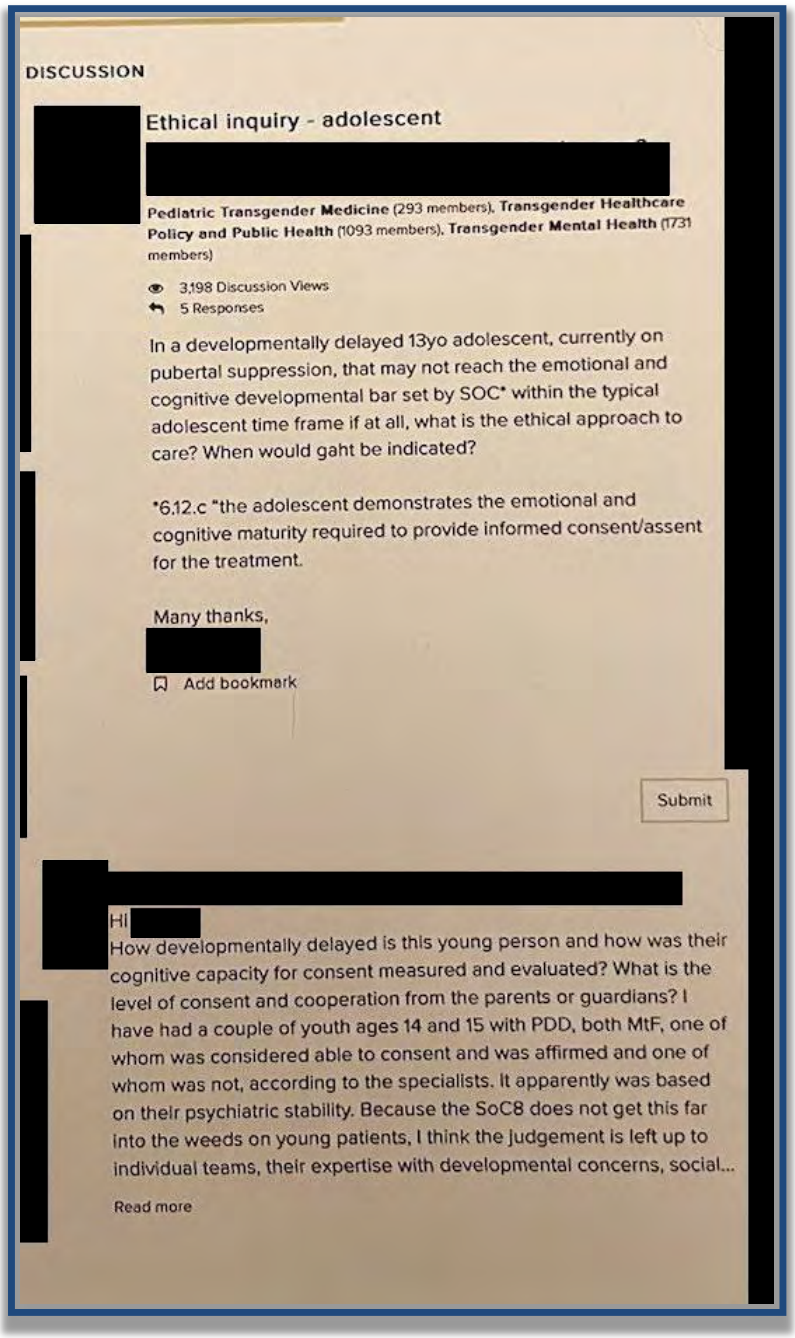
I have had a similar patient who is requesting finasteride to prevent bottom growth whilst starting testosterone.

We have not been able to find any evidence for this but it is clearly something that is being discussed in the community.

It has been difficult to give them a definitive answer. Any resources, evidence or advice would be appreciated.

21) ETHICAL GUIDELINES TO ADOLESCENT CARE

a) WPATH members discuss the Standards of Care (SOC) ethics for treating a developmentally delayed, 13-year-old



DISCUSSION

Ethical inquiry - adolescent

[redacted]

Pediatric Transgender Medicine (293 members), Transgender Healthcare Policy and Public Health (1093 members), Transgender Mental Health (1731 members)

3,198 Discussion Views
5 Responses

In a developmentally delayed 13yo adolescent, currently on pubertal suppression, that may not reach the emotional and cognitive developmental bar set by SOC* within the typical adolescent time frame if at all, what is the ethical approach to care? When would gaht be indicated?

*6.12.c "the adolescent demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment.

Many thanks,

[redacted]

Add bookmark

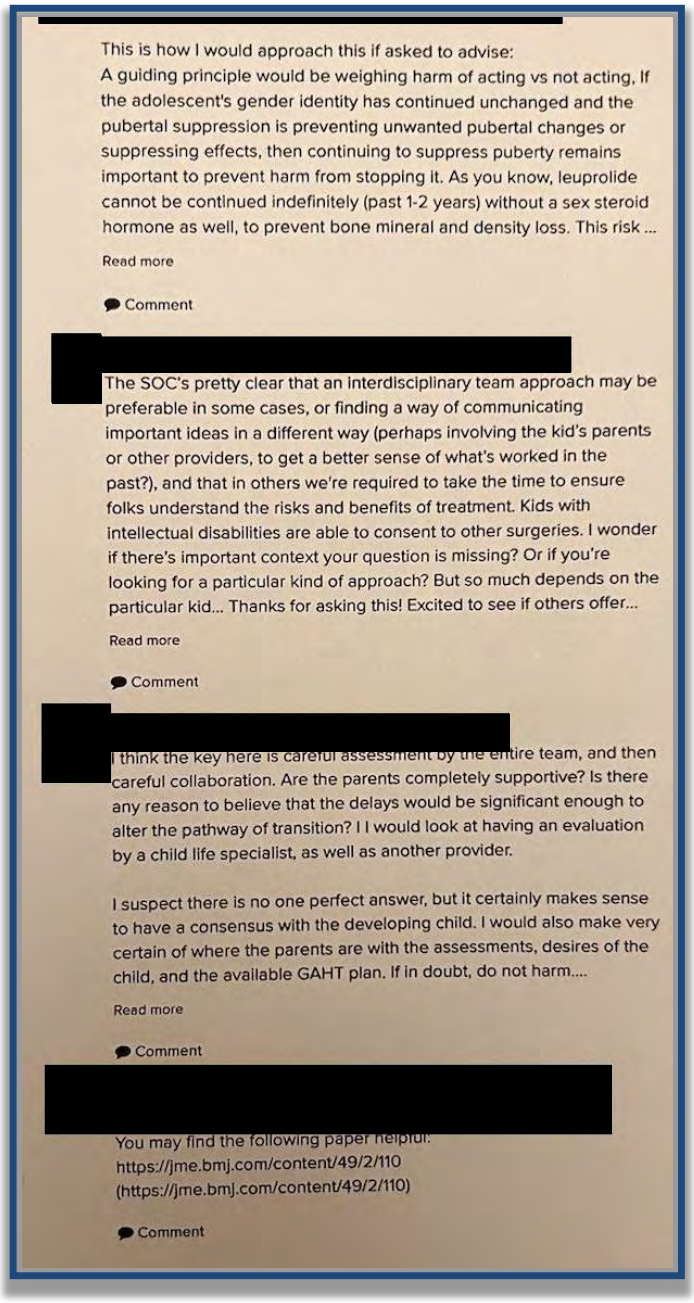
Submit

[redacted]

Hi [redacted]

How developmentally delayed is this young person and how was their cognitive capacity for consent measured and evaluated? What is the level of consent and cooperation from the parents or guardians? I have had a couple of youth ages 14 and 15 with PDD, both MtF, one of whom was considered able to consent and was affirmed and one of whom was not, according to the specialists. It apparently was based on their psychiatric stability. Because the SoC8 does not get this far into the weeds on young patients, I think the judgement is left up to individual teams, their expertise with developmental concerns, social...

Read more



[redacted]

This is how I would approach this if asked to advise:
A guiding principle would be weighing harm of acting vs not acting. If the adolescent's gender identity has continued unchanged and the pubertal suppression is preventing unwanted pubertal changes or suppressing effects, then continuing to suppress puberty remains important to prevent harm from stopping it. As you know, leuprolide cannot be continued indefinitely (past 1-2 years) without a sex steroid hormone as well, to prevent bone mineral and density loss. This risk ...

Read more

Comment

[redacted]

The SOC's pretty clear that an interdisciplinary team approach may be preferable in some cases, or finding a way of communicating important ideas in a different way (perhaps involving the kid's parents or other providers, to get a better sense of what's worked in the past?), and that in others we're required to take the time to ensure folks understand the risks and benefits of treatment. Kids with intellectual disabilities are able to consent to other surgeries. I wonder if there's important context your question is missing? Or if you're looking for a particular kind of approach? But so much depends on the particular kid... Thanks for asking this! Excited to see if others offer...

Read more

Comment

[redacted]

I think the key here is careful assessment by the entire team, and then careful collaboration. Are the parents completely supportive? Is there any reason to believe that the delays would be significant enough to alter the pathway of transition? I I would look at having an evaluation by a child life specialist, as well as another provider.

I suspect there is no one perfect answer, but it certainly makes sense to have a consensus with the developing child. I would also make very certain of where the parents are with the assessments, desires of the child, and the available GAHT plan. If in doubt, do not harm....

Read more

Comment

[redacted]

You may find the following paper helpful:
https://jme.bmj.com/content/49/2/110
(https://jme.bmj.com/content/49/2/110)

Comment

Transcript: Identity Evolution Workshop held on May 6, 2022

A different recording of a 1 minute and 30 second clip from the panel discussion (which is 1 hour and 22 minutes in total) was leaked into the public domain over a year ago. The video in the WPATH Files is a new recording, has a different layout, and has no connection to the previous leak. The time stamp of the previously released portion of the WPATH video is 23:16 - 24:43. This is the first time the panel discussion has been made publicly available in full.

CLIP 1

Cecile Ferrando: Transmasculine patients. And we talk about, you know, early oophorectomy, so early removal of the ovaries and what that means in somebody who is taking testosterone therapy but may not be on testosterone their whole lives. And I simply sort of explain the need to have to supplement, you know, in order to have cardiovascular protection, bone health, good bone health as they get older.

Um, so those are the things that we think about in this cohort of 20 year olds in whom we're removing the ovaries. There's some concern that long term, if they ever stop their testosterone, they could be at, um, um, at metabolic risk, which is just something that needs to be considered. But historically, we have a patient population that also doesn't seek out medical care.

So there's that sort of confounding factor too, which makes it a little bit trickier. Um, but at the end of the day, it's about informed consent. And on my end, I'm just managing patients who have sought out treatment in alternative ways. Um, and that those are, those, those can be pretty challenging.

Ren Massey: Thanks, Cecile. Would anybody else like to add some observations?

Dan Metzger: I think, you know, when we, when we start people on, um, testosterone or estrogen, uh, you know, we, we try to be as clear as we can, um, about the stuff that's going to be permanent and the stuff that's, that's going to go backwards. So if you started testosterone, your voice is going to change. That's permanent, but you might get more muscly, but then that's not permanent if you were to stop.

Um, I think the thing you have to remember about kids is that we're often explaining these sorts of things to people who haven't even had biology in high school yet. And, and, um, uh, and I know I've, I've heard others in, in this kind of a, in this kind of a setting say, well, we think adults are like really slick biologically.

And in fact, lots of people have very little medical understanding of stuff like that. We just put medical professionals and. mental health professionals take for granted. So I think we have to be, um, more concrete than we think we need to be. Um, short of surgical stuff, you know, I think, I think, um, uh, and the permanent physical changes that happen with testosterone or estrogen, um, you know, you might get some breast development that maybe you would later regret.

Uh, but I think, um, it's reasonably safe to, to be on hormone X for a while and then stop and go back to your, to your natal hormones. Provided you haven't had some sort of a gonadectomy, then, as Cecile mentioned, that's a different issue if you're hormone less, um, so, um, I think that is important, um, for people to know, and I think we also, like, just in general, you know, people want this, but they don't want this, but they want this, but they don't want this from a hormone, and I'm like, well, you know, you might not be binary, but hormones are binary, and so, you know, you can't get a deeper voice without probably a bit of a beard.

It doesn't work that way, or you can't, um, you can't, uh, you know, get estrogen to feel more feminine without some breast development. It, that doesn't, that doesn't work very well. And there are different ways of trying to get around some of these things, but in general, um, you know, when you give a hormone, it's going to do what hormones do.

It's going to act on a receptor, the receptors are everywhere, and you're going to get some sort of a physiologic effect, and it's hard to kind of pick and choose the effects that you want. And, and I know that that's, um, I know that that's, uh, like something that kids wouldn't, wouldn't normally understand because they haven't had biology yet, but I think a lot of adults as well are hoping to be able to get X without getting Y,

and that's not always possible.

CLIP 2

Ren Massey: Thanks, Dan. Yes, expectations and informed consent. We have a lot of work to do here, even as mental health professionals, um, in my work, I, even before having folks start on hormones, I go over a lengthy, um, information about the effects of the different kinds of hormone therapies, uh, just so they, I have the clarity that they have some sense of understanding what they're going to because even the good hormone docs here in my area.

Don't always take the time, or it's easy for us to make assumptions that people understand. You know, but that estrogen is not going to make somebody's voice go higher. Or if you're a certain age, testosterone is not going to make you taller. So, um, manage expectations, I think is really important. Uh, it looks like Dianne's ready to say something.

Dianne Berg: Yeah, I just wanted to piggyback on all of the importance that comes up with the informed consent. Um,

I often see people who, because there's such a backlog of therapists to do some of the mental health therapeutic support, I often see people who have already engaged in some sort of, and this is again with youth, who've already engaged in some sort of medical, um, Intervention. And so one of the things I do is I just kind of I'm sitting with the youth and their parents and I say, Oh, well, so tell me more about what you know about that medical intervention.

And kind of like what Dan was saying, you know, children and young adolescents, we wouldn't really expect them. It's kind of a developmental it's out of their developmental range sometimes to understand the extent to which some of these medical interventions are impacting them. And so I think I, I try to kind of do whatever I can to help them understand best, best I can.

But what really disturbs me is when the parents can't tell me what they need to know about a medical intervention that apparently they signed off for. And so I think informed consent has to happen very differently for parents. That it has to happen for

children and early adolescents and adolescents, but it needs to happen and it needs to be a process and, and I think therapists are in a really good position to do that process because we have a lot more time.

with our people than like the 20 to 20 minute medical appointment the way that and that's another problem is the way the medical system works is is there's often very little time. So I think it's really one of our roles is to really do that and to really suss that out and take quite a bit of time to do that and it's more than just like we certainly provide information but then you kind of have to listen to what the the youth is doing with that information to to kind of not, not catch them, but to pick up on the ways that they're not really understanding what, because they'll say they understand, but then they'll say something else that makes you think, Oh, they didn't really understand that they, that they are going to have facial hair, right?

Because they say something else that makes you think, Oh, they didn't get that point, but they'll say they totally get it.

CLIP 3

Dianne Berg: This comment on is that I worked in a, um, an intersex or disorders of sex development clinic for a number of years as the psychologist. And I would come in to the session with the parents and usually these were very young kids. So I wasn't really working with the kids. I was more working with the parents and, and I would come in there after the, after the medical doctor had, after the pediatric endocrinologist had been in there and done, had been in there for an hour and had talked with them.

Um, and. The pediatric endocrinologist came out and said, yeah, they totally get it on board. I don't have any concerns about their understanding. I would go in and I would say, okay, so tell me what you learned from, and they'd just be like, 'We have no idea what they were talking about.' Because they, they feel deferential.

Part of it is that they feel less deferential to the kind of doctor I am than the kind of doctor, the medical doctor is. And so, and because they really are seeking the care, they're just gonna. Say they know when they really, they really aren't picking up on what's happening. And so I think the more we can normalize that it is okay to not get this right away.

It is okay to have questions is, you know, the more we're going to actually do a real informed consent process. Then what I think has been currently happening and that I think is frankly, not what we need to be doing ethically.

Ren Massey: Thanks, Dianne. I appreciate those comments. Um, anything you want to add in there, Gaya?

Gaya Chelvakumar: I would just say I agree with all the comments that have been made. I think the informed consent process is so important and definitely that it's a process is really important to recognize that it's not one conversation at one point in time that is many conversations over time, um, and that those conversations don't have to stop once the Medicaid and intervention has been started, that those conversations can be ongoing even after the intervention has occurred.

Um, even asking how they feel about changes that are happening and, and having discussions about is this something you want to continue with to not, um, you know, informed consent is such an important piece of starting any intervention and it's so, it's so hard. And I often wonder about what you mentioned, Dianne, about people saying they understand when they don't, just because they're so focused on the intervention that, um, They're afraid to share things that they might not be understanding about the information we're sharing with them and how, how to address that I think is very, is very important.

I will say just personally my practice, it has evolved, how in the medical setting. I think we have these Conversations and, um, around informed consent has evolved a lot over time as well, just recognizing a couple of different things, you know, that identities may shift and transition needs may shift, um, that also has shifted how we have, I think, conversations around, um, around informed consent and starting an intervention.

But it's so important and just that it's a process and it's a continual conversation, I think, is the biggest thing.

CLIP 4

Dianne Berg: And Gaia, I don't know if other people do, but I really struggle with, with, because I kind of want The kids that I work with, whether they're nine to, you know, 13

and looking at puberty suppression or hormones in some ways to be a little pediatric endocrinologist, like I, I want them to understand it at that level, um, in an age appropriate way.

And I struggle with that on one level because it's like, well, when a kid takes diabetic medication, do they have to understand? everything about their pancreas and everything that's happening and all of all of that do we do we do that same process around other medical kinds of things and so is this an unfair So, I just struggle with that line, um, and I just kind of wanted to, to say that because I'm not quite sure what to do about that.

The other thing that, that I, that I really like to do is I like to have the children or the young adult or the young adolescent or the adolescent come up with questions that they have for their medical doctor. So let's, let's, let's write a great question. Write that down. Write that down. We're going to ask that you ask that the next time you come back so that they're, they're really, I think, um, one of the things we have in one of the papers that we published is how important it is to instill a level of autonomy into Okay.

Children and adolescents about their medical care and transgender people about their medical care that they get to be assertive. They get to ask questions. They get to be really well informed. And so we want to start that very young by having children like, ask a question, write down what you think and ask the doctor.

You can ask the doctor. Well, I can't really. Yes, you can. Yes, you can. You get to ask the doctor anything that you want to ask them. Um, and so really instilling that way of thinking about medical care, I think is important.

CLIP 5

Gaya Chelvakumar: Important point two is just collaboration between the medical team and the mental health care providers so that there can be also ongoing discussions between team members. So if, when mental health providers are having conversations around expectations around Medicaid, it's just like, Hey, you may want to spend a little more time talking about this, or this is an area that the, there seems to be some confusion about, or parents or child are really, um, concerned about, I think.

In this, in this area of healthcare right now, multidisciplinary care is so important and being able to collaborate with each other is so, is so important and so helpful, um, because sometimes we're not, you know, maybe in the context of a medical appointment, the conversations that need to happen can't happen and then maybe there needs to be further conversations with, with a mental health provider to help make sure parents and children have all the information they need to make the best decisions for themselves.

Yeah, I agree. It's so helpful to be on these on these panels just to hear where everyone's at because I think we all are struggling with how to do this and that in the best way without overburdening our patients and families as well.

Jamison Green: But our health care system doesn't If I may jump in here, our health care system doesn't encourage this.

I mean, if you have a clinic, like already, like a university setting where Dianne is, or where Cecile is even, and I'm not sure where you are exactly, Dan, but I know many people providing this care are independent practitioners, and they're referring their clients to surgeons. Uh, across the country and their endocrinologist might be their actual May, they may not never, they may never have a, an endocrinologist.

They may be able to get their hormones prescribed through their primary care provider who doesn't really know necessarily everything about Transcare. They're basically trying to be supportive and you know, our health care system. It leaves us in the lurch all the time. And so to create, I agree that we don't necessarily need to be able to have If you have a known condition, like diabetes, you don't have to understand every nuance about what the insulin is going to do to you in order to give informed consent.

You need, but, because there's so much experience with that. But in this field, this is all new, this is all contentious, and that's where we run into problems. because everyone's afraid. And I know for a fact, people, even adults, even well educated, older adults, accessing care for the first time, sit down with the person who's going to prescribe their hormones, and they look at an informed consent form that says your hormones are going to do this, this, and this. They don't take any of that in yet because they're so scared that they're not going to get what they need. They, they just so, show me where to sign. Cause I'm, this is my moment, I gotta grab it. And they don't really take in the information.

CLIP 6

Jamison Green: And people also are afraid many times about surgery and so they can read other people's descriptions about surgery and they'll miss details or they'll miss the, the, uh, the most important piece of information for them simply because they're afraid to read it. You know, it's just how human beings work.

So I think at the same time we're fighting against The community's desire to have less gatekeeping, less professional intrusion, less spending time in doctor's offices. And how do we manage that and make sure that everybody's got the right level of education to make good decisions for themselves? So this is a problem that we're facing.

And this is where I think some of the detransition comes in. Because the over medicalization, as well as Uh, over binarying, as well as just the pressures that people are under because of the opposition creates a dynamic that's very, very hard for all of us to work in. Trans people and clinicians, very, very hard.

So I think these dialogues are crucial and we need to take them outside of this space ultimately as well.

Ren Massey: All right. So I'm, I'm sorry. Did you want to go ahead?

Dan Metzger: Good. We can do it after the.

Ren Massey: Yeah, I was going to suggest you this great conversation. I have more comments, but I'm like, ah, people probably need a break attendees as well as panelists. So, uh, I've asked for a 12 minute break. And we will reconvene back here and look forward to seeing y'all back here in a little bit. Thanks.

CLIP 7

Ren Massey: I think we're pretty close to on time for that 12 minutes. Appreciate everybody being back here. Um, I'm wondering if, uh, well, I wanted to share just a little bit about informed consent. And then after, if anybody else wants to chime in, feel

free to. I saw a little bit going on there. I do think that that's a really important part of what we can do to help folks.

Um, in terms of their decision making processes and also, you know, just to start out with, I make it clear to people that I don't have an investment, whether they're youth, whether it's parents. Whether it's adults that I have no investment in what their gender identity is even just because transitioning was right for me doesn't mean that it's right for somebody else.

And that's not a bias that I have. And, um, I hope that that gives people from the start a sense of safety in, um, considering a range of options in, um, in terms of gender identity and gender expression possibilities. Uh, when we do get to talking about, um, hormonal and medical interventions for those who, uh, are considering those options. You know, one important thing I believe is to make sure we address fertility preservation. If you all have looked at the drafts of the standards of care coming out, S. O. C. Eight. Hopefully next month, you'll see, you know, a number of places where it's encouraged and ethical to talk about fertility preservation options And that's even for youth who are going on puberty blockers, because many of those youth Thank you for nodding heads. Many of those youth will go directly on to affirming hormone therapies, which may eliminate Or will eliminate, you know the development of you know, they're gonads producing sperm or eggs that are going to be able to be usable if they want to be partners with somebody else later in contributing genetic material for reproduction

CLIP 8

Ren Massey: I start even with puberty blockers to talk about fertility and a useful tool has been John Strang's TYFAQ, the Trans Youth Fertility Attitudes Questionnaire. It's not necessarily standardized to my knowledge, but it's a mechanism for discussing. There's a parent version and a child, a youth version for discussing some fertility issues just over, I think it's 16 questions.

And then also my informed consent process, I will include, um, as a non medical person, but somebody in the healthcare profession with a lot of. experience and knowledge and G. E. I. S. Under my belt attend all these conferences. Always learn something. I cover the reversible and irreversible effects and the potential risks to the best of my again.

I'm a lay person as far as being not a medical provider. Um, knowledge and I base that on the standards of care seven and we're gonna have the new ones coming out as I mentioned as well as the interim guidelines. Uh, the latest being in 2017. And there are some other resources out there. So, um, I see somebody put a file up there but there Are ways I think we can all go over this.

And also just finally, I'll just add that I go over it with the youth separately from the parents. Uh, and then with the parents separately from the youth, ideally, and then bring them all together. Make sure we're all on the same page of under what we understand. Um, Limitations acknowledged, and, uh, you know, they're often having questions, and I say you have to ask your hormone provider, the consultant you're, uh, going to be meeting with about, uh, certain questions.

So there are certainly, I stay within my lane, but I do think that part of the multidisciplinary nature of this work is being well versed in these things, at least to a certain level, and that's part of why we have a multidisciplinary panel here.

CLIP 9

Ren Massey: wants to, I see somebody added the QIFAQ in there. Anybody wants to add any comments on that before we move on and we could potentially start looking at cases in a little bit? Does anybody want to add anything to what I said? Looks like Dan might.

Dan Metzger: I, I was just gonna say, you know, like, like it's always a good theory that you talk about fertility preservation with a 14 year old, but I know I'm talking to a blank wall. And the same would happen for a cisgender kid, right? They'd be like, Ew, kids, babies, gross. Or, or the usual SPAC answer is I'm going to adopt. I'm just going to adopt. And then you ask them, well, what does that involve? Like, how much does it cost? Oh, I thought you just like went to the orphanage and they gave you a baby.

No, it's not quite like that. Um, but, um, and I was just trying to find it, but I can't, I can't quickly locate it because I only have is like a picture of a slide, but apparently last week at the Pediatric Endocrine Society, uh, some of the Dutch researchers started, uh, gave some data about, um, young adults who had transitioned and reproductive regret, like regret, and it's there.

Um, and I don't think any of that surprises us. I don't remember any of the numbers or anything. I just, again, I have a picture of a slide. But hopefully this is something that will get published in the next while. But, um, you know, I think, I think now that I follow a lot of kids into their mid twenties, I'm always like, Oh, the dog isn't doing it for you, right?

Yeah, they're like, no, I just found this, you know, wonderful partner and now we're kids and da da da. So I think, you know, it doesn't surprise me, but I don't know still what to do for the 14 year olds. The parents have it on their minds, but the 14 year olds, you just... It's like talking with diabetic complications with a 14 year old. They don't care. They're not going to die. They're, they're going to live forever. Right? So I think, I think when we're doing informed consent, I know that that's still a big lacuna of, of that we're just, we do it. We try to talk about it, but most of the kids are nowhere in any kind of a brain space to really, really, really talk about it in a serious way. I, that's always bothered me, but you know, we still want the kids to. Be happy, happier in the moment, right?

CLIP 10

Dianne Berg: I appreciate that much less with a 9, 10 or 11 year old who's, who's, um, who's starting puberty suppression. And like Ren said, if they continue on then, and, and I mean, it's, it's like developmentally not in their space to be able to have, have to think about that. And it shouldn't be, um, right. And so I think it is.

I think it is a real growing edge in our field to kind of figure out how we can, how we can approach that. Um, I'm definitely a little stumped on it.

Gaya Chelvakumar: I'll just add one more complication in there is that then if you do have, which doesn't commonly happen, but if you are interested in preserving fertility, then the options for for doing that, depending on age and stage of development also can be. From a medical standpoint, may or may not be possible, but then from a financial standpoint, also may or may not be possible, and that's another complexity to the, adds another layer of complexity to these discussions as well, and that's at any age, I guess.

Dianne Berg: And from a social and sexual standpoint, right? Um, in some ways, the stuff that you need to do to be able to preserve your fertility might be beyond kind of what a youth, where a youth is at in terms of their sexual development, and yet.

That's kind of what's needing to happen and, um, yeah,

Ren Massey: yeah, I don't think that we have all the answers and I appreciate y'all's comments, bringing, you know, highlighting the nuances and the challenges here. I find a range of. Maturity levels and having thought about this or not having thought about it. Um, again, depending also on the age and the cognitive maturity, emotional maturity.

Um, I still, I know you all do these kinds of things too. I think that it's better to give them the information and have them, Be able to reconcile, like we wish we could afford this, but at this point we can't. And so we will proceed down this avenue anyway, but not later on then find out, Oh, nobody ever told me that I couldn't, you know, do that.

CLIP 11

Ren Massey: Like, why didn't somebody tell us? And so I think that there's a shift in the field, but I just think we need the spotlight that, um, it's part of the discussion in the informed consent process for youth as well as adults. Um, And back to the thing I said the very beginning of after the break, part of also trying to make sure people have a sense of I have no investment in where their gender identity or identities land is because that part in this study where people said they didn't go back to the same provider, that that bothers me, I would like people to feel like they can continue with me whoever they are.

Um, if I can help in other issues, you know, a few of the folks I've worked with, it's been, um, some of what Dianne was saying earlier, you know, their sexuality got to clarify some of their gender identity issues. And, um, they, I've been pleased when they've gotten clear. Okay. Maybe I'm not trans, maybe I'm non binary, maybe I'm cis, um, and maybe this was more of a sexuality issue.

And they were willing to continue to work with me as they explored sexuality issues. You know, I want people to feel like they don't have to perform a certain gender to be

working with me. Um, that I want to be inclusive and supportive of all aspects of their being, so. All right.

CLIP 12

Ren Massey: Any other thoughts before we maybe look at cases? Alright, as, as we shift to cases, then, uh, this is always the tricky part for me to work on.

Dianne Berg: I'm sorry, Ren, can we just, Melissa Goldstein is just asking if anyone has great resources for fertility and preservation especially. Oh, Gaia just put it, did you just put it in?

Gaya Chelvakumar: I just popped in one article that starts to discuss some of it.

Ren Massey: I'm, I'm glad. I think, I think that that's a knowledge, right? And there isn't a ton of, of that existing. So I just wanted to acknowledge that. Yeah. All right. Thank you. Um, it's wonderful how we've got all these wonderful resources here. All right. So, uh, bear with me a second. I am going to try to share screen to, uh, go over some cases that our panelists have, uh, put together.

And this is the part where I always grapple.

CLIP 13

Ren Massey: Read the case of DJ. Give me a thumbs up, panelists.

Okay. All right. So I'm wondering if panelists have any comments or thoughts you all want to start with in getting this discussion going around this young person and their experience.

Oh, sorry, Randall. I'll read the next one.

Dan Metzger: To me, this is a not an untypical story. I mean, this person's got some significant mental health stuff, which is, you know, that they need to deal with. It

sounds like they had an unfortunate sexual traumatic sexual event, which that sounds probably pretty horrible. But to me, this is a kid who, who, who. Um, got a false start and, uh, and, um, maybe it wasn't in a place where they were fully supported or they feel fully supported.

Um, but to me, this is not de transitioning. This is just a kid working through crap. And, um, I mean, I obviously may feel sorry for the kid, but to me, this is not like something that should hit the news as a, you know, a system problem. You know, assuming that this kid's been getting the mental health care that they need.

To me, this is like, not an untypical story. Um, and with a happy ending. So, yay.

CLIP 14

Dianne Berg: highlights the importance of having ongoing support and following kids over time, um, so that you're getting as much of the picture as you possibly can. And, and so kind of the important role of, of behavioral health, mental health, um, component. Um, I think, I think oftentimes mental health can get a really bad rap.

Um, in terms of that, we're trying to do things that we're not actually trying to do and, and so I think this is a good case that kind of exemplifies if you're following this kid and meeting relatively recently, relatively, um, often with them, you're going to kind of be seeing this in real time and be going through this with them and be helping them to process and figure out kind of the meaning that it has for them.

Um, And hopefully as you have enough of a rapport, I don't know if it happened in this case, but that it looks like the, the person didn't disclose some of the bullying and the traumatic sexual event until a year later. The hope would be that if we can build enough rapport over time with kids in whatever specialty we have.

That, that we would learn about that in more real time than a year later, and that we would be able to be, you know, kind of just doing it as part of the regular process of checking in about all spheres of life. Um, so it really highlights the importance of that for certain, for certain youth.

CLIP 15

Ren Massey: comment. I noticed an observation or a wish that, uh, therapists involved in able to Help the young person distinguish between the assault and their gender identity. I think, um, that there are times working with young people where they don't even disclose an assault or some type of sexually, Coercive or unpleasant experience.

It may not even have been coercive, but it may be almost like self coerced. They thought they were supposed to do X, and so they, like, I guess this is how people interact sexually, and so they showed up voluntarily, like this other person at

the moment, um, wasn't coercing them, but they were kind of trying to get themselves to learn about sex. And so they may have done things they didn't even feel comfortable with. And so they don't want to talk about it with therapists. So, I mean, um Even good therapists, you know, we're going to be limited at times where we're, uh, we can't get everything that's going on with our kids that we're working with.

And sometimes the adults also don't bring it forward. So, um, it's a, it's a high bar to cross sometimes to try to catch everything that. may be affecting somebody's view of themselves and across domains of their life experiences.

CLIP 16

Gaya Chelvakumar: And I'll just echo Brennan and Dianne's statement. I think the case to me just highlights the need for, in addition to continued, you know, ongoing care, but also maybe like leaving the door open, that if this is your decision at this point in time, but that may change and we're, you know, we're here to support you, whatever your decision is, and that you can always, you know, continue to see us continue to see the team, um, you know, keeping, keeping engaged with young people and letting them know that they can, It's okay to change your mind.

It's okay to, to come back and knowing that, um, people sometimes have to disclose things in their own time as well. So that while we hope things are disclosed in real time, sometimes people just aren't in a place to face, to face their trauma and what's going on. And so even more so becomes important, I think, to have that ongoing care.

Um, and even if there is an ongoing care, at least leaving the door open, young people, or adults even, are in a place where they want, where they want to reengage that that door is still open?

Dianne Berg: Yeah, there, there was a comment. There was a comment in the chat about, um, sometimes our, our discomfort with asking questions, particularly pertaining to sexuality.

And I, and I think that that's, that's really true. I mean, we have not gotten to the place yet where it's just part of, Every typical kind of area that you inquire about, and I think that that's really important, um, and is, is part of, and, and to not, and to not frame sexuality, I think the other thing that happens with sexuality is it gets framed as negative, all the things that we shouldn't be doing, um, rather than having a positive, kind of positive take on sexuality, and so how with, with youth and, are adults.

Do we just naturally feed that into the conversation? And how do we as clinicians get comfortable with sexuality and sexuality themes? Um, in a society that isn't very comfortable with it, but isn't comfortable with it in appropriate ways is very comfortable with it in some ways that probably aren't very healthy.

And so how do we teach people to do that? I think that's one of the benefits that That I have working in a sexual health kind of clinic that has a gender component to it. And I think that's really important.

CLIP 17

Ren Massey: All right, thanks. Going, going, gone. Move on to our next case. Okay, if I can get my screen share to cooperate with me. Ah, here we go. All right. Cases. This is a collective consideration. Several trans men in their late 20s, early 30s have done a range of social and medical interventions. They're now clear that in hindsight, if they had come out ten years later, they may not have taken all the medical transition steps that they did if the option of a non binary identity had been on the table.They don't like to be seen by others as male, but given the physical changes, don't feel like they have a choice. There are different intensities of how upsetting this is to them, but a common theme is not likened to be perceived as male by others to the extent they are seen as male. I found this really interesting.

Who would like to jump into this conversation?

Dan Metzger: This is a bit beyond my age group, but I think one thing that they could do, uh, medically is to talk with their hormone provider to see if there's a way. I'm presuming these people are still on testosterone, if they are, that they could at least lower the dose to something that's still bone protective and still would make them feel okay, but maybe wouldn't, uh, would less stimulate, uh, you Like facial hair growth or or the other kinds of things.

I mean, their voice is not going to change, obviously, but, uh, there might be some room to play with the testosterone dosage just to make things a little bit less, uh, um, less masculine.

CLIP 18

Cecile Ferrando: Um, so I think this is about goal setting. Um, so you know, while I'm a surgeon, I do a lot of testosterone implants for patients. So I do testopel implants. Um, and, um, when I talk to a lot of patients, the majority of the patients I see, they are seeking, um, realization, masculinization. So I dose them to sort of physiologic levels.

Um, but I have sort of this, um, cohort of patients that is seeking sort of, you know, underdosing, but wants testosterone, um, supplementation. Um, so we sit and we talk about. The goals of therapy, understanding whether, you know, I have to explain to them that sometimes underdosing can, um, will not lead to cessation of menses, which is sometimes the actual goal, like not virilization, but cessation of menses.

And so, in those situations, we talk about, you know, what other things we can do that, um, that may not have sort of either feminizing effects, you know, a lot of our, Transmasculine patients don't want to be on oral contraceptive pills, etc. So sometimes I'll underdose testosterone in a pellet form. Um, and also, um, place an IUD in those patients.

And so it's really sort of about discussing what their goals are. I'm now seeing younger patients. So not necessarily patients who were dosed on, on doses of testosterone and who are now working backwards. But I have a couple of patients in their twenties who.

Sort of err on the side of the masculine side on the spectrum, but don't want to be fully masculinized.

So I'll underdose them as well. And, you know, I think that there's a physiologic component to this improving their, their sort of state of being and giving them a sense of wellbeing. But also I think that there's this component of, um, I feel like I'm taking some steps towards masculinization, but not completely.

So that makes me feel good. And I think that there's. Also, I think we, um, uh, actually to this crowd, I'm not gonna say undervalue. I think, um, uh, people in my, um, from where I'm coming from undervalue the importance of giving a patient a sense of control of their transition and their care plan, which is not a foreign concept when we talk about.

You know, paternalism and autonomy, but certainly when it comes to this type of care, allowing patients to have some control over what it how their transition is or what it is, is really important. So even in patients who've been on high dosing who want to work backwards, but like Dan just pointed out, sometimes you can't reverse everything.

Right. So there's some masculinization that will have already have occurred, but perhaps just the giving a patient the sense of being able to control what's going to happen down the road is really important.

CLIP 19

Cecile Ferrando: testosterone dosing. For me it's easier in the pellet form because you can really sort of dose to certain levels. It's in my, from my experience, easier to control than intramuscular and subcutaneous dosing. But it's about goal setting and discussing and so much can just come from a discussion of I understand that what your goals are and let me see if I can help you achieve them.

Certainly that conversation is easier when it comes to hormones than it is surgery.

Dianne Berg: There are a little bit, I think what it comes up, what comes up for me is helping people to explore socioculturally what it means to be masculine, feminine, male, female, um, because there's kind of the internal sense of it and then there's also

the the way that that gets perceived in the world and It sounds like for some of, for some of these folks, like, for whatever reason, it's more about how they're being perceived by others and maybe, maybe kind of what others are then attributing to them or assuming about them because they're, they're interpreting them as male when maybe that's those things, those, those aspects of maleness are not what they, aspire to or what they want.

And so I think it's, it's, it's all about kind of that, that therapy around what does it mean in our culture to be kind of, what does gender, what does gender mean in our culture? And how is that going to play out for how you see yourself and how others see you? So it's kind of those deeper, those deeper conversations.

CLIP 20

Ren Massey: I just want to add something here. I appreciate what you were just saying, Dianne. One of my adjustments with my transition was, um, losing, um, automatically being perceived as safe. by females who I was meeting for the first time. And, uh, it was a very strange experience to be walking in a parking lot, you know, following a woman out in the parking lot from the grocery store, and to realize, oh, she's looking over her shoulder to, like, see, am I following her?

Am I a threat? Or to be in an elevator and... have, you know, somebody kind of scoot just about as far away as they can. And, um, it, it was, it was, it was a loss, candidly, not to be, uh, perceived or assumed to be safe anymore. Um, so I can easily see that some of these things would be, um, really distressing, um, social impacts of, um.

Being perceived as masculine in our culture. So, looks like you wanted to say something there.

CLIP 21

Dianne Berg: Around kind of the other way too, right? I mean, so many of my trans feminine adult and even adolescent clients, um, Talk a lot about They they they hear

about it theoretically, but it's not until it happens that they really get it like not being paid Not being given as much airtime as they Become perceived as a woman.

Um, you know kind of all the the things that feminists have been saying for a really long time, I think, start to become more clear to people. And, and I think those are some losses or just some, some realizations around how gender plays out in, in sociocultural spaces. And And kind of what is that going to mean and how does how what meaning does that have for people.

So I think it, I think it goes both ways because gender is such a powerful mediator, whether we like it or not, it's such a powerful mediator of sociocultural spaces and interactions and environment.

Ren Massey: Yeah, I'm going to add to that, you know. A lot of us are youth or focused or heavy in our practices. Um, or young adults and, and minors.

Um, but One of my mentees, who I think is on this, um, meeting today and some other folks have talked to me about, you know, and I've even had clients as well who were adults who were assigned male at birth and found the loss of privilege and safety that they experienced in the world, um, was really disturbing.

And particularly some of the older folks. Um, we're actually, um, de transitioning, re transitioning for, for reasons of fitting in not just either around job stuff, but sometimes to be able to go into assisted care facilities with less hassle. And a greater sense of safety. So I think there are other issues, again, outside pressure sometimes, it may not even be the internal experience, that we need to be able to be aware of supporting people for in different contexts that we may be encountering.

CLIP 22

Ren Massey: So um, yeah, one of the thing I would like to highlight on this case, I think that it underscores that from the in the outset, we also may help people explore more non binary options. You know, I have a young person I'm working with right now, um, who's been on blockers for about two years. Mother's anxious for the kid to come off.

Pediatric endocrinologist is saying maybe go a little longer. Um, and the kid is vacillating. Um, really not wanting facial hair. Um, but... about having menstrual cycles and kind of vacillates about whether breast development, chest development bothers them or not, and which pronouns they use. And we all know that chest surgery is pretty inevitable, or at least it looks like that, because that has consistently been a bothersome thing.

So, is there more, um, benefit of staying on blockers or letting the kid... switch back to their endogenous estrogen? Or is it better to go low dose testosterone or what? You know, and at what point in time? So, um, if the kid doesn't want facial hair, but maybe doesn't mind their chest growing and they're planning on having chest surgery anyways.

So we may want to, you know, be creative in how we help folks approach these. Situations that are complex.

CLIP 23

Ren Massey: All right. So, um, I'm going to shift to the next one. I see we got a few other comments on, yeah, what people wanting. And being perceived male can happen very fast. Yes. All right. Let me try to get my screen to cooperate again. Okay. I'm going to read case three in S. 14 years, 11 months, assigned male at birth who identified as female preferred by previous mental health provider for gender dysphoria in the past year.

No significant medical history. Gender history and initial presentation, patient reported that a year prior to presentation a friend came out as bisexual and patient reports it clicked. Hey, that's what I'm feeling. Did not initially share this with anyone, but then six months later told mom about being bisexual.

Felt this confused mom. Around the same time, patient also reported feeling, looking pretty, cute and pretty. wearing female clothing. Reports always having felt this way, but never acted on the impulse to express self using feminine clothing. Patient reports that one month after school started, came to the conclusion they were trans.

Patient disclosed to an online friend first then told girlfriend who encouraged patient to tell mother. When patient told mom about identifying as transgender reports that mom's reaction was unsurprised. Patient had been trying out different names and eventually chose the name Nora. Patient reported feeling dysphoric and that sadness goes hand in hand with dysphoria.

Patient reported interest in starting gender affirming hormones but felt the gender affirming surgery was scary. Felt that mother was supportive of starting hormones, but father was not, and this could be a barrier. Extensive mental health history, starting at age 4, including aggression, ADHD, oppositionality, depression, anxiety, and challenges with behavior.

hospitalizations.

At 15 years, 10 months, the family is open to the patient starting spironolactone, but not ready to provide consent for estrogen. The patient's excited to start medication. Patient continued to follow the mental health provider two or three month intervals. At six month follow up after starting spironolactone, patient started, uh, reported that they felt more male and was feeling comfortable with he him pronouns.

Reported that I felt like a boy who wants to, I feel like a boy who wants to wear nail polish. Patient wanted to stop spironolactone and not interested in pursuing estrogen at this time. Plan for patient to continue to follow the mental health provider. Has follow up appointment in two weeks.

CLIP 24

Ren Massey: Anybody want to jump in here?

Dan Metzger: I, I'm, so again, another kind of happy ending. Kids happy. Um, parents are happy. I, I, I think it's important to remember that not all kids are as smart as every other kid or as in tune with their bodies or minds or minds of kids.

CLIP 25

Dan Metzger: sophisticated as other kids. Some kids like just get things and some kids don't and it takes a little bit longer. And the point is just because you're 15 doesn't mean you know everything. And I, I, I mean, I talk to this all the time, right? You're 15. That's great. But, um, you're probably going to know more than when you're 16.

You actually better know more when you're 16 than when you're 15. So I think it is kind of important to get, uh, uh, And this is our, you know, what our, what our assessors do is to get a level of sort of capacity of not just able to consent for stuff, but like they're understanding where they are. And do they understand that there's a difference between sexuality and gender and being trans and, and, and being, you know, cross dresser.

Um, that, that, that there's more than one way of. You know, liking nail polish. You don't have to be a girl to like nail polish. You can just be a boy and wear nail polish, whatever. So I think, you know, when these kinds of kids are working with their mental health professional, I think it is important for somebody to also really see, well, like, this is a kid that's kind of, not changed, but, you know, well, it's changed their direction three or four times within a short period of time.

That's not somebody you're going to want to rush in to do something permanent with. You're going to want to make sure that the kid, Really is starting to, you know, I have a clear direction of where they're heading before you do something and as well, you know, to make sure that the family are coming along with the kid.

CLIP 26

Gaya Chelvakumar: I will also add that like an anti androgen like spironolactone is a nice place to start because it's something that probably is not going to give you, you know, irreversible changes. And so, you know, if needed to help kind of clarify needs and goals and identity, it's a nice, nice medication to use.

Dan Metzger: Yeah, I would second that, you know, like if this was a kid that was clearly binary and, and wanting to move forward, you know, then we would probably use Lupron because Lupron works better. It's way more expensive. But I think Lupron without a plan of moving towards estrogen for this kid would just make this kid feel crappy, probably because he's, she, sorry, is well through puberty.

Um, so she's probably just going to feel like whatever a teenage kid would feel when they have their testosterone taken away, kind of, you know, whatever, menopausal. So I, I think, um, Just to, just to, just to affirm, I think Spyro is a really good way to go because it's harmless. It's cheap. It works to, for the beard.

It's not going to prevent the bigger boy changes that happen with male puberty, but, um, it is a nice way to kind of ease into things and often, um, for families, for, for parents that are kind of holding back, it's a nice way to move forward. That's, you know, affordable, cheap, safe, and reversible.

Dianne Berg: I'm noticing a lot of stuff in the chat, but I think the medical people could maybe address that kind of comes from how fast testosterone maybe works and does low dose affect that can just noticing that.

Dan Metzger: Yeah, so it's true. I mean, we all, you know, Adult men all have the same testosterone levels, but there's clearly a different range of like how hairy you are or how fast you go bald or whatever.

And it doesn't have to do with your testosterone levels. It may have to do a bit with your testosterone receptors and a million other things that you inherit, um, in your genes. So, so, you know, I, I always kid the Persian, the Persian kids that come and see me, I'm like, don't even look at the bottle. You're going to get a beard.

Like, because we know it's going to happen really fast, and then some of the poor Asian kids, you know, they try forever, they could barely get a mustache going, like their brothers, and so, um, you know, but everybody's the same level, it's all the same dose, so, um, you, you, you do have to let people know that just because you're taking dose X is not, doesn't mean you're going to get results Y to, to, to the same extent.

And the same is true, of course, for, for, for, for girls taking estrogen, you know, breast

CLIP 27

Dan Metzger: Level. Level provided your estrogen levels more or less in the nor in, in a, you know, in a normal range. It has much more to do with other genetic factors and body weight and stuff like that.

Ren Massey: Alright, great. So I think we have time maybe to go into one more case and um, then we may have some time for some concluding comments. Let's see. The biggest challenge is always there, the technology. Actually, the technology user is the biggest challenge. Okay, case four. An AMAB person assigned male at birth, who is now 13, who early on identified as binary trans girl and took all social transition steps.

Medically, the client is on Lupron and she's not been in a rush to start estrogen. However, she's been very invested in doing so at some point in the future. Within the last six months, this youth has begun to identify more as non binary, trying out different pronouns and names. She's very avoidant to have any discussions about What the shift toward non binary gender identity may or may not mean in terms of the decision she's always thought she would make in terms of medical transition.

When brooch will shut down and no longer engage. Have had some success processing when discussions are framed from an embodiment lens.

Dianne Berg: I can say a little bit about this case. I'm not sure whether it's one that I submitted and it just got kind of morphed and changed, um, which is totally fine. Um, but I think the thing that comes up for me, if it is kind of based on one of the cases is, um, But it was very difficult to, to kind of, um, the youth always kind of had it in their mind how their transition was going to work.

I'm going to do this. So I'm going to do this. So I'm going to do this. Then I'm going to do this. And, and it was all a very binary related kind of transition process and how they were thinking about it. And then as they, as they began to kind of try on. Different non binary identities and, and,

um, they started to kind of talk to people, uh, at least with the, with the, um, kid that I worked with.

CLIP 28

Dianne Berg: Where we kind of got to was a general not wanting to talk about things because they were just kind of at that place. But also that they really thought that if they said anything about this and really delved into it, it would mean that their options

for any of that medical transition that they had always thought they were going to do would be off the table.

And so they were like, I can't, I don't want to explore that the non binary shift, because if I explore that, that means that I'm never going to be able to get estrogen or I'm never going to be able, and it was kind of like having some education around. No, it doesn't mean that what it means is we are trying to meet your embodiment goals.

And if your embodiment goals are such that you need a certain type of medical intervention, then you need that medical intervention and we can move forward with that. And you don't have to be afraid that, um, That your identity is going to drive necessarily drive your medical decision. It's more about your embodiment goals are going to are going to drive some of the medical decision making.

And so I don't know. That's kind of how we were able to get through that impasse. Um, So I don't know what other people kind of have to say about that. But, um, embodiment is certainly a concept that I'm using a lot more of with my adolescence and Children.

CLIP 29

Dan Metzger: I, you know, like sort of 13 and a half is sort of our, like a kind of cut off where we, where we're okay to do hormones, if everything, it seems like it's going to work. Um, but I always told the kids, God, you're 13, you don't know everything. Um, I don't expect to know everything. And this is like a journey and you're going to take us, you know, we're coming along for the ride.

And, you know, we start this, it doesn't mean you have to continue. It doesn't mean you have to go up. every single time you come, I'm going to ask you what you want to do with your hormones. Are you happy where they are? And kids do shift with time. A lot of the, particularly the non binary kids, um, um, think that they want to be initially more vascularized than they end up wanting to be.

And they find that there's a happy dose that's gotten rid of their periods or whatever, and that they're happy on that dose. And they don't necessarily want to push forward

as they had thought that they might at the beginning. So. I think it's important that you just lay that out right at the beginning.

You do not, you do not have to have all the answers. You know, even an 18 year old, you do not have to have all the answers. Let's work with all we got today, and you keep letting me know, and I'm going to keep pestering you, you know, what do you want to do about this? What do about this? Or you're not ready to make any decisions, you don't even want to talk about it today.

Fine, let's just leave it in the same. And I think the kids need that space to, to know that A, they're in charge. Uh, B, I'm a little bit pushing them to think about it, like, by asking them, and, and C, you know, they have permission to go backwards, stay where they are, go forwards to, to whatever degree, and, um, and I think that, uh, I think that the kids, um, I think there are kids who are a little bit timid at the beginning, and they don't feel, they can, I, I feel that there is a group of kids who say they're non binary because they're not, Really ready to go full on.

And as they go, they actually find, no, this is working for me. I'm, I really actually do want to go to the, to the end of the binary there. But, um, I think, I think you just got to let kids have that, that permission to do that.

CLIP 30

Ren Massey: I'll just add in that, uh, this actually reminds me of a successful 30 something I have, um, you know, who's, uh, very accomplished in their field and is, uh, was first aware in the last few years really more about their gender identity and, um, thinking, you know, they were identifying as a woman. Uh, and when the first came really more open to their awareness about six months ago.

Um, took him a couple months to call me, then a couple months on my waiting list. And I've been seeing the person, I don't know, a couple months now. And They were hesitant to acknowledge maybe a non binary space might be good, maybe a fluid space might be good. And it's hard to tell how much feels true to their gender versus how much is external factors, and that's kind of stuff we're sorting through with time.

Um, and I think they're feeling some relief to know that there are a range of medical options, and we're not, The, the fortunate thing is this person is not in a rush rush and has some ways of being able to express, um, their feminine side, uh, with their significant other and friends and, and one of their family members, uh, from their family of origin.

But, um, I, I, my main point is in adults as well as young people. I mean, mature, more mature adults, like 30 somethings.

All right, so if we don't have any other comments on this one, actually, I would really like it if we could get to the next case and then we could close up.

CLIP 31

Dianne Berg: I'm just noticing that Jameson is telling us that we should talk, look more at the chat. Jameson, is there a particular thing?

Jason: I was just wanted to draw your attention to the Q& A box as well as the chat. There are questions in the Q& A stream as well as in the chat. So just, just to make sure that.

Dianne Berg: Thank you. I didn't even know about that.

Jason: Yep. Yep. I've answered a few, but, um, the clinical ones I can't.

Dianne Berg: Okay. While we look at the q amp a there's a couple coming up in the chat just about that embodiment discussion. Yes. It's, it's a, it's a growing edge for me. And so I certainly don't want to. To misspeak, but my understanding and what I'm trying to kind of incorporate in my clinical practice is in some ways moving away from, um, what is your identity and therefore because you have this identity, you're going to want to do these particular medical interventions to change your body, not having it be as identity driven, because I think that's been the historical basis of kind of how things have operated.

And instead, regardless of your identity, What, what do you think about your body and what do you want your body to be able to be and how do you feel in your body and,

and what's going to help your, your, you feel better about being in your body and how do we address some of that? Um, regardless of what your identity is, and that might mean medical, that might mean lifting weights, that might mean eating better, I mean, there's a whole range, but it just kind of goes shifting your thinking from identity driven interventions to more, um, for some people, more body driven interventions.

It is kind of my, is what I would try to say about that.

CLIP 32

Ren Massey: Kind of related to that, Dianne, there are some questions about co occurring diagnoses or considerations in the Q& A section, and I would just say it's hard to do it justice in a little bit of time here, but, you know, when there are co occurring conditions of any type, I am more cautious and take a slower approach in terms of.

Um, questions to in considering both identity and embodiment. Um, and, you know, may ask people and encourage people to look at things from all of those kinds of perspectives. Um, and maybe try to get creative in asking them to. You know, just as an example, who is somebody who you'd like to look like who, um, not somebody who's a TV star who's super attractive, but just like kind of an average looking person, you know, um, so that we're not engaging in a fantasy realm of transition expectations with like facial hair, no facial hair, chest of wet socks, flat, brown, small, wet.

And, um, sometimes those discussions. are very helpful, especially with folks who may struggle with the identity piece. Um, and, uh, I think that also just we have to be careful when we recognize there are folks who may have things that make understanding identity uh, more fluid or complex or more challenging.

So I just Take a lot more caution. That's what I would say.

Alright, um, I'm going to try to get us to that very last one.

CLIP 33

Dianne Berg: Not wanting to take up more space, but since other people aren't jumping in, I think it just speaks to the importance of the intersection between sexuality and gender and how, um, I think that the field of gender, it feels like the fields are very separate as someone who's in both of ASAC certified person.

I'm, you know, I go to a lot of the sexuality conferences that are starting to. Care more about gender and I think in the gender conferences. There's there's very little focus on actually sexuality and so I think for me this case just Exemplifies a way that they intersect and I think there's lots of ways that they intersect and I know that WPATH Is gonna do a specialty thing on sexual pleasure which I think is is awesome and And so I think just for me, I want to, I just want to point out that that, that intersection, we don't, we don't often do a good job with that.

And I think that's someplace that we could, that we could be doing better.

Dan Metzger: You know, I totally agree. And I'm sure putting a kid on a blocker at age nine, and then letting them get to the age of whatever, when they're developing a sexual identity, can that be. Uh, cannot be great, right? So I think I think that the other people brought this up that we are to a degree robbing these kids of that sort of early to mid pubertal sexual stuff that's happening with their with their cisgender peers.

That's not happening because we've got the one loop running and their you know, their brains are just not thinking that way. There's no, you know, they're getting older and smarter about, you know, math, but they're not learning how their body works. They're learning how to masturbate because they don't, because they don't have the urge to do that, right?

And all of a sudden they're, you know, they're, they're way many years behind their peers trying to like figure their sex stuff out.

CLIP 34

Ren Massey: Yeah, I'll, uh, add somebody asked when that sexual health workshops going to be, um, we're in the process of developing a number of new workshops this year. Um, as we're updating the foundations curriculum for Montreal, where we'll present the SOC eight, um, based, uh, foundations course for the first time.

Uh, in the meantime, we have a number of. Uh, workshops this summer, including the one Dianne referred to on sexual health, and I believe it's going to be July 29th. Um, I'm pretty sure that's the date we got lined up in, uh, I'm trying to remember. I think it's like eight to 11 Pacific time, 8:00 AM to 11 Pacific time.

But, um, I'm, I'm not gonna bet my life on that. Um, but um, we also have. Some other comments about sexuality and neuroticism, not neuroticism, eroticism. Um, and, uh, you know, I think that that is some of the complexity of gender and sexuality. Both. being processes of discovery and evolution, um, for a lot of, you know, tweenagers and teenagers.

And, uh, so it's not surprising sometimes that they need some help discerning those things. Looks like you wanted to say something, Dianne.

Dianne Berg: Well, I think for adults, historically, if, if people with some sort of gender. Identity have, have, have mentioned anything about their sexuality, it, um, or if they there's always been, at least I have had many clients tell me, I did not tell you the truth about, about a lot of things about my sexuality, because I figured if I told you that.

You would gatekeep and assume it was a fetish or assume it was, um, you know, some of the terms that we no longer are using. And so I think there is a huge historical context. To to sexuality being seen as a being seen in a way that does act that does create barriers access to access to care, and I just want I think it's very important that we acknowledge that historical context, um, and that we work against that historical context, um, by talking more about positive sexuality and pleasure and that that they can go together and that it's okay.

Um, and not create barriers to care because people have that belief that that's what we're going to do.

CLIP 35

Jamison Green: Yes, and gender and sex are two different things, but gender informs your sexuality tremendously. And, uh, no matter who you are, trans people, cis people, male, female, non binary, all those things are really informative to each other. And

when you deny any aspect of it, you are limiting yourself. Uh, to a certain extent, you're, you're cutting off parts of yourself if you pretend it doesn't exist.

And clinically, we've been told, trans people have been told historically, Oh no, don't talk about that. So, it's really, really something that our professions need to combat. Thank you, Dianne. That's good.

Ren Massey: All right, so I'm going to end with a question. I'm going to stop my screen share here, and I'm going to bring this up to my panelists really quickly.

If anybody has any closing thoughts, one question that we didn't get to was steps to support folks who have regret or interventions. I think it's such a new area. We don't have data on it. to my knowledge, but it looks like a lot of folks are looking for support and I would say we need to normalize their exploration just as we would normalize people considering transitioning to a gender different than what they were assigned at birth and to get them supports to do that.

Um, and again, try not to other, other people in the process, not to marginalize or. Put down other people. If other folks have a quick comment.

All right, that that's to be continued in our ongoing growth in the field. I want to thank all of the attendees. Uh, I appreciate the great input, the questions, the comments, the exchange, the thought provoking, um, dialogue among all of us. I want to thank the production staff, Mike Evans and Cheryl Field.

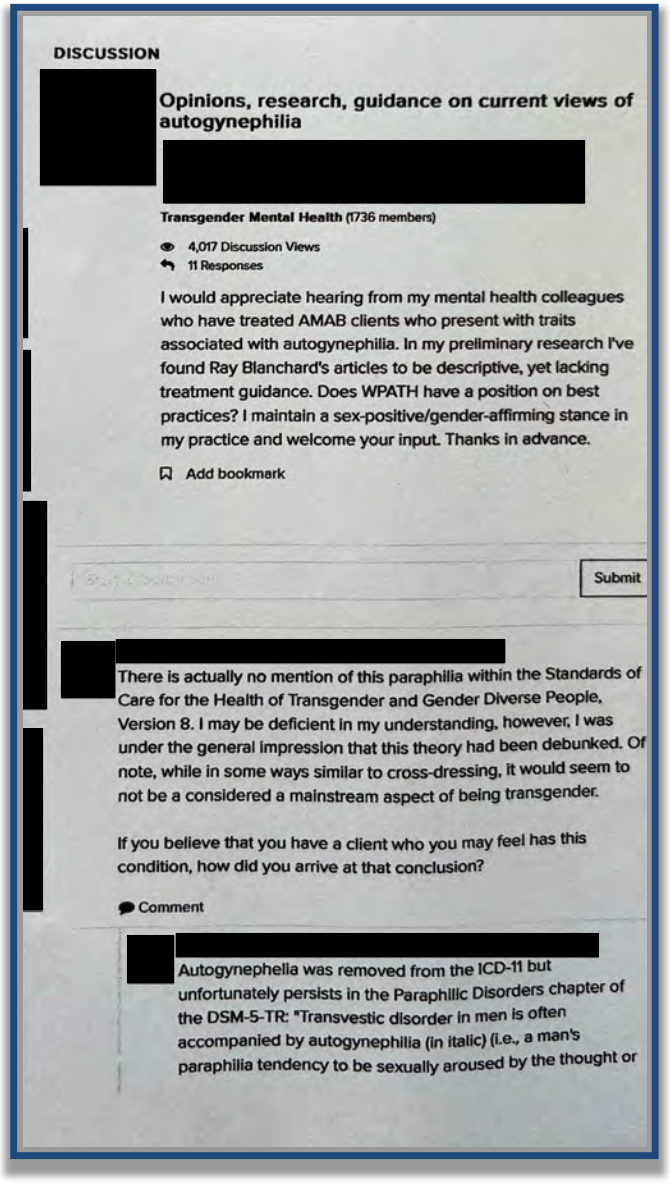
Y'all are awesome. And our WPATH staff as well, Tricia, Kat, Rebecca. Wayne and Jamie. Uh, I see Tricia, Kat, and Rebecca doing the heavy lifting today. And then I thank all of my colleagues for being here and the thought you put in in advance and for taking part in this conversation to try to advance health care for our trans and gender questioning clients.

Thank you.

23) APPENDIX: ADDITIONAL FILES

THE FOLLOWING FILES WERE SHARED WITH ENVIRONMENTAL PROGRESS BY A SOURCE OR SOURCES AFTER OUR REPORT AND INITIAL ANALYSIS WERE COMPLETED. WE HAVE ADDED THESE ADDITIONAL FILES BELOW AND ENCOURAGE THE READER TO REVIEW THEM AS WELL.

a) A WPATH member seeks guidance on transgender client who presents with traits associated with autogynephilia



DISCUSSION

[redacted] **Opinions, research, guidance on current views of autogynephilia**

[redacted]

Transgender Mental Health (1736 members)

4,017 Discussion Views
11 Responses

I would appreciate hearing from my mental health colleagues who have treated AMAB clients who present with traits associated with autogynephilia. In my preliminary research I've found Ray Blanchard's articles to be descriptive, yet lacking treatment guidance. Does WPATH have a position on best practices? I maintain a sex-positive/gender-affirming stance in my practice and welcome your input. Thanks in advance.

Add bookmark

Submit

[redacted] There is actually no mention of this paraphilia within the Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. I may be deficient in my understanding, however, I was under the general impression that this theory had been debunked. Of note, while in some ways similar to cross-dressing, it would seem to not be a considered a mainstream aspect of being transgender.

If you believe that you have a client who you may feel has this condition, how did you arrive at that conclusion?

Comment

[redacted] Autogynephelia was removed from the ICD-11 but unfortunately persists in the Paraphilic Disorders chapter of the DSM-5-TR: "Transvestic disorder in men is often accompanied by autogynephilia (in italic) (i.e., a man's paraphilia tendency to be sexually aroused by the thought or

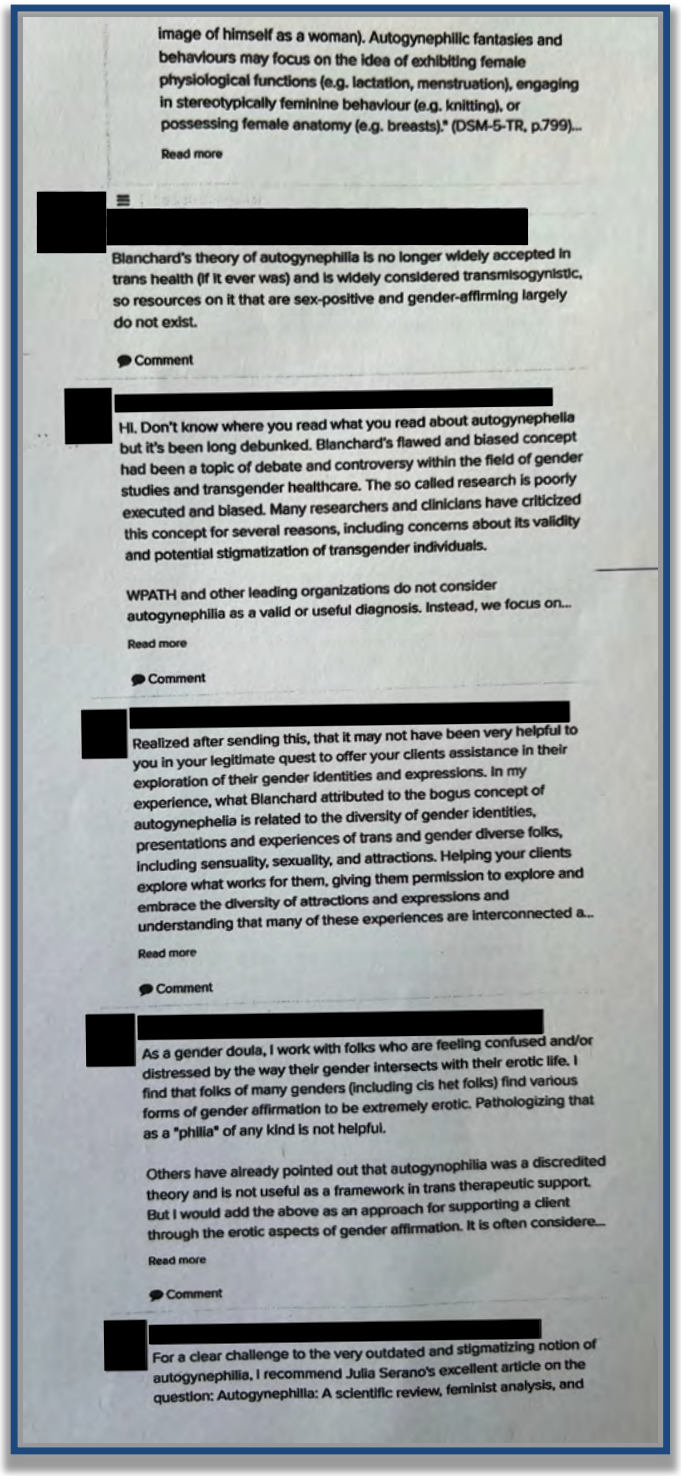


image of himself as a woman). Autogynephilic fantasies and behaviours may focus on the idea of exhibiting female physiological functions (e.g. lactation, menstruation), engaging in stereotypically feminine behaviour (e.g. knitting), or possessing female anatomy (e.g. breasts)." (DSM-5-TR, p.799)...

Read more

[redacted]

Blanchard's theory of autogynephilia is no longer widely accepted in trans health (if it ever was) and is widely considered transmisogynistic, so resources on it that are sex-positive and gender-affirming largely do not exist.

Comment

[redacted]

Hi. Don't know where you read what you read about autogynephelia but it's been long debunked. Blanchard's flawed and biased concept had been a topic of debate and controversy within the field of gender studies and transgender healthcare. The so called research is poorly executed and biased. Many researchers and clinicians have criticized this concept for several reasons, including concerns about its validity and potential stigmatization of transgender individuals.

WPATH and other leading organizations do not consider autogynephilia as a valid or useful diagnosis. Instead, we focus on...

Read more

Comment

[redacted]

Realized after sending this, that it may not have been very helpful to you in your legitimate quest to offer your clients assistance in their exploration of their gender identities and expressions. In my experience, what Blanchard attributed to the bogus concept of autogynephelia is related to the diversity of gender identities, presentations and experiences of trans and gender diverse folks, including sensuality, sexuality, and attractions. Helping your clients explore what works for them, giving them permission to explore and embrace the diversity of attractions and expressions and understanding that many of these experiences are interconnected a...

Read more

Comment

[redacted]

As a gender doula, I work with folks who are feeling confused and/or distressed by the way their gender intersects with their erotic life. I find that folks of many genders (including cis het folks) find various forms of gender affirmation to be extremely erotic. Pathologizing that as a "philia" of any kind is not helpful.

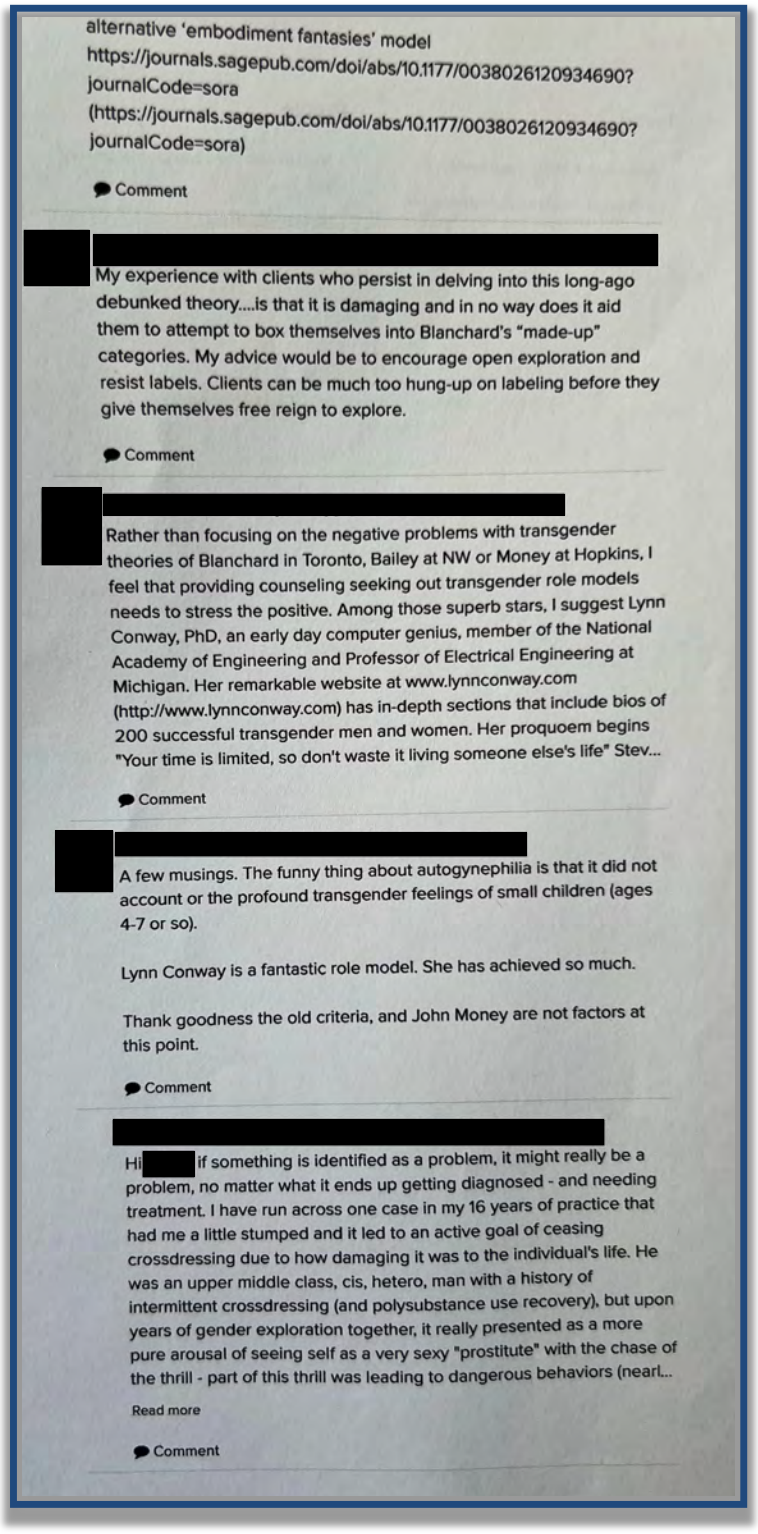
Others have already pointed out that autogynophilia was a discredited theory and is not useful as a framework in trans therapeutic support. But I would add the above as an approach for supporting a client through the erotic aspects of gender affirmation. It is often considere...

Read more

Comment

[redacted]

For a clear challenge to the very outdated and stigmatizing notion of autogynephilia, I recommend Julia Serano's excellent article on the question: Autogynephilia: A scientific review, feminist analysis, and



alternative 'embodiment fantasies' model
https://journals.sagepub.com/doi/abs/10.1177/0038026120934690?journalCode=sora
(https://journals.sagepub.com/doi/abs/10.1177/0038026120934690?journalCode=sora)

Comment

[redacted]
My experience with clients who persist in delving into this long-ago debunked theory....is that it is damaging and in no way does it aid them to attempt to box themselves into Blanchard's "made-up" categories. My advice would be to encourage open exploration and resist labels. Clients can be much too hung-up on labeling before they give themselves free reign to explore.

Comment

[redacted]
Rather than focusing on the negative problems with transgender theories of Blanchard in Toronto, Bailey at NW or Money at Hopkins, I feel that providing counseling seeking out transgender role models needs to stress the positive. Among those superb stars, I suggest Lynn Conway, PhD, an early day computer genius, member of the National Academy of Engineering and Professor of Electrical Engineering at Michigan. Her remarkable website at www.lynnconway.com (http://www.lynnconway.com) has in-depth sections that include bios of 200 successful transgender men and women. Her proquoem begins "Your time is limited, so don't waste it living someone else's life" Stev...

Comment

[redacted]
A few musings. The funny thing about autogynephilia is that it did not account or the profound transgender feelings of small children (ages 4-7 or so).

Lynn Conway is a fantastic role model. She has achieved so much.

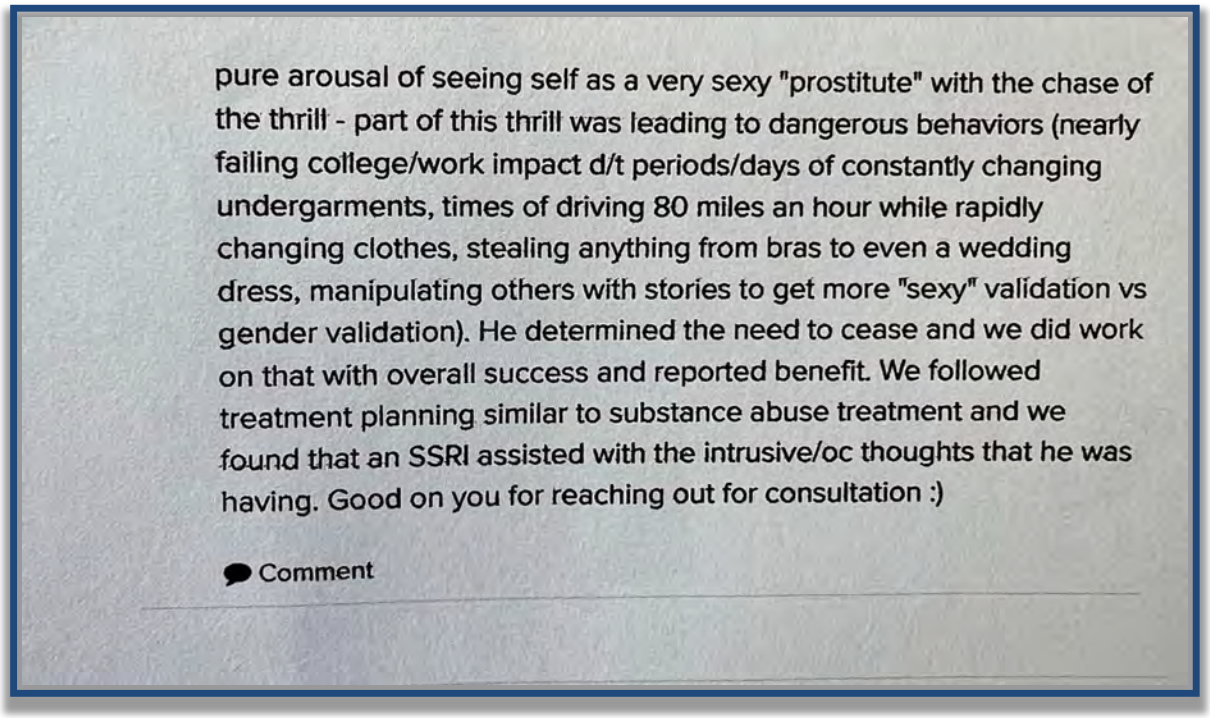
Thank goodness the old criteria, and John Money are not factors at this point.

Comment

[redacted]
Hi [redacted] if something is identified as a problem, it might really be a problem, no matter what it ends up getting diagnosed - and needing treatment. I have run across one case in my 16 years of practice that had me a little stumped and it led to an active goal of ceasing crossdressing due to how damaging it was to the individual's life. He was an upper middle class, cis, hetero, man with a history of intermittent crossdressing (and polysubstance use recovery), but upon years of gender exploration together, it really presented as a more pure arousal of seeing self as a very sexy "prostitute" with the chase of the thrill - part of this thrill was leading to dangerous behaviors (nearl...

Read more

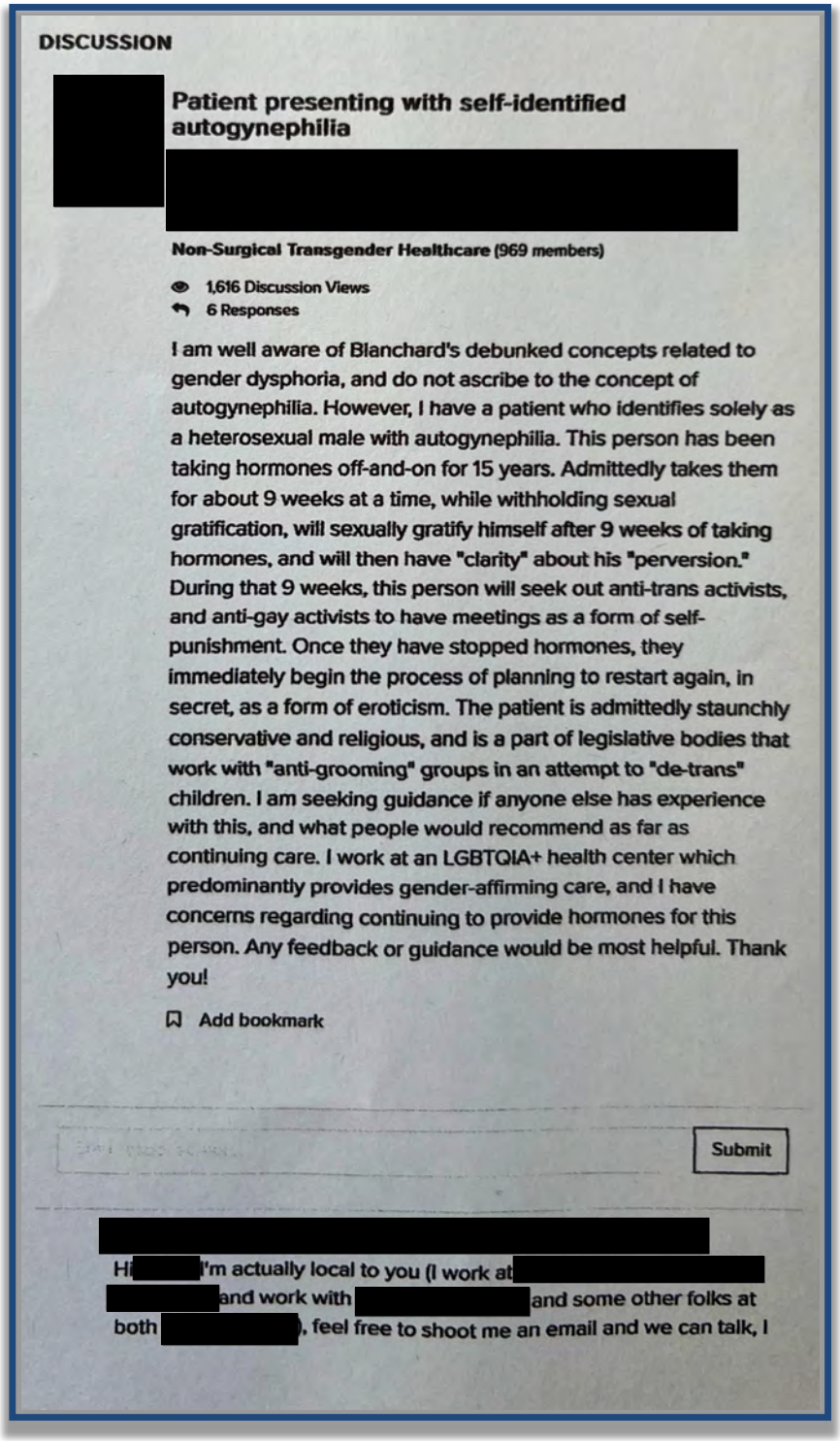
Comment



pure arousal of seeing self as a very sexy "prostitute" with the chase of the thrill - part of this thrill was leading to dangerous behaviors (nearly failing college/work impact d/t periods/days of constantly changing undergarments, times of driving 80 miles an hour while rapidly changing clothes, stealing anything from bras to even a wedding dress, manipulating others with stories to get more "sexy" validation vs gender validation). He determined the need to cease and we did work on that with overall success and reported benefit. We followed treatment planning similar to substance abuse treatment and we found that an SSRI assisted with the intrusive/oc thoughts that he was having. Good on you for reaching out for consultation :)

Comment

b) A WPATH member seeks guidance on patient who identifies solely as a heterosexual male with autogynephilia



DISCUSSION

[redacted]

Patient presenting with self-identified autogynephilia

[redacted]

Non-Surgical Transgender Healthcare (969 members)

1,616 Discussion Views
6 Responses

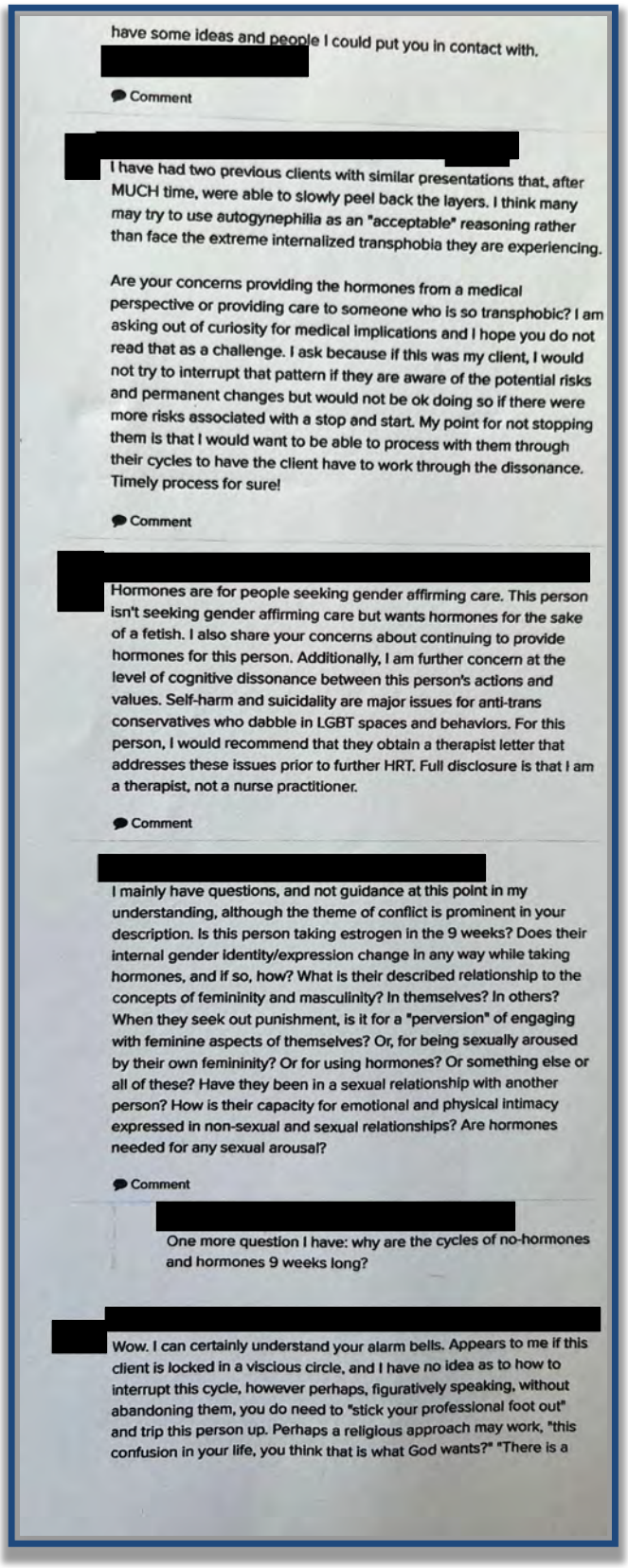
I am well aware of Blanchard's debunked concepts related to gender dysphoria, and do not ascribe to the concept of autogynephilia. However, I have a patient who identifies solely as a heterosexual male with autogynephilia. This person has been taking hormones off-and-on for 15 years. Admittedly takes them for about 9 weeks at a time, while withholding sexual gratification, will sexually gratify himself after 9 weeks of taking hormones, and will then have "clarity" about his "perversion." During that 9 weeks, this person will seek out anti-trans activists, and anti-gay activists to have meetings as a form of self-punishment. Once they have stopped hormones, they immediately begin the process of planning to restart again, in secret, as a form of eroticism. The patient is admittedly staunchly conservative and religious, and is a part of legislative bodies that work with "anti-grooming" groups in an attempt to "de-trans" children. I am seeking guidance if anyone else has experience with this, and what people would recommend as far as continuing care. I work at an LGBTQIA+ health center which predominantly provides gender-affirming care, and I have concerns regarding continuing to provide hormones for this person. Any feedback or guidance would be most helpful. Thank you!

Add bookmark

Submit

[redacted]

Hi [redacted] I'm actually local to you (I work at [redacted] and work with [redacted] and some other folks at both [redacted]), feel free to shoot me an email and we can talk, I



have some ideas and people I could put you in contact with. [redacted]

Comment

[redacted]

I have had two previous clients with similar presentations that, after MUCH time, were able to slowly peel back the layers. I think many may try to use autogynephilia as an "acceptable" reasoning rather than face the extreme internalized transphobia they are experiencing.

Are your concerns providing the hormones from a medical perspective or providing care to someone who is so transphobic? I am asking out of curiosity for medical implications and I hope you do not read that as a challenge. I ask because if this was my client, I would not try to interrupt that pattern if they are aware of the potential risks and permanent changes but would not be ok doing so if there were more risks associated with a stop and start. My point for not stopping them is that I would want to be able to process with them through their cycles to have the client have to work through the dissonance. Timely process for sure!

Comment

[redacted]

Hormones are for people seeking gender affirming care. This person isn't seeking gender affirming care but wants hormones for the sake of a fetish. I also share your concerns about continuing to provide hormones for this person. Additionally, I am further concern at the level of cognitive dissonance between this person's actions and values. Self-harm and suicidality are major issues for anti-trans conservatives who dabble in LGBT spaces and behaviors. For this person, I would recommend that they obtain a therapist letter that addresses these issues prior to further HRT. Full disclosure is that I am a therapist, not a nurse practitioner.

Comment

[redacted]

I mainly have questions, and not guidance at this point in my understanding, although the theme of conflict is prominent in your description. Is this person taking estrogen in the 9 weeks? Does their internal gender identity/expression change in any way while taking hormones, and if so, how? What is their described relationship to the concepts of femininity and masculinity? In themselves? In others? When they seek out punishment, is it for a "perversion" of engaging with feminine aspects of themselves? Or, for being sexually aroused by their own femininity? Or for using hormones? Or something else or all of these? Have they been in a sexual relationship with another person? How is their capacity for emotional and physical intimacy expressed in non-sexual and sexual relationships? Are hormones needed for any sexual arousal?

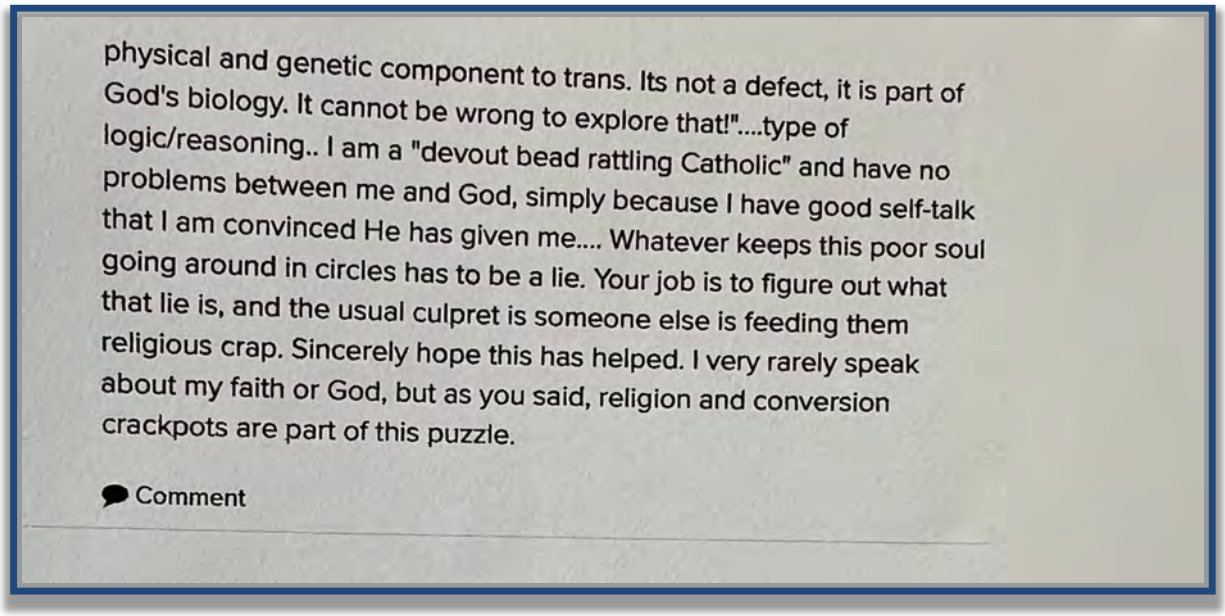
Comment

[redacted]

One more question I have: why are the cycles of no-hormones and hormones 9 weeks long?

[redacted]

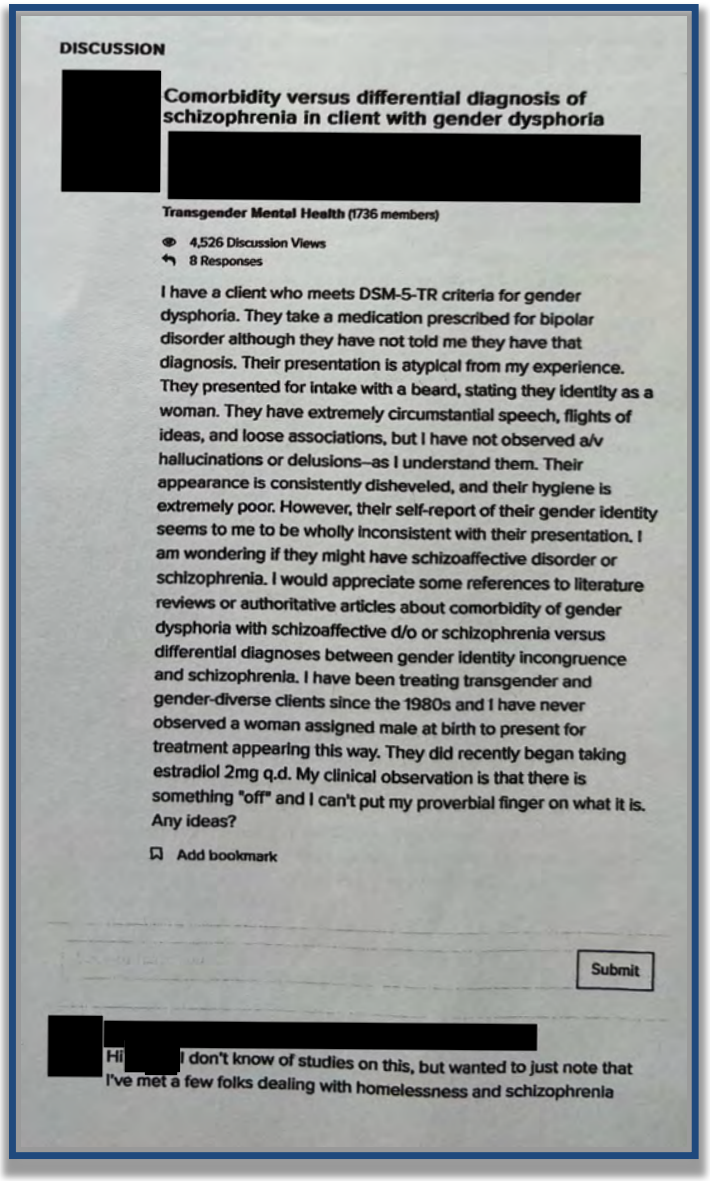
Wow. I can certainly understand your alarm bells. Appears to me if this client is locked in a viscious circle, and I have no idea as to how to interrupt this cycle, however perhaps, figuratively speaking, without abandoning them, you do need to "stick your professional foot out" and trip this person up. Perhaps a religious approach may work, "this confusion in your life, you think that is what God wants?" "There is a



physical and genetic component to trans. Its not a defect, it is part of God's biology. It cannot be wrong to explore that!"....type of logic/reasoning.. I am a "devout bead rattling Catholic" and have no problems between me and God, simply because I have good self-talk that I am convinced He has given me.... Whatever keeps this poor soul going around in circles has to be a lie. Your job is to figure out what that lie is, and the usual culpret is someone else is feeding them religious crap. Sincerely hope this has helped. I very rarely speak about my faith or God, but as you said, religion and conversion crackpots are part of this puzzle.

Comment

c) A WPATH member seeks clarification on comorbidity versus differential diagnosis for client with gender dysphoria and schizophrenia



DISCUSSION

[redacted]

Comorbidity versus differential diagnosis of schizophrenia in client with gender dysphoria

[redacted]

Transgender Mental Health (1736 members)

4,526 Discussion Views
8 Responses

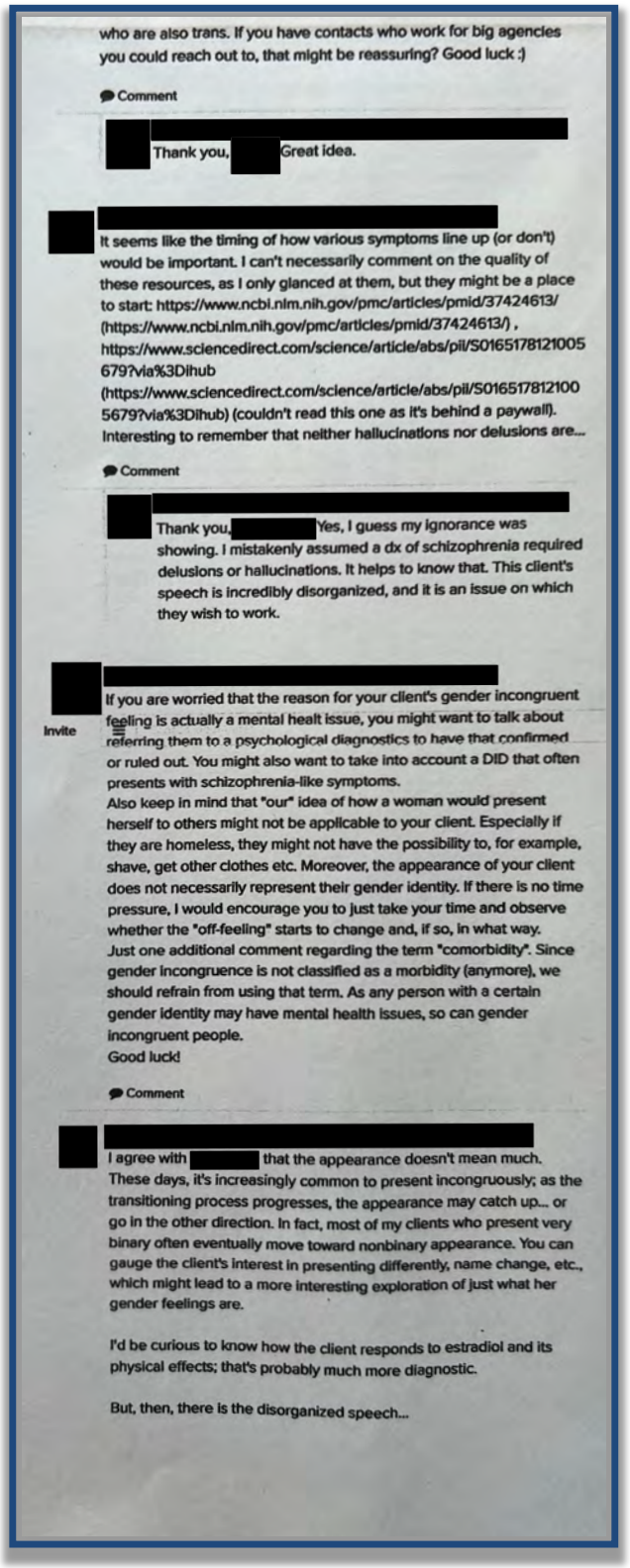
I have a client who meets DSM-5-TR criteria for gender dysphoria. They take a medication prescribed for bipolar disorder although they have not told me they have that diagnosis. Their presentation is atypical from my experience. They presented for intake with a beard, stating they identity as a woman. They have extremely circumstantial speech, flights of ideas, and loose associations, but I have not observed a/v hallucinations or delusions–as I understand them. Their appearance is consistently disheveled, and their hygiene is extremely poor. However, their self-report of their gender identity seems to me to be wholly inconsistent with their presentation. I am wondering if they might have schizoaffective disorder or schizophrenia. I would appreciate some references to literature reviews or authoritative articles about comorbidity of gender dysphoria with schizoaffective d/o or schizophrenia versus differential diagnoses between gender identity incongruence and schizophrenia. I have been treating transgender and gender-diverse clients since the 1980s and I have never observed a woman assigned male at birth to present for treatment appearing this way. They did recently began taking estradiol 2mg q.d. My clinical observation is that there is something "off" and I can't put my proverbial finger on what it is. Any ideas?

Add bookmark

Submit

[redacted]

Hi [redacted] I don't know of studies on this, but wanted to just note that I've met a few folks dealing with homelessness and schizophrenia



who are also trans. If you have contacts who work for big agencies you could reach out to, that might be reassuring? Good luck :)

Comment

[redacted] Thank you, [redacted] Great idea.

[redacted]
It seems like the timing of how various symptoms line up (or don't) would be important. I can't necessarily comment on the quality of these resources, as I only glanced at them, but they might be a place to start: https://www.ncbi.nlm.nih.gov/pmc/articles/pmid/37424613/ (https://www.ncbi.nlm.nih.gov/pmc/articles/pmid/37424613/) , https://www.sciencedirect.com/science/article/abs/pii/S0165178121005679?via%3Dihub (https://www.sciencedirect.com/science/article/abs/pii/S0165178121005679?via%3Dihub) (couldn't read this one as it's behind a paywall). Interesting to remember that neither hallucinations nor delusions are...

Comment

[redacted] Thank you, [redacted] Yes, I guess my ignorance was showing. I mistakenly assumed a dx of schizophrenia required delusions or hallucinations. It helps to know that. This client's speech is incredibly disorganized, and it is an issue on which they wish to work.

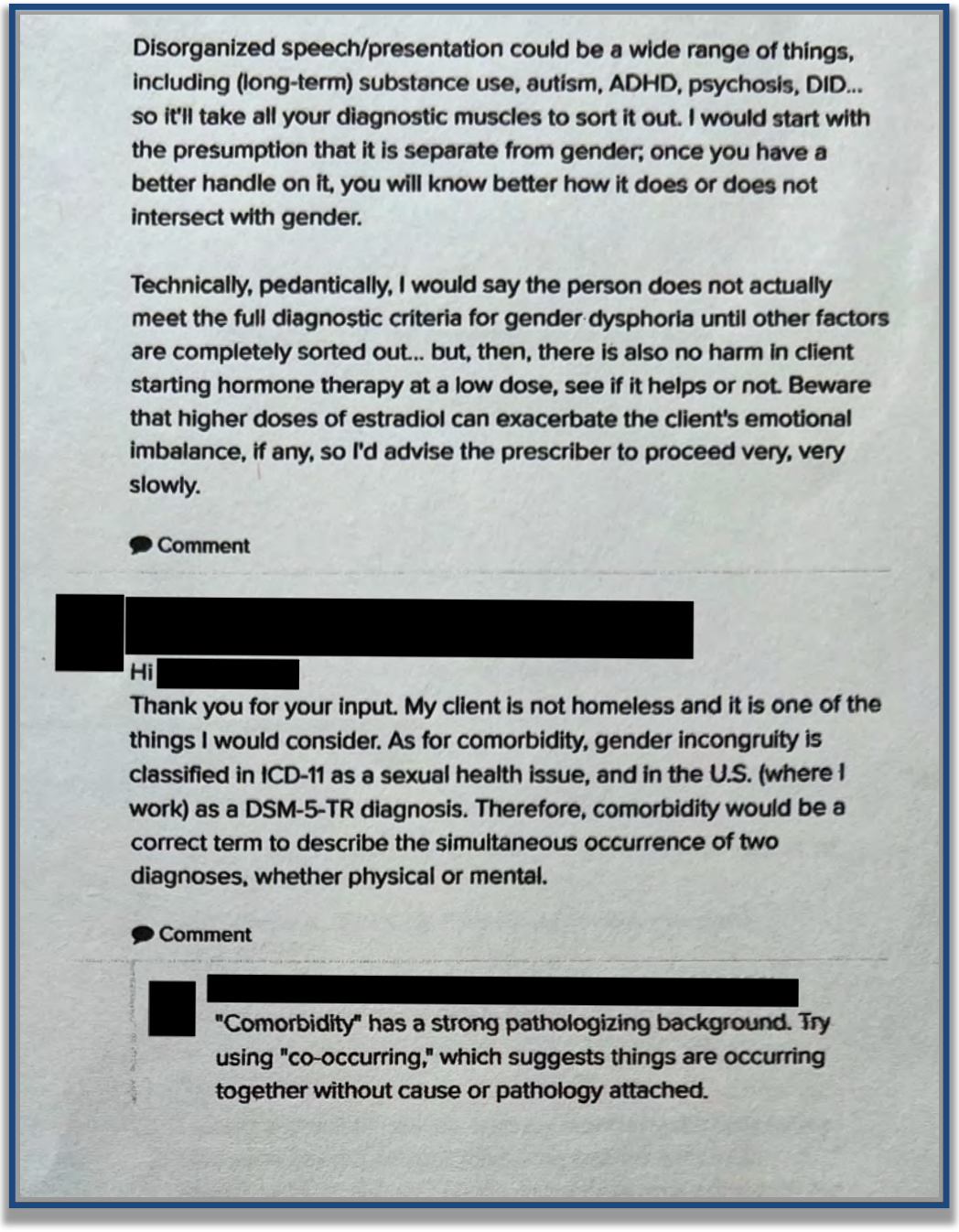
[redacted]
Invite
If you are worried that the reason for your client's gender incongruent feeling is actually a mental healt issue, you might want to talk about referring them to a psychological diagnostics to have that confirmed or ruled out. You might also want to take into account a DID that often presents with schizophrenia-like symptoms.
Also keep in mind that "our" idea of how a woman would present herself to others might not be applicable to your client. Especially if they are homeless, they might not have the possibility to, for example, shave, get other clothes etc. Moreover, the appearance of your client does not necessarily represent their gender identity. If there is no time pressure, I would encourage you to just take your time and observe whether the "off-feeling" starts to change and, if so, in what way.
Just one additional comment regarding the term "comorbidity". Since gender incongruence is not classified as a morbidity (anymore), we should refrain from using that term. As any person with a certain gender identity may have mental health issues, so can gender incongruent people.
Good luck!

Comment

[redacted]
I agree with [redacted] that the appearance doesn't mean much. These days, it's increasingly common to present incongruously; as the transitioning process progresses, the appearance may catch up... or go in the other direction. In fact, most of my clients who present very binary often eventually move toward nonbinary appearance. You can gauge the client's interest in presenting differently, name change, etc., which might lead to a more interesting exploration of just what her gender feelings are.

I'd be curious to know how the client responds to estradiol and its physical effects; that's probably much more diagnostic.

But, then, there is the disorganized speech...



Disorganized speech/presentation could be a wide range of things, including (long-term) substance use, autism, ADHD, psychosis, DID... so it'll take all your diagnostic muscles to sort it out. I would start with the presumption that it is separate from gender; once you have a better handle on it, you will know better how it does or does not intersect with gender.

Technically, pedantically, I would say the person does not actually meet the full diagnostic criteria for gender dysphoria until other factors are completely sorted out... but, then, there is also no harm in client starting hormone therapy at a low dose, see if it helps or not. Beware that higher doses of estradiol can exacerbate the client's emotional imbalance, if any, so I'd advise the prescriber to proceed very, very slowly.

Comment

[redacted]

Hi [redacted]

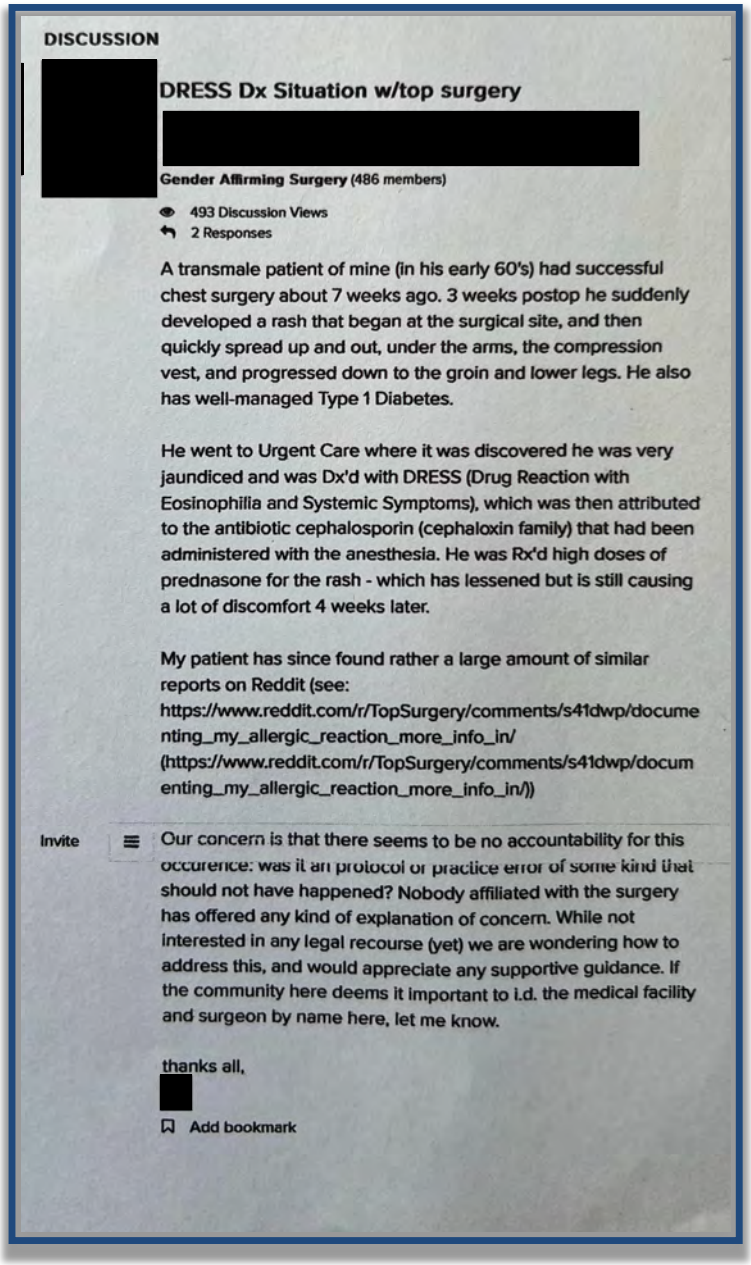
Thank you for your input. My client is not homeless and it is one of the things I would consider. As for comorbidity, gender incongruity is classified in ICD-11 as a sexual health issue, and in the U.S. (where I work) as a DSM-5-TR diagnosis. Therefore, comorbidity would be a correct term to describe the simultaneous occurrence of two diagnoses, whether physical or mental.

Comment

[redacted]

"Comorbidity" has a strong pathologizing background. Try using "co-occurring," which suggests things are occurring together without cause or pathology attached.

d) A WPATH member discusses surgical complication of transgender patient after top surgery



DISCUSSION

[redacted]

DRESS Dx Situation w/top surgery

[redacted]

Gender Affirming Surgery (486 members)

493 Discussion Views
2 Responses

A transmale patient of mine (in his early 60's) had successful chest surgery about 7 weeks ago. 3 weeks postop he suddenly developed a rash that began at the surgical site, and then quickly spread up and out, under the arms, the compression vest, and progressed down to the groin and lower legs. He also has well-managed Type 1 Diabetes.

He went to Urgent Care where it was discovered he was very jaundiced and was Dx'd with DRESS (Drug Reaction with Eosinophilia and Systemic Symptoms), which was then attributed to the antibiotic cephalosporin (cephaloxin family) that had been administered with the anesthesia. He was Rx'd high doses of prednasone for the rash - which has lessened but is still causing a lot of discomfort 4 weeks later.

My patient has since found rather a large amount of similar reports on Reddit (see: https://www.reddit.com/r/TopSurgery/comments/s41dwp/documenting_my_allergic_reaction_more_info_in/ (https://www.reddit.com/r/TopSurgery/comments/s41dwp/documenting_my_allergic_reaction_more_info_in/))

Invite

Our concern is that there seems to be no accountability for this occurence: was it an protocol or practice error of some kind that should not have happened? Nobody affiliated with the surgery has offered any kind of explanation of concern. While not interested in any legal recourse (yet) we are wondering how to address this, and would appreciate any supportive guidance. If the community here deems it important to i.d. the medical facility and surgeon by name here, let me know.

thanks all,

[redacted]

Add bookmark

[redacted]

Hi!

It seems an allegic reaction to the antibiotic administered. It is always possible. Good that he referred to urgent care and he received adequate medications. The supportive guidance is that he should disclose the reaction at next medical consultation, and eventually be tested for allergy to the antibiotics.

Strange that he developed the reaction 3 weeks later...

Anyway, everything is possible following medications and surgery, including anaphylactic shock to drugs, as well as necrotising fasciitis following surgery or minor trauma. You can check up these two conditions.

Our work is difficult ! But we must do it! For the benefit of the patients !

Comment

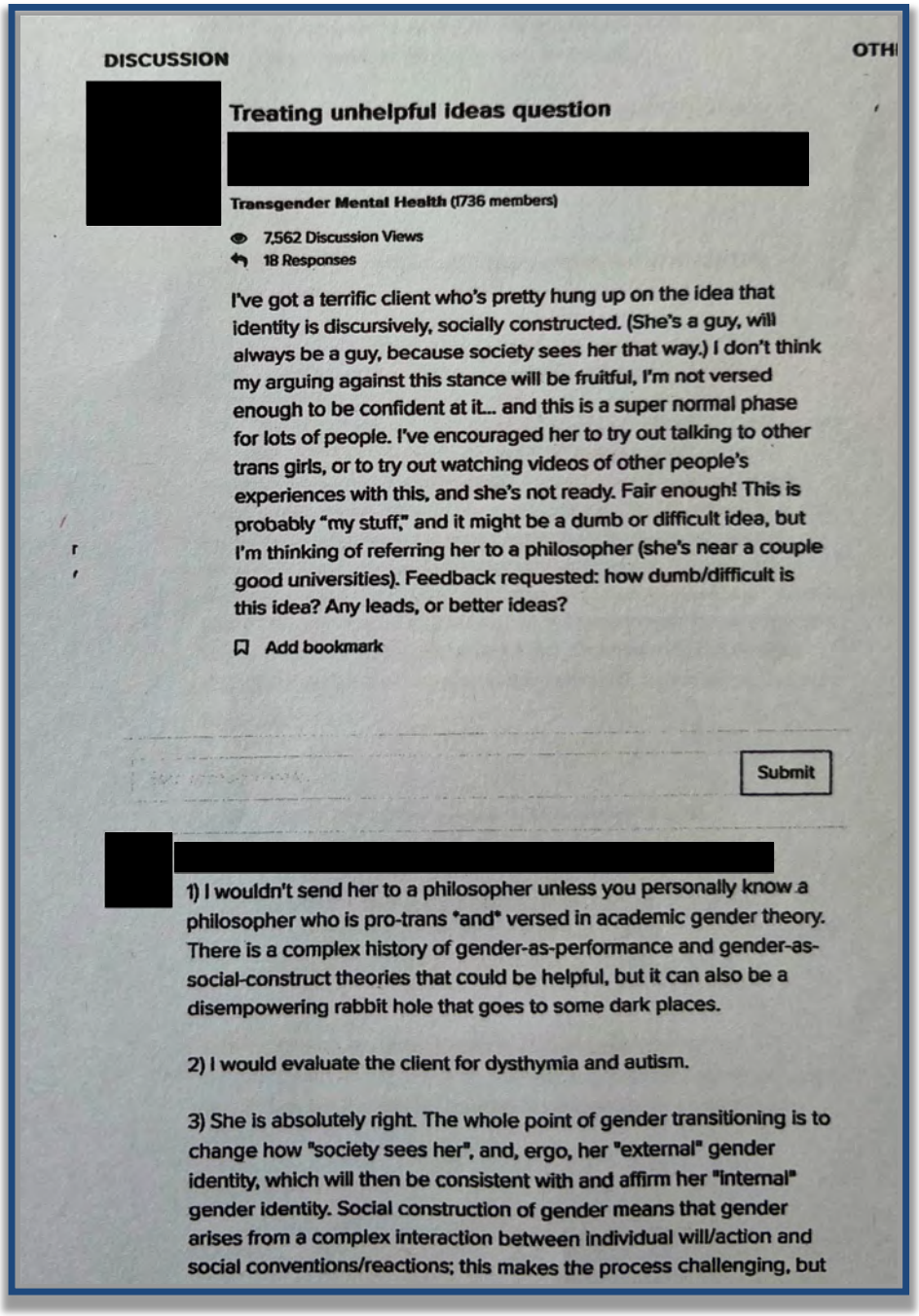
[redacted]

Thanks very much for your sensitive comments. My patient reports reading that many others report the same delay in symptoms of several weeks - of course this is anecdotal and to my knowledge there has been no focused research on such issues yet.

However – Is it not odd that such a possible adverse and potentially dangerous reaction was not assessed before the surgery?

Please feel free to continue to add to this conversation as you ponder it. I have posted this case before the Surgeon's Group here at WPATH, and am looking forward to their responses, too.

e) A WPATH member seeks advice on sending patient to a philosopher to help change their views on gender identity



DISCUSSION

OTH

[redacted]

Treating unhelpful ideas question

[redacted]

Transgender Mental Health (1736 members)

7,562 Discussion Views

18 Responses

I've got a terrific client who's pretty hung up on the idea that identity is discursively, socially constructed. (She's a guy, will always be a guy, because society sees her that way.) I don't think my arguing against this stance will be fruitful, I'm not versed enough to be confident at it... and this is a super normal phase for lots of people. I've encouraged her to try out talking to other trans girls, or to try out watching videos of other people's experiences with this, and she's not ready. Fair enough! This is probably "my stuff," and it might be a dumb or difficult idea, but I'm thinking of referring her to a philosopher (she's near a couple good universities). Feedback requested: how dumb/difficult is this idea? Any leads, or better ideas?

Add bookmark

Submit

[redacted]

[redacted]

1) I wouldn't send her to a philosopher unless you personally know a philosopher who is pro-trans *and* versed in academic gender theory. There is a complex history of gender-as-performance and gender-as-social-construct theories that could be helpful, but it can also be a disempowering rabbit hole that goes to some dark places.

2) I would evaluate the client for dysthymia and autism.

3) She is absolutely right. The whole point of gender transitioning is to change how "society sees her", and, ergo, her "external" gender identity, which will then be consistent with and affirm her "internal" gender identity. Social construction of gender means that gender arises from a complex interaction between individual will/action and social conventions/reactions; this makes the process challenging, but

through the morass of cognitive dissonances... which are necessary for any kind of social change... hence the recommendation to evaluate for her for dysthymia/autism, i.e., her response to seeming contradictions.

4) It may simply be that her desire to be more congruent is not strong enough to clearly outweigh the obstacles. If so, it just isn't time... if it ever will be.

Hope this helps!

Comment

[redacted] Thanks, [redacted] That is helpful :)

[redacted] If it's rooted in recognition in that way, what does the client make of the fact that plenty of people recognize trans women as women? Or the fact that they may not even be recognized as trans at all in the first place?The thing with recognition-based accounts is that people actually don't have consistent criteria for gender!

My feeling is that the client may be overintellectualizing what is essentially a form of self-doubt and internalized transphobia. If so, I'm not sure philosophers would help much.

Comment

[redacted] Exactly

[redacted] The "idea that identity is discursively, socially constructed" comes from the work of Michel Foucault, a French philosopher. Rather than referring her to a philosopher, I would recommend reading Loizos Heracleous's book, "Discourse, Interpretation, Organization," in which the author discusses Foucault's conceptions of discourse and its relationship with power and sociopolitical interests. I would also suggest reading Foucault's "Discipline and Punish." Here is a YouTube video ("Michel Foucault's Conception of Discourse as Knowledge and Power") that will help get you started on the road to being versed enough to be competent (and hence confident) at discussing this wit...

Read more

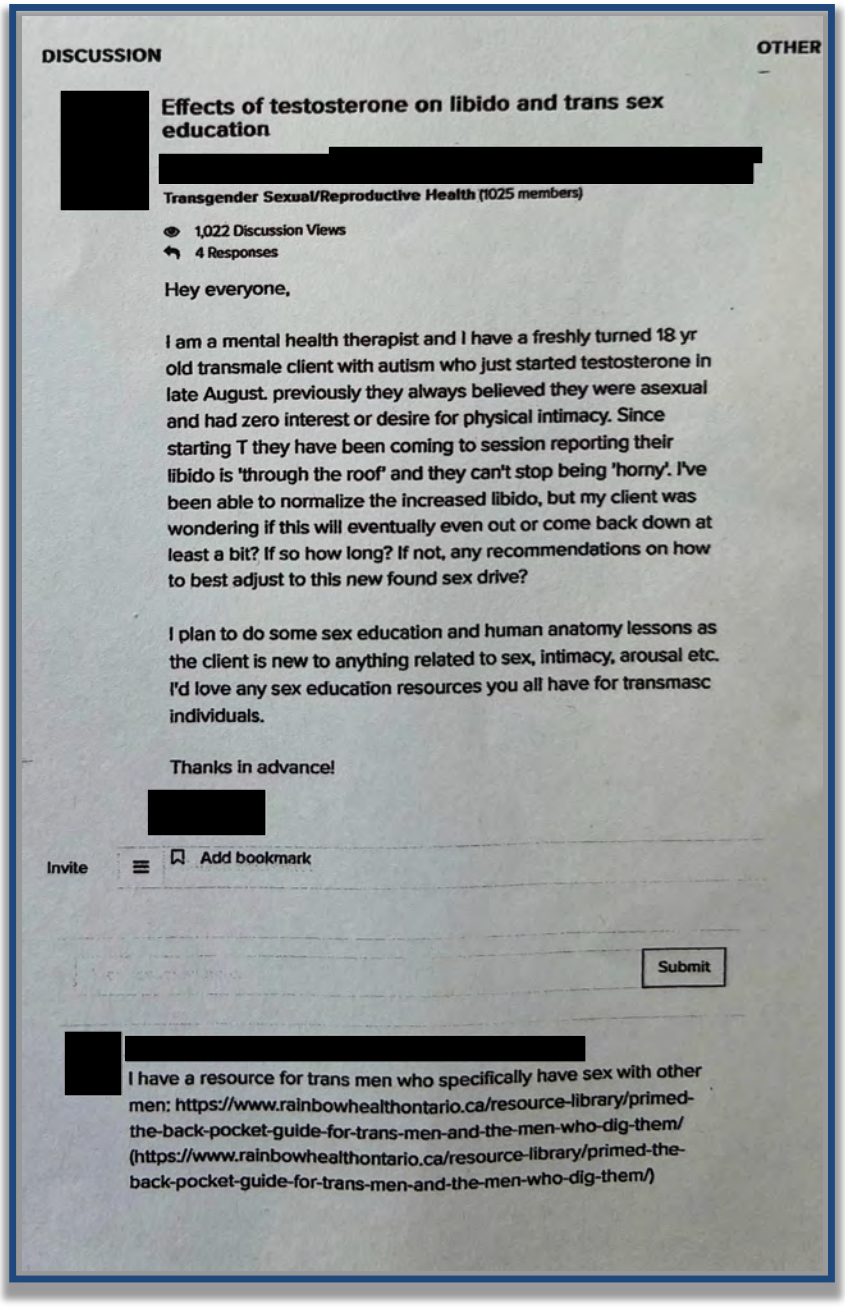
Comment

[redacted] Wow, thanks a bunch, [redacted] I'm going to start with the University Quick Course youtube you recommended and marinate on the idea that we must take an active role in negotiating the presentation of self. I like it, and I want to think more about the implications there. Thanks again :)

[redacted] I understand your problem! To refer her to a philosopher might be a good idea, but it might be an advantage that this is a competent philosopher.

[redacted]

f) A WPATH member seeks guidance for client whose libido has drastically increased on testosterone



DISCUSSION OTHER

[redacted] **Effects of testosterone on libido and trans sex education**

[redacted]

Transgender Sexual/Reproductive Health (1025 members)

1,022 Discussion Views
4 Responses

Hey everyone,

I am a mental health therapist and I have a freshly turned 18 yr old transmale client with autism who just started testosterone in late August. previously they always believed they were asexual and had zero interest or desire for physical intimacy. Since starting T they have been coming to session reporting their libido is 'through the roof' and they can't stop being 'horny'. I've been able to normalize the increased libido, but my client was wondering if this will eventually even out or come back down at least a bit? If so how long? If not, any recommendations on how to best adjust to this new found sex drive?

I plan to do some sex education and human anatomy lessons as the client is new to anything related to sex, intimacy, arousal etc. I'd love any sex education resources you all have for transmasc individuals.

Thanks in advance!

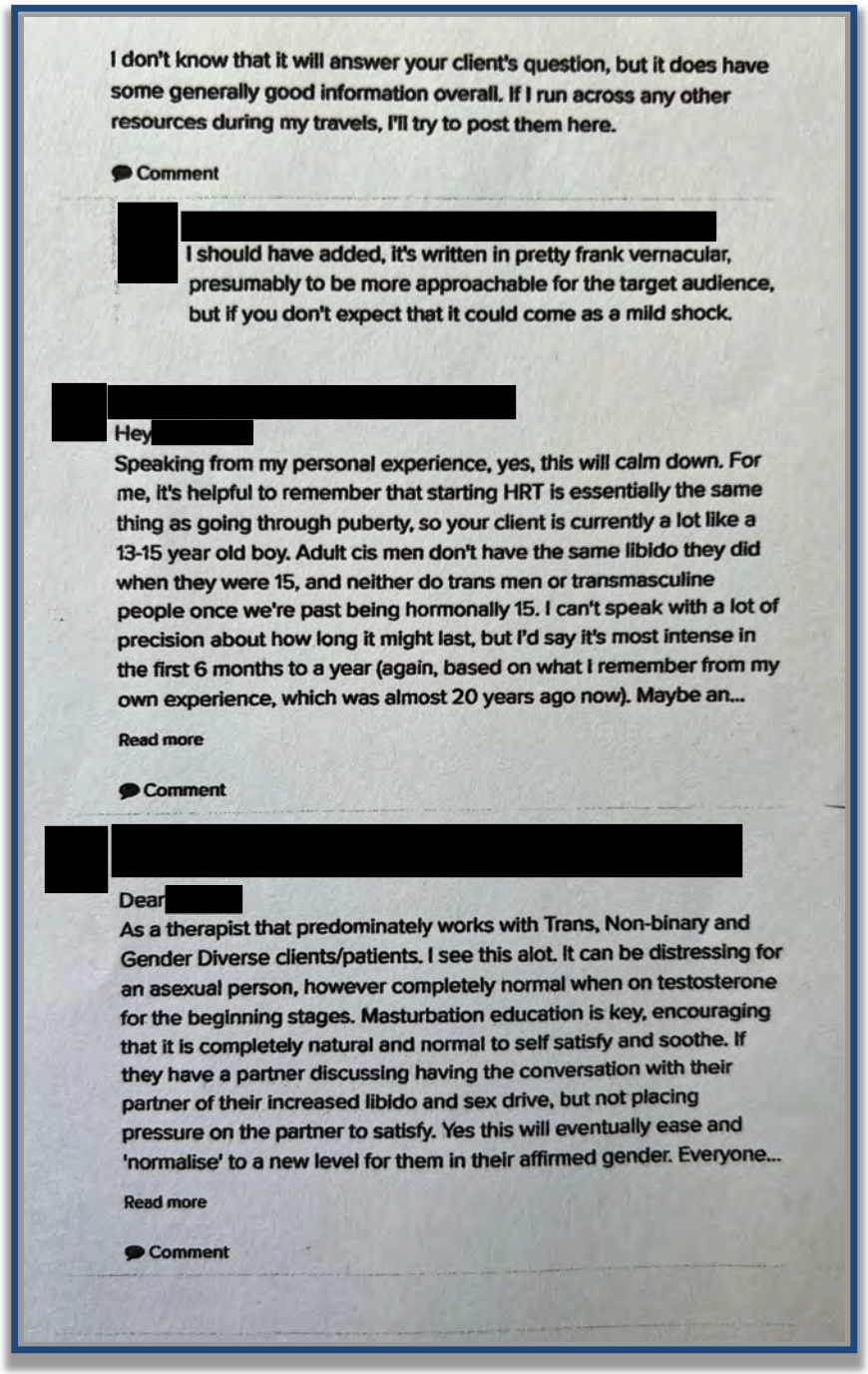
[redacted]

Invite ≡ Add bookmark

Submit

[redacted]

I have a resource for trans men who specifically have sex with other men: https://www.rainbowhealthontario.ca/resource-library/primed-the-back-pocket-guide-for-trans-men-and-the-men-who-dig-them/ (https://www.rainbowhealthontario.ca/resource-library/primed-the-back-pocket-guide-for-trans-men-and-the-men-who-dig-them/)



I don't know that it will answer your client's question, but it does have some generally good information overall. If I run across any other resources during my travels, I'll try to post them here.

Comment

[redacted] I should have added, it's written in pretty frank vernacular, presumably to be more approachable for the target audience, but if you don't expect that it could come as a mild shock.

[redacted]

Hey [redacted]

Speaking from my personal experience, yes, this will calm down. For me, it's helpful to remember that starting HRT is essentially the same thing as going through puberty, so your client is currently a lot like a 13-15 year old boy. Adult cis men don't have the same libido they did when they were 15, and neither do trans men or transmasculine people once we're past being hormonally 15. I can't speak with a lot of precision about how long it might last, but I'd say it's most intense in the first 6 months to a year (again, based on what I remember from my own experience, which was almost 20 years ago now). Maybe an...

Read more

Comment

[redacted]

Dear [redacted]

As a therapist that predominately works with Trans, Non-binary and Gender Diverse clients/patients. I see this alot. It can be distressing for an asexual person, however completely normal when on testosterone for the beginning stages. Masturbation education is key, encouraging that it is completely natural and normal to self satisfy and soothe. If they have a partner discussing having the conversation with their partner of their increased libido and sex drive, but not placing pressure on the partner to satisfy. Yes this will eventually ease and 'normalise' to a new level for them in their affirmed gender. Everyone...

Read more

Comment

[redacted]

Hey [redacted]

Speaking from my personal experience, yes, this will calm down. For me, it's helpful to remember that starting HRT is essentially the same thing as going through puberty, so your client is currently a lot like a 13-15 year old boy. Adult cis men don't have the same libido they did when they were 15, and neither do trans men or transmasculine people once we're past being hormonally 15. I can't speak with a lot of precision about how long it might last, but I'd say it's most intense in the first 6 months to a year (again, based on what I remember from my own experience, which was almost 20 years ago now). Maybe an endocrinologist can speak on this question with a broader knowledge base.

I hope this is helpful in supporting your client as they try to adjust to their new experience of their body and figure out what to expect in the future!

[redacted]

Comment

[redacted]

Dear [redacted]

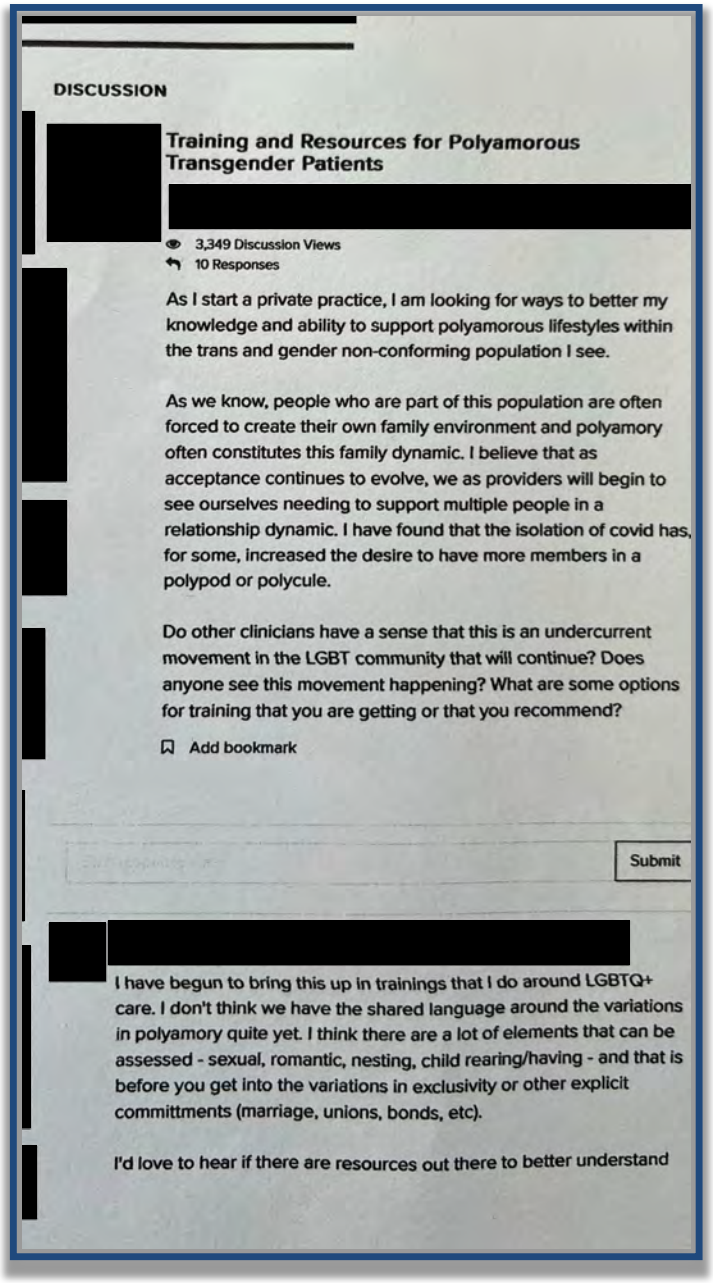
As a therapist that predominately works with Trans, Non-binary and Gender Diverse clients/patients. I see this alot. It can be distressing for an asexual person, however completely normal when on testosterone for the beginning stages. Masturbation education is key, encouraging that it is completely natural and normal to self satisfy and soothe. If they have a partner discussing having the conversation with their partner of their increased libido and sex drive, but not placing pressure on the partner to satisfy. Yes this will eventually ease and 'normalise' to a new level for them in their affirmed gender. Everyone is different and it last varying times for each person. It is a 'second' puberty but a 'first' puberty in their affirmed gender, so it's about exploring with them the 'newness' in the experience of being. Doing alot of somatic body work and being in the here and now. it's important for them to explore their sexuality now at this stage providing psychoeducation that sexuality is fluid and every changing and may now be abrosexual i.e. fluctuating between being asexual and then not sometimes. Don't make things too clinical and medical, it's all about the experience.

queersextherapy on Instagram would be most suitable for them especially that they are a young person. It provides body positive, quick, easy and simple psycho education on the matter, and recently did a post a couple of weeks ago on being asexual and experiencing sexual desires that may be overwhelming.

I also specialise in GSRD, I don't know where you are based but I am happy to see clients online as well, for short periods if needs be. I have a programme called [redacted] where they can see me for 6weeks or more for focused support within their transition.

Comment

g) *A WPATH member seeks guidance to better support polyamorous lifestyles within the transgender and gender non-conforming population*



DISCUSSION

Training and Resources for Polyamorous Transgender Patients

[redacted]

3,349 Discussion Views
10 Responses

As I start a private practice, I am looking for ways to better my knowledge and ability to support polyamorous lifestyles within the trans and gender non-conforming population I see.

As we know, people who are part of this population are often forced to create their own family environment and polyamory often constitutes this family dynamic. I believe that as acceptance continues to evolve, we as providers will begin to see ourselves needing to support multiple people in a relationship dynamic. I have found that the isolation of covid has, for some, increased the desire to have more members in a polypod or polycule.

Do other clinicians have a sense that this is an undercurrent movement in the LGBT community that will continue? Does anyone see this movement happening? What are some options for training that you are getting or that you recommend?

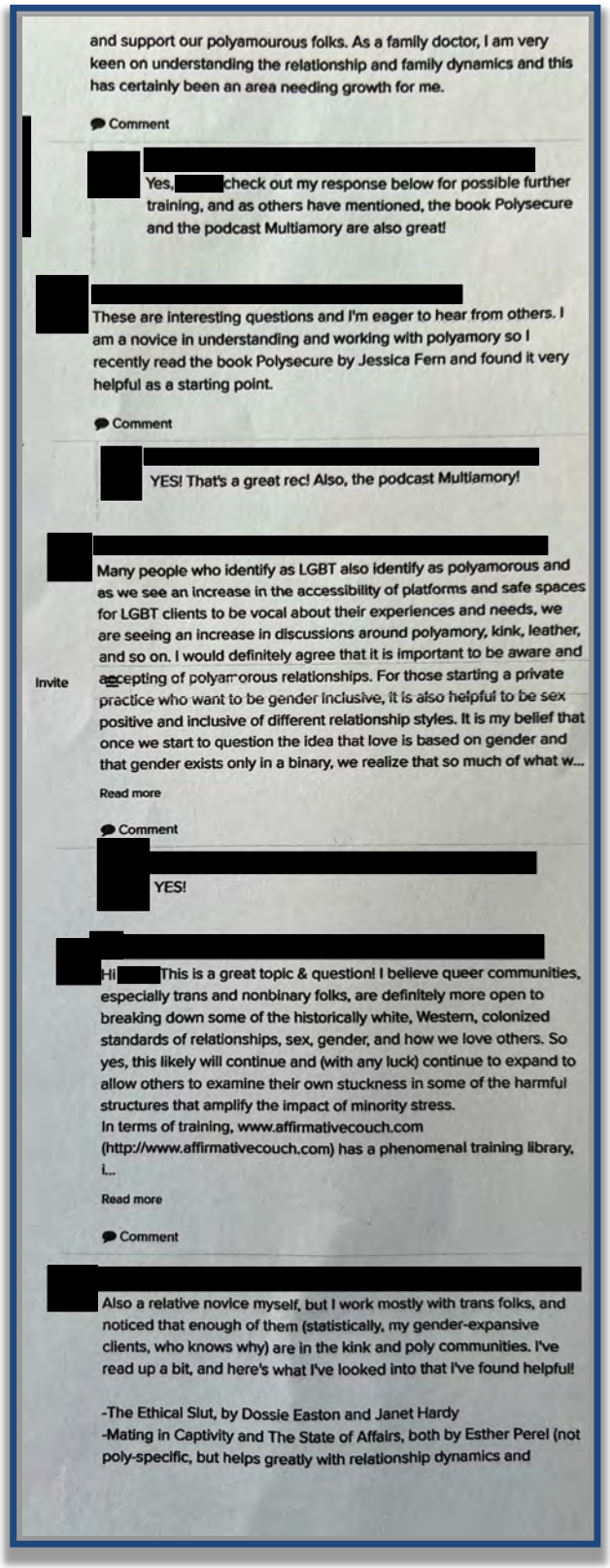
Add bookmark

Submit

[redacted]

I have begun to bring this up in trainings that I do around LGBTQ+ care. I don't think we have the shared language around the variations in polyamory quite yet. I think there are a lot of elements that can be assessed - sexual, romantic, nesting, child rearing/having - and that is before you get into the variations in exclusivity or other explicit committments (marriage, unions, bonds, etc).

I'd love to hear if there are resources out there to better understand



and support our polyamourous folks. As a family doctor, I am very keen on understanding the relationship and family dynamics and this has certainly been an area needing growth for me.

Comment

[redacted] Yes, [redacted] check out my response below for possible further training, and as others have mentioned, the book Polysecure and the podcast Multiamory are also great!

[redacted] These are interesting questions and I'm eager to hear from others. I am a novice in understanding and working with polyamory so I recently read the book Polysecure by Jessica Fern and found it very helpful as a starting point.

Comment

[redacted] YES! That's a great rec! Also, the podcast Multiamory!

[redacted] Many people who identify as LGBT also identify as polyamorous and as we see an increase in the accessibility of platforms and safe spaces for LGBT clients to be vocal about their experiences and needs, we are seeing an increase in discussions around polyamory, kink, leather, and so on. I would definitely agree that it is important to be aware and accepting of polyamorous relationships. For those starting a private practice who want to be gender inclusive, it is also helpful to be sex positive and inclusive of different relationship styles. It is my belief that once we start to question the idea that love is based on gender and that gender exists only in a binary, we realize that so much of what w...

Invite

Read more

Comment

[redacted] YES!

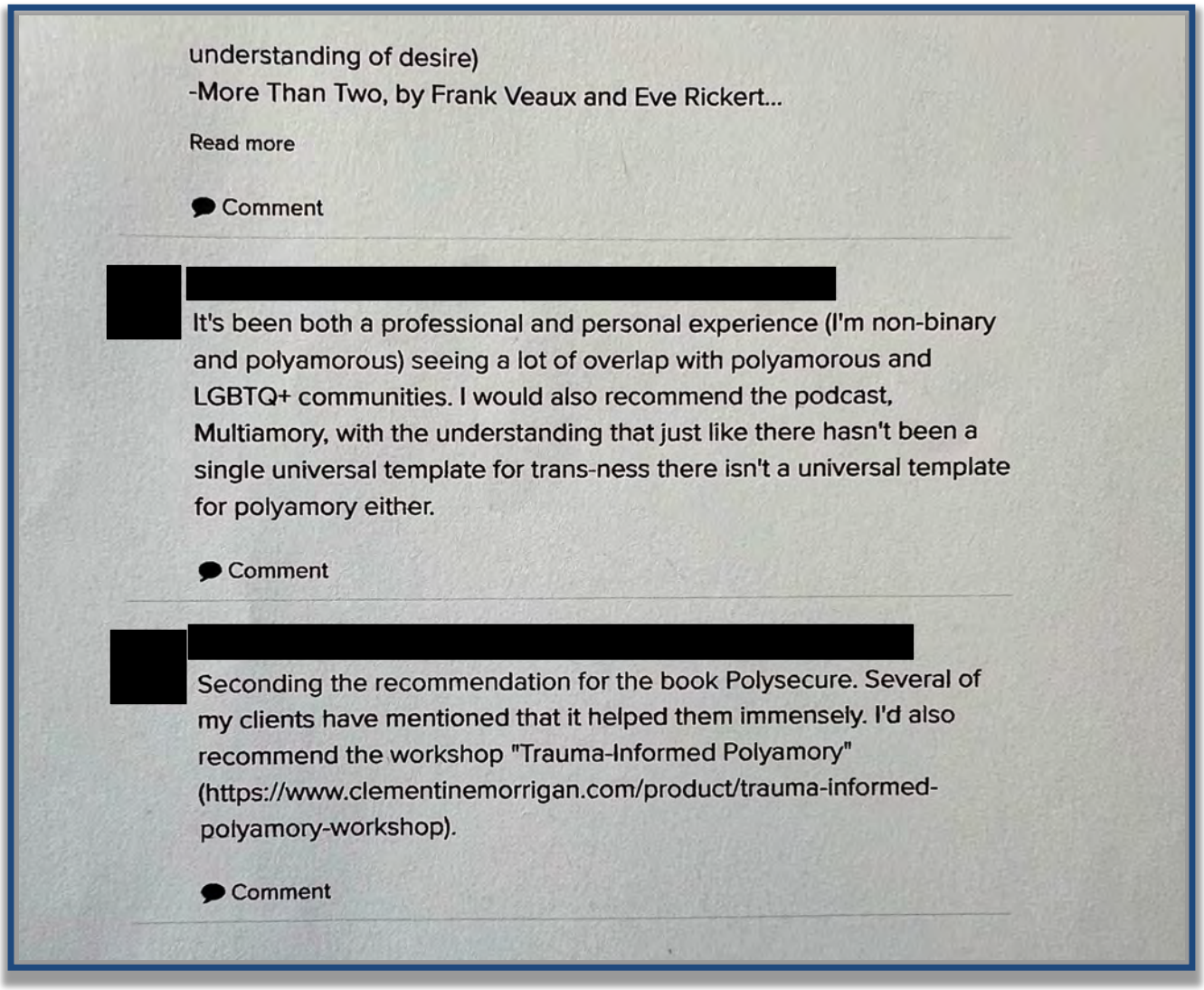
[redacted] Hi [redacted] This is a great topic & question! I believe queer communities, especially trans and nonbinary folks, are definitely more open to breaking down some of the historically white, Western, colonized standards of relationships, sex, gender, and how we love others. So yes, this likely will continue and (with any luck) continue to expand to allow others to examine their own stuckness in some of the harmful structures that amplify the impact of minority stress.
In terms of training, www.affirmativecouch.com (http://www.affirmativecouch.com) has a phenomenal training library, i...

Read more

Comment

[redacted] Also a relative novice myself, but I work mostly with trans folks, and noticed that enough of them (statistically, my gender-expansive clients, who knows why) are in the kink and poly communities. I've read up a bit, and here's what I've looked into that I've found helpful!

-The Ethical Slut, by Dossie Easton and Janet Hardy
-Mating in Captivity and The State of Affairs, both by Esther Perel (not poly-specific, but helps greatly with relationship dynamics and



understanding of desire)
-More Than Two, by Frank Veaux and Eve Rickert...

Read more

Comment

[redacted]

It's been both a professional and personal experience (I'm non-binary and polyamorous) seeing a lot of overlap with polyamorous and LGBTQ+ communities. I would also recommend the podcast, Multiamory, with the understanding that just like there hasn't been a single universal template for trans-ness there isn't a universal template for polyamory either.

Comment

[redacted]

Seconding the recommendation for the book Polysecure. Several of my clients have mentioned that it helped them immensely. I'd also recommend the workshop "Trauma-Informed Polyamory" (https://www.clementinemorrigan.com/product/trauma-informed-polyamory-workshop).

Comment

h) WPATH members debate the conclusions of a new research paper on the harm of gatekeeping transgender people from gender-affirming care

[redacted]

Must Read Article: Important New Paper on Gatekeeping as Harm Concludes Gender Assessments are Useless Barriers to Care

[redacted]

4,099 Discussion Views
9 Responses

Hi all,

There is a new, exciting, and important read about the harm of gatekeeping trans people from gender-affirming care. The paper reviews the literature on gender assessments, and its authors conclude that attempts at assessing people's gender identity and/or dysphoria are not more effective at preventing regret in accessing gender-affirming care than self-report and that assessments are based on stereotyping, arbitrary, and unproven considerations.

Per Florence Ashley, one of the paper's esteemed authors, "The paper offers an important rebuttal to jurisdictions like Missouri and Saskatchewan that strive to restrict access to medical or social transition under the guise of needing "careful assessment."

As most of us working in gender-affirming care already know, whether through experience or reviewing prior trans-led research, there is no evidence, as shown here, that lengthy gender assessments confer any mental health benefits.

The paper is attached; there is an audio version, and the pdf is free at the link! Enjoy :)

In solidarity,

[redacted]

Link: [https://psycnet.apa.org/doi/10.1037/sgd0000672 (https://psycnet.apa.org/doi/10.1037/sgd0000672)] (https://psycnet.apa.org/doi/10.1037/sgd0000672 (https://psycnet.apa.org/doi/10.1037/sgd0000672))

Audio version:

[https://podcasters.spotify.com/pod/show/florence-ashley/episodes/Do-gender-assessments-prevent-regret-in-transgender-healthcare--A-narrative-review-e2ana4b (https://podcasters.spotify.com/pod/show/florence-ashley/episodes/Do-gender-assessments-prevent-regret-in-transgender-healthcare--A-narrative-review-e2ana4b)] (https://podcasters.spotify.com/pod/show/florence-ashley/episodes/Do-gender-assessments-prevent-regret-in-transgender-healthcare--A-narrative-review-e2ana4b (https://podcasters.spotify.com/pod/show/florence-ashley/episodes/Do-gender-assessments-prevent-regret-in-transgender-healthcare--A-narrative-review-e2ana4b))

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[redacted]

Thank you for letting us know about this article. As a woman assigned male at birth and a clinical social worker, I disagree with the authors' conclusions that clinical assessments unnecessarily impede a person's access to gender-affirming care. The point of these assessments is not to gatekeep access to care. It is to help the person seeking care assess the relative risks and benefits for themselves. Doing otherwise violates a patient's rights to self-determination. As part of evaluating the risks and benefits, providers have a responsibility to inform the patient that there is a small possibility that they may regret their decision, however strongly they feel about proceeding at the time. This is no different than informing a patient that death a risk, however small, of any surgical procedure. Moreover, as half of the participants in Littman's (2021) study emphasized, they felt that inadequate assessments were responsible for beginning gender-affirming care that they now regret. It is true that some providers perceive their role as gatekeeping to the extent that they have the power to deny access to care. In my own case, I saw a licensed clinical psychologist for years, and when I asked for a letter to undergo "surgical sex reassignment" (1996 lexicon), she informed me she would not because I "was not ready." When I asked what I needed to do to appear ready, she literally shrugged her shoulders. This kind of gatekeeping is unethical, as it violates a client's right to self-determination. Ashley et al. (2023) err in arguing that, "Delaying access to gender-affirming interventions for those who are at elevated risk of regret would not be an appropriate alternative to withholding care" because the average time to reget is about a decade (p. 5). To the best of my knowledge, there have been no prospective sudies exploring the time to regret, which is the only valid way to determine the time to regret. Assessment may, indeed, take a period of months as one explores the risks and benefits of treatment with a clinician who has expertise in transgender and gender-diverse healthcare issues. However, permitting a patient to begin gender-affirming medical interventions without assessment would be akin to failing to assess the duration of a patient's distress (a core component of all DSM-5-TR diagnoses) for depression, post-traumatic stress disorder, or many other issues prior to making a diagnosis. Given most TGD people cannot access care without a diagnosis of gender dysphoria to meet 3rd party payor requirements, the issue is with the insurance companies, not the providers doing the assessments. The WPATH SOC-7 make it clear that insurance companies need to change their policies to improve access to care. Moreover, the argument that it is unethical to delay access to care because only a small minority will regret their decision to obtain gender-affirming care is as irrational as arguing that any law or policy should be passed despite the potential or probable disadvantage to any marginalized group. This was the kind of thinking

that led to bans on LGBTQ people serving in the military--that permitting the minority access to service would harm the operational integrity of the many. The Red Cross prevented gay men from donating blood because the that small minority was known to be at disproportionately high risk of having HIV that could adversely impact the entire blood donation system. Of course, I am not saying I agree with that policy (I don't). We delay any number of medical interventions because we want to do lab work and other diagnostic procedures to make sure the patient will benefit from treatment. The same should be no different when assessing WITH the patient or client the risks and benefits of beginning gender-affirming medical intervention. In sum, Ashley et al. (2023) mischaracterizes the contemporary reason for assessment. It is not to unnecessarily impede or delay care. It is to weigh WITH the patient the potential risks and benefits of THEIR receiving gender-affirming medical interventions. This is, in fact, a core component of the WPATH SOC-7. Moreover, I would content that many professionals providing gender-affirming care have not received the training required to meet these standards of care. This training and supervised experience is essential to ensuring one is competent to help a patient sort out the risks and benefits of care. I have worked with many TGD patients who decided in the course of weighing the benefits and risks that, like most TGD people, gender-affirming medical interventions were unnecessary or undesirable. I have had patients show up demanding (not merely requesting) access to care because they wanted to "fit in" with their gender diverse peers or because they preferred activities stereotypically associated with a different gender than they identify with. They were not experiencing distress or discomfort for any other reason. Certainly, carte blanche access to gender-affirming medical care could have been viable. However, invariably they stated they appreciated the opportunity to question their motivations. Finally, one point Ashley et al. (2023) make is incorrect. They state the WPATH SOC-7 does not require a diagnosis of gender dysphoria for adolescents for initiation of gender-affirming care. In fact, it does. It states, "The following recommendations are made regarding the requirements for gender-affirming medical and surgical treatment (All of them must be met): 6.12- We recommend health care professionals assessing transgender and gender diverse adolescents only recommend gender-affirming medical or surgical treatments requested by the patient when: 6.12.a- The adolescent meets the diagnostic criteria of gender incongruence as per the ICD-11 in situations where a diagnosis is necessary to access health care." Finally, it seems to me that Ahsley et al. (2023) did their research to prove a point rather than test any hypotheses or systematically review the literature aligned with Cochrane criteria. They certainly make some valid points. However, many of their points seem irrational and inconsistent with providing ethical care. I am 100% in support of gender-affirming care for those who determine they want them. However, I would never recommend care for this care (or any other for that matter) without doing a thorough assessment WITH the patient of the risks and benefits of treatment, an essential part of informed consent for any health care. It is consistent with best medical practices to make these assessments and base one's recommendations on them.

Comment

[redacted]

Thanks for sharing your take on this, [redacted] insurance companies are a huge problem - agreed! But therapists aren't required to assess folks who need hip replacement surgery (larger regret rate) or nose jobs.

[redacted]

For clarity, you reference SOC-7, but I think you are actually meaning SOC-8. Could you confirm?

[redacted] [redacted] thanks for this full some response. As an MD providing care to detransitioners, and as an MD who has provided care for trans adults for almost 2 decades, I completely agree. We have a novel population now, like it or not. If we are not careful, the roll-backs on care at rhe government levels, in response to a loss or lack of gatekeeping/proper assessments by the system will lead to a loss of services for consenting, fully informed adults. Individuals under 18 (really under 26, in my opinion), are an unknown, especially those with what appears to be adolescent onset GD. We truly have no idea what to expect and in Canada, the majority of GAC programs are not following them into adulthood. So the sloppy approach to delivering this care will come back to bite us all, I am sure. Even in Canada we are seeing a rising political right-leaning reaction to these inadequate approaches to a significant intervention. We have a choice. Either we do a better job at the health care level or we put ourselves at risk of having politics make these decisions for us. That is the most terrifying to envision.

[redacted]

[redacted] Your response seems to conflate informed consent discussions and gender assessments as a requirement for care. The article is about gender assessments as a requirement for care.

As for not using a Cochrane review, it would have been completely pointless because there are virtually no studies that actually bear on gender assessments' role in preventing regret and would meet rigorous inclusion criteria.

...

Read more

[redacted]

As a transgender man, I tend to agree with the move toward informed consent. In my own experiences, I never had any difficulties with care providers who provided gender affirming care on an informed consent basis. I faced enormous difficulties (trauma, unwanted surgical results, additional surgery) after receiving care from a provider who relied on the SOC.

The rigidity of the SOC vs informed consent puts a fear in patients that they will be turned away from the care they know they need because of the least irregularity in their narrative or their desired outcome. It's getting better, but there have been times when people would practice for their appointments with friends to avoid saying the wrong thing. A system based on informed consent would eliminate these situations and fears.

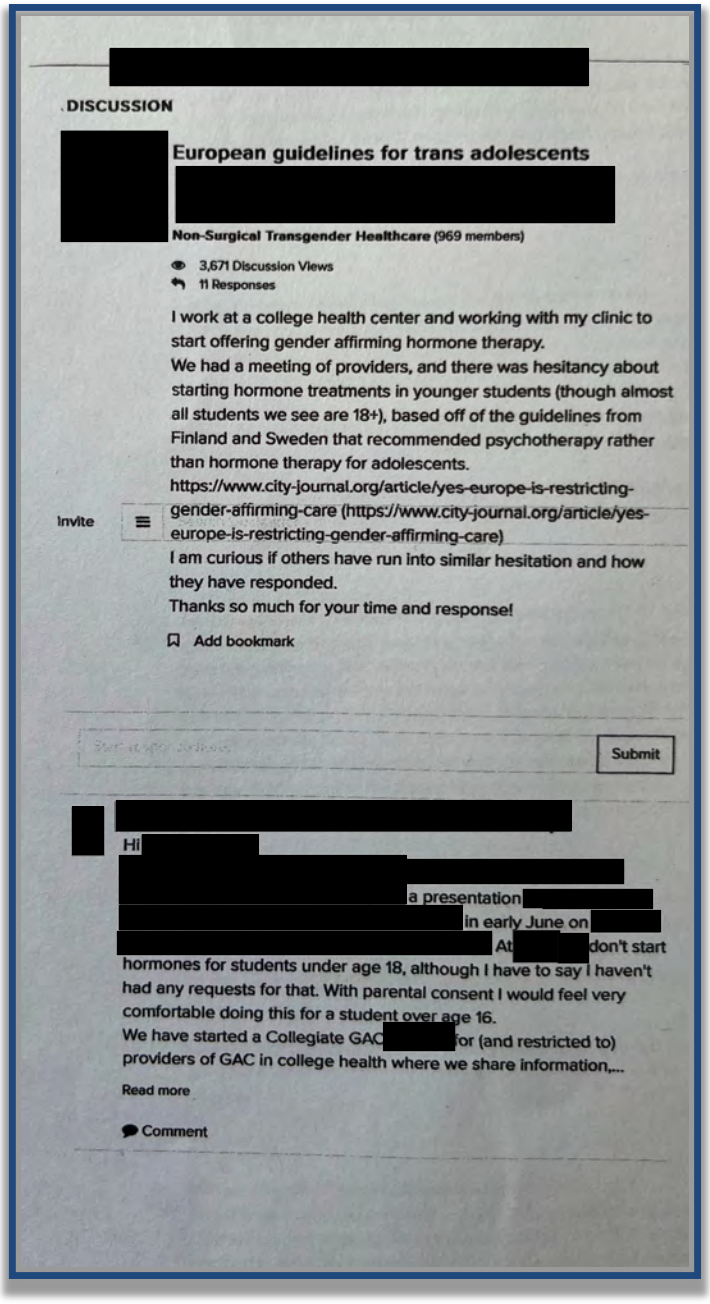
The ability to speak freely with one's providers is more readily assured under informed consent than in a system with rigid gatekeeping. It is incredibly important to be able to communicate openly without fear of losing access to care.

We look back at the times when trans people had to pretend to be straight to receive care, for instance, and consider that abhorrent at best and a violation of their basic human rights at worst. Someday, the gatekeeping that is considered normal now may look very much much the same.

The sooner this is identified, the better.

Comment

i) A WPATH member discusses certain European providers' hesitancy about starting hormone treatments in younger students



[redacted]

DISCUSSION

[redacted] European guidelines for trans adolescents [redacted]

Non-Surgical Transgender Healthcare (969 members)

3,671 Discussion Views
11 Responses

I work at a college health center and working with my clinic to start offering gender affirming hormone therapy.
We had a meeting of providers, and there was hesitancy about starting hormone treatments in younger students (though almost all students we see are 18+), based off of the guidelines from Finland and Sweden that recommended psychotherapy rather than hormone therapy for adolescents.
https://www.city-journal.org/article/yes-europe-is-restricting-gender-affirming-care (https://www.city-journal.org/article/yes-europe-is-restricting-gender-affirming-care)
I am curious if others have run into similar hesitation and how they have responded.
Thanks so much for your time and response!

Invite

Add bookmark

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[redacted]

Hi [redacted] a presentation [redacted] in early June on [redacted] At [redacted] don't start hormones for students under age 18, although I have to say I haven't had any requests for that. With parental consent I would feel very comfortable doing this for a student over age 16.
We have started a Collegiate GAC [redacted] for (and restricted to) providers of GAC in college health where we share information,...

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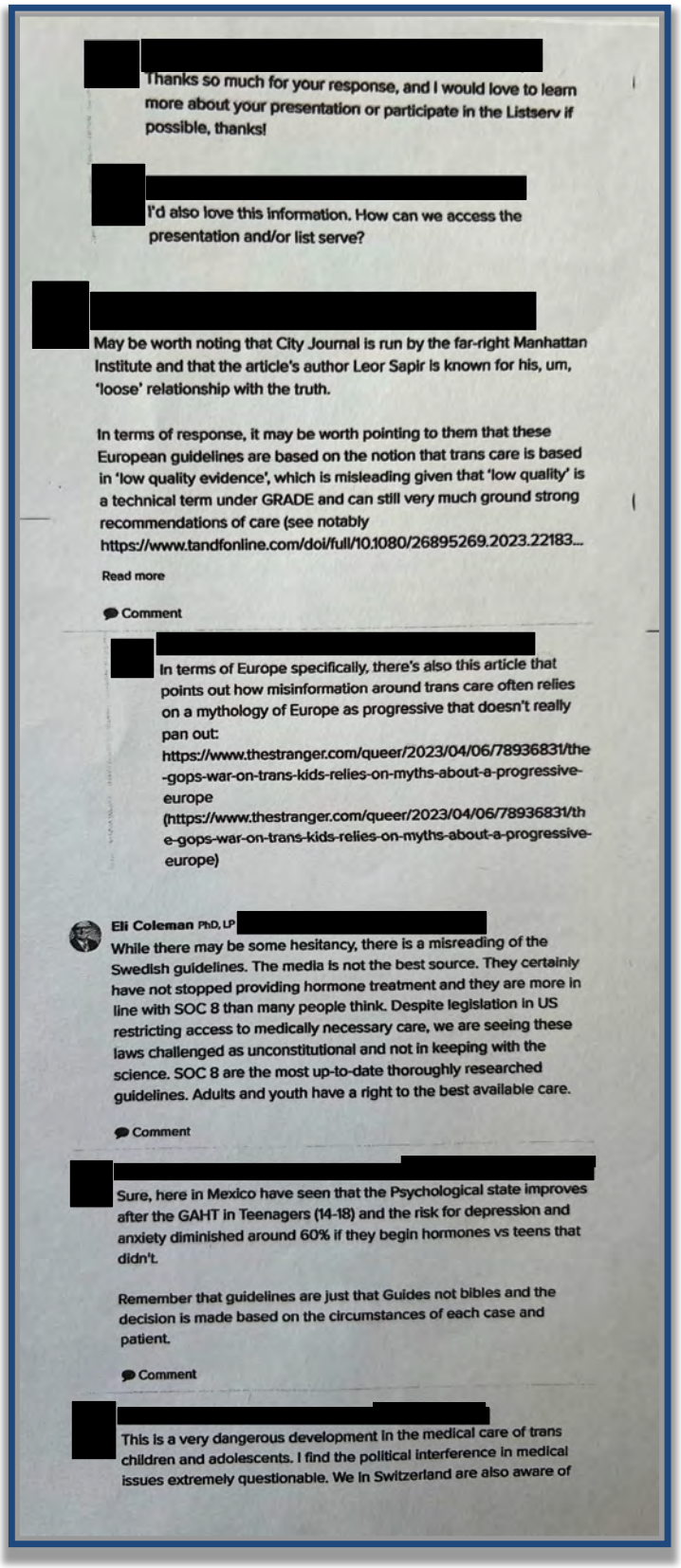

[redacted] Thanks so much for your response, and I would love to learn more about your presentation or participate in the Listserv if possible, thanks!

[redacted] I'd also love this information. How can we access the presentation and/or list serve?

[redacted] May be worth noting that City Journal is run by the far-right Manhattan Institute and that the article's author Leor Sapir is known for his, um, 'loose' relationship with the truth.

In terms of response, it may be worth pointing to them that these European guidelines are based on the notion that trans care is based in 'low quality evidence', which is misleading given that 'low quality' is a technical term under GRADE and can still very much ground strong recommendations of care (see notably https://www.tandfonline.com/doi/full/10.1080/26895269.2023.22183...

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[redacted] In terms of Europe specifically, there's also this article that points out how misinformation around trans care often relies on a mythology of Europe as progressive that doesn't really pan out: https://www.thestranger.com/queer/2023/04/06/78936831/the-gops-war-on-trans-kids-relies-on-myths-about-a-progressive-europe (https://www.thestranger.com/queer/2023/04/06/78936831/the-gops-war-on-trans-kids-relies-on-myths-about-a-progressive-europe)

Eli Coleman PhD, LP [redacted] While there may be some hesitancy, there is a misreading of the Swedish guidelines. The media is not the best source. They certainly have not stopped providing hormone treatment and they are more in line with SOC 8 than many people think. Despite legislation in US restricting access to medically necessary care, we are seeing these laws challenged as unconstitutional and not in keeping with the science. SOC 8 are the most up-to-date thoroughly researched guidelines. Adults and youth have a right to the best available care.

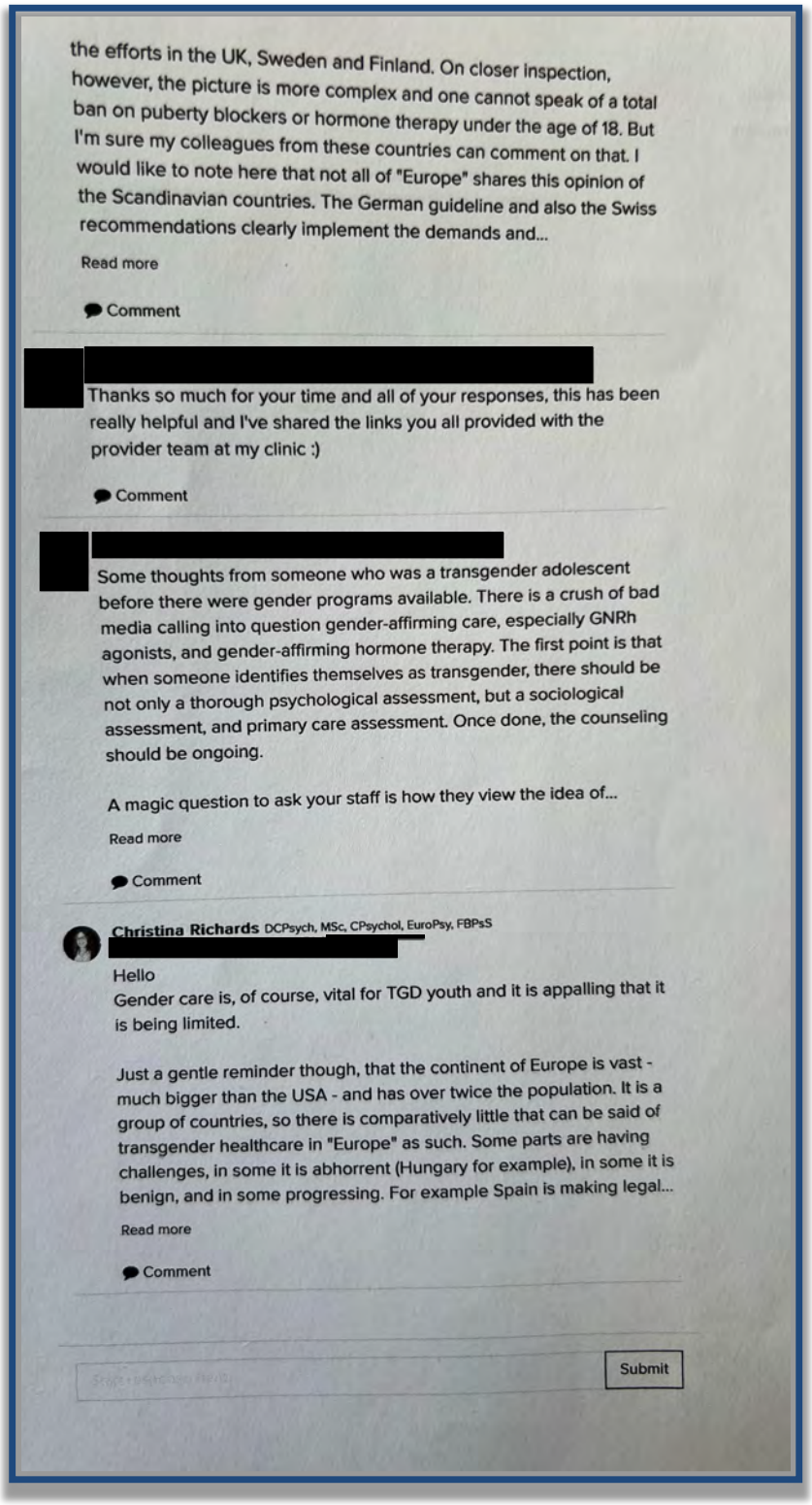
Comment

[redacted] Sure, here in Mexico have seen that the Psychological state improves after the GAHT in Teenagers (14-18) and the risk for depression and anxiety diminished around 60% if they begin hormones vs teens that didn't.

Remember that guidelines are just that Guides not bibles and the decision is made based on the circumstances of each case and patient.

Comment

[redacted] This is a very dangerous development in the medical care of trans children and adolescents. I find the political interference in medical issues extremely questionable. We in Switzerland are also aware of



the efforts in the UK, Sweden and Finland. On closer inspection, however, the picture is more complex and one cannot speak of a total ban on puberty blockers or hormone therapy under the age of 18. But I'm sure my colleagues from these countries can comment on that. I would like to note here that not all of "Europe" shares this opinion of the Scandinavian countries. The German guideline and also the Swiss recommendations clearly implement the demands and...

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[redacted]

Thanks so much for your time and all of your responses, this has been really helpful and I've shared the links you all provided with the provider team at my clinic :)

Comment

[redacted]

Some thoughts from someone who was a transgender adolescent before there were gender programs available. There is a crush of bad media calling into question gender-affirming care, especially GNRh agonists, and gender-affirming hormone therapy. The first point is that when someone identifies themselves as transgender, there should be not only a thorough psychological assessment, but a sociological assessment, and primary care assessment. Once done, the counseling should be ongoing.

A magic question to ask your staff is how they view the idea of...

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Comment

Christina Richards DCPsych, MSc, CPsychol, EuroPsy, FBPsS

[redacted]

Hello
Gender care is, of course, vital for TGD youth and it is appalling that it is being limited.

Just a gentle reminder though, that the continent of Europe is vast - much bigger than the USA - and has over twice the population. It is a group of countries, so there is comparatively little that can be said of transgender healthcare in "Europe" as such. Some parts are having challenges, in some it is abhorrent (Hungary for example), in some it is benign, and in some progressing. For example Spain is making legal...

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