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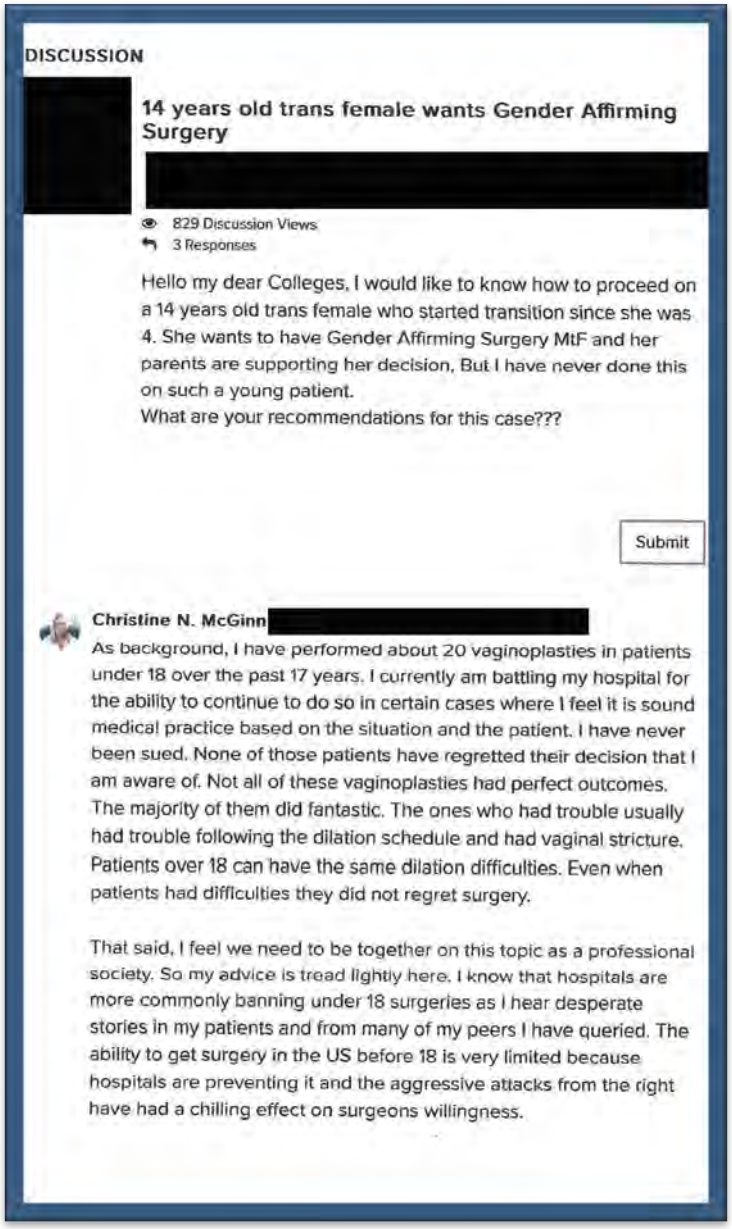
The WPATH Files appear in full below. We have organized the files for accessibility, but we have not edited, removed, or added any material. Dates are included when available, and all discussions occurred within the last four years. Members' names are redacted, except in the case of the WPATH president, surgeons, and other prominent members. The files are unedited and nothing has been removed or added.

1) GENDER AFFIRMING SURGERY FOR MINORS

a) WPATH members discuss transition surgery for a 14-year-old



DISCUSSION

[redacted]

14 years old trans female wants Gender Affirming Surgery

[redacted]

829 Discussion Views
3 Responses

Hello my dear Colleges, I would like to know how to proceed on a 14 years old trans female who started transition since she was 4. She wants to have Gender Affirming Surgery MtF and her parents are supporting her decision, But I have never done this on such a young patient.
What are your recommendations for this case???

Submit

Christine N. McGinn [redacted]

As background, I have performed about 20 vaginoplasties in patients under 18 over the past 17 years. I currently am battling my hospital for the ability to continue to do so in certain cases where I feel it is sound medical practice based on the situation and the patient. I have never been sued. None of those patients have regretted their decision that I am aware of. Not all of these vaginoplasties had perfect outcomes. The majority of them did fantastic. The ones who had trouble usually had trouble following the dilation schedule and had vaginal stricture. Patients over 18 can have the same dilation difficulties. Even when patients had difficulties they did not regret surgery.

That said, I feel we need to be together on this topic as a professional society. So my advice is tread lightly here. I know that hospitals are more commonly banning under 18 surgeries as I hear desperate stories in my patients and from many of my peers I have queried. The ability to get surgery in the US before 18 is very limited because hospitals are preventing it and the aggressive attacks from the right have had a chilling effect on surgeons willingness.

I think we need a strong message that "gender surgeries" should not be lumped together and each specific surgery has its own discussion. For example a trach shave is not the same as Vaginoplasty.

I think we need to reject the argument that consent is impossible in a minor. My hospital performs all kinds of surgeries on minors without issue; they are singling these out because it is politically convenient.

I think we should strive for consensus regarding what a consent should look like for each of these surgeries.

Specific to Vaginoplasty, I have better success with dilation when the patient is at late 16 or 17. I would discourage Vaginoplasty surgery prior to that. In dealing with my hospital, I have offered to limit the under 18 surgery to 17. There is practical reason for this. Many of the bad outcomes are a direct result of rushing to get surgery before heading off to college/university. There are too many stressors in college that limit patients ability to dilate. For well prepared patients, I feel the ideal time in the US is surgery the summer before their last year of high school. I have heard many other surgeons echo this.

I also welcome appointments for the sole purpose of fact finding. I think it would be great for your 14 year old to hear about the surgery and what recovery is like and about hair removal if you require that. Conversations about surgery can be helpful at younger ages so that the parents and children can get their questions answered and navigate surgery and hormones as they relate to surgery. Penoscrotal hypo plasma is also an important topic to discuss early.

Good luck with this challenging case and good for you to seek information from others!!

Comment

Marci L. Bowers [redacted]

i would not do it.... tissue too immature. dilation routine too critical. Age 16 is the youngest i've EVER done though feel sometime before the end of high school does make some sense in that they are under the watch of parents in the home they grew up in. currently our standard is 18, though do agree this number is arbitrary. decision should be individual based on maturity.

Comment

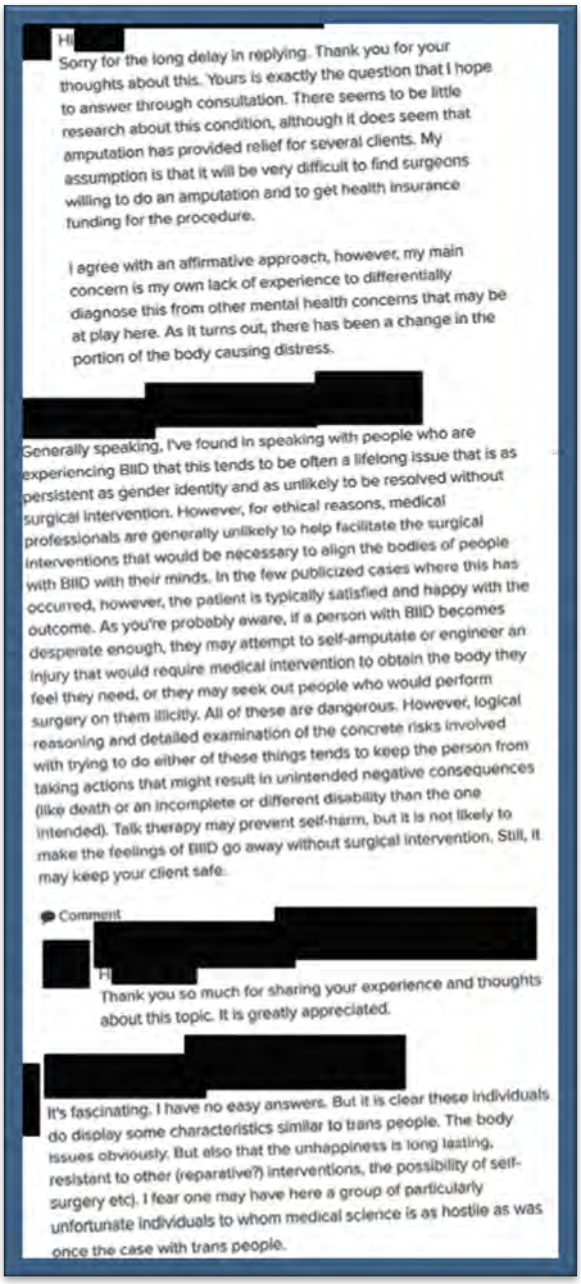
[redacted]

We at GrS Montreal would not undertake a surgery at 14. Genital surgery is delayed until the patient reaches 18.

Comment

2) MENTAL HEALTH CONCERNS

a) WPATH members discuss amputation for patients with body integrity identity disorder (BIID)



Hi [redacted]

Sorry for the long delay in replying. Thank you for your thoughts about this. Yours is exactly the question that I hope to answer through consultation. There seems to be little research about this condition, although it does seem that amputation has provided relief for several clients. My assumption is that it will be very difficult to find surgeons willing to do an amputation and to get health insurance funding for the procedure.

I agree with an affirmative approach, however, my main concern is my own lack of experience to differentially diagnose this from other mental health concerns that may be at play here. As it turns out, there has been a change in the portion of the body causing distress.

[redacted]

Generally speaking, I've found in speaking with people who are experiencing BIID that this tends to be often a lifelong issue that is as persistent as gender identity and as unlikely to be resolved without surgical intervention. However, for ethical reasons, medical professionals are generally unlikely to help facilitate the surgical interventions that would be necessary to align the bodies of people with BIID with their minds. In the few publicized cases where this has occurred, however, the patient is typically satisfied and happy with the outcome. As you're probably aware, if a person with BIID becomes desperate enough, they may attempt to self-amputate or engineer an injury that would require medical intervention to obtain the body they feel they need, or they may seek out people who would perform surgery on them illicitly. All of these are dangerous. However, logical reasoning and detailed examination of the concrete risks involved with trying to do either of these things tends to keep the person from taking actions that might result in unintended negative consequences (like death or an incomplete or different disability than the one intended). Talk therapy may prevent self-harm, but it is not likely to make the feelings of BIID go away without surgical intervention. Still, it may keep your client safe.

Comment

[redacted]

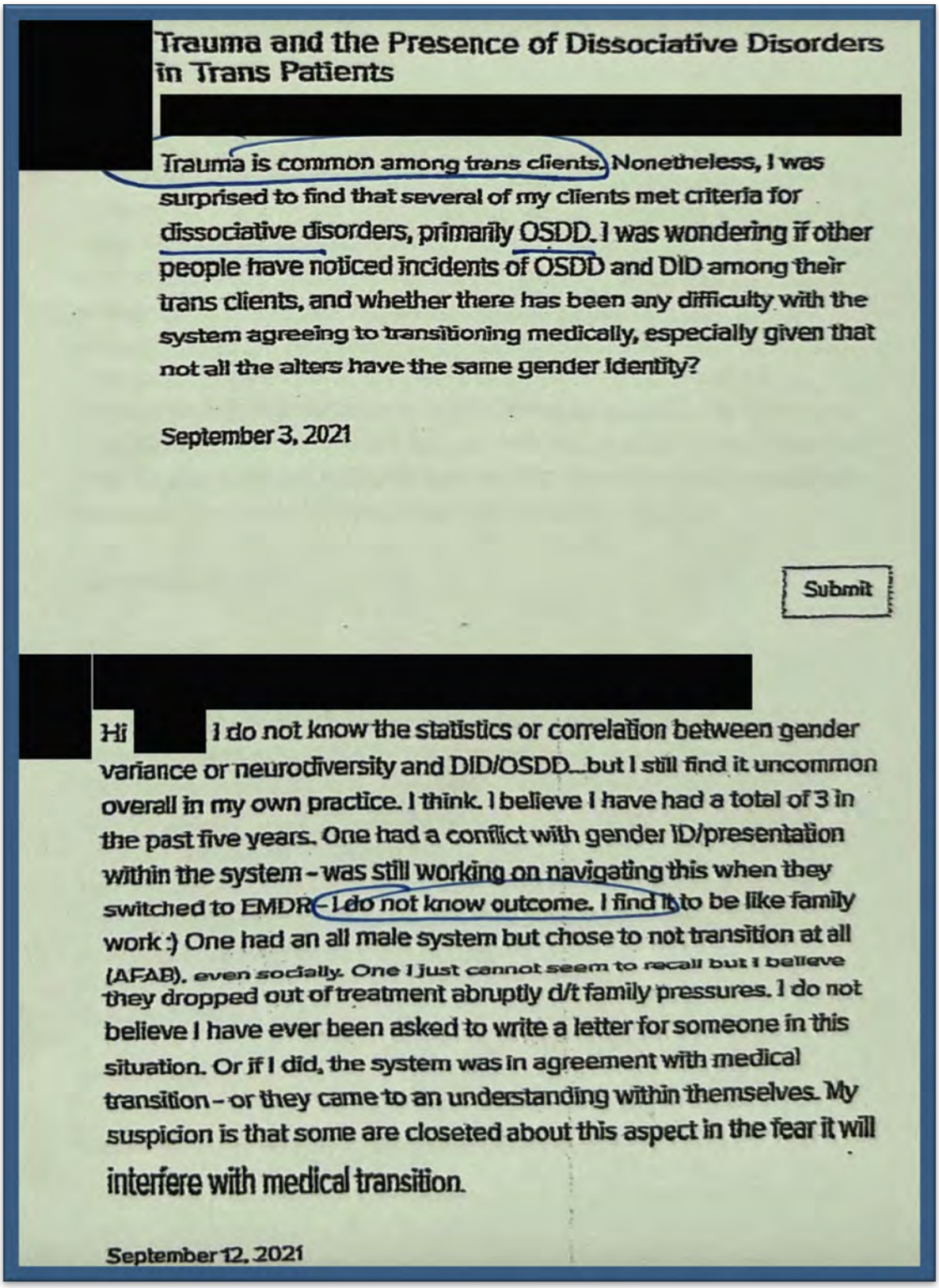
Hi [redacted]

Thank you so much for sharing your experience and thoughts about this topic. It is greatly appreciated.

[redacted]

It's fascinating. I have no easy answers. But it is clear these individuals do display some characteristics similar to trans people. The body issues obviously. But also that the unhappiness is long lasting, resistant to other (reparative?) interventions, the possibility of self-surgery etc). I fear one may have here a group of particularly unfortunate individuals to whom medical science is as hostile as was once the case with trans people.

b) WPATH members discuss trauma and dissociative orders in trans patients



Trauma and the Presence of Dissociative Disorders in Trans Patients

[redacted]

Trauma is common among trans clients. Nonetheless, I was surprised to find that several of my clients met criteria for dissociative disorders, primarily OSDD. I was wondering if other people have noticed incidents of OSDD and DID among their trans clients, and whether there has been any difficulty with the system agreeing to transitioning medically, especially given that not all the alters have the same gender identity?

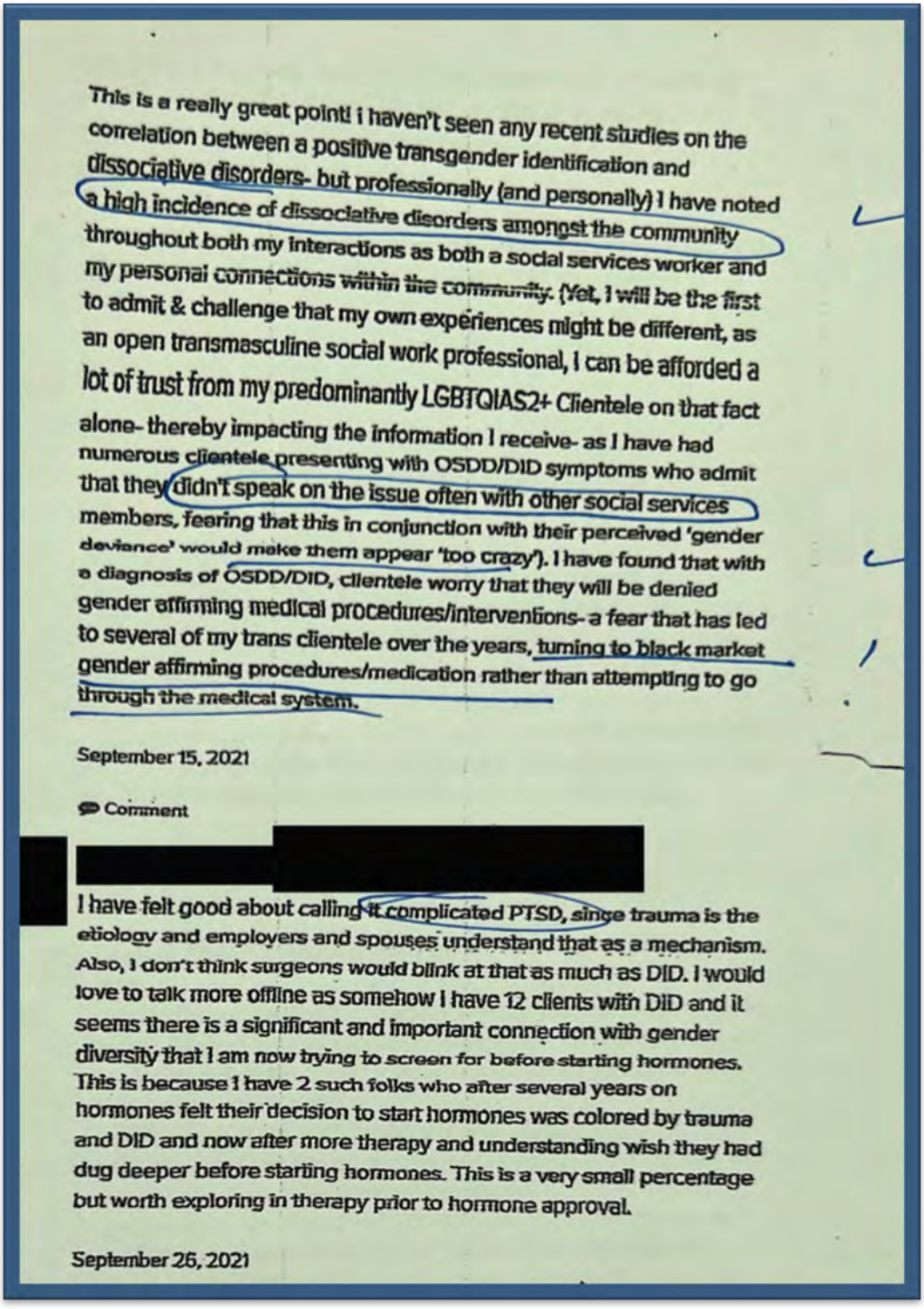
September 3, 2021

Submit

[redacted]

Hi [redacted] I do not know the statistics or correlation between gender variance or neurodiversity and DID/OSDD...but I still find it uncommon overall in my own practice. I think. I believe I have had a total of 3 in the past five years. One had a conflict with gender ID/presentation within the system - was still working on navigating this when they switched to EMDR - I do not know outcome. I find it to be like family work :) One had an all male system but chose to not transition at all (AFAB), even socially. One I just cannot seem to recall but I believe they dropped out of treatment abruptly d/t family pressures. I do not believe I have ever been asked to write a letter for someone in this situation. Or if I did, the system was in agreement with medical transition - or they came to an understanding within themselves. My suspicion is that some are closeted about this aspect in the fear it will interfere with medical transition.

September 12, 2021



This is a really great point! I haven't seen any recent studies on the correlation between a positive transgender identification and dissociative disorders- but professionally (and personally) I have noted a high incidence of dissociative disorders amongst the community throughout both my interactions as both a social services worker and my personal connections within the community. (Yet, I will be the first to admit & challenge that my own experiences might be different, as an open transmasculine social work professional, I can be afforded a lot of trust from my predominantly LGBTQIAS2+ Clientele on that fact alone- thereby impacting the information I receive- as I have had numerous clientele presenting with OSDD/DID symptoms who admit that they didn't speak on the issue often with other social services members, fearing that this in conjunction with their perceived 'gender deviance' would make them appear 'too crazy'). I have found that with a diagnosis of OSDD/DID, clientele worry that they will be denied gender affirming medical procedures/interventions- a fear that has led to several of my trans clientele over the years, turning to black market gender affirming procedures/medication rather than attempting to go through the medical system.

September 15, 2021

Comment

[redacted]

I have felt good about calling it complicated PTSD, since trauma is the etiology and employers and spouses understand that as a mechanism. Also, I don't think surgeons would blink at that as much as DID. I would love to talk more offline as somehow I have 12 clients with DID and it seems there is a significant and important connection with gender diversity that I am now trying to screen for before starting hormones. This is because I have 2 such folks who after several years on hormones felt their decision to start hormones was colored by trauma and DID and now after more therapy and understanding wish they had dug deeper before starting hormones. This is a very small percentage but worth exploring in therapy prior to hormone approval.

September 26, 2021

[redacted]

With one client who had DID we worked on all alters giving consent to HRT before it was started. They had alters who were both male and female gender and it was imperative to get all alters who would be effected by HRT to be aware and consent to the changes. Ethically, if you do not get consent from all alters you have not really received consent and you may be open to being sued later, if they decide HRT or surgery was not in their best interest.

October 7, 2021

Comment

[redacted]

Thanks [redacted] for raising this issue and for those who have responded.

I too have seen a relatively small but significant number of trans and gender diverse clients with DID; and have noticed an increase in the number of new clients with dissociative experience (cPTSD).

I am curious about how we collectively - clients, therapist, treating physicians & surgeons - adequately respond to this. It concerns me that some individuals may not disclose for fear of denied access to treatment, yet I am also concerned about transition (even when all known parts/alters agree).

Is there a way those of us working with dissociative clients could work together to more fully describe the scope and approaches in this area?

October 17, 2021

[redacted] Hi [redacted]

I wondered if anyone responded to your request of working together in this area. I think you've raised this multiple times over the years. Gender health specialists really need to be working with clinicians with extensive experience in dissociation. I know these are both areas where you've worked extensively. I do not know if this new platform has the ability to create small groups, but if we could set up some sort of ongoing discussion on this topic it would be great.

November 11, 2021

[redacted]

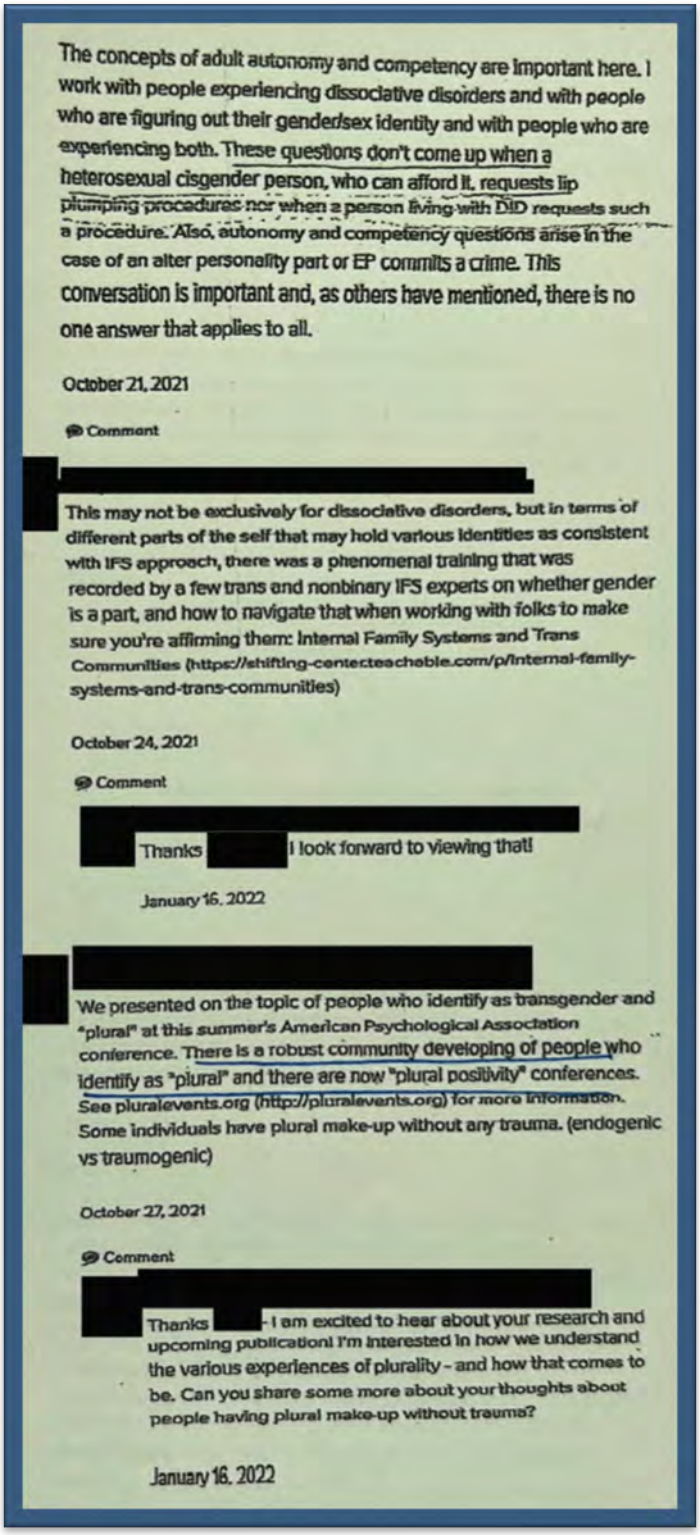
Hello,
Would it be worthwhile to consider looking at the International Society for the Study of Trauma and Dissociation (https://www.isst-d.org/) and beginning a dialogue to see if there is something that can be be looked at as a collective?
I have a large number of clients who have DDNOS/DID/c-PTSD or have dissociation on some level as part of their experience who are transitioning and are trans or gender diverse. I use EMDR in my practice and I have found that ISST-D to be helpful though not as inclusive as I would like. Would this be worth consideration and a potential way to define more approaches or interventions that are used/that could be talked about in this context?

October 17, 2021

Comment

[redacted] I am grateful for your response, and I hope it prompts more discussion about this issue. Personally, I am pursuing training in treating trauma and dissociative disorders, as well as consulting with a specialist in these disorders, but it is difficult, and dissociative disorders are, after all, covert. I too would love to hear from others how we as clinicians and as clinical support teams can work with these clients to honor their gender identity and their fractured ego identities.

October 18, 2021



The concepts of adult autonomy and competency are important here. I work with people experiencing dissociative disorders and with people who are figuring out their gender/sex identity and with people who are experiencing both. These questions don't come up when a heterosexual cisgender person, who can afford it, requests lip plumping procedures nor when a person living with DID requests such a procedure. Also, autonomy and competency questions arise in the case of an alter personality part or EP commits a crime. This conversation is important and, as others have mentioned, there is no one answer that applies to all.

October 21, 2021

Comment

[redacted]

This may not be exclusively for dissociative disorders, but in terms of different parts of the self that may hold various identities as consistent with IFS approach, there was a phenomenal training that was recorded by a few trans and nonbinary IFS experts on whether gender is a part, and how to navigate that when working with folks to make sure you're affirming them: Internal Family Systems and Trans Communities (https://shifting-contecteachable.com/p/internal-family-systems-and-trans-communities)

October 24, 2021

Comment

[redacted] Thanks [redacted] I look forward to viewing that!

January 16, 2022

[redacted]

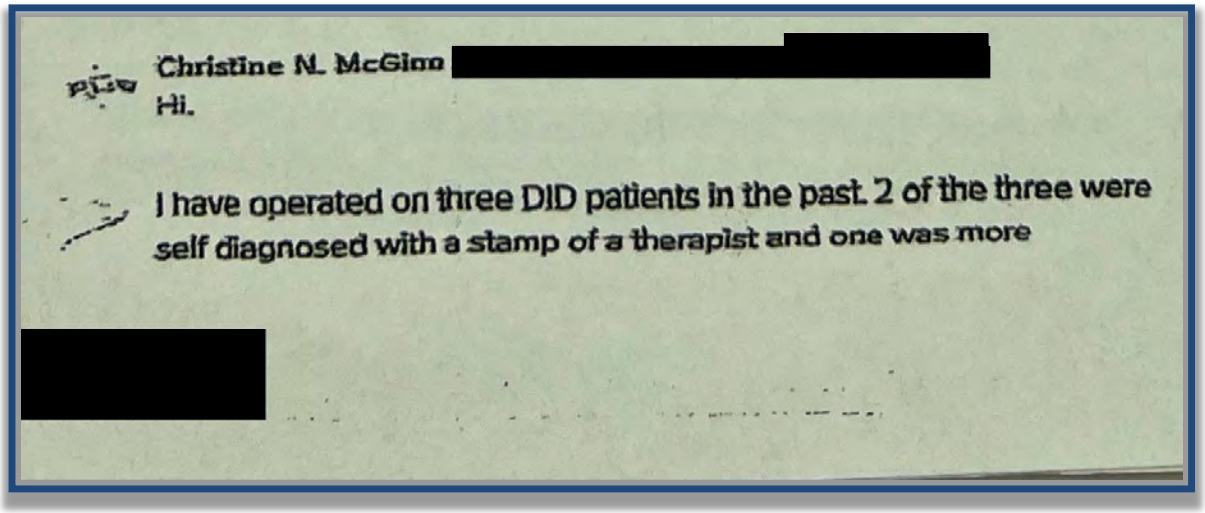
We presented on the topic of people who identify as transgender and "plural" at this summer's American Psychological Association conference. There is a robust community developing of people who identify as "plural" and there are now "plural positivity" conferences. See pluralevents.org (http://pluralevents.org) for more information. Some individuals have plural make-up without any trauma. (endogenic vs traumogenic)

October 27, 2021

Comment

[redacted] Thanks [redacted] - I am excited to hear about your research and upcoming publication! I'm interested in how we understand the various experiences of plurality - and how that comes to be. Can you share some more about your thoughts about people having plural make-up without trauma?

January 16, 2022

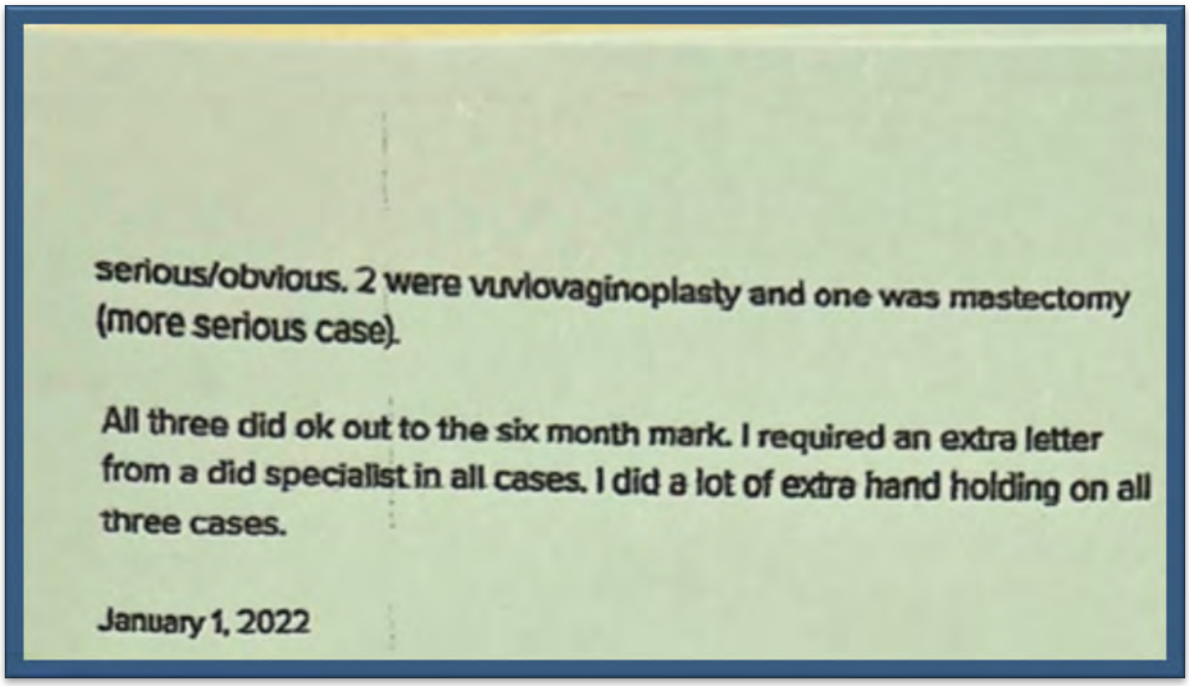


Christine N. McGinn [redacted]

Hi.

I have operated on three DID patients in the past. 2 of the three were self diagnosed with a stamp of a therapist and one was more

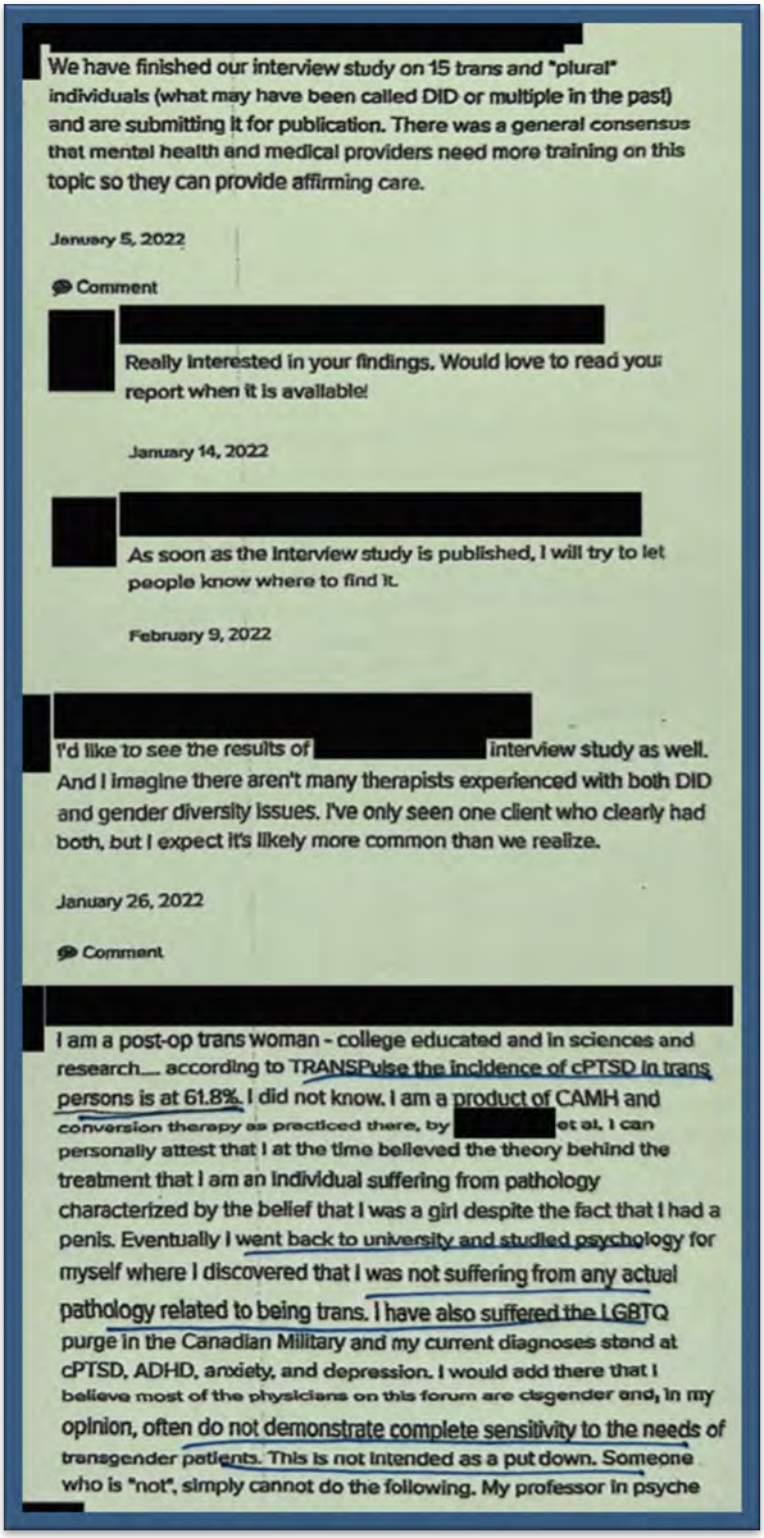
[redacted]



serious/obvious. 2 were vuvlovaginoplasty and one was mastectomy (more serious case).

All three did ok out to the six month mark. I required an extra letter from a did specialist in all cases. I did a lot of extra hand holding on all three cases.

January 1, 2022



[redacted]

We have finished our interview study on 15 trans and "plural" individuals (what may have been called DID or multiple in the past) and are submitting it for publication. There was a general consensus that mental health and medical providers need more training on this topic so they can provide affirming care.

January 5, 2022

Comment

[redacted]

Really interested in your findings. Would love to read your report when it is available!

January 14, 2022

[redacted]

As soon as the interview study is published, I will try to let people know where to find it.

February 9, 2022

[redacted]

I'd like to see the results of [redacted] interview study as well. And I imagine there aren't many therapists experienced with both DID and gender diversity issues. I've only seen one client who clearly had both, but I expect it's likely more common than we realize.

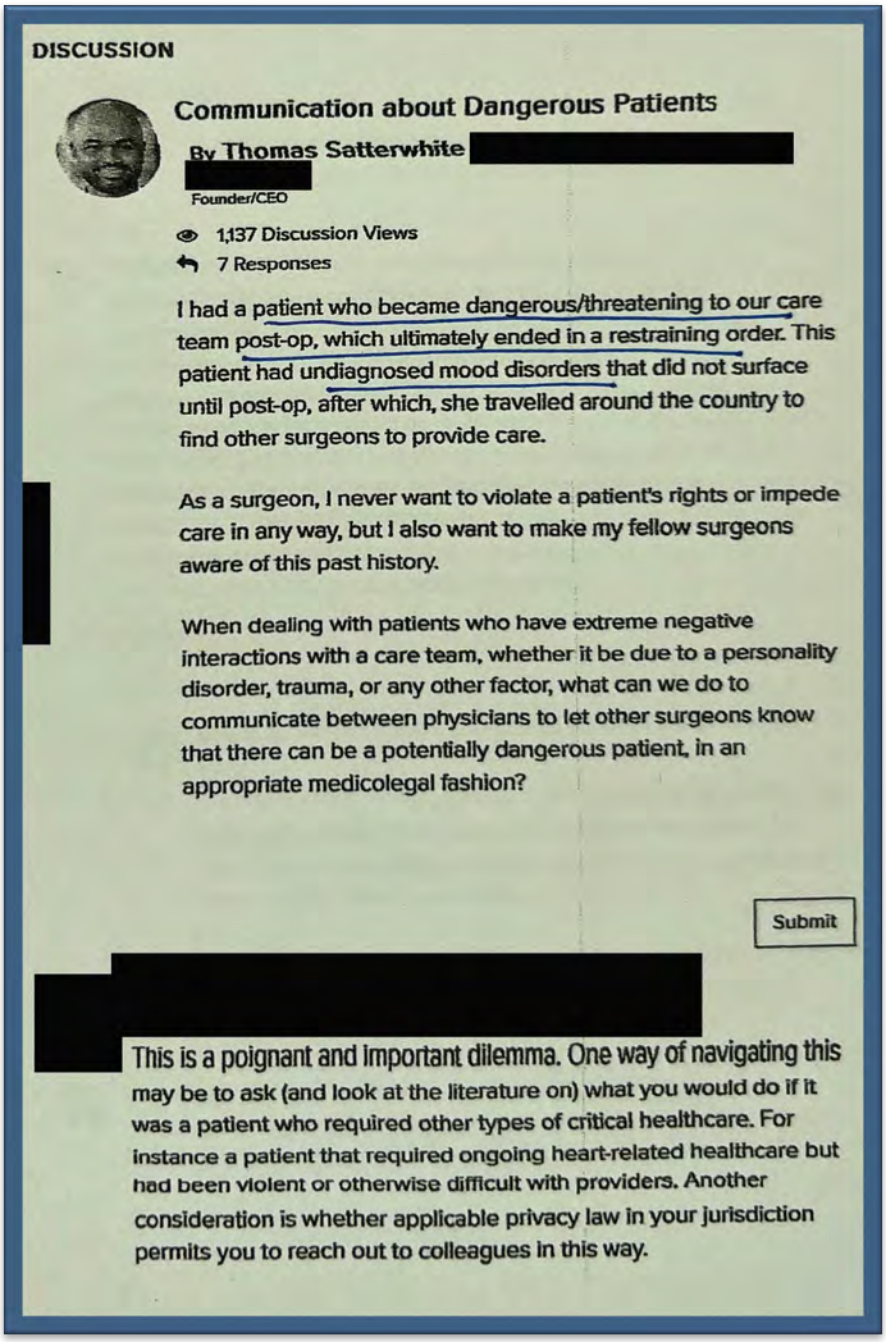
January 26, 2022

Comment

[redacted]

I am a post-op trans woman - college educated and in sciences and research.... according to TRANSPulse the incidence of cPTSD in trans persons is at 61.8%. I did not know. I am a product of CAMH and conversion therapy as practiced there, by [redacted] et al. I can personally attest that I at the time believed the theory behind the treatment that I am an individual suffering from pathology characterized by the belief that I was a girl despite the fact that I had a penis. Eventually I went back to university and studied psychology for myself where I discovered that I was not suffering from any actual pathology related to being trans. I have also suffered the LGBTQ purge in the Canadian Military and my current diagnoses stand at cPTSD, ADHD, anxiety, and depression. I would add there that I believe most of the physicians on this forum are cisgender and, in my opinion, often do not demonstrate complete sensitivity to the needs of transgender patients. This is not intended as a put down. Someone who is "not", simply cannot do the following. My professor in psyche

c) WPATH members discuss a patient with undiagnosed mood disorders who threatened medical staff



DISCUSSION

Communication about Dangerous Patients

By Thomas Satterwhite [redacted]

[redacted]
Founder/CEO

1,137 Discussion Views

7 Responses

I had a patient who became dangerous/threatening to our care team post-op, which ultimately ended in a restraining order. This patient had undiagnosed mood disorders that did not surface until post-op, after which, she travelled around the country to find other surgeons to provide care.

[redacted]

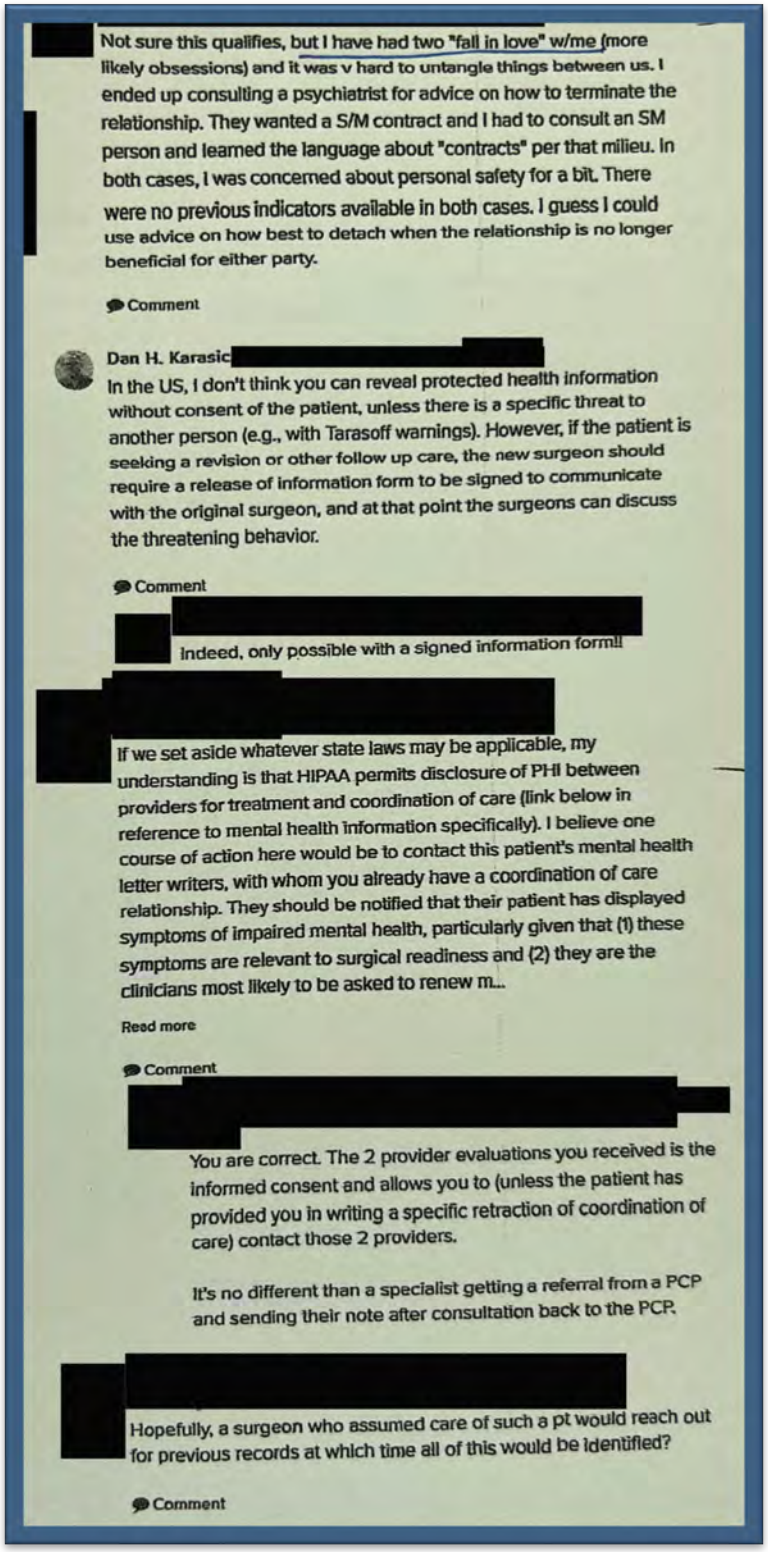
As a surgeon, I never want to violate a patient's rights or impede care in any way, but I also want to make my fellow surgeons aware of this past history.

When dealing with patients who have extreme negative interactions with a care team, whether it be due to a personality disorder, trauma, or any other factor, what can we do to communicate between physicians to let other surgeons know that there can be a potentially dangerous patient, in an appropriate medicolegal fashion?

Submit

[redacted]

This is a poignant and important dilemma. One way of navigating this may be to ask (and look at the literature on) what you would do if it was a patient who required other types of critical healthcare. For instance a patient that required ongoing heart-related healthcare but had been violent or otherwise difficult with providers. Another consideration is whether applicable privacy law in your jurisdiction permits you to reach out to colleagues in this way.



[redacted] Not sure this qualifies, but I have had two "fall in love" w/me (more likely obsessions) and it was v hard to untangle things between us. I ended up consulting a psychiatrist for advice on how to terminate the relationship. They wanted a S/M contract and I had to consult an SM person and learned the language about "contracts" per that milieu. In both cases, I was concerned about personal safety for a bit. There were no previous indicators available in both cases. I guess I could use advice on how best to detach when the relationship is no longer beneficial for either party.

Comment

Dan H. Karasic [redacted]
In the US, I don't think you can reveal protected health information without consent of the patient, unless there is a specific threat to another person (e.g., with Tarasoff warnings). However, if the patient is seeking a revision or other follow up care, the new surgeon should require a release of information form to be signed to communicate with the original surgeon, and at that point the surgeons can discuss the threatening behavior.

Comment

[redacted] indeed, only possible with a signed information form!!

[redacted] If we set aside whatever state laws may be applicable, my understanding is that HIPAA permits disclosure of PHI between providers for treatment and coordination of care (link below in reference to mental health information specifically). I believe one course of action here would be to contact this patient's mental health letter writers, with whom you already have a coordination of care relationship. They should be notified that their patient has displayed symptoms of impaired mental health, particularly given that (1) these symptoms are relevant to surgical readiness and (2) they are the clinicians most likely to be asked to renew m...

Read more

Comment

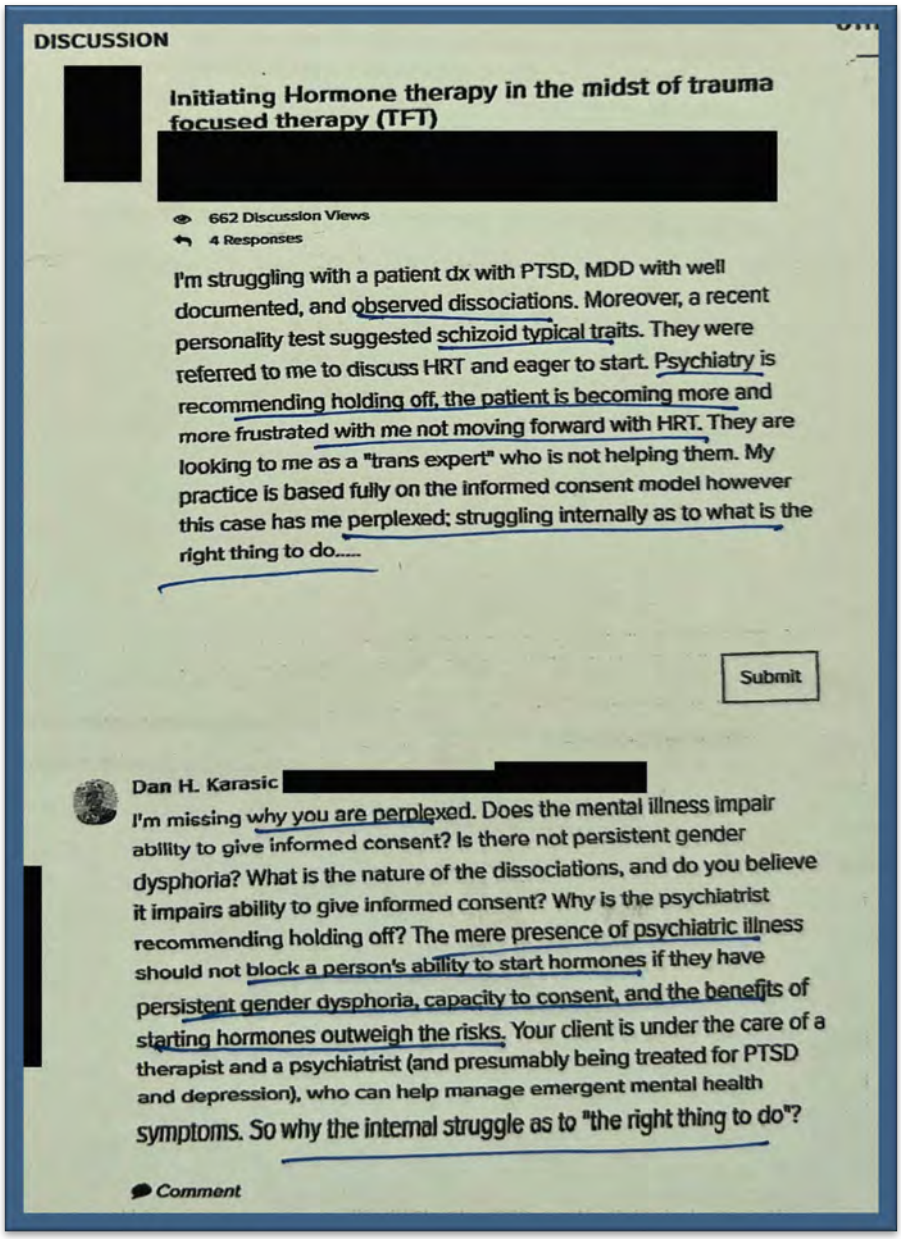
[redacted] You are correct. The 2 provider evaluations you received is the informed consent and allows you to (unless the patient has provided you in writing a specific retraction of coordination of care) contact those 2 providers.

It's no different than a specialist getting a referral from a PCP and sending their note after consultation back to the PCP.

[redacted] Hopefully, a surgeon who assumed care of such a pt would reach out for previous records at which time all of this would be identified?

Comment

d) WPATH members discuss initiating hormone therapy for a patient with trauma



DISCUSSION

[redacted]

Initiating Hormone therapy in the midst of trauma focused therapy (TFT)

[redacted]

662 Discussion Views
4 Responses

I'm struggling with a patient dx with PTSD, MDD with well documented, and observed dissociations. Moreover, a recent personality test suggested schizoid typical traits. They were referred to me to discuss HRT and eager to start. Psychiatry is recommending holding off, the patient is becoming more and more frustrated with me not moving forward with HRT. They are looking to me as a "trans expert" who is not helping them. My practice is based fully on the informed consent model however this case has me perplexed; struggling internally as to what is the right thing to do.....

Submit

Dan H. Karasic [redacted]

I'm missing why you are perplexed. Does the mental illness impair ability to give informed consent? Is there not persistent gender dysphoria? What is the nature of the dissociations, and do you believe it impairs ability to give informed consent? Why is the psychiatrist recommending holding off? The mere presence of psychiatric illness should not block a person's ability to start hormones if they have persistent gender dysphoria, capacity to consent, and the benefits of starting hormones outweigh the risks. Your client is under the care of a therapist and a psychiatrist (and presumably being treated for PTSD and depression), who can help manage emergent mental health symptoms. So why the internal struggle as to "the right thing to do"?

Comment

[redacted]

Understood,

But I don't see how HT would interfere negatively with the symptoms your patient is experiencing, nor with trauma focused therapy. In fact, withholding HT can make the patient experience more distress and thus intensified symptoms. I've had patients/clients with diagnosed DID, MDD, bipolar, schizophrenia, etc., who do just fine on HT. Think of it this way - would you deny a cisgender patient with the same psychiatric dx hormone therapy if they were hypogonadic? This is harm reduction and so doing nothing is not a "neutral option."

Comment

[redacted]

I agree with other comments. Start slow, be careful. With severe PTSD with dissociations, if the client isn't making progress with current psych, switch. They might have better ideas on calming the glutamate receptor such as use of NAC, Lithium, memantine to slow down the triggering and dissociation. It is good this client has someone who cares, which is the most important thing they need.

Comment

[redacted]

I agree with previous comments, and I strongly recommend reading this article on the matter: Kinnon R. MacKinnon, Daniel Grace, Stella L. Ng, Suzanne R. Sicchia & Lori E. Ross (2020): "I don't think they thought I was ready": How pre-transition assessments create care inequities for trans people with complex mental health in Canada, International Journal of Mental Health, DOI: 10.1080/00207411.2019.1711328 (Abstract (https://www.tandfonline.com/doi/abs/10.1080/00207411.2019.1711328))

e) A WPATH member questions the surgical readiness of patients displaying serious mental illness

[redacted]

CUSSION

[redacted]

Serious Mental Illness and Readiness for Medical/Surgical Transition

[redacted]

4,670 Discussion Views
5 Responses

I have several trans clients with serious mental illness. For example, bipolar disorder and autism or schizoaffective disorder. Even though these clients have a well-established trans gender identity, their likely stability post initiation of HRT or surgery is difficult to predict. What criteria do other people use to determine whether or not they can write a letter supporting surgical transition for this population? In particular, given the extensive recovery period and postnatal care required for vaginoplasty, have other clinicians found that their clients with serious mental illness can follow post-surgical dilation protocols?

Submit

[redacted]

Thank you for posting this [redacted]. I have a number of cases of folks with significant mental health issues (with various markers of "stability") including Autism Spectrum, PTSD/C-PTSD, Psychosis. I think part of our role is in treatment planning toward mental health sx stability pre and post medical interventions including surgery. In my mind this necessitates interdisciplinary, collaborative care and planning.

To be frank, I have a few who are (or will likely be) in a sort of holding pattern because of the lack of mental health and other support resources that I am recommending.

Does anyone know of literature on medical AND psychological outcomes for these/similar issues?

[redacted]
Hello,

It depends on many factors that equally affect those without any psychiatric concerns - do they have a support system with actual humans to help them on a daily basis, do they have a safe place to recover, and do they understand instructions such as dilate, wash, monitor - or do they have one or two persons who can help? Also - autism is neurodivergence on a spectrum with variability in function but not classified as "serious mental illness." In addition, as gender affirmative practitioners, we always consider harm reduction as our primary lens - in other words, what will happen to these patients if they do NOT undergo their affirmative treatment, which is also a medical necessity?

In my practice, I have found that those with diagnosed psychiatric concerns, e.g., schizophrenia controlled by medication, usually have a prior support system of sorts and can get help. But I have also intervened on behalf of people who have been diagnosed with major depressive disorder, cPTSD, homeless and got at least an orchiectomy - which made a huge difference in their lives and put them on the road to emotional recovery and enabled them to seek assistance (and yes, they were successful). To me, the letter is an assessment of mental capacity to provide informed consent; if such capacity clearly does not exist, the patient needs to be informed and a new appointment for changes in psychiatric meds or at least one discussion with their treating psychiatrist need to happen. I am personally not invested in the "well controlled" criterion phrase unless absolutely necessary, and I believe it's disappearing in the SOC v 8 version. Meanwhile, in the last 15 years I had to regrettably decline writing only one letter, mainly b/c the person evaluated was in active psychosis and hallucinated during the assessment session. Other than that - nothing - everyone got their assessment letter, insurance approval, and are living [presumably] happily ever after.

Comment

[redacted]
Correct me if I'm wrong, but my impression is that the SOC7 recommend a letter stipulates: "While the SOC allow for an individualized approach to best meet a patient's health care needs, a criterion for all breast/chest and genital surgeries is documentation of persistent gender dysphoria by a qualified mental health professional." The letter of support is primarily to establish the primary/durable indication for surgery: gender dysphoria. And while this likely qualifies as an individualized approach, I'm concerned that denying necessary surgical care (even for the severely mentally ill) encroaches strongly on a patient's autonomy–presuming the patient in question has capacity to make their own medical decisions.

If you've already established persistent gender dysphoria to your own threshold of assessment, then the role of mental health here may simply be one of "optimization" rather than clearance. Any medical doctor would do the same prior to necessary operations by a surgeon as well. It would be great if every patient could be perfectly cleared prior to every surgical intervention, but at the end of the day it is a risk/benefit decision between you, the patient, the surgeon, and any other resources/family you can recruit to help promote the best outcome for the person(s) in question. If a patient can't follow a

dilation schedule, they may lose depth, but as long as they're capable of making that decision of sound mind while fully informed of the risks, then that may be all you can do. Please keep in mind that any surgeon should also be assessing for risks and ability for a person to recover optimally since they are more intimately familiar with post-operative complications, so you're not alone in your fear of complicated outcomes.

Comment

[redacted]

It is my understanding that for top surgery (roughly) that medical and mental health issues need to be "reasonably well-controlled" and for genital surgery, the issues need to be "well-controlled" according to SOC 7. However, there is not a clear line on what well-controlled versus reasonably well-controlled are. It's a clinical judgment from the best I can tell, and I use consultations with my WPATH Mentors (they are so awesome and have so many years of experience to bounce things off of) to determine this if I have concerns. I think an interdisciplinary team approach to helping someone get what they need. Also, I like to adopt the "and" framework rather than the "or" framework for this. Someone can have schizophrenia and be ready for surgery...it is just a matter of what you see concerns are, communicating those concerns, and working in a patient-centered way with a team (ideally) to help them get to close to the goals as possible for surgery readiness. I also believe that collaboration with the surgeon(s) is ideal because their staff can help support with aftercare realities and a plan for pre and post-op care. I also am reminded that it has been pointed out to me that withholding care (letters of referral, etc.) is more problematic when compared to the provider's feelings about the potential for stability after surgery and/or difficulty with following through with aftercare instructions. things like exploring minimal depth vaginoplasty are also an option. I say all of this in the most client-centered and supportive way to help patients get what they need for care. Thank you!

Comment

[redacted]

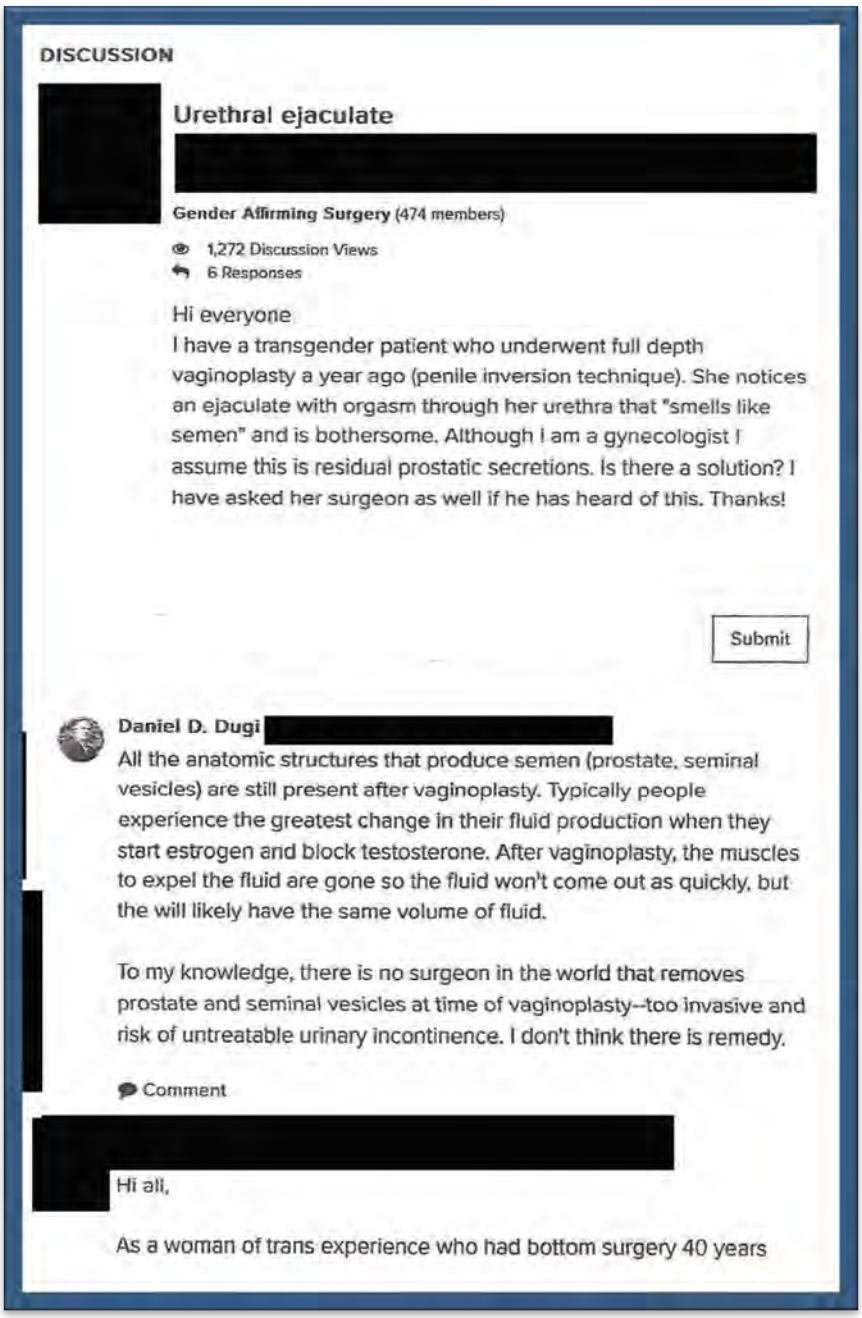
My feeling is that, in general, mental illness is not a reason to withhold needed medical care from clients. Doing so just increases the day-to-day level of distress these clients are called upon to manage, in the form of gender dysphoria. In contrast, receiving gender-affirming care can often significantly stabilize client's mental health.

My assumption is that you're asking this question because you're taking seriously your responsibility to care for and guide your clients. Unfortunately, though, I think the broader context in which this question even exists is one in which we, as mental health professionals, have been put inappropriately into gatekeeper roles. I'm not aware of any other medical procedure that requires the approval of a therapist. I think requiring this for trans clients is another way that our healthcare system positions gender-affirming care as "optional" or only for those who can prove they deserve it.

Even if your clients might struggle with some of the needs and challenges that come with surgeries, for example, I believe that they will likely be better off in the long run. More importantly, I also believe that they have the right to access that care if they choose.

3) SURGICAL OR HEALTHCARE COMPLICATIONS

a) A WPATH member reports their concerns regarding their patient's urethral ejaculate



DISCUSSION

[redacted]

Urethral ejaculate

[redacted]

Gender Affirming Surgery (474 members)

1,272 Discussion Views
6 Responses

Hi everyone
I have a transgender patient who underwent full depth vaginoplasty a year ago (penile inversion technique). She notices an ejaculate with orgasm through her urethra that "smells like semen" and is bothersome. Although I am a gynecologist I assume this is residual prostatic secretions. Is there a solution? I have asked her surgeon as well if he has heard of this. Thanks!

Submit

Daniel D. Dugi [redacted]

All the anatomic structures that produce semen (prostate, seminal vesicles) are still present after vaginoplasty. Typically people experience the greatest change in their fluid production when they start estrogen and block testosterone. After vaginoplasty, the muscles to expel the fluid are gone so the fluid won't come out as quickly, but the will likely have the same volume of fluid.

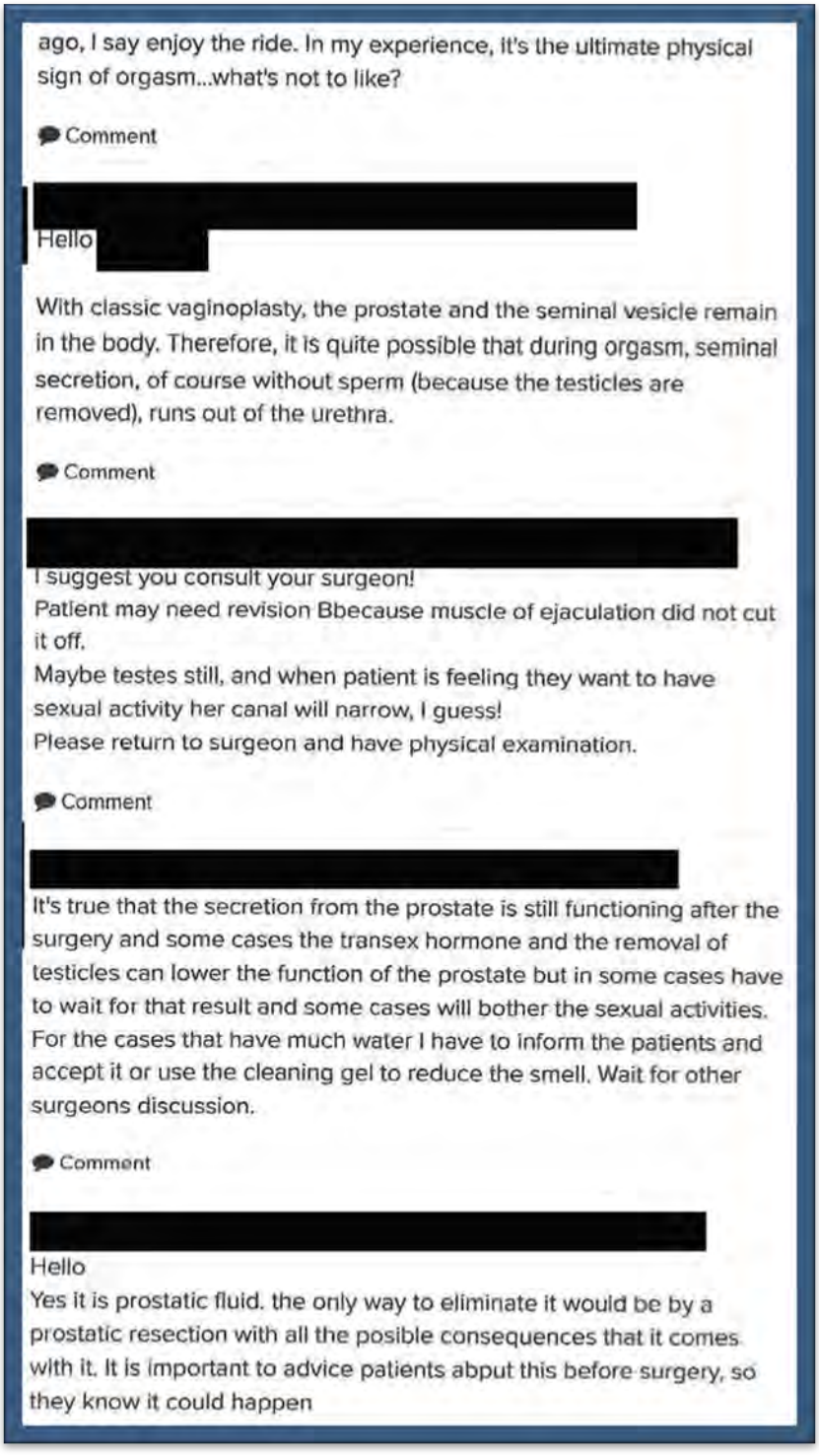
To my knowledge, there is no surgeon in the world that removes prostate and seminal vesicles at time of vaginoplasty--too invasive and risk of untreatable urinary incontinence. I don't think there is remedy.

Comment

[redacted]

Hi all,

As a woman of trans experience who had bottom surgery 40 years



ago, I say enjoy the ride. In my experience, it's the ultimate physical sign of orgasm...what's not to like?

Comment

[redacted]

Hello

With classic vaginoplasty, the prostate and the seminal vesicle remain in the body. Therefore, it is quite possible that during orgasm, seminal secretion, of course without sperm (because the testicles are removed), runs out of the urethra.

Comment

[redacted]

I suggest you consult your surgeon!
Patient may need revision Bbecause muscle of ejaculation did not cut it off.
Maybe testes still, and when patient is feeling they want to have sexual activity her canal will narrow, I guess!
Please return to surgeon and have physical examination.

Comment

[redacted]

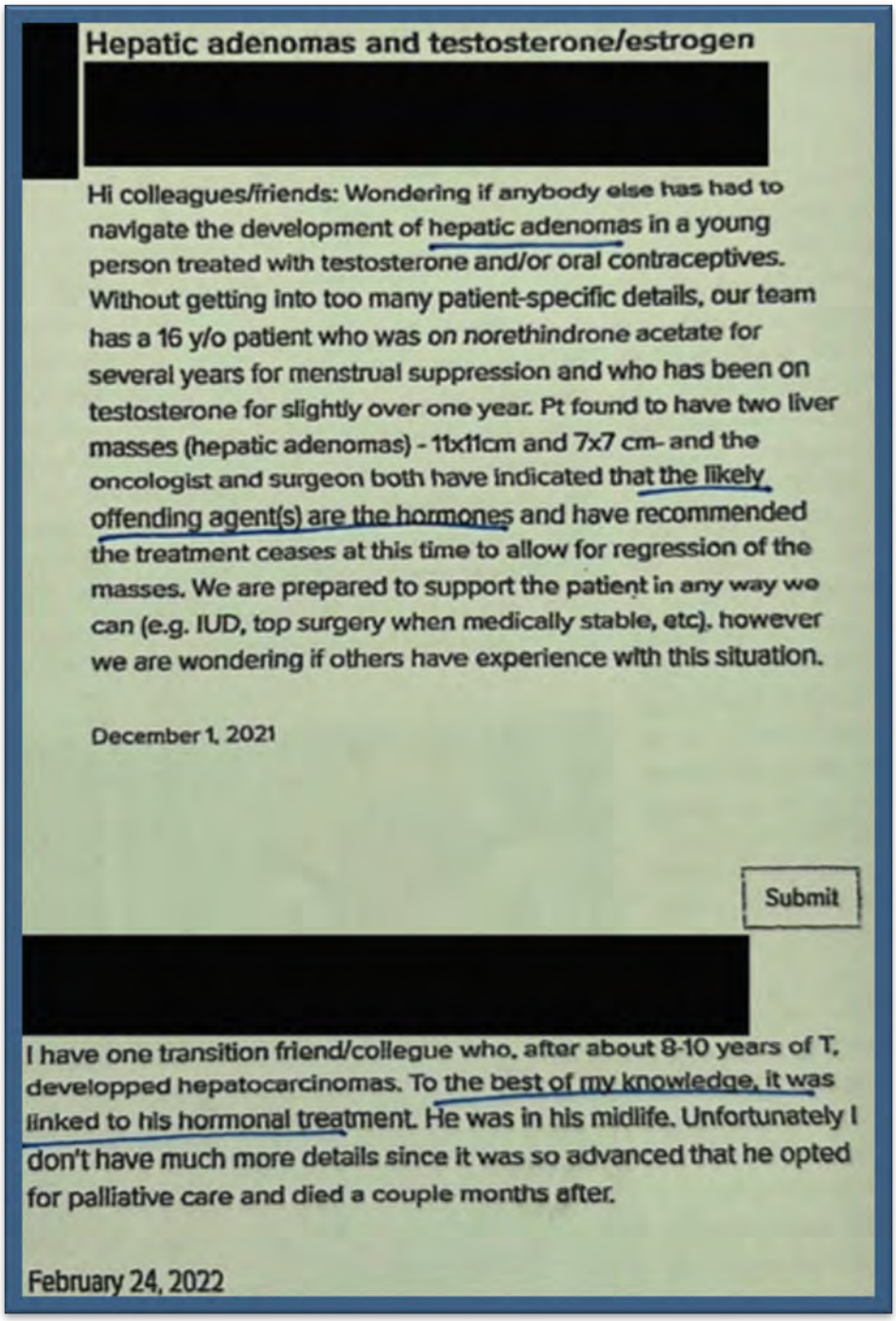
It's true that the secretion from the prostate is still functioning after the surgery and some cases the transex hormone and the removal of testicles can lower the function of the prostate but in some cases have to wait for that result and some cases will bother the sexual activities. For the cases that have much water I have to inform the patients and accept it or use the cleaning gel to reduce the smell. Wait for other surgeons discussion.

Comment

[redacted]

Hello
Yes it is prostatic fluid. the only way to eliminate it would be by a prostatic resection with all the posible consequences that it comes with it. It is important to advice patients abput this before surgery, so they know it could happen

b) A WPATH member discusses the development of hepatic adenomas on a client taking testosterone/estrogen



Hepatic adenomas and testosterone/estrogen

[redacted]

Hi colleagues/friends: Wondering if anybody else has had to navigate the development of hepatic adenomas in a young person treated with testosterone and/or oral contraceptives. Without getting into too many patient-specific details, our team has a 16 y/o patient who was on norethindrone acetate for several years for menstrual suppression and who has been on testosterone for slightly over one year. Pt found to have two liver masses (hepatic adenomas) - 11x11cm and 7x7 cm- and the oncologist and surgeon both have indicated that the likely offending agent(s) are the hormones and have recommended the treatment ceases at this time to allow for regression of the masses. We are prepared to support the patient in any way we can (e.g. IUD, top surgery when medically stable, etc). however we are wondering if others have experience with this situation.

December 1, 2021

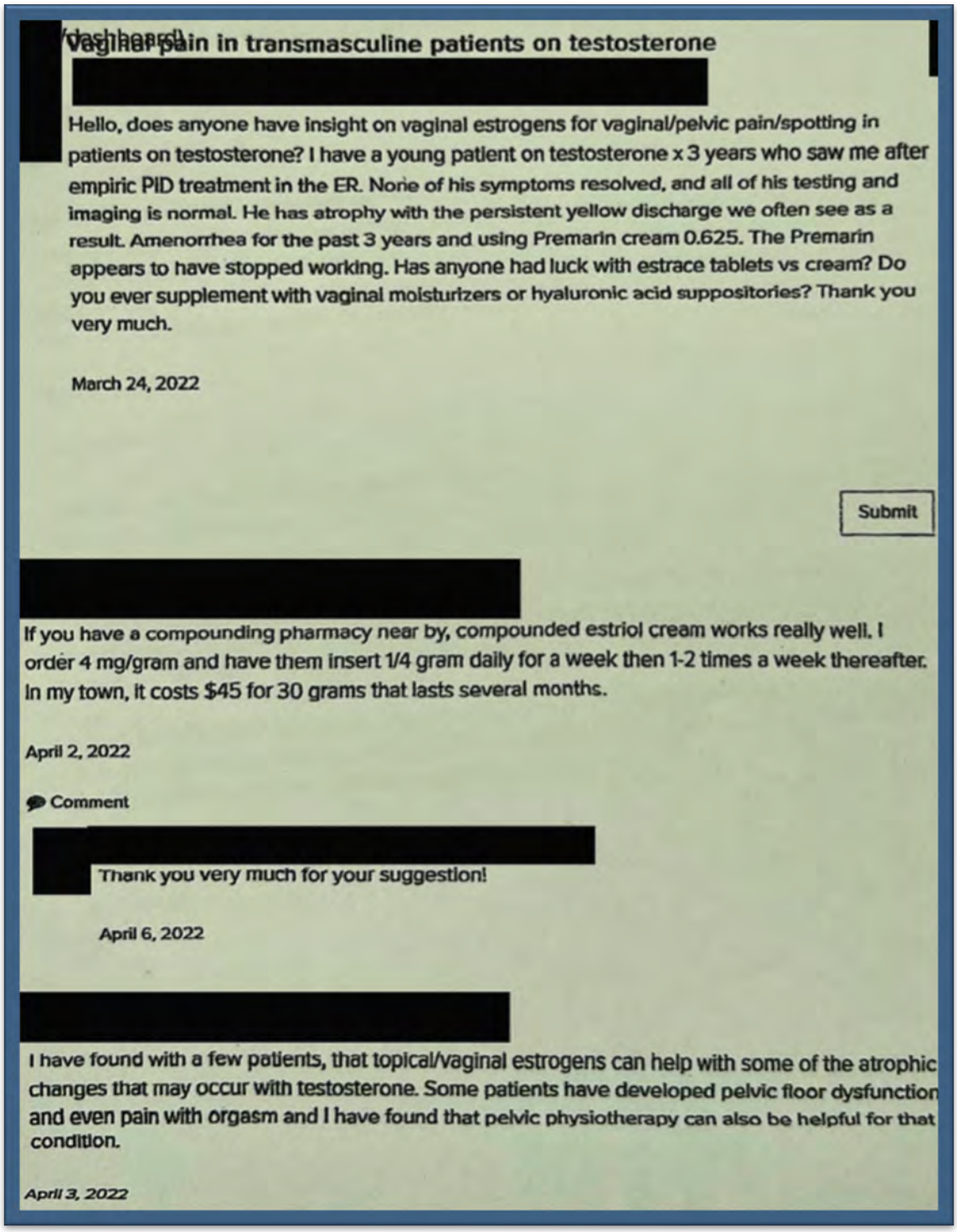
Submit

[redacted]

I have one transition friend/collegue who, after about 8-10 years of T, developped hepatocarcinomas. To the best of my knowledge, it was linked to his hormonal treatment. He was in his midlife. Unfortunately I don't have much more details since it was so advanced that he opted for palliative care and died a couple months after.

February 24, 2022

c) A WPATH member reports their young patient is experiencing vaginal pain on testosterone



(dashboard)

Vaginal pain in transmasculine patients on testosterone

[redacted]

Hello, does anyone have insight on vaginal estrogens for vaginal/pelvic pain/spotting in patients on testosterone? I have a young patient on testosterone x 3 years who saw me after empiric PID treatment in the ER. None of his symptoms resolved, and all of his testing and imaging is normal. He has atrophy with the persistent yellow discharge we often see as a result. Amenorrhea for the past 3 years and using Premarin cream 0.625. The Premarin appears to have stopped working. Has anyone had luck with estrace tablets vs cream? Do you ever supplement with vaginal moisturizers or hyaluronic acid suppositories? Thank you very much.

March 24, 2022

Submit

[redacted]

If you have a compounding pharmacy near by, compounded estriol cream works really well. I order 4 mg/gram and have them insert 1/4 gram daily for a week then 1-2 times a week thereafter. In my town, it costs $45 for 30 grams that lasts several months.

April 2, 2022

Comment

[redacted]

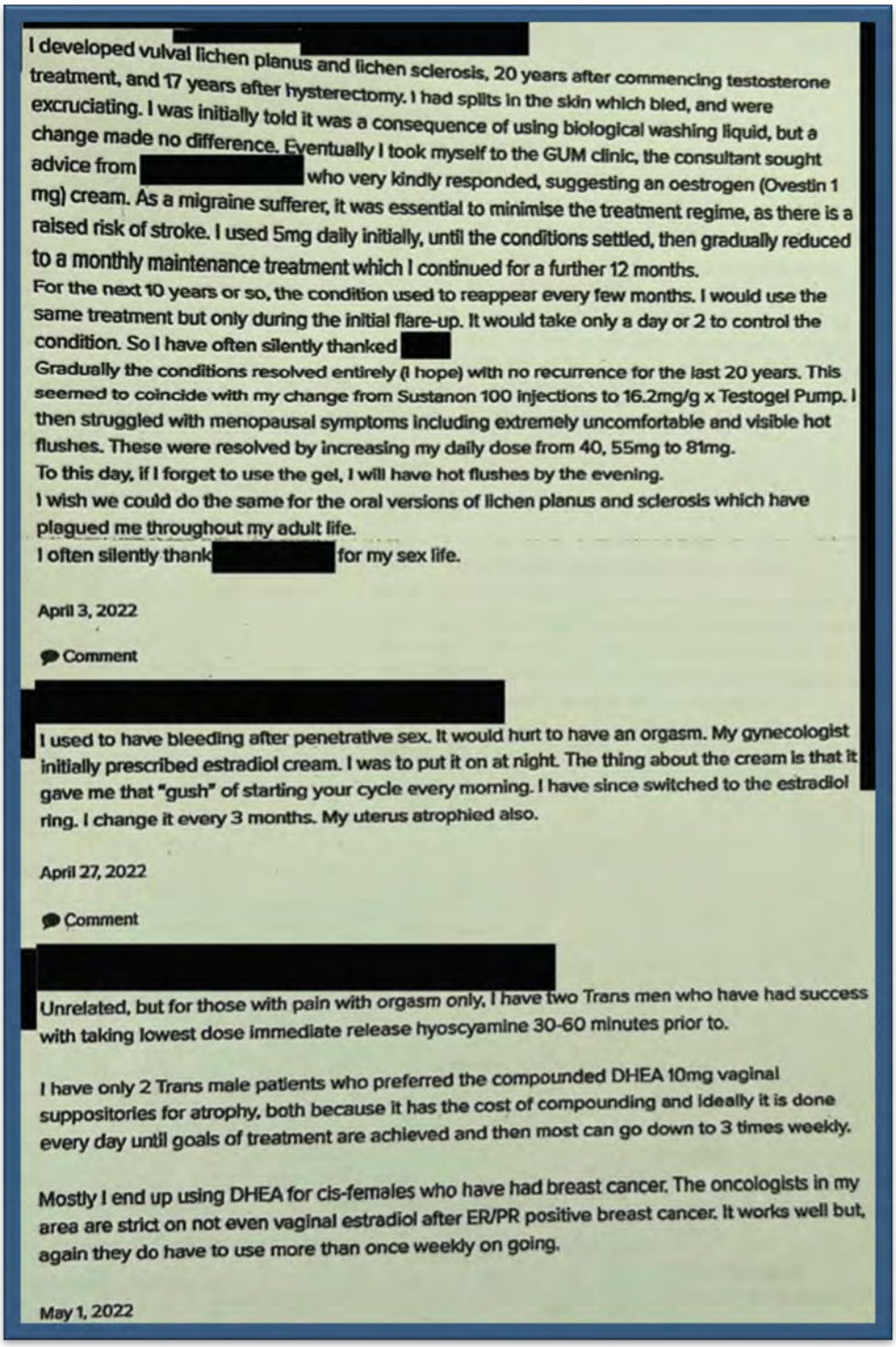
Thank you very much for your suggestion!

April 6, 2022

[redacted]

I have found with a few patients, that topical/vaginal estrogens can help with some of the atrophic changes that may occur with testosterone. Some patients have developed pelvic floor dysfunction and even pain with orgasm and I have found that pelvic physiotherapy can also be helpful for that condition.

April 3, 2022



I developed vulval lichen planus and lichen sclerosis, 20 years after commencing testosterone treatment, and 17 years after hysterectomy. I had splits in the skin which bled, and were excruciating. I was initially told it was a consequence of using biological washing liquid, but a change made no difference. Eventually I took myself to the GUM clinic, the consultant sought advice from [redacted] who very kindly responded, suggesting an oestrogen (Ovestin 1 mg) cream. As a migraine sufferer, it was essential to minimise the treatment regime, as there is a raised risk of stroke. I used 5mg daily initially, until the conditions settled, then gradually reduced to a monthly maintenance treatment which I continued for a further 12 months.
For the next 10 years or so, the condition used to reappear every few months. I would use the same treatment but only during the initial flare-up. It would take only a day or 2 to control the condition. So I have often silently thanked [redacted]
Gradually the conditions resolved entirely (I hope) with no recurrence for the last 20 years. This seemed to coincide with my change from Sustanon 100 injections to 16.2mg/g x Testogel Pump. I then struggled with menopausal symptoms including extremely uncomfortable and visible hot flushes. These were resolved by increasing my daily dose from 40, 55mg to 81mg.
To this day, if I forget to use the gel, I will have hot flushes by the evening.
I wish we could do the same for the oral versions of lichen planus and sclerosis which have plagued me throughout my adult life.
I often silently thank [redacted] for my sex life.

April 3, 2022

Comment

[redacted]

I used to have bleeding after penetrative sex. It would hurt to have an orgasm. My gynecologist initially prescribed estradiol cream. I was to put it on at night. The thing about the cream is that it gave me that "gush" of starting your cycle every morning. I have since switched to the estradiol ring. I change it every 3 months. My uterus atrophied also.

April 27, 2022

Comment

[redacted]

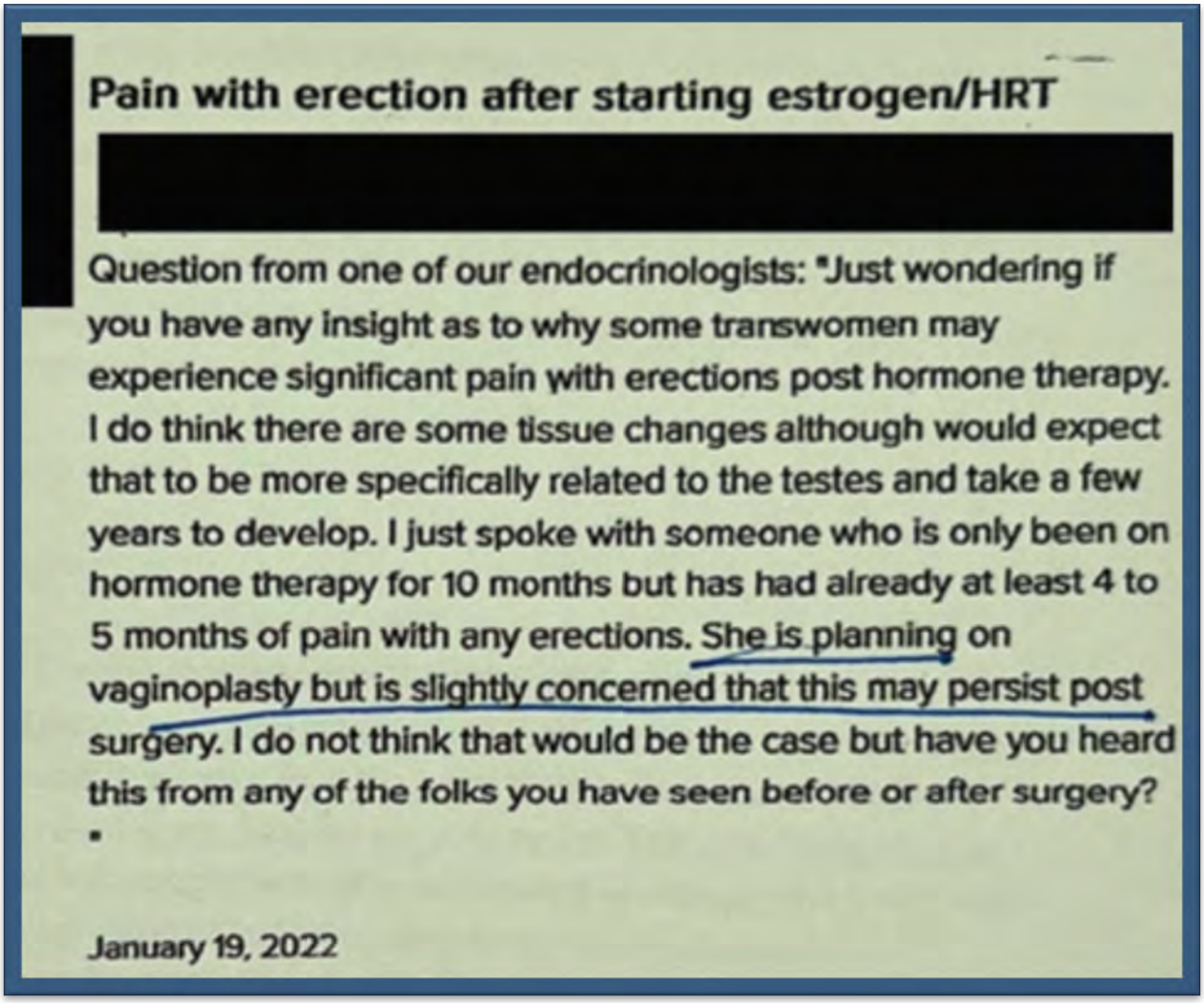
Unrelated, but for those with pain with orgasm only, I have two Trans men who have had success with taking lowest dose immediate release hyoscyamine 30-60 minutes prior to.

I have only 2 Trans male patients who preferred the compounded DHEA 10mg vaginal suppositories for atrophy, both because it has the cost of compounding and ideally it is done every day until goals of treatment are achieved and then most can go down to 3 times weekly.

Mostly I end up using DHEA for cis-females who have had breast cancer. The oncologists in my area are strict on not even vaginal estradiol after ER/PR positive breast cancer. It works well but, again they do have to use more than once weekly on going.

May 1, 2022

d) WPATH members discuss erection pain in a patient on estrogen

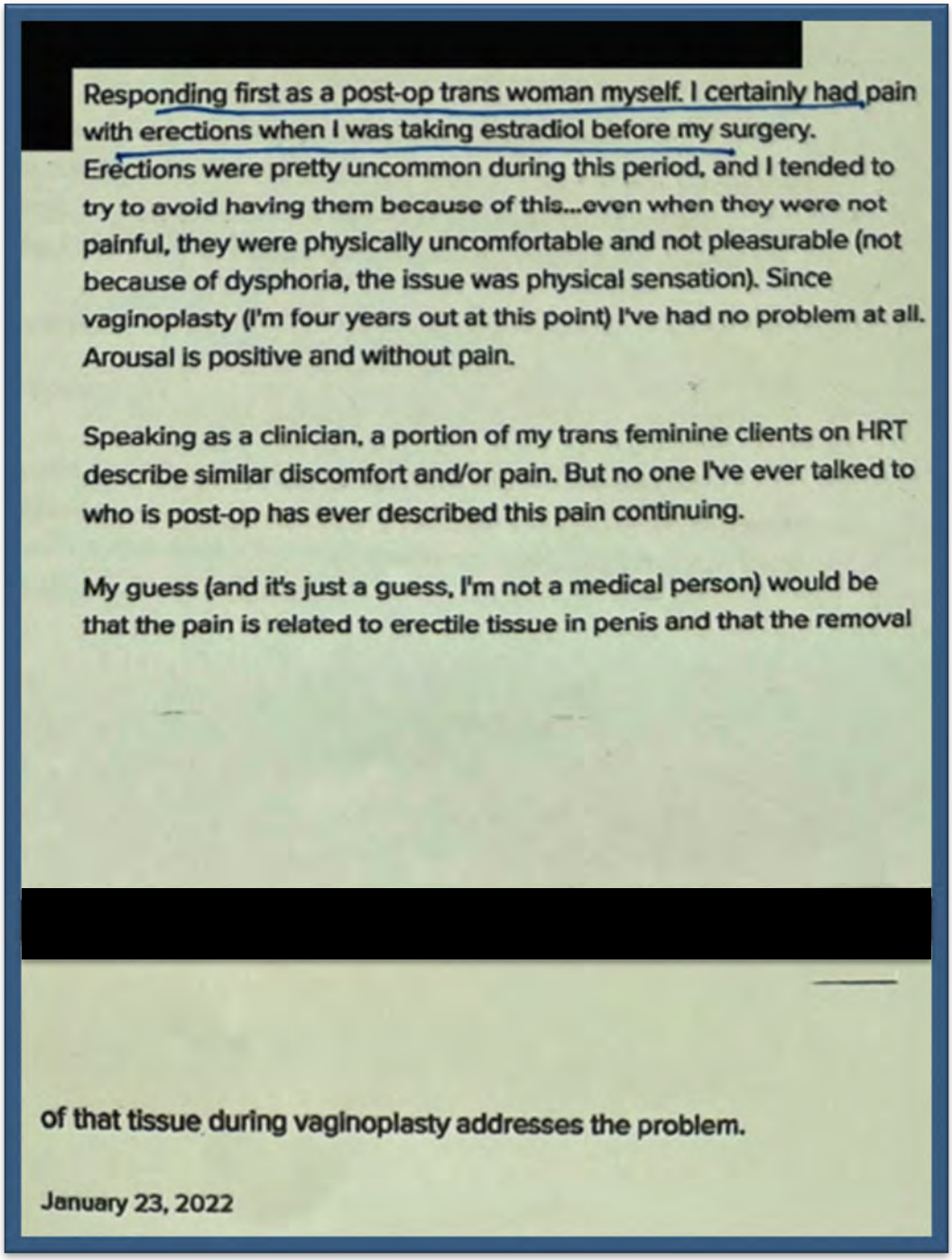


Pain with erection after starting estrogen/HRT

[redacted]

Question from one of our endocrinologists: "Just wondering if you have any insight as to why some transwomen may experience significant pain with erections post hormone therapy. I do think there are some tissue changes although would expect that to be more specifically related to the testes and take a few years to develop. I just spoke with someone who is only been on hormone therapy for 10 months but has had already at least 4 to 5 months of pain with any erections. She is planning on vaginoplasty but is slightly concerned that this may persist post surgery. I do not think that would be the case but have you heard this from any of the folks you have seen before or after surgery?

January 19, 2022



[redacted]

Responding first as a post-op trans woman myself. I certainly had pain with erections when I was taking estradiol before my surgery. Erections were pretty uncommon during this period, and I tended to try to avoid having them because of this...even when they were not painful, they were physically uncomfortable and not pleasurable (not because of dysphoria, the issue was physical sensation). Since vaginoplasty (I'm four years out at this point) I've had no problem at all. Arousal is positive and without pain.

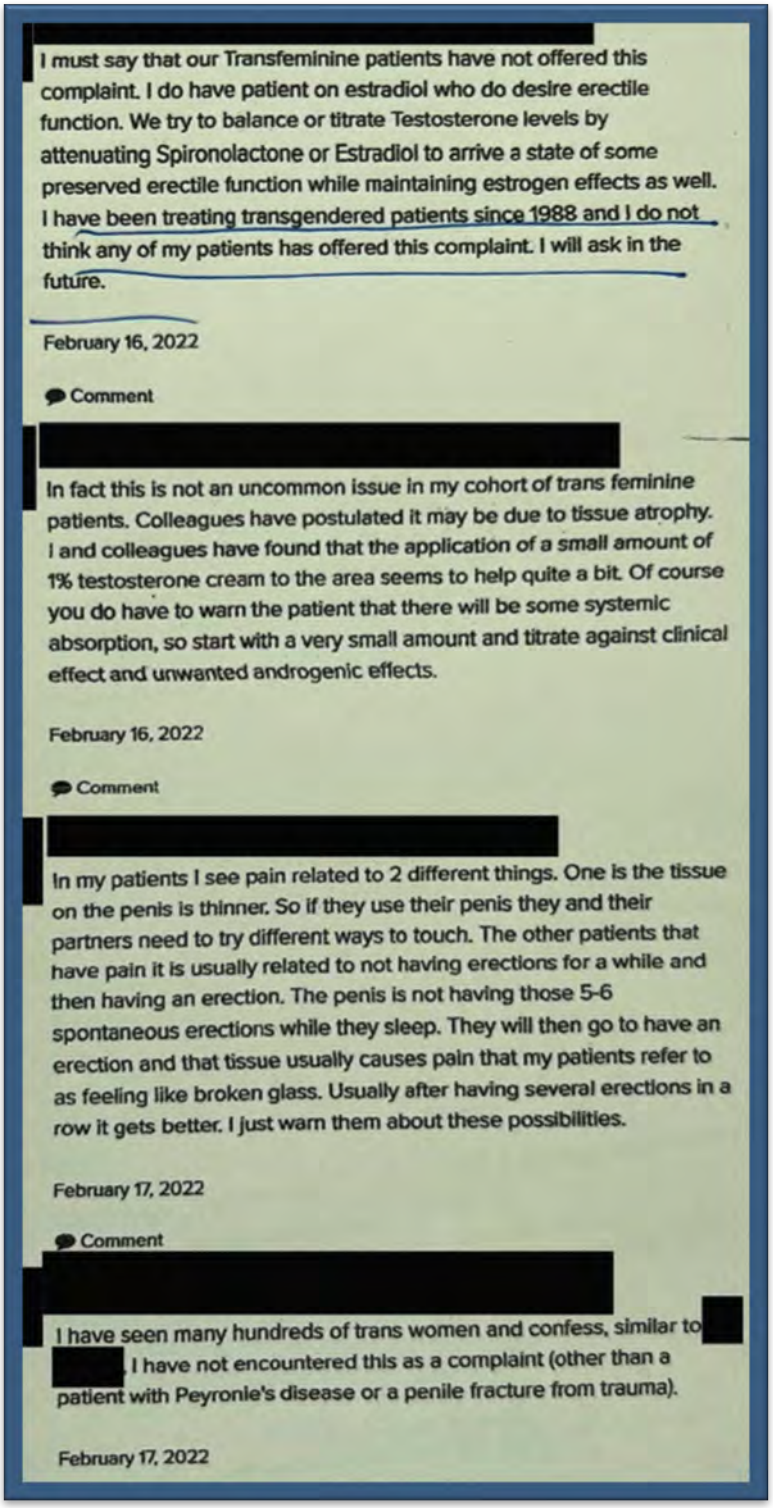
Speaking as a clinician, a portion of my trans feminine clients on HRT describe similar discomfort and/or pain. But no one I've ever talked to who is post-op has ever described this pain continuing.

My guess (and it's just a guess, I'm not a medical person) would be that the pain is related to erectile tissue in penis and that the removal

[redacted]

of that tissue during vaginoplasty addresses the problem.

January 23, 2022



I must say that our Transfeminine patients have not offered this complaint. I do have patient on estradiol who do desire erectile function. We try to balance or titrate Testosterone levels by attenuating Spironolactone or Estradiol to arrive a state of some preserved erectile function while maintaining estrogen effects as well. I have been treating transgendered patients since 1988 and I do not think any of my patients has offered this complaint. I will ask in the future.

February 16, 2022

Comment

[redacted]

In fact this is not an uncommon issue in my cohort of trans feminine patients. Colleagues have postulated it may be due to tissue atrophy. I and colleagues have found that the application of a small amount of 1% testosterone cream to the area seems to help quite a bit. Of course you do have to warn the patient that there will be some systemic absorption, so start with a very small amount and titrate against clinical effect and unwanted androgenic effects.

February 16, 2022

Comment

[redacted]

In my patients I see pain related to 2 different things. One is the tissue on the penis is thinner. So if they use their penis they and their partners need to try different ways to touch. The other patients that have pain it is usually related to not having erections for a while and then having an erection. The penis is not having those 5-6 spontaneous erections while they sleep. They will then go to have an erection and that tissue usually causes pain that my patients refer to as feeling like broken glass. Usually after having several erections in a row it gets better. I just warn them about these possibilities.

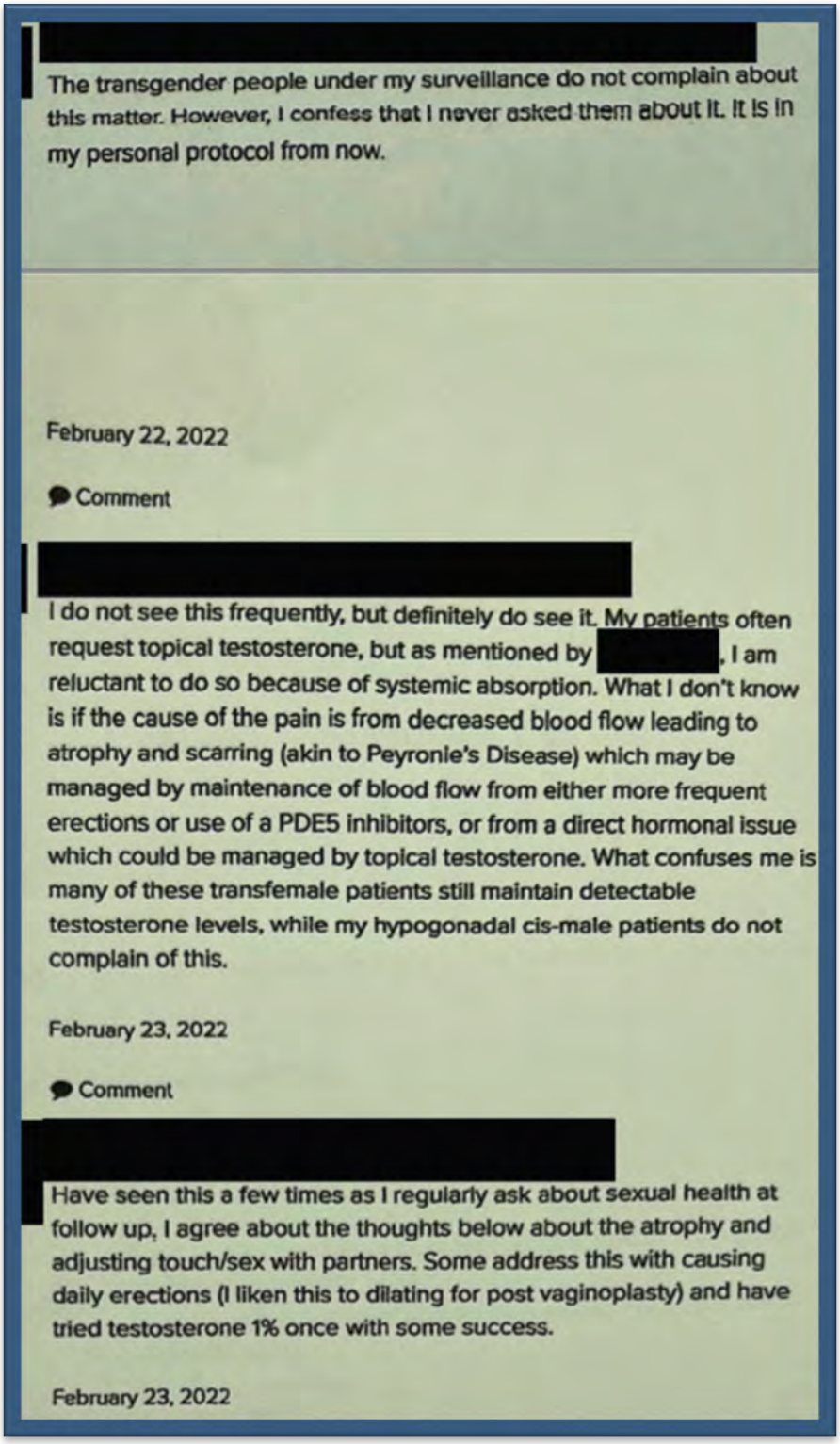
February 17, 2022

Comment

[redacted]

I have seen many hundreds of trans women and confess, similar to [redacted], I have not encountered this as a complaint (other than a patient with Peyronie's disease or a penile fracture from trauma).

February 17, 2022



[redacted]

The transgender people under my surveillance do not complain about this matter. However, I confess that I never asked them about it. It is in my personal protocol from now.

February 22, 2022

Comment

[redacted]

I do not see this frequently, but definitely do see it. My patients often request topical testosterone, but as mentioned by [redacted], I am reluctant to do so because of systemic absorption. What I don't know is if the cause of the pain is from decreased blood flow leading to atrophy and scarring (akin to Peyronie's Disease) which may be managed by maintenance of blood flow from either more frequent erections or use of a PDE5 inhibitors, or from a direct hormonal issue which could be managed by topical testosterone. What confuses me is many of these transfemale patients still maintain detectable testosterone levels, while my hypogonadal cis-male patients do not complain of this.

February 23, 2022

Comment

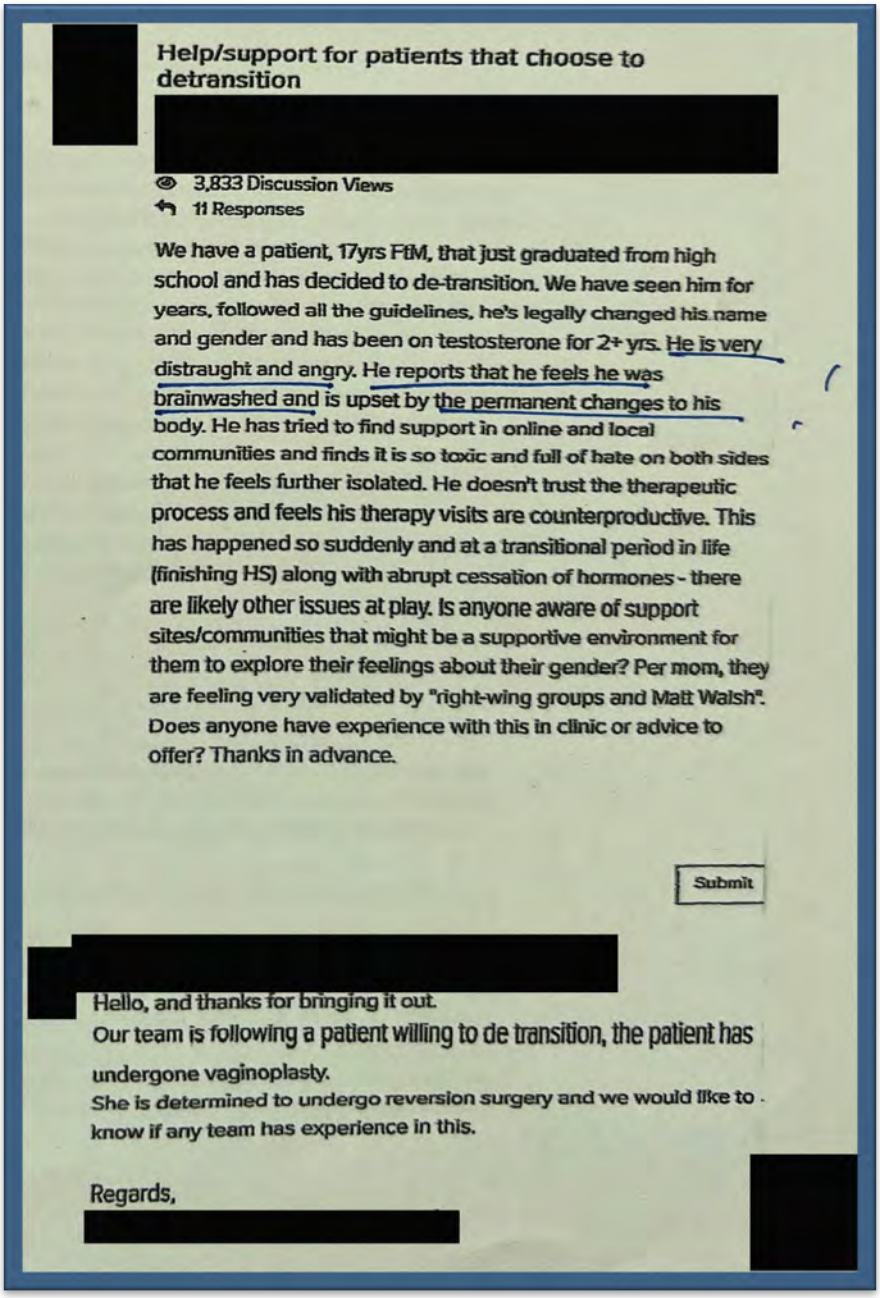
[redacted]

Have seen this a few times as I regularly ask about sexual health at follow up, I agree about the thoughts below about the atrophy and adjusting touch/sex with partners. Some address this with causing daily erections (I liken this to dilating for post vaginoplasty) and have tried testosterone 1% once with some success.

February 23, 2022

4) DETRANSITION CONCERNS

a) A WPATH member reports a patient who reports feeling "brainwashed" into transition



[redacted]

Help/support for patients that choose to detransition

[redacted]

3,833 Discussion Views
11 Responses

We have a patient, 17yrs FtM, that just graduated from high school and has decided to de-transition. We have seen him for years, followed all the guidelines, he's legally changed his name and gender and has been on testosterone for 2+ yrs. He is very distraught and angry. He reports that he feels he was brainwashed and is upset by the permanent changes to his body. He has tried to find support in online and local communities and finds it is so toxic and full of hate on both sides that he feels further isolated. He doesn't trust the therapeutic process and feels his therapy visits are counterproductive. This has happened so suddenly and at a transitional period in life (finishing HS) along with abrupt cessation of hormones - there are likely other issues at play. Is anyone aware of support sites/communities that might be a supportive environment for them to explore their feelings about their gender? Per mom, they are feeling very validated by "right-wing groups and Matt Walsh". Does anyone have experience with this in clinic or advice to offer? Thanks in advance.

Submit

[redacted]

Hello, and thanks for bringing it out.
Our team is following a patient willing to de transition, the patient has undergone vaginoplasty.
She is determined to undergo reversion surgery and we would like to know if any team has experience in this.

Regards,

[redacted]

[redacted]

I have a patient I am currently seeing in psychotherapy who is also in high school and, medically at least, has opted to pursue a similar path. However, throughout discussion on this change in course with me and with his parents (also AFAB), he is framing it quite differently. Instead of even using the term "detransition," he is simply describing this as a turn in his gender journey. He does not regret the course he has taken so far, and acknowledges that he was the driver in getting him to this point. He also has had a very supportive environment (home, school, friends, therapy) that has allowed him to appreciate his ability to have agency in his journey, but simply says that, for now at least, he needs to take a breath, pause the T, and see how that feels to him (e.g., will it feel gender-congruent).

I don't have any suggestions for any group, as this young person has found what he needs in his support network and has not expressed a need for any additional support group. I would, however, be very interested in any suggestions others may have for your person.

[redacted]

Comment

[redacted]

Maybe this young person needs to engage in anti-trans platforms as a place where she (pronoun?) can connect with her anger and feel less alone. The isolation you describe is pretty typical I think, which is why I am considering starting a support group (if there are enough people interested in joining). I worked with a 16 year old who detransitioned after being on T for more that 2 years and having top surgery. She was very angry and actively engaged in anti-trans online groups. In her case, as well as with the 20 year old I am currently working with, they believe their issue was really body dysmorphia rather than gender dysphoria, and both had presented as being very appropriate for hormones and surgery.

I don't know what to recommend for your patient, especially since it sounds like she believes therapy is counterproductive. If I end up starting a support group, however, I would be happy to talk with you about whether she might benefit from joining.

Thanks,

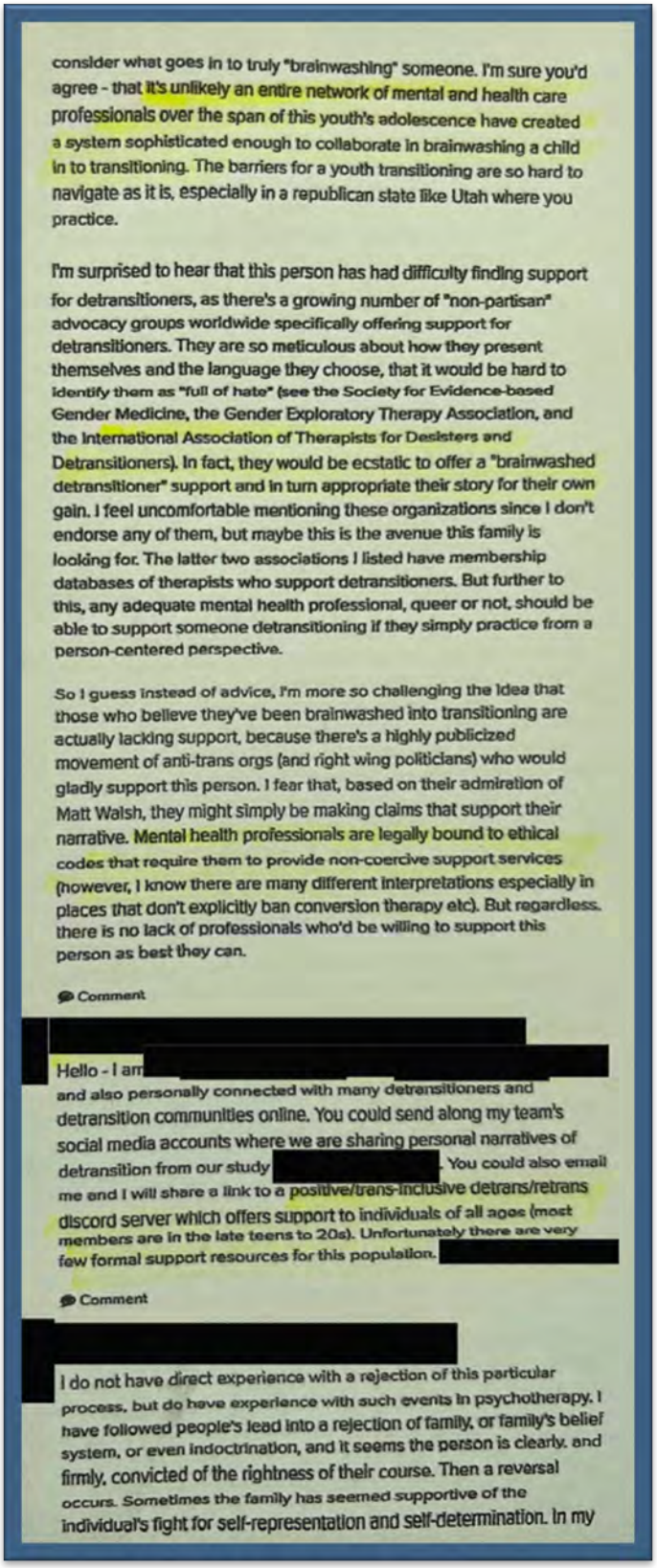
[redacted]

Comment

[redacted]

Hi there, I am not a medical professional - I'm just a queer therapist who specializes in working with queer people, including those who navigate the transition process and gender affirming procedures.

I want to offer this portion of my response as a disclaimer: While I've supported people who've detransitioned or just experience fluidity in their gender over time, I've never witnessed someone claiming to be brainwashed. In my experience, these stories have come from people who have an active agenda against the rights of trans people and a truly insignificant number of people who've detransitioned and believe that their singular experience is part of a greater conspiracy to "turn the kids gay/trans". I think in this case it's also important to critically



consider what goes in to truly "brainwashing" someone. I'm sure you'd agree - that it's unlikely an entire network of mental and health care professionals over the span of this youth's adolescence have created a system sophisticated enough to collaborate in brainwashing a child in to transitioning. The barriers for a youth transitioning are so hard to navigate as it is, especially in a republican state like Utah where you practice.

I'm surprised to hear that this person has had difficulty finding support for detransitioners, as there's a growing number of "non-partisan" advocacy groups worldwide specifically offering support for detransitioners. They are so meticulous about how they present themselves and the language they choose, that it would be hard to identify them as "full of hate" (see the Society for Evidence-based Gender Medicine, the Gender Exploratory Therapy Association, and the International Association of Therapists for Desisters and Detransitioners). In fact, they would be ecstatic to offer a "brainwashed detransitioner" support and in turn appropriate their story for their own gain. I feel uncomfortable mentioning these organizations since I don't endorse any of them, but maybe this is the avenue this family is looking for. The latter two associations I listed have membership databases of therapists who support detransitioners. But further to this, any adequate mental health professional, queer or not, should be able to support someone detransitioning if they simply practice from a person-centered perspective.

So I guess instead of advice, I'm more so challenging the idea that those who believe they've been brainwashed into transitioning are actually lacking support, because there's a highly publicized movement of anti-trans orgs (and right wing politicians) who would gladly support this person. I fear that, based on their admiration of Matt Walsh, they might simply be making claims that support their narrative. Mental health professionals are legally bound to ethical codes that require them to provide non-coercive support services (however, I know there are many different interpretations especially in places that don't explicitly ban conversion therapy etc). But regardless, there is no lack of professionals who'd be willing to support this person as best they can.

Comment

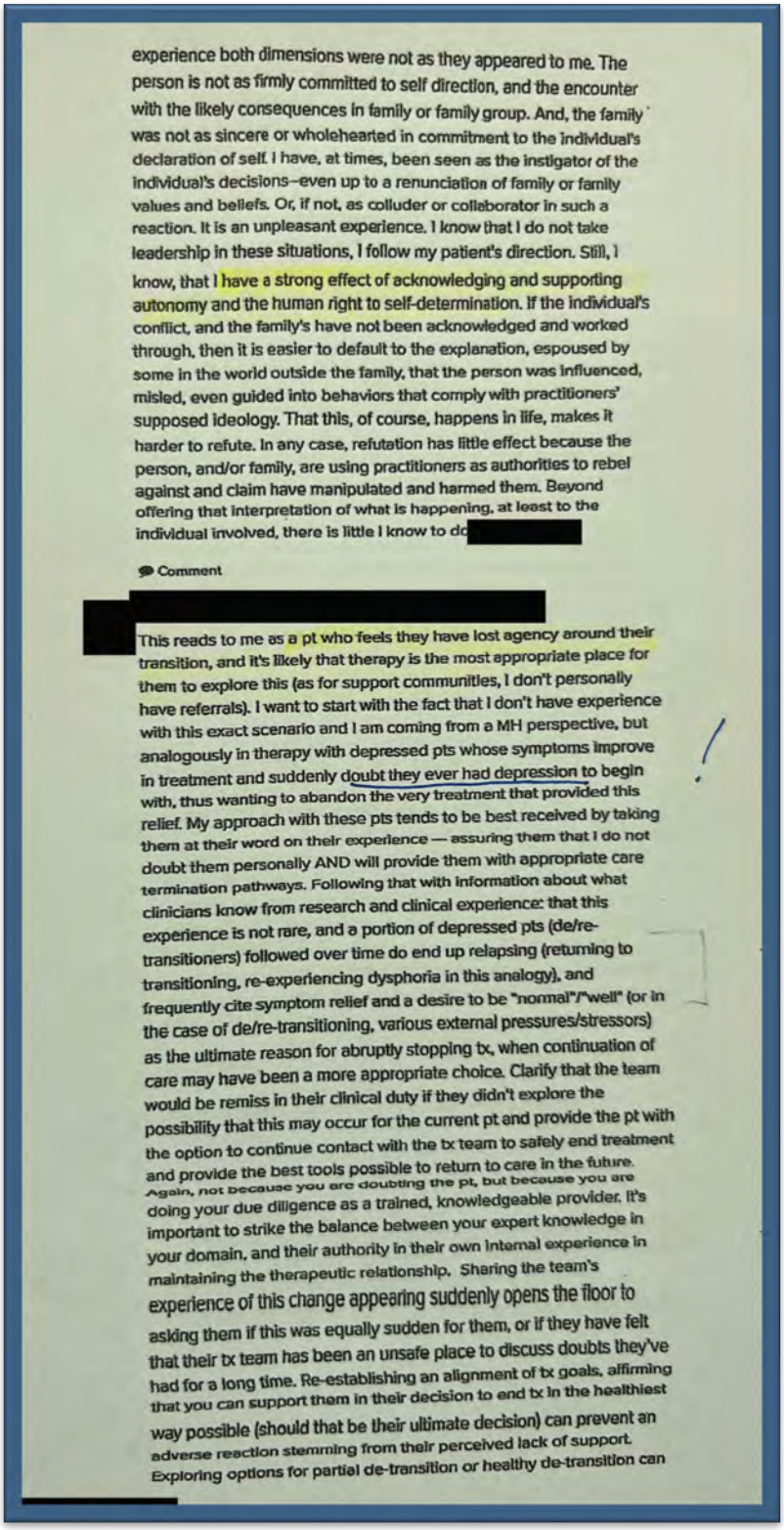
[redacted]

Hello - I am [redacted] and also personally connected with many detransitioners and detransition communities online. You could send along my team's social media accounts where we are sharing personal narratives of detransition from our study [redacted]. You could also email me and I will share a link to a positive/trans-inclusive detrans/retrans discord server which offers support to individuals of all ages (most members are in the late teens to 20s). Unfortunately there are very few formal support resources for this population. [redacted]

Comment

[redacted]

I do not have direct experience with a rejection of this particular process, but do have experience with such events in psychotherapy. I have followed people's lead into a rejection of family, or family's belief system, or even indoctrination, and it seems the person is clearly, and firmly, convicted of the rightness of their course. Then a reversal occurs. Sometimes the family has seemed supportive of the individual's fight for self-representation and self-determination. In my



experience both dimensions were not as they appeared to me. The person is not as firmly committed to self direction, and the encounter with the likely consequences in family or family group. And, the family was not as sincere or wholehearted in commitment to the individual's declaration of self. I have, at times, been seen as the instigator of the individual's decisions–even up to a renunciation of family or family values and beliefs. Or, if not, as colluder or collaborator in such a reaction. It is an unpleasant experience. I know that I do not take leadership in these situations, I follow my patient's direction. Still, I know, that I have a strong effect of acknowledging and supporting autonomy and the human right to self-determination. If the individual's conflict, and the family's have not been acknowledged and worked through, then it is easier to default to the explanation, espoused by some in the world outside the family, that the person was influenced, misled, even guided into behaviors that comply with practitioners' supposed ideology. That this, of course, happens in life, makes it harder to refute. In any case, refutation has little effect because the person, and/or family, are using practitioners as authorities to rebel against and claim have manipulated and harmed them. Beyond offering that interpretation of what is happening, at least to the individual involved, there is little I know to do [redacted]

Comment

[redacted]

This reads to me as a pt who feels they have lost agency around their transition, and it's likely that therapy is the most appropriate place for them to explore this (as for support communities, I don't personally have referrals). I want to start with the fact that I don't have experience with this exact scenario and I am coming from a MH perspective, but analogously in therapy with depressed pts whose symptoms improve in treatment and suddenly doubt they ever had depression to begin with, thus wanting to abandon the very treatment that provided this relief. My approach with these pts tends to be best received by taking them at their word on their experience — assuring them that I do not doubt them personally AND will provide them with appropriate care termination pathways. Following that with information about what clinicians know from research and clinical experience: that this experience is not rare, and a portion of depressed pts (de/re-transitioners) followed over time do end up relapsing (returning to transitioning, re-experiencing dysphoria in this analogy), and frequently cite symptom relief and a desire to be "normal"/"well" (or in the case of de/re-transitioning, various external pressures/stressors) as the ultimate reason for abruptly stopping tx, when continuation of care may have been a more appropriate choice. Clarify that the team would be remiss in their clinical duty if they didn't explore the possibility that this may occur for the current pt and provide the pt with the option to continue contact with the tx team to safely end treatment and provide the best tools possible to return to care in the future. Again, not because you are doubting the pt, but because you are doing your due diligence as a trained, knowledgeable provider. It's important to strike the balance between your expert knowledge in your domain, and their authority in their own internal experience in maintaining the therapeutic relationship. Sharing the team's experience of this change appearing suddenly opens the floor to asking them if this was equally sudden for them, or if they have felt that their tx team has been an unsafe place to discuss doubts they've had for a long time. Re-establishing an alignment of tx goals, affirming that you can support them in their decision to end tx in the healthiest way possible (should that be their ultimate decision) can prevent an adverse reaction stemming from their perceived lack of support. Exploring options for partial de-transition or healthy de-transition can

give them the space they are desperately seeking to explore what this experience means to them and helps establish their care team as the space where they can openly discuss it. It might also open them up to the reality check that political pundits are not neutral support, even if their work resonates and affirm that they are allowed to explore what about the work of those pundits does resonate, openly with their treatment team. Additionally contrasting that the treatment team is not ideologically or politically motivated, but oath-bound to provide care in the best interest of their pt based on the best research available.

Explicitly state that the tx team's goal isn't to advocate for transitioning or de/re-transitioning, but to help the pt figure out the best path for themself and support them in that, and if the pt feels they haven't been heard in some way that the team wants to give them space to tell them how and why. If the pt had experiences with the team where they felt their concerns about transition or thoughts of de/re-transition were not taken seriously in the past, it is important to affirm that the team will put in effort to rectify that. If the trust is completely gone, maybe the team can offer a referral to an alternate therapist or clinic? Hopefully this will give the pt room to explore their concerns, and help the team determine the appropriate course of tx. Should this discussion result in de/re-transition and termination of tx, it would be important for the team to provide resources for the possibility of returning to transition, again because it is developmentally and clinically indicated, not because you expect this specific person to do something they have clearly expressed a desire that they do not want to do. It is important that this is addressed as an entire team, especially with the MH provider[s]. I hope this is a helpful conceptualization. I'm unsure if others might be able to provide more evidence-based approaches or referrals in contrast to my more clinical reflection.

Comment

[redacted]

I have done some research around individuals wishing to detransition. I know many have found a subreddit, r/detrans to be a supportive community for them to find others with a shared experience. Unfortunately there aren't many established support groups for detransitioners, but some are finding success plugging into other local mental health support groups or other online forums like the one mentioned. I may be able to get you information about at least one specific online support group versus online forum if interested. I hope this helps.

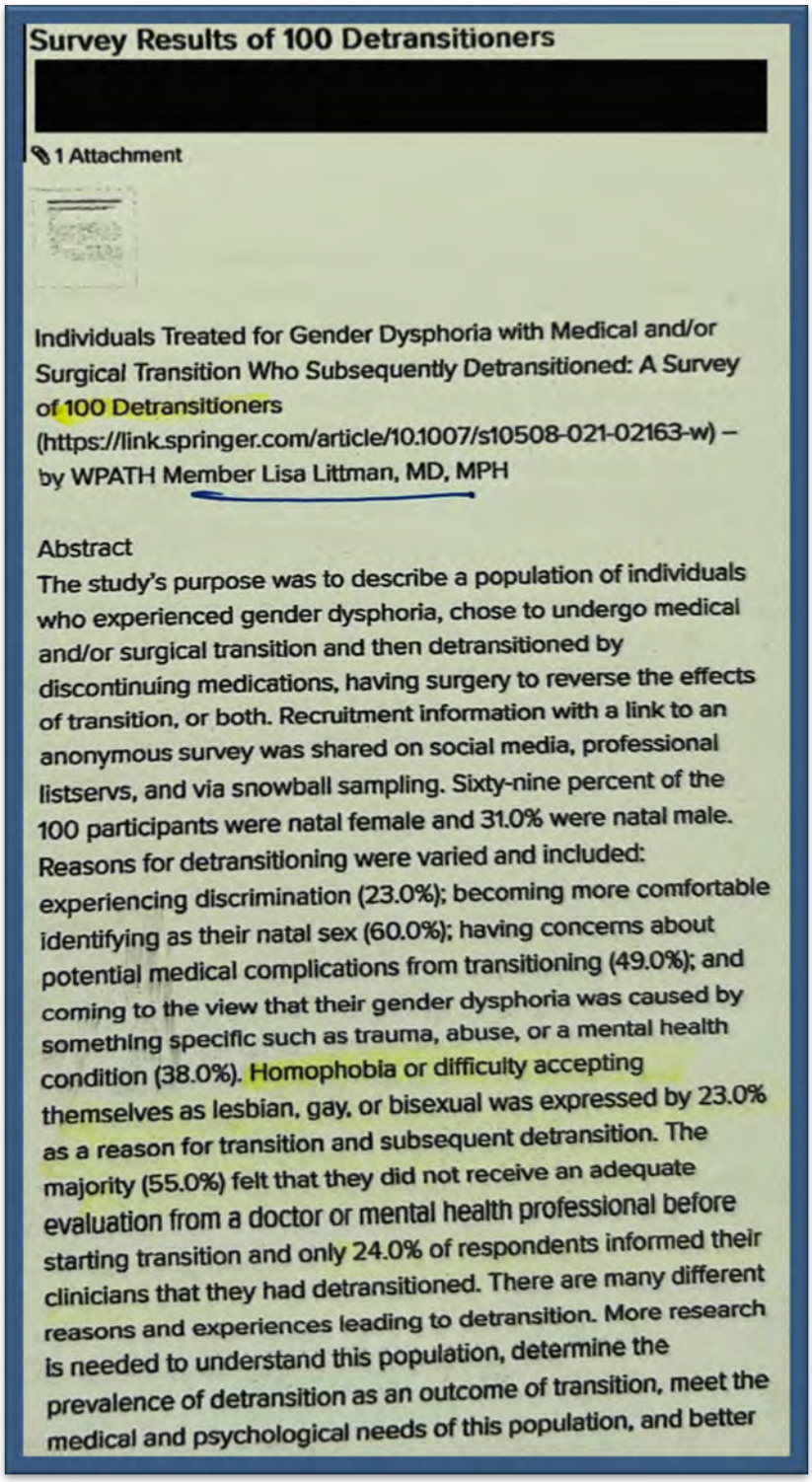
Comment

[redacted]

1 Attachment

Thank you for the responses. This was just published and might be helpful/informative to others interested in this topic: PMID: 35877120 (https://www.ncbi.nlm.nih.gov/pubmed/35877120), Full Text (https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2794543).

b) A WPATH member discusses another WPATH member's new study on detransitioners



Survey Results of 100 Detransitioners

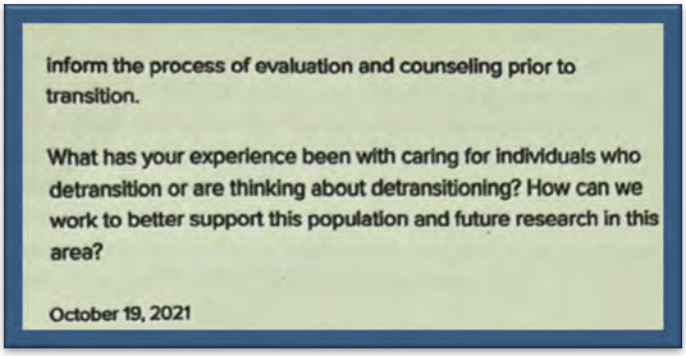
[redacted]

1 Attachment

Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners (https://link.springer.com/article/10.1007/s10508-021-02163-w) – by WPATH Member Lisa Littman, MD, MPH

Abstract

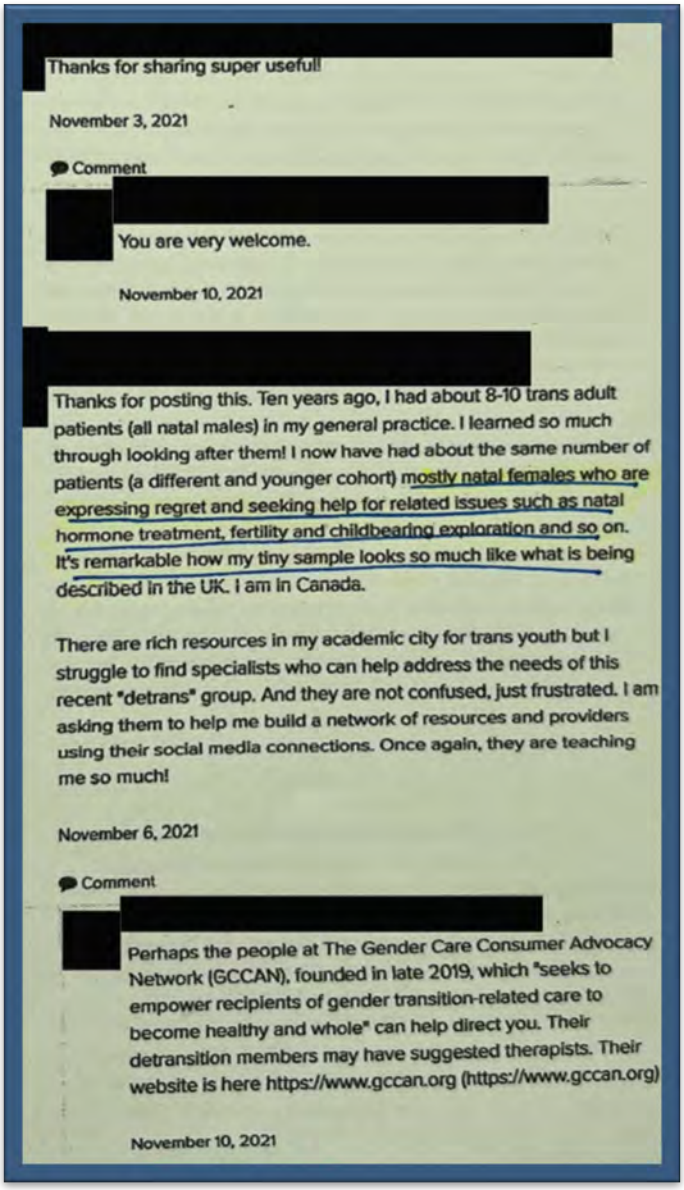
The study's purpose was to describe a population of individuals who experienced gender dysphoria, chose to undergo medical and/or surgical transition and then detransitioned by discontinuing medications, having surgery to reverse the effects of transition, or both. Recruitment information with a link to an anonymous survey was shared on social media, professional listservs, and via snowball sampling. Sixty-nine percent of the 100 participants were natal female and 31.0% were natal male. Reasons for detransitioning were varied and included: experiencing discrimination (23.0%); becoming more comfortable identifying as their natal sex (60.0%); having concerns about potential medical complications from transitioning (49.0%); and coming to the view that their gender dysphoria was caused by something specific such as trauma, abuse, or a mental health condition (38.0%). Homophobia or difficulty accepting themselves as lesbian, gay, or bisexual was expressed by 23.0% as a reason for transition and subsequent detransition. The majority (55.0%) felt that they did not receive an adequate evaluation from a doctor or mental health professional before starting transition and only 24.0% of respondents informed their clinicians that they had detransitioned. There are many different reasons and experiences leading to detransition. More research is needed to understand this population, determine the prevalence of detransition as an outcome of transition, meet the medical and psychological needs of this population, and better



inform the process of evaluation and counseling prior to transition.

What has your experience been with caring for individuals who detransition or are thinking about detransitioning? How can we work to better support this population and future research in this area?

October 19, 2021



[redacted] Thanks for sharing super useful!

November 3, 2021

Comment

[redacted] You are very welcome.

November 10, 2021

[redacted] Thanks for posting this. Ten years ago, I had about 8-10 trans adult patients (all natal males) in my general practice. I learned so much through looking after them! I now have had about the same number of patients (a different and younger cohort) mostly natal females who are expressing regret and seeking help for related issues such as natal hormone treatment, fertility and childbearing exploration and so on. It's remarkable how my tiny sample looks so much like what is being described in the UK. I am in Canada.

There are rich resources in my academic city for trans youth but I struggle to find specialists who can help address the needs of this recent "detrans" group. And they are not confused, just frustrated. I am asking them to help me build a network of resources and providers using their social media connections. Once again, they are teaching me so much!

November 6, 2021

Comment

[redacted] Perhaps the people at The Gender Care Consumer Advocacy Network (GCCAN), founded in late 2019, which "seeks to empower recipients of gender transition-related care to become healthy and whole" can help direct you. Their detransition members may have suggested therapists. Their website is here https://www.gccan.org (https://www.gccan.org)

November 10, 2021

My thought is that the framing around "detransition" is really important. Given the history of pathologizing and medicalizing transgender identity, this idea of detransition often makes it feel like a mistake has been made in some capacity. This is often used to justify further increasing barriers to accessing care, or unintentionally furthering the belief that as providers, we should gatekeep access to medical transition. I'm not saying this is what you're saying of course, it's just what I hear about often in the media and by providers who don't have significant experience working with transgender patients.

And when I think about the ways we are trying to move toward destigmatization and informed-consent models of trans health care, I think it's important to emphasize the way it is okay for gender and interest in medical options to change over time for each individual. I think about the many "irreversible" procedures that we allow adults to easily access in our society (cis-gender people getting plastic surgery, tattoos, etc.). And for example, the rates of surgical regret for cis-gender people getting plastic surgery (like breast augmentation) is not used as a reason why we should create more barriers for cis-gender people having (informed) access to surgery. The most recent study I saw examining post-surgical regret for cis-gender women getting breast augmentation was 47.2% expressed mild, moderate, or strong surgical regret.

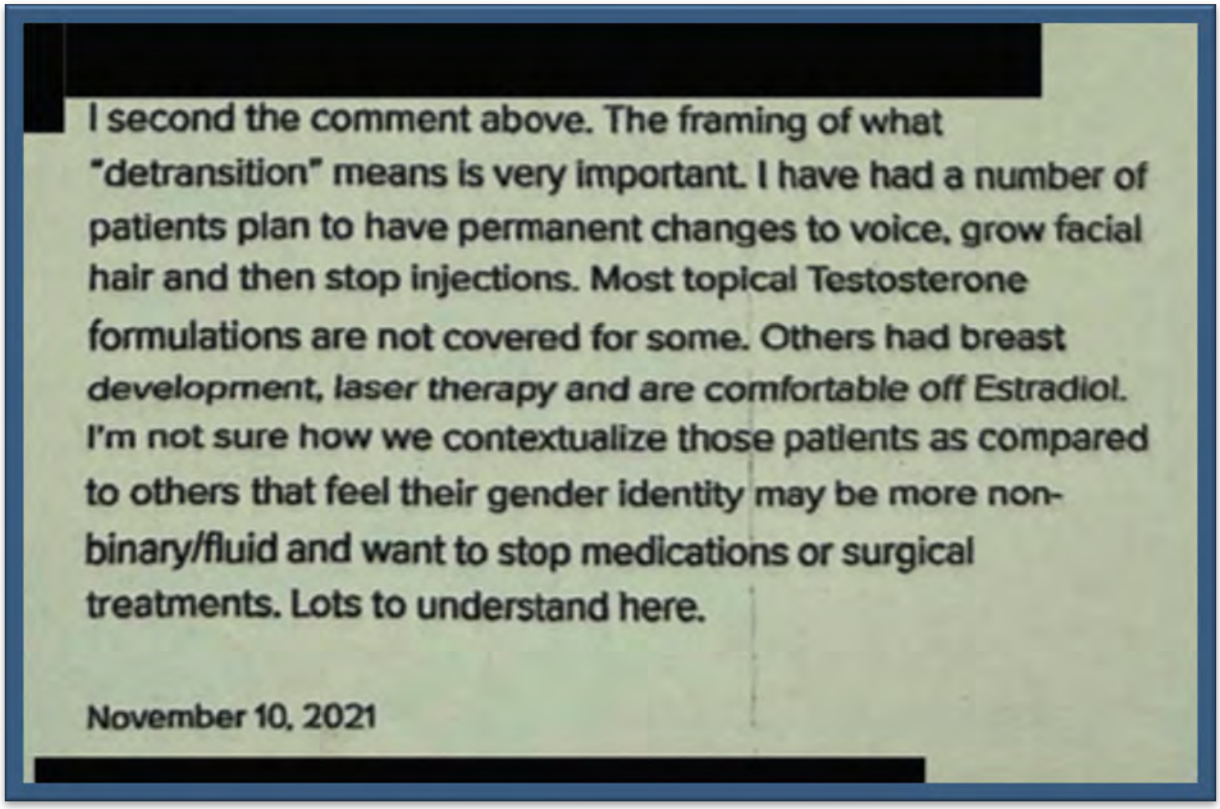
And then interpersonally, the people I know who have "detransitioned" by medical standards have stopped taking hormones because they had medical complications (DVT/PE, hypertension, etc.), or hate needles, or originally took hormones to get some of the irreversible changes (eg. voice change) but never intended to stay on them long term. All of those people would be considered "detransitioners" but didn't feel like they made a mistake.

To get back to your original question on how to support patients thinking about this, I think the best we can do is support each individual and be careful with how we let this be framed by the general public. Learning new things about your gender or what you want from your medical care should be something to be celebrated, and we don't have to see it as a mistake that was made. Of course, if an individual patient feels that they made a mistake, we can support them through that as well, but hopefully we can be careful with not letting that change the way others receive care. Those are just my general thoughts!

November 6, 2021

Comment

[redacted] I second the comment above. The framing of what "detransition" means is very important. I have had a number of patients plan to have permanent changes to voice, grow facial hair and then stop injections. Most topical Testosterone formulations are not covered for some. Others had breast development, laser therapy and are comfortable off Estradiol. I'm not sure how we contextualize those patients as compared to others that feel their gender identity may be more non-binary/fluid and want to stop medications or surgical treatments. Lots to understand here.



[redacted]

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November 10, 2021

[redacted]

[redacted] Thanks for commenting [redacted] I believe this is probably a growing issue that will need to be dealt with by making room for a variety of voices on the subject, including those who have detransitioned. Listening to their "lived experiences" may provide us with a deeper understanding of the topic. I have appreciated watching the various videos made by the Pique Resilience Project (https://www.youtube.com/channel/UCmGEMjyAwk6R1lTmG_JjLUA)

November 10, 2021

[redacted] Definitely agree with you [redacted] What is problematic is the idea of detransitioning, as it frames being cisgender as the default, and reinforces transness as a pathology. It makes more sense to frame gender as something that can shift over time, and to figure out ways to support people making the choices they want to make in the moment, with the understanding that feelings around decisions make change over time.

November 10, 2021

[redacted] I really love this...
"Learning new things about your gender or what you want from your medical care should be something to be celebrated, and we don't have to see it as a mistake that was made. Of course, if an individual patient feels that they made a mistake, we can support them through that as well, but hopefully we can be careful with not letting that change the way others receive care."

November 17, 2021

[redacted] Absolutely agree with [redacted] here. We can't say that gender is fluid then view "detransitioning" as a mistake. Instead it's a further-stigmatized part of some individuals' gender journey.

November 19, 2021

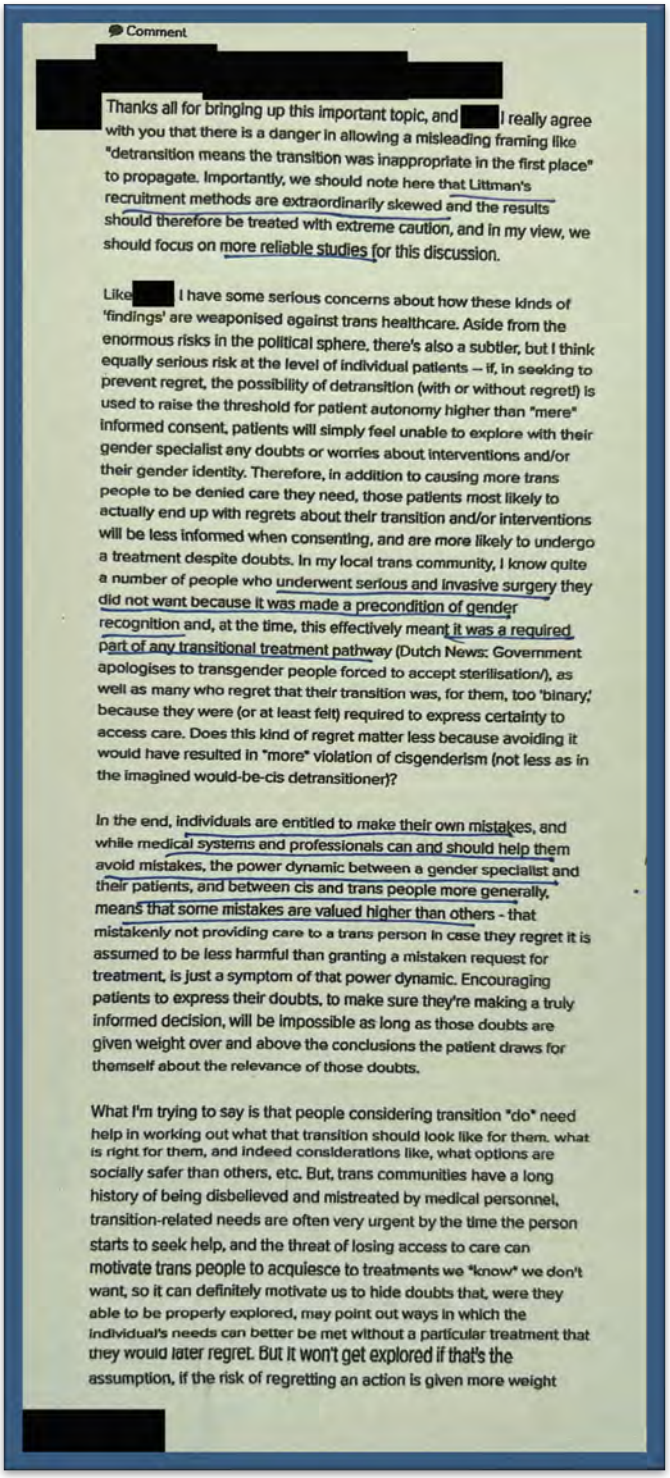
[redacted] Thank you for sharing this.

I see the "detransitioning" phenomenon often among the elderly transwomen here in Indonesia.
Some of them chose to detransition due to the difficulty of being rejected by their family, or environment.
As they got older, it became harder for them to get money from being a sex worker, so they chose to detransition to fit into society.

I agree with the comment made by [redacted]

Informative post [redacted]

November 10, 2021



Comment

[redacted]

Thanks all for bringing up this important topic, and [redacted] I really agree with you that there is a danger in allowing a misleading framing like "detransition means the transition was inappropriate in the first place" to propagate. Importantly, we should note here that Littman's recruitment methods are extraordinarily skewed and the results should therefore be treated with extreme caution, and in my view, we should focus on more reliable studies for this discussion.

Like [redacted] I have some serious concerns about how these kinds of 'findings' are weaponised against trans healthcare. Aside from the enormous risks in the political sphere, there's also a subtler, but I think equally serious risk at the level of individual patients – if, in seeking to prevent regret, the possibility of detransition (with or without regret) is used to raise the threshold for patient autonomy higher than "mere" informed consent, patients will simply feel unable to explore with their gender specialist any doubts or worries about interventions and/or their gender identity. Therefore, in addition to causing more trans people to be denied care they need, those patients most likely to actually end up with regrets about their transition and/or interventions will be less informed when consenting, and are more likely to undergo a treatment despite doubts. In my local trans community, I know quite a number of people who underwent serious and invasive surgery they did not want because it was made a precondition of gender recognition and, at the time, this effectively meant it was a required part of any transitional treatment pathway (Dutch News: Government apologises to transgender people forced to accept sterilisation), as well as many who regret that their transition was, for them, too 'binary,' because they were (or at least felt) required to express certainty to access care. Does this kind of regret matter less because avoiding it would have resulted in "more" violation of cisgenderism (not less as in the imagined would-be-cis detransitioner)?

In the end, individuals are entitled to make their own mistakes, and while medical systems and professionals can and should help them avoid mistakes, the power dynamic between a gender specialist and their patients, and between cis and trans people more generally, means that some mistakes are valued higher than others - that mistakenly not providing care to a trans person in case they regret it is assumed to be less harmful than granting a mistaken request for treatment, is just a symptom of that power dynamic. Encouraging patients to express their doubts, to make sure they're making a truly informed decision, will be impossible as long as those doubts are given weight over and above the conclusions the patient draws for themself about the relevance of those doubts.

What I'm trying to say is that people considering transition "do" need help in working out what that transition should look like for them, what is right for them, and indeed considerations like, what options are socially safer than others, etc. But, trans communities have a long history of being disbelieved and mistreated by medical personnel, transition-related needs are often very urgent by the time the person starts to seek help, and the threat of losing access to care can motivate trans people to acquiesce to treatments we "know" we don't want, so it can definitely motivate us to hide doubts that, were they able to be properly explored, may point out ways in which the individual's needs can better be met without a particular treatment that they would later regret. But it won't get explored if that's the assumption, if the risk of regretting an action is given more weight

[redacted]

than the risk of regretting inaction.

So the first thing we can do to support detransitioners, retransitioners and everyone, is to make discussing doubts and complexity a normal part of the gender consult and not something that will prevent the patient from making their own informed choice. Another thing we need to do is to investigate what detransitioners want, because at present the focus of much research seems to be to use their existence to invalidate that of (other) trans people. Do they want interventions to reverse something? Are they just re-rejecting the gender binary after being shoved from one end of it to the other? If so, do they need [redacted] medical/social/legal/psychological support to do so? How can we reduce the discrimination against transitioning/ed people that often precipitates a (temporary?) detransition? Most of all, how can we support detransitioners to benefit from the experience, to help them celebrate and implement the self-knowledge they've gained, and not to see themselves as "traitors" (to trans people or to their AGAB), "failures" or "mistakes"?'

Your original response:
'Thanks all for bringing up this important topic, and [redacted] I really agree with you that there is a danger in allowing a misleading framing like "detransition means the transition was inappropriate in the first place" to propagate. Importantly, we should note here that Littman's recruitment methods are extraordinarily skewed and the results should therefore be treated with extreme caution. She is not the champion of detransitioners she would like to think, and in my view, discussions centering on her work will not help anyone, and we should focus on more reliable sources.

Like [redacted] I have some serious concerns about how these kinds of 'findings' are weaponised against trans healthcare. Aside from the enormous risks in the political sphere, there's also a subtler, but I think equally serious risk at the level of individual patients – if, in seeking to prevent regret, the possibility of detransition (with or without regret!) is used to raise the threshold for patient autonomy higher than "mere" informed consent, patients will simply feel unable to explore with their gender specialist any doubts or worries about interventions and/or their gender identity. Therefore, in addition to causing more trans people to be denied care they need, those patients most likely to actually end up with regrets about their transition and/or interventions will be less informed when consenting, and are more likely to undergo a treatment despite doubts. In my local trans community, I know quite a number of people who underwent serious and invasive surgery they did not want because it was made a precondition of gender recognition and, at the time, this effectively meant it was a required part of any transitional treatment pathway (Dutch News: Government apologises to transgender people forced to accept sterilisation/), as well as many who regret that their transition was, for them, too 'binary,' because they were (or at least felt) required to express certainty to access care. Does this kind of regret matter less because avoiding it would have resulted in "more" violation of cisgenderism (not less as in the imagined would-be-cis detransitioner)?

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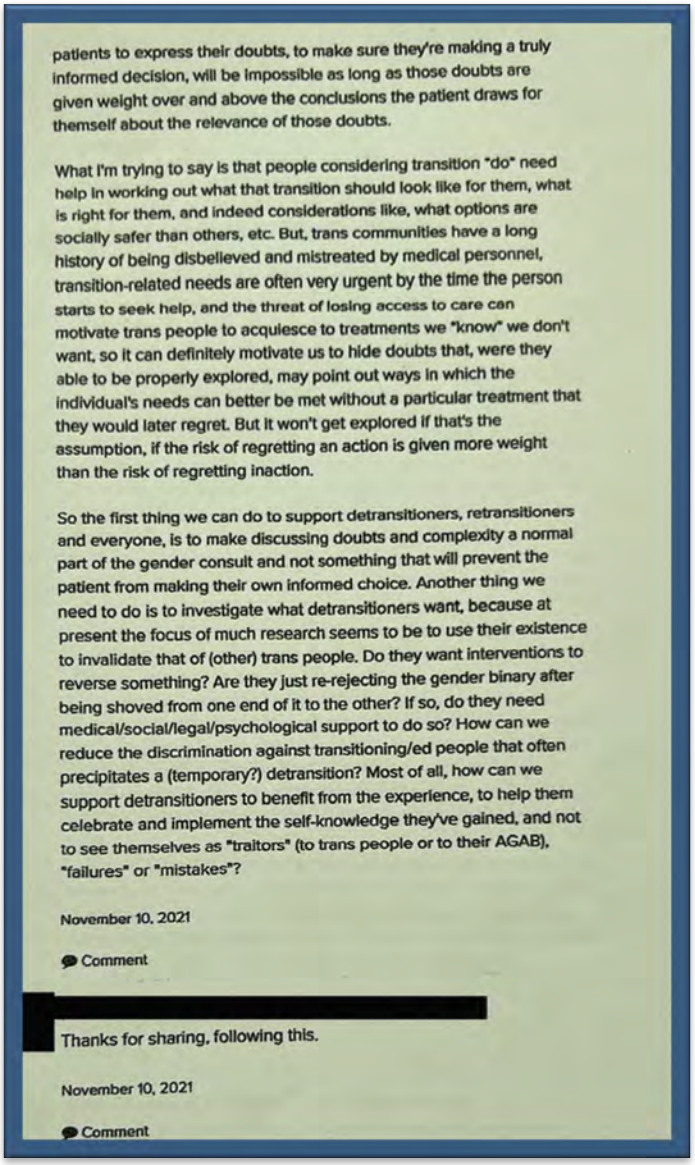

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November 10, 2021

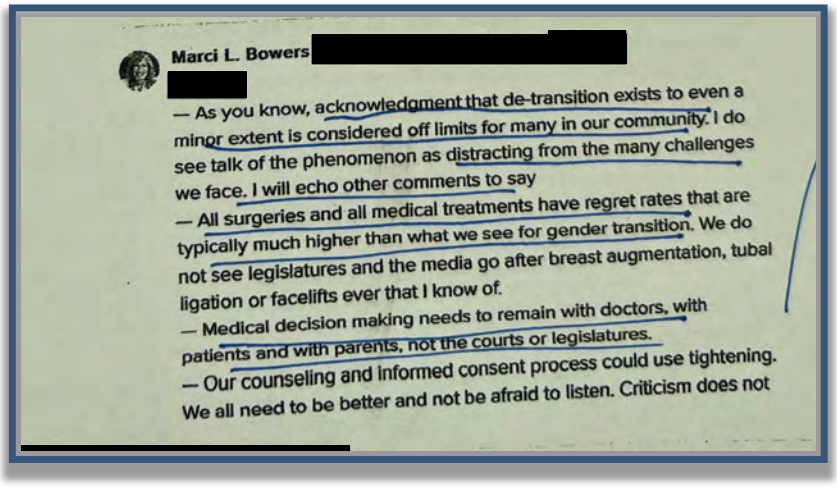
Comment

[redacted]

Thanks for sharing, following this.

November 10, 2021

Comment



Marci L. Bowers [redacted]

— As you know, acknowledgment that de-transition exists to even a minor extent is considered off limits for many in our community. I do see talk of the phenomenon as distracting from the many challenges we face. I will echo other comments to say

— All surgeries and all medical treatments have regret rates that are typically much higher than what we see for gender transition. We do not see legislatures and the media go after breast augmentation, tubal ligation or facelifts ever that I know of.

— Medical decision making needs to remain with doctors, with patients and with parents, not the courts or legislatures.

— Our counseling and informed consent process could use tightening. We all need to be better and not be afraid to listen. Criticism does not

mean blame, it means we need to do better for our patients. — Patients need to own and take active responsibility for medical decisions, especially those that have potentially permanent effects.

November 10, 2021

[redacted]

Three points to address here:

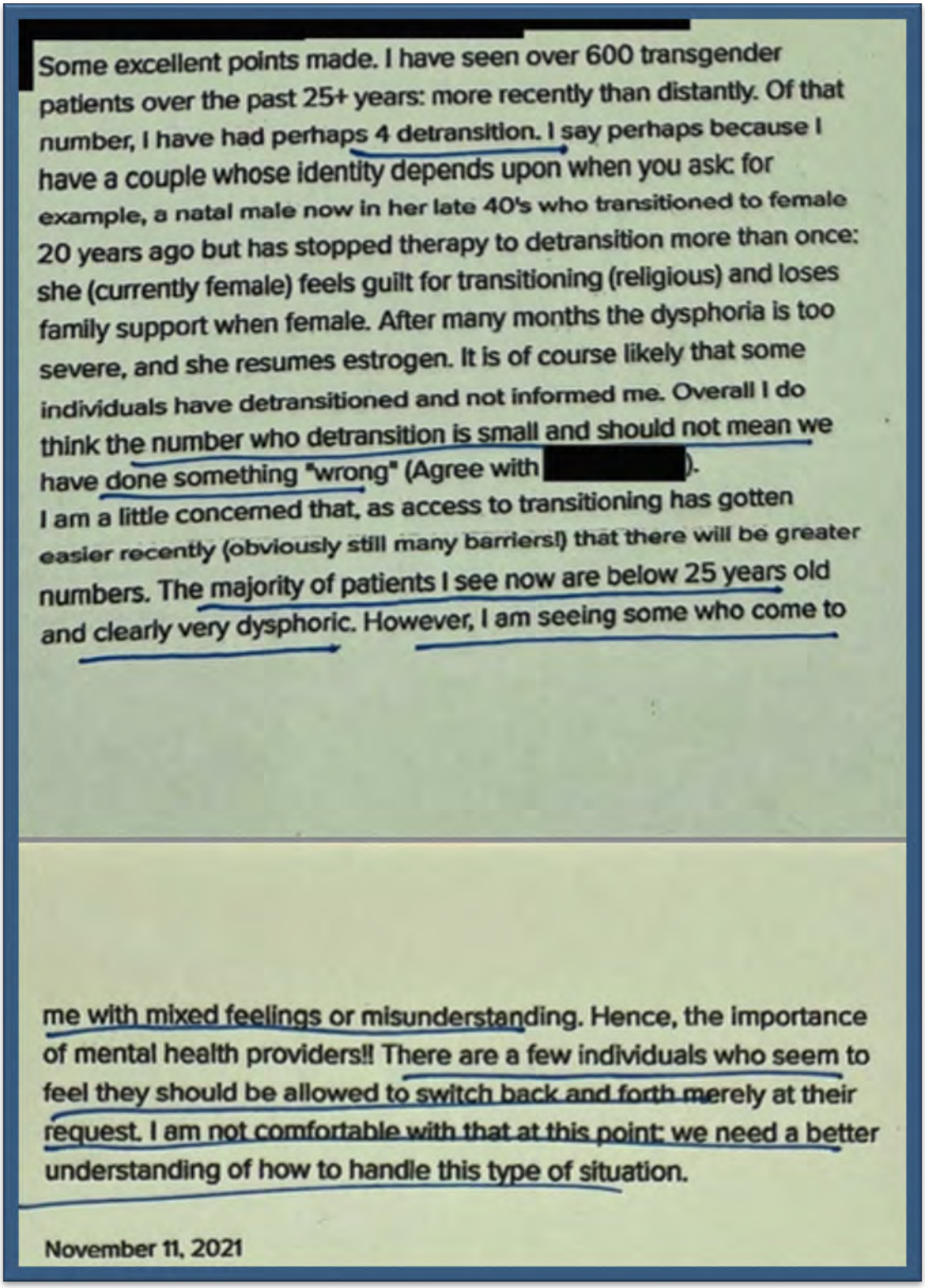
1. "Framing" of detransitioning by society is unrelated to the experience of people who made decisions in their earlier years (under 25 usually). These are young adults who made decisions to change their bodies in irreversible ways, at a time in their lives then their physical and sexual identities were in developmental flux. Many, if not most, had co-morbidities that were not fully addressed before transition was offered to them. They were rushed; they all report that feeling. And their feelings are what this discussion should be about; it has nothing to do with public "framing." "Detransition" can be called something else: regret, a change of heart, whatever. But the way it is interpreted by our community of care providers should not be weaponized to discount these real experiences by claiming they are being used as "gatekeeping" devices. The detransitioned adults I look after, if anything, are very much immersed in their own suffering, loss and grief.
2. It was stated that aesthetic plastic surgery (rhinoplasty, breast augmentation, etc.) and tattoos as "easily accessible" in society. In fact, they are only easily accessible to the privileged few who can afford them - adults or older youth with access to some degree of "luxury" funds. The hormonal and surgical interventions now so easily available to young, impulsive, mentally and cognitively unstable youth are being funded (in some countries, publicly) and advocated by registered health professionals, "framed" as "life-saving" when, to my knowledge, this claim is based on very loosely drawn conclusions from very weak data.
3. If, in fact, rates of regret for breast augmentation are as high as 47%, when chosen by compos mentis adults, that worries me deeply. I fear that rates of regret of gender transition, especially as it relates to future sexual health and fertility in adults who make these irreversible decisions at such a young age may, in fact, be even higher

November 11, 2021

Comment

[redacted]

Some excellent points made. I have seen over 600 transgender patients over the past 25+ years: more recently than distantly. Of that number, I have had perhaps 4 detransition. I say perhaps because I have a couple whose identity depends upon when you ask: for example, a natal male now in her late 40's who transitioned to female 20 years ago but has stopped therapy to detransition more than once: she (currently female) feels guilt for transitioning (religious) and loses family support when female. After many months the dysphoria is too severe, and she resumes estrogen. It is of course likely that some individuals have detransitioned and not informed me. Overall I do think the number who detransition is small and should not mean we have done something "wrong" (Agree with [redacted]).
I am a little concerned that, as access to transitioning has gotten easier recently (obviously still many barriers!) that there will be greater numbers. The majority of patients I see now are below 25 years old and clearly very dysphoric. However, I am seeing some who come to



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I am a little concerned that, as access to transitioning has gotten easier recently (obviously still many barriers!) that there will be greater numbers. The majority of patients I see now are below 25 years old and clearly very dysphoric. However, I am seeing some who come to me with mixed feelings or misunderstanding. Hence, the importance of mental health providers!! There are a few individuals who seem to feel they should be allowed to switch back and forth merely at their request. I am not comfortable with that at this point: we need a better understanding of how to handle this type of situation.

November 11, 2021

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November 11, 2021

Comment

[redacted]

I recommend this 2021 study with 2242 participants recruited from community organizations serving people who identify as Trans, gender expansive, questioning, and detransitioned. It's a bit broader than the study cited here based on the cherry-picked results of 100 curated interviewees out of 237 recruited from "detransitioner communities," which are at very high risk of being enriched with anti-trans activists. As a side note, these are the same locales where the parents interviewed for the ROGD study were recruited (not a single Trans person was interviewed for the ROGD study on Trans youth).
Turban, Jack L.; Loo, Stephanie S.; Almazan, Anthony N.; Keuroghlian, AlexS. (May 2021). "Factors Leading to "Detransition" Among Transgender and Gender Diverse People in the United States: A Mixed-Methods Analysis" (PMID:33794108, Full Text)

I also think that it is important to note that reliance on these inferior studies may be contributing to the suffering of Trans youth. Here's a recent report from the Trevor Project: Trevor Project: Acceptance of Transgender and Nonbinary Youth from Adults and Peers Associated with Significantly Lower Rates of Attempted Suicide

The Transgender Day of Remembrance is on November 20th, a scant 9 days from now, as people of all sorts come together across the world to remember the murdered dead and hope for a year when the numbers may someday go DOWN.

November 11, 2021

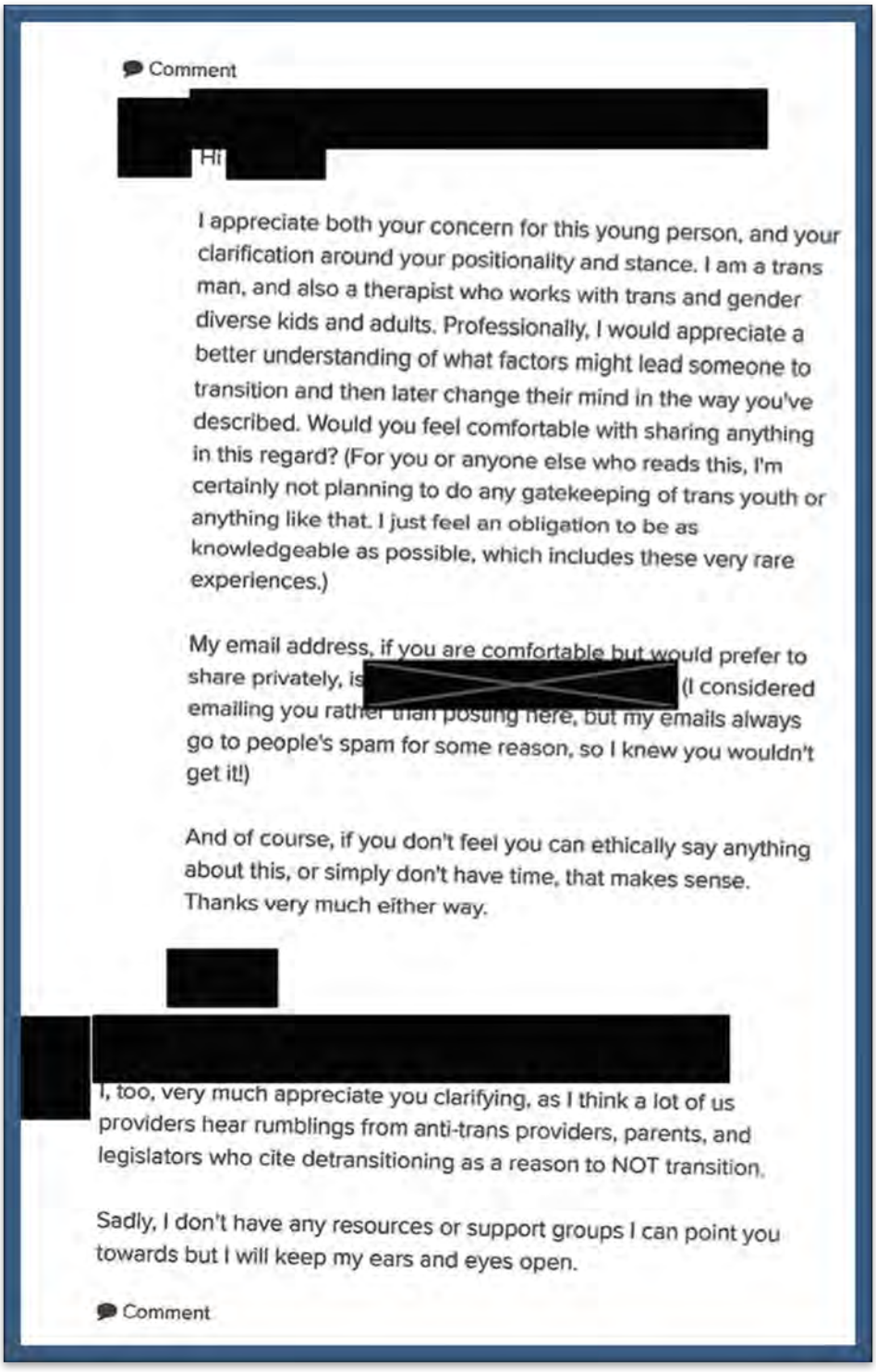
Comment

Marci L. Bowers [redacted]
Well said.

January 14, 2022

Comment

c) WPATH members seek clarification on detransition



Comment

[redacted]

Hi [redacted]

I appreciate both your concern for this young person, and your clarification around your positionality and stance. I am a trans man, and also a therapist who works with trans and gender diverse kids and adults. Professionally, I would appreciate a better understanding of what factors might lead someone to transition and then later change their mind in the way you've described. Would you feel comfortable with sharing anything in this regard? (For you or anyone else who reads this, I'm certainly not planning to do any gatekeeping of trans youth or anything like that. I just feel an obligation to be as knowledgeable as possible, which includes these very rare experiences.)

My email address, if you are comfortable but would prefer to share privately, is [redacted] (I considered emailing you rather than posting here, but my emails always go to people's spam for some reason, so I knew you wouldn't get it!)

And of course, if you don't feel you can ethically say anything about this, or simply don't have time, that makes sense. Thanks very much either way.

[redacted]

[redacted]

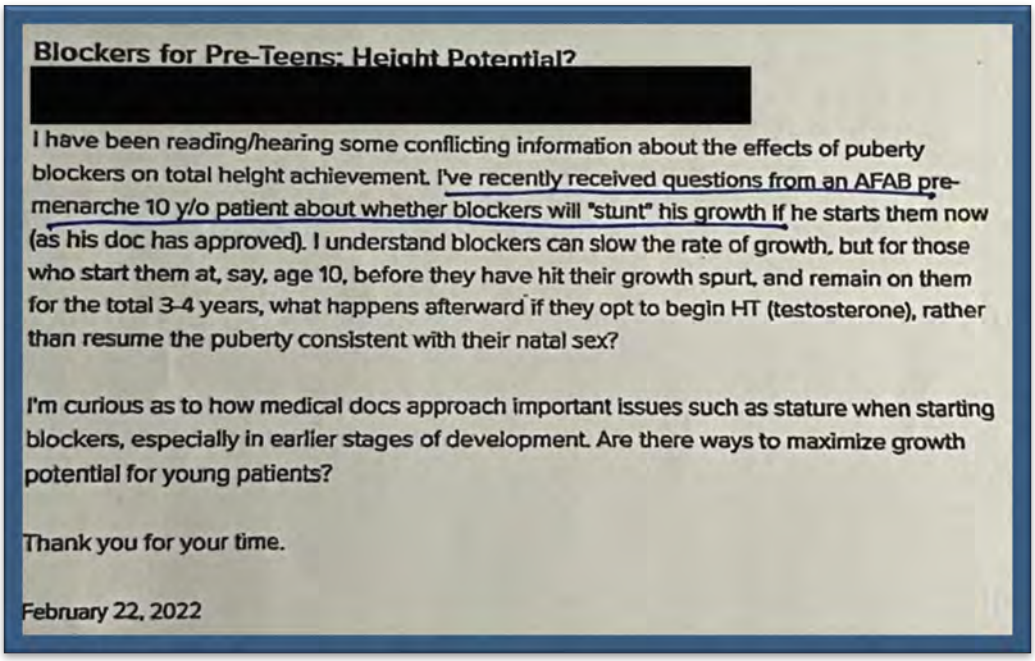
I, too, very much appreciate you clarifying, as I think a lot of us providers hear rumblings from anti-trans providers, parents, and legislators who cite detransitioning as a reason to NOT transition.

Sadly, I don't have any resources or support groups I can point you towards but I will keep my ears and eyes open.

Comment

5) PUBERTY SUPPRESSION TACTICS

a) A WPATH member questions the effects of puberty blockers on total height achievement for a 10-year-old patient



Blockers for Pre-Teens: Height Potential?

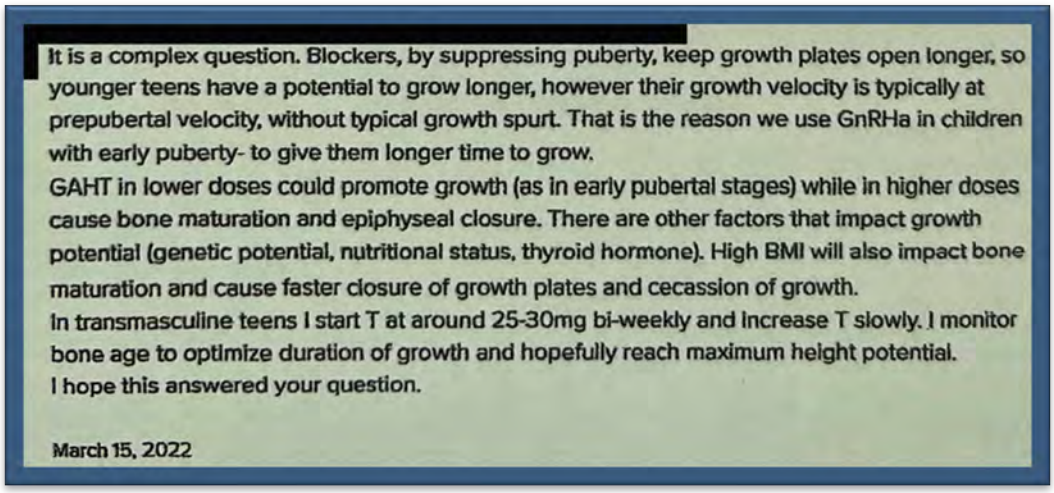
[redacted]

I have been reading/hearing some conflicting information about the effects of puberty blockers on total height achievement. I've recently received questions from an AFAB pre-menarche 10 y/o patient about whether blockers will "stunt" his growth if he starts them now (as his doc has approved). I understand blockers can slow the rate of growth, but for those who start them at, say, age 10, before they have hit their growth spurt, and remain on them for the total 3-4 years, what happens afterward if they opt to begin HT (testosterone), rather than resume the puberty consistent with their natal sex?

I'm curious as to how medical docs approach important issues such as stature when starting blockers, especially in earlier stages of development. Are there ways to maximize growth potential for young patients?

Thank you for your time.

February 22, 2022



[redacted]

It is a complex question. Blockers, by suppressing puberty, keep growth plates open longer, so younger teens have a potential to grow longer, however their growth velocity is typically at prepubertal velocity, without typical growth spurt. That is the reason we use GnRHa in children with early puberty- to give them longer time to grow.

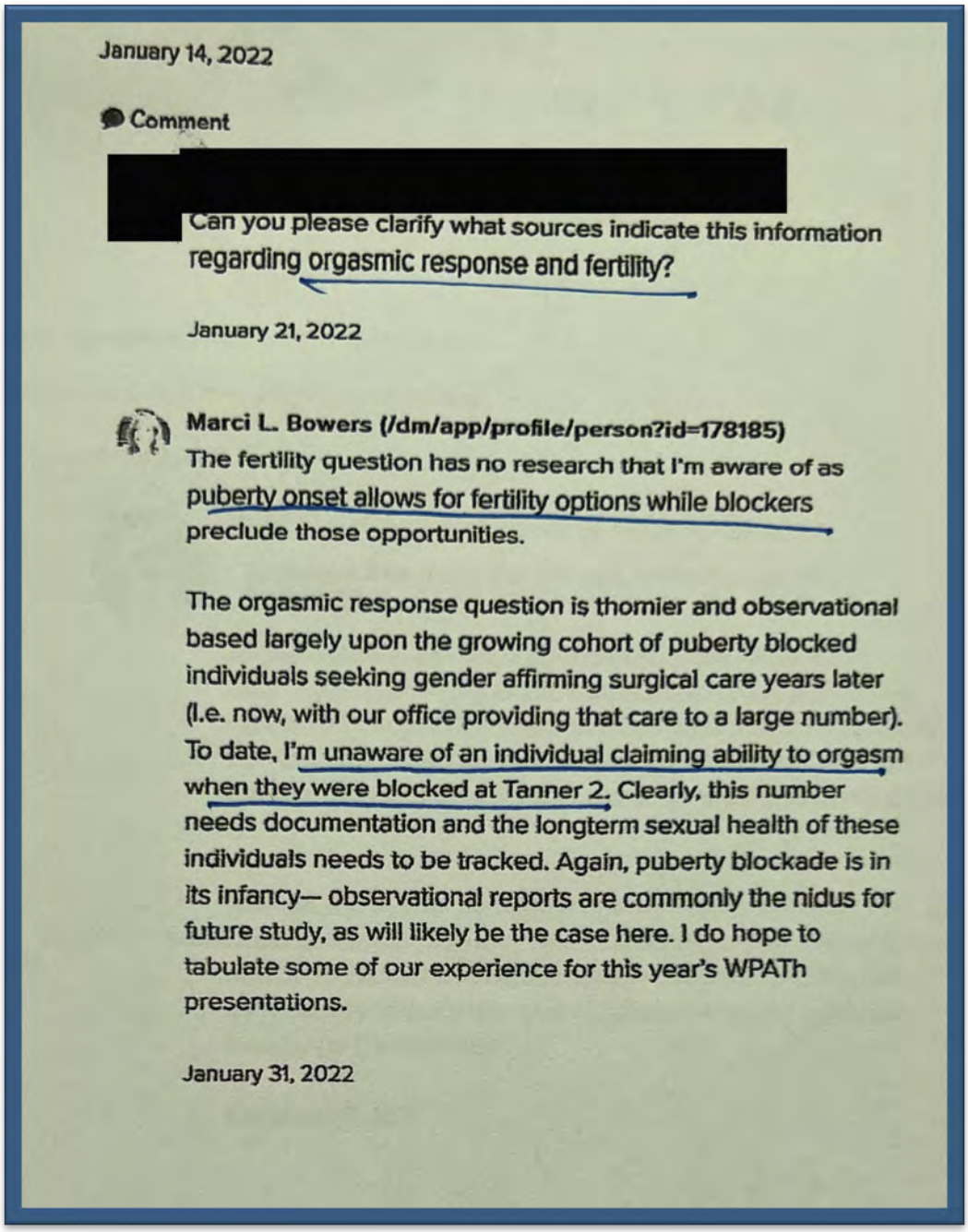
GAHT in lower doses could promote growth (as in early pubertal stages) while in higher doses cause bone maturation and epiphyseal closure. There are other factors that impact growth potential (genetic potential, nutritional status, thyroid hormone). High BMI will also impact bone maturation and cause faster closure of growth plates and cecassion of growth.

In transmasculine teens I start T at around 25-30mg bi-weekly and increase T slowly. I monitor bone age to optimize duration of growth and hopefully reach maximum height potential.

I hope this answered your question.

March 15, 2022

b) WPATH members discuss how puberty blockers preclude fertility options for trans patients



January 14, 2022

Comment

[redacted] Can you please clarify what sources indicate this information regarding orgasmic response and fertility?

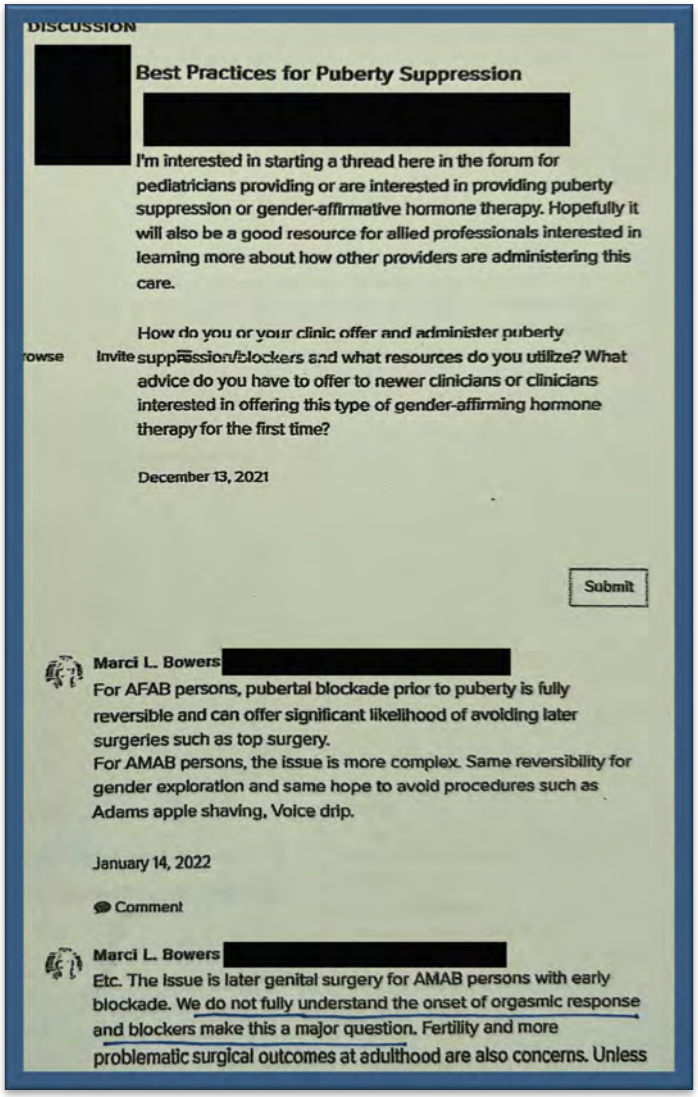
January 21, 2022

Marci L. Bowers (/dm/app/profile/person?id=178185)
The fertility question has no research that I'm aware of as puberty onset allows for fertility options while blockers preclude those opportunities.

The orgasmic response question is thornier and observational based largely upon the growing cohort of puberty blocked individuals seeking gender affirming surgical care years later (I.e. now, with our office providing that care to a large number). To date, I'm unaware of an individual claiming ability to orgasm when they were blocked at Tanner 2. Clearly, this number needs documentation and the longterm sexual health of these individuals needs to be tracked. Again, puberty blockade is in its infancy— observational reports are commonly the nidus for future study, as will likely be the case here. I do hope to tabulate some of our experience for this year's WPATh presentations.

January 31, 2022

c) WPATH members share best practices for puberty suppression and hormone therapy



DISCUSSION

[redacted]

Best Practices for Puberty Suppression

[redacted]

I'm interested in starting a thread here in the forum for pediatricians providing or are interested in providing puberty suppression or gender-affirmative hormone therapy. Hopefully it will also be a good resource for allied professionals interested in learning more about how other providers are administering this care.

How do you or your clinic offer and administer puberty suppression/blockers and what resources do you utilize? What advice do you have to offer to newer clinicians or clinicians interested in offering this type of gender-affirming hormone therapy for the first time?

December 13, 2021

Submit

Marci L. Bowers [redacted]

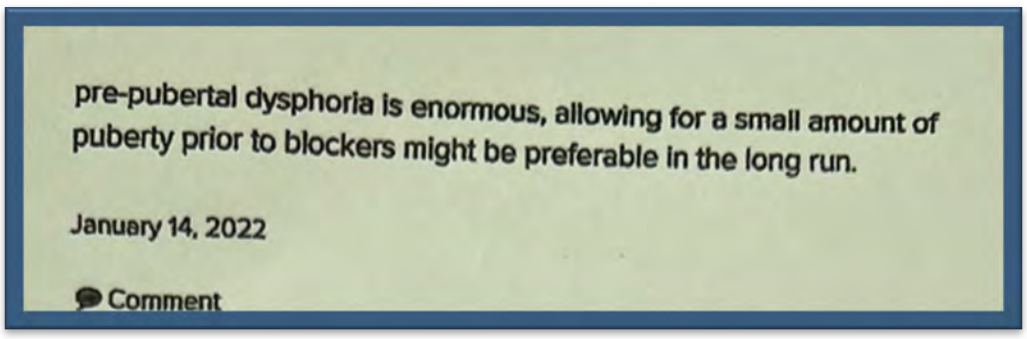
For AFAB persons, pubertal blockade prior to puberty is fully reversible and can offer significant likelihood of avoiding later surgeries such as top surgery.
For AMAB persons, the issue is more complex. Same reversibility for gender exploration and same hope to avoid procedures such as Adams apple shaving, Voice drip.

January 14, 2022

Comment

Marci L. Bowers [redacted]

Etc. The issue is later genital surgery for AMAB persons with early blockade. We do not fully understand the onset of orgasmic response and blockers make this a major question. Fertility and more problematic surgical outcomes at adulthood are also concerns. Unless



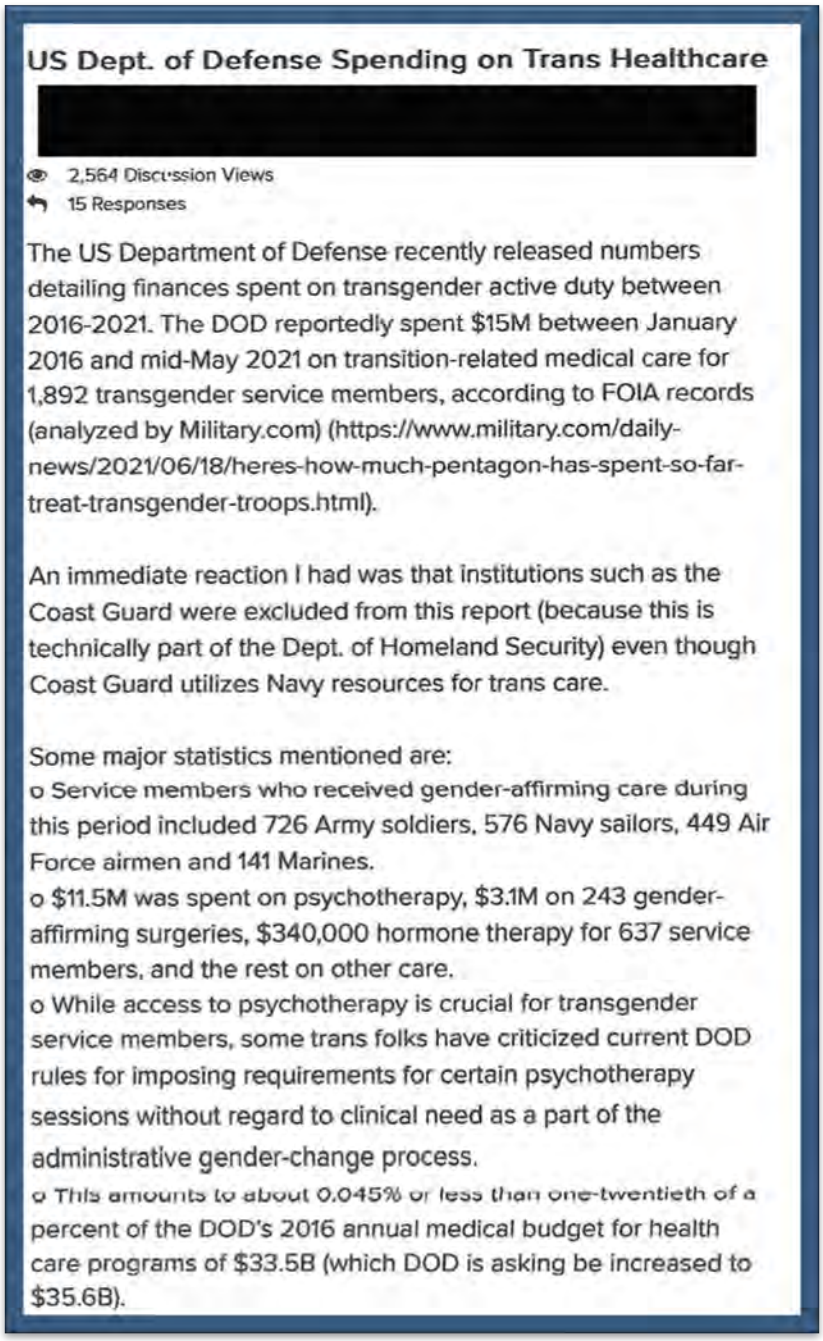
pre-pubertal dysphoria is enormous, allowing for a small amount of puberty prior to blockers might be preferable in the long run.

January 14, 2022

Comment

6) DOD SPENDING ON TRANS HEALTHCARE

a) WPATH members overview the Department of Defense's (DOD) newest report on trans healthcare finances



US Dept. of Defense Spending on Trans Healthcare

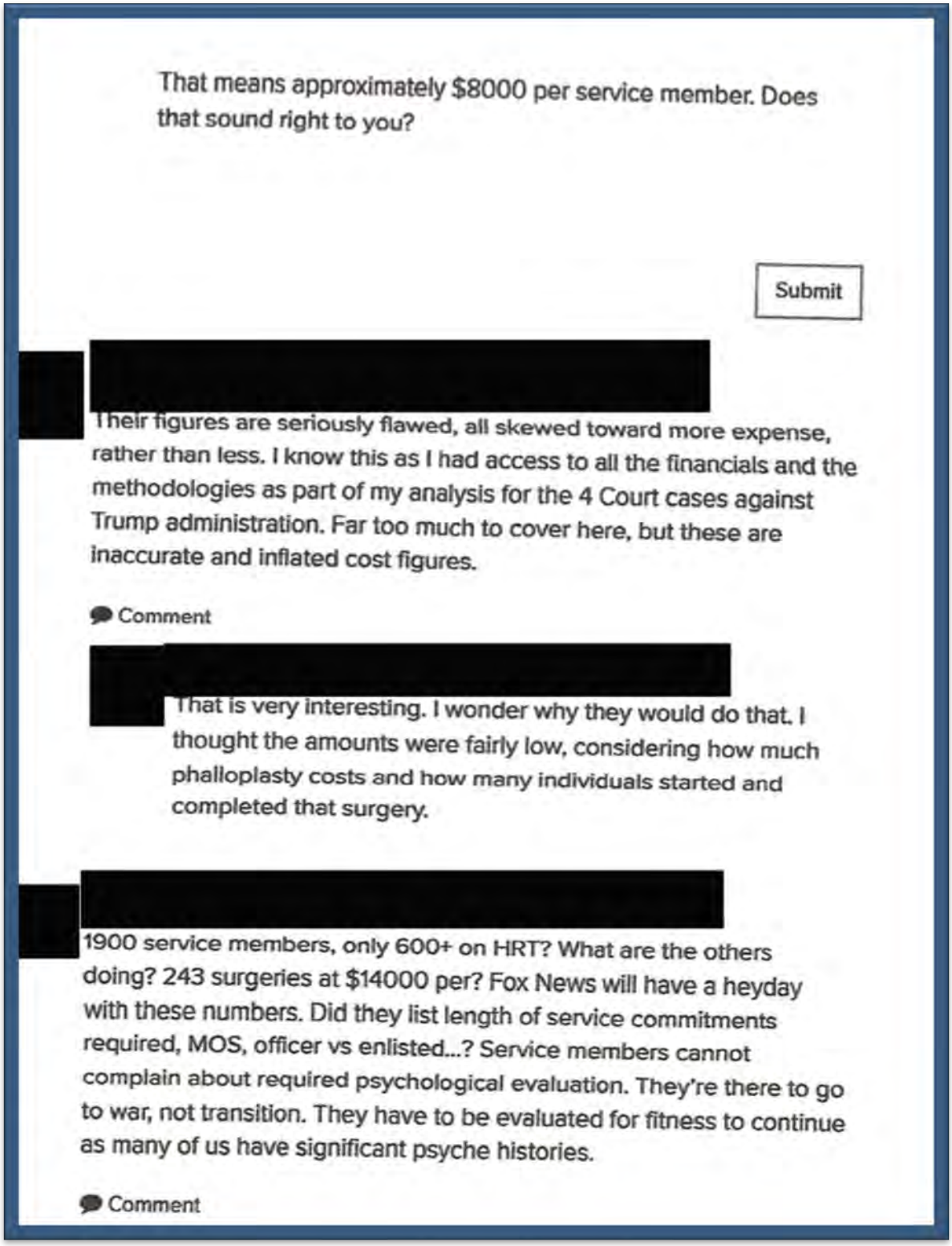
[redacted]

2,564 Discussion Views
15 Responses

The US Department of Defense recently released numbers detailing finances spent on transgender active duty between 2016-2021. The DOD reportedly spent $15M between January 2016 and mid-May 2021 on transition-related medical care for 1,892 transgender service members, according to FOIA records (analyzed by Military.com) (https://www.military.com/daily-news/2021/06/18/heres-how-much-pentagon-has-spent-so-far-treat-transgender-troops.html).

An immediate reaction I had was that institutions such as the Coast Guard were excluded from this report (because this is technically part of the Dept. of Homeland Security) even though Coast Guard utilizes Navy resources for trans care.

Some major statistics mentioned are:
o Service members who received gender-affirming care during this period included 726 Army soldiers, 576 Navy sailors, 449 Air Force airmen and 141 Marines.
o $11.5M was spent on psychotherapy, $3.1M on 243 gender-affirming surgeries, $340,000 hormone therapy for 637 service members, and the rest on other care.
o While access to psychotherapy is crucial for transgender service members, some trans folks have criticized current DOD rules for imposing requirements for certain psychotherapy sessions without regard to clinical need as a part of the administrative gender-change process.
o This amounts to about 0.045% or less than one-twentieth of a percent of the DOD's 2016 annual medical budget for health care programs of $33.5B (which DOD is asking be increased to $35.6B).



That means approximately $8000 per service member. Does that sound right to you?

Submit

[redacted]

Their figures are seriously flawed, all skewed toward more expense, rather than less. I know this as I had access to all the financials and the methodologies as part of my analysis for the 4 Court cases against Trump administration. Far too much to cover here, but these are inaccurate and inflated cost figures.

Comment

[redacted]

That is very interesting. I wonder why they would do that. I thought the amounts were fairly low, considering how much phalloplasty costs and how many individuals started and completed that surgery.

[redacted]

1900 service members, only 600+ on HRT? What are the others doing? 243 surgeries at $14000 per? Fox News will have a heyday with these numbers. Did they list length of service commitments required, MOS, officer vs enlisted...? Service members cannot complain about required psychological evaluation. They're there to go to war, not transition. They have to be evaluated for fitness to continue as many of us have significant psyche histories.

Comment

First, thank you for all that you do for the trans military community, it's a community that is close to my heart.

I 100% agree with you. Being in NC, I have worked with more trans military personnel since 2008 than I can count. Before Obama, I had commands send me their soldiers, sailors, air-wingers, and marines because they knew their folks needed help. All on the "down-low" or looked the other way.

Obama came into office and made it possible for military personnel (and their families) to receive trans care.....unfortunately, they were ill-equipped, untrained, backlogged, and often times just bigots.

I started seeing a surge in commands finding me and sending me their military personnel (some of my enlisted folks commanding officers paid out of their own pocket to see me....warmed my heart). They just knew their trans military folks were some of the hardest working people they had and if they just got this off their "plate" they'd be even better (cost benefit analysis I suppose).

Now this is active duty.

On the VA side, I received so many referrals from the Salisbury VA.

Again, they were backlogged and there was no one trained to help these trans vets. This went on for a few years until I got a phone call from one of their psychologist saying she needed help but that was told that the VA system would no longer be referring trans veterans to me. She asked if I would speak to her supervisor (I can't remember if he was a psychologist or a psychiatrist) regarding providing them some training. I did and he made it very clear that my services for trans vets were no longer needed nor was the training I offered. He went on to say he established a "Transgender Task Force" (sorry I thought it was a bit much, strange, and so military). This person was unfamiliar with WPATH, its protocols, the SOCs.

After a few months, the trans vets started to return stating that their hormones were d/c'd because they were still trying to coordinate or figure out how to prescribe and in the interim put into a trans group.

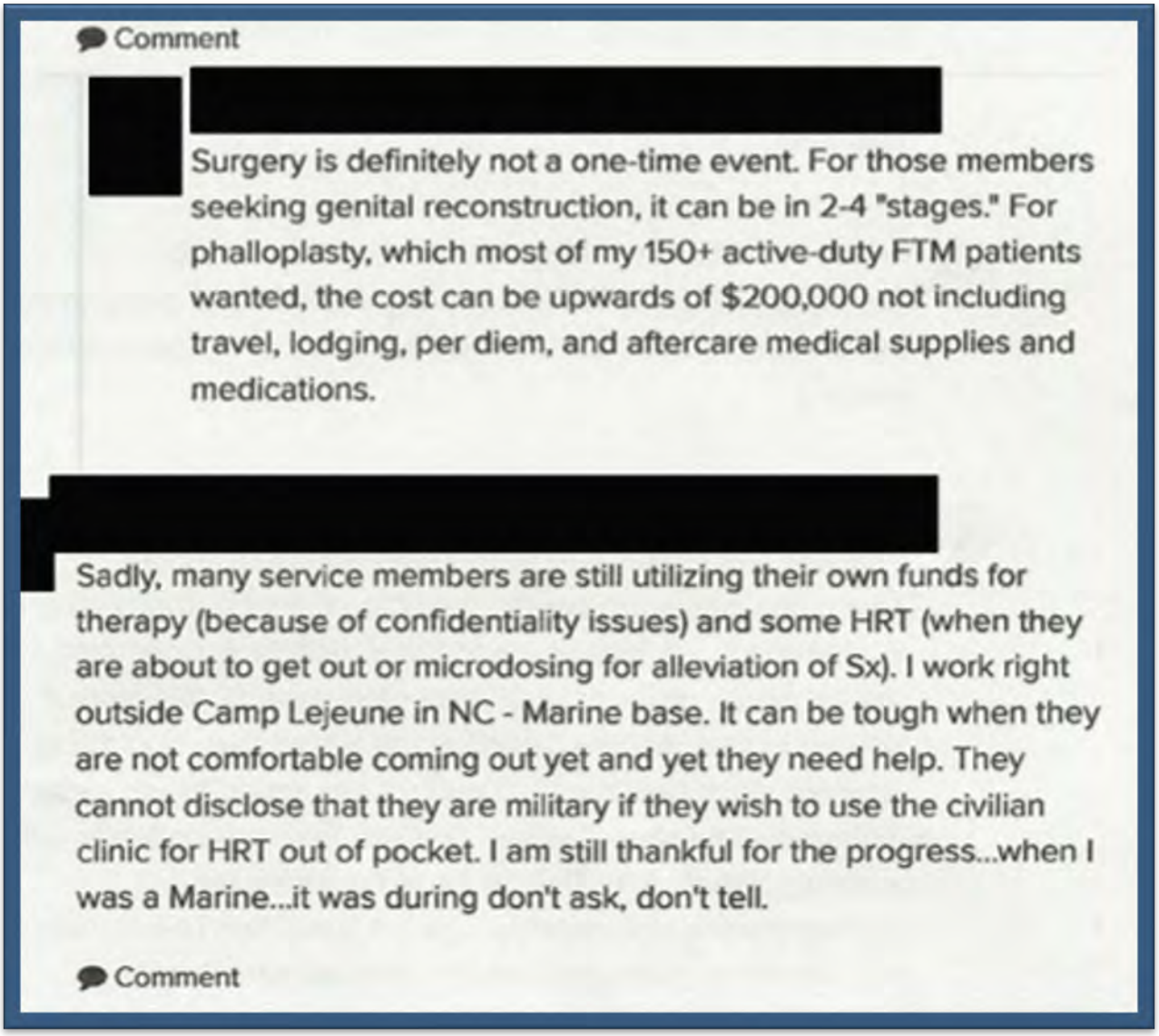
If they weren't paying out of pocket, I was still billing the VA but for PTSD and a doc in Winston Salem, NC worked to help me keep them on their hormones.

All this to say their numbers are absolutely wrong. If Officers, trans military members, and military vets were paying out of their own pockets, the DoD couldn't have possibly spent that amount.

Granted, it's not like I saw 100,000 people. Over the years, I know enough to feel comfortably saying, therapy is not required, hormones are cheap, and surgery, well that's a one time event. Trans care is far more affordable and far easier to manage than treating active duty, veterans, and/or their family members who have chronic illness's.

Even if that number is true (we all know it's not), it is still such a tiny tiny tiny part of their budget. I guess my other argument is, Did they assess the numbers for treating for PTSD, hypertension, diabetes, or mental health in general?

Their skewed numbers boils down to not wanting to pay for and justifying medically neglecting those that served protecting our freedom.



Comment

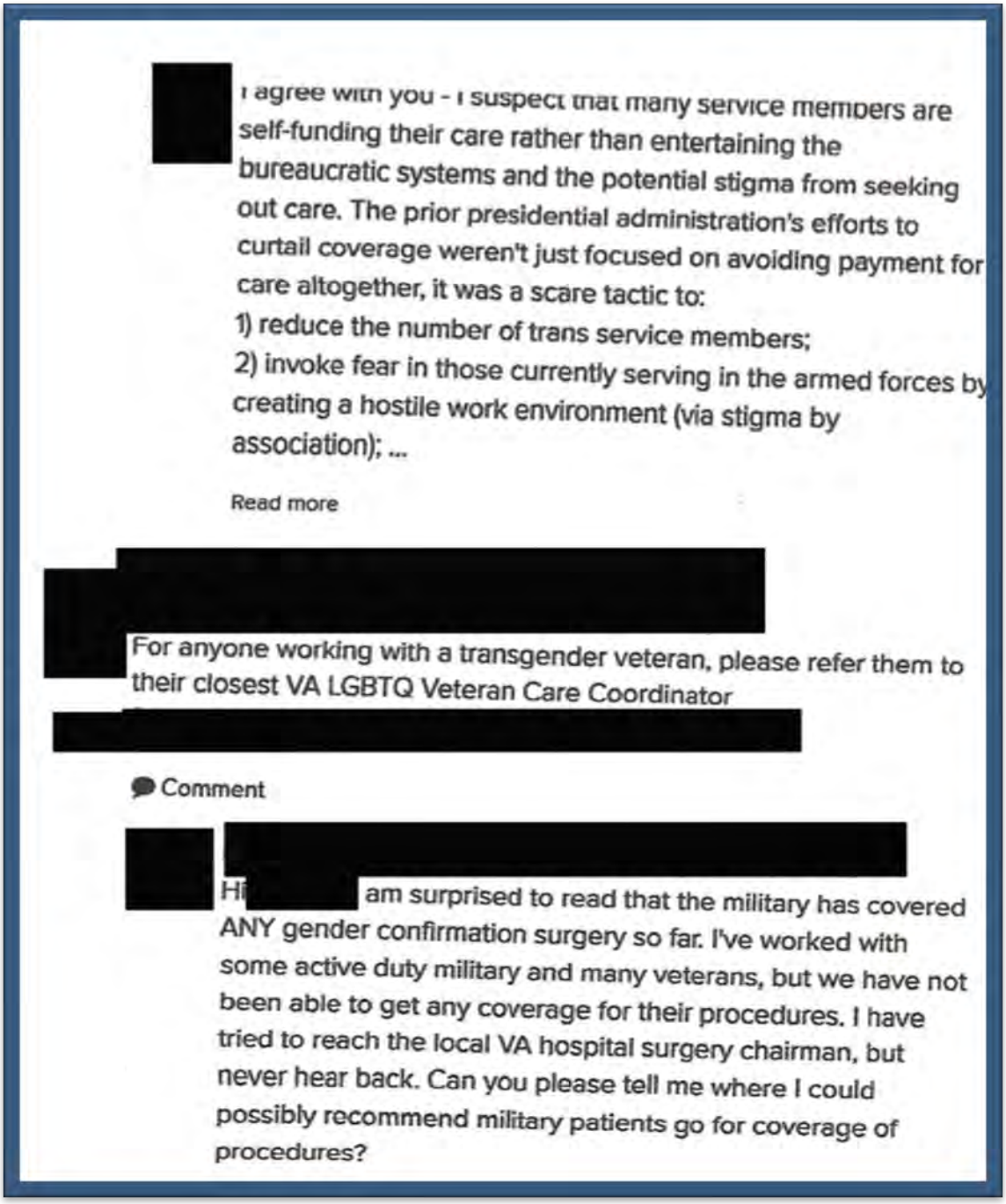
[redacted]

Surgery is definitely not a one-time event. For those members seeking genital reconstruction, it can be in 2-4 "stages." For phalloplasty, which most of my 150+ active-duty FTM patients wanted, the cost can be upwards of $200,000 not including travel, lodging, per diem, and aftercare medical supplies and medications.

[redacted]

Sadly, many service members are still utilizing their own funds for therapy (because of confidentiality issues) and some HRT (when they are about to get out or microdosing for alleviation of Sx). I work right outside Camp Lejeune in NC - Marine base. It can be tough when they are not comfortable coming out yet and yet they need help. They cannot disclose that they are military if they wish to use the civilian clinic for HRT out of pocket. I am still thankful for the progress...when I was a Marine...it was during don't ask, don't tell.

Comment



[redacted] I agree with you - I suspect that many service members are self-funding their care rather than entertaining the bureaucratic systems and the potential stigma from seeking out care. The prior presidential administration's efforts to curtail coverage weren't just focused on avoiding payment for care altogether, it was a scare tactic to:
1) reduce the number of trans service members;
2) invoke fear in those currently serving in the armed forces by creating a hostile work environment (via stigma by association); ...

Read more

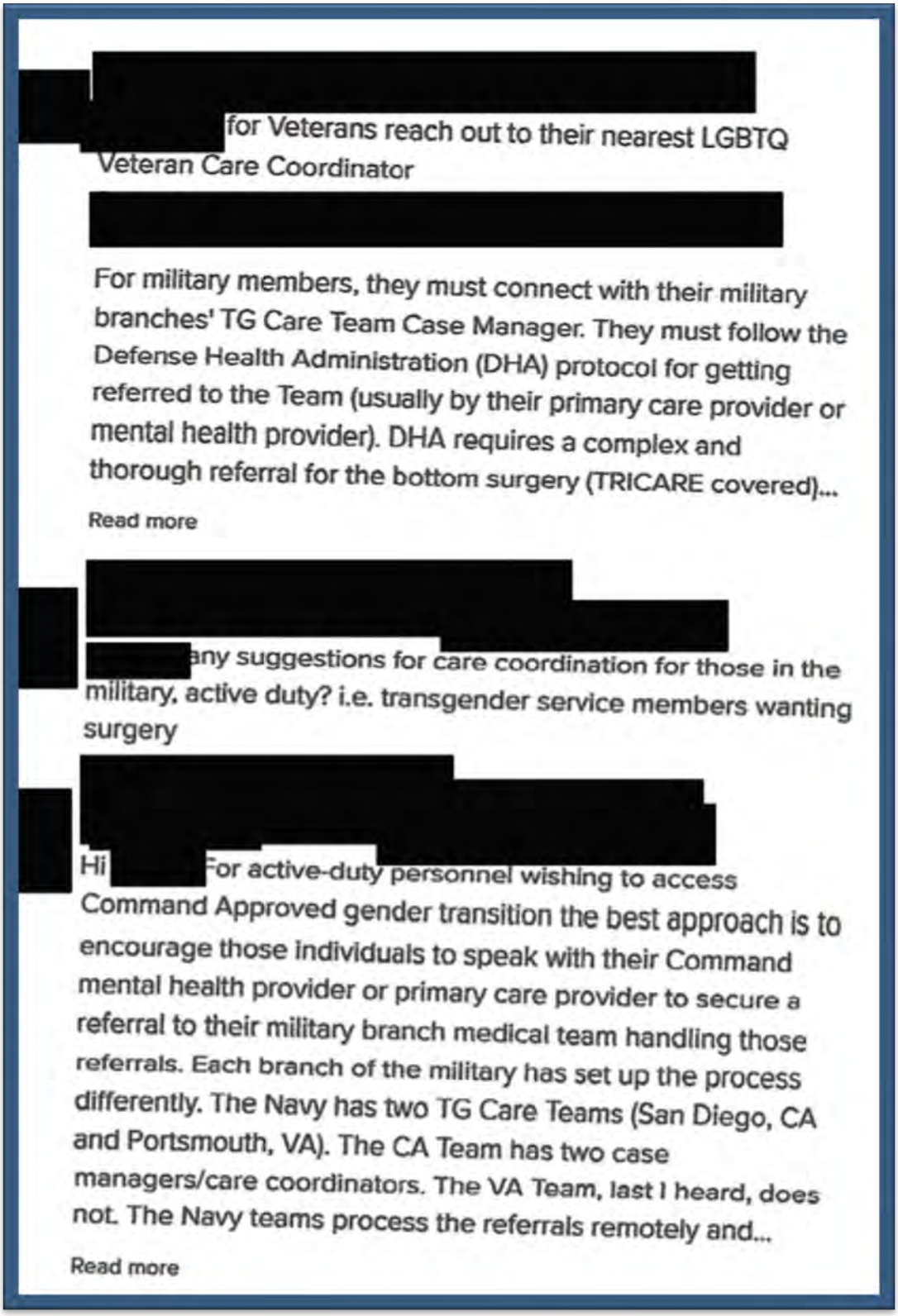
[redacted]

For anyone working with a transgender veteran, please refer them to their closest VA LGBTQ Veteran Care Coordinator

[redacted]

Comment

[redacted] Hi [redacted] am surprised to read that the military has covered ANY gender confirmation surgery so far. I've worked with some active duty military and many veterans, but we have not been able to get any coverage for their procedures. I have tried to reach the local VA hospital surgery chairman, but never hear back. Can you please tell me where I could possibly recommend military patients go for coverage of procedures?



[redacted] for Veterans reach out to their nearest LGBTQ Veteran Care Coordinator

[redacted]

For military members, they must connect with their military branches' TG Care Team Case Manager. They must follow the Defense Health Administration (DHA) protocol for getting referred to the Team (usually by their primary care provider or mental health provider). DHA requires a complex and thorough referral for the bottom surgery (TRICARE covered)...

Read more

[redacted] any suggestions for care coordination for those in the military, active duty? i.e. transgender service members wanting surgery

[redacted] Hi [redacted] For active-duty personnel wishing to access Command Approved gender transition the best approach is to encourage those individuals to speak with their Command mental health provider or primary care provider to secure a referral to their military branch medical team handling those referrals. Each branch of the military has set up the process differently. The Navy has two TG Care Teams (San Diego, CA and Portsmouth, VA). The CA Team has two case managers/care coordinators. The VA Team, last I heard, does not. The Navy teams process the referrals remotely and...

Read more

[redacted]

Also, because of the high need for transgender resources, if you are a clinician/therapist - you might be able to get special contract to work with transgender service-connected members if you cannot get paneled with Tricare.

Here are a couple sites that also might be helpful for trans service members:
SPARTA Pride (https://spartapride.org/) - certain bases will have chapters such as we do here in Camp Lejeune NC
Transgender American Veterans Association (https://transveteran.org/)

Comment

[redacted]

Feel like this information is also entirely useless out of context. How much do they spend on insulin and diabetic care? How much do they spend on mental health care for PTSD diagnosis? There are a lot of things that I'm sure they're paying money for and without any context behind these numbers or any ability to compare them people are just going to see them and make what they will of them.

Comment

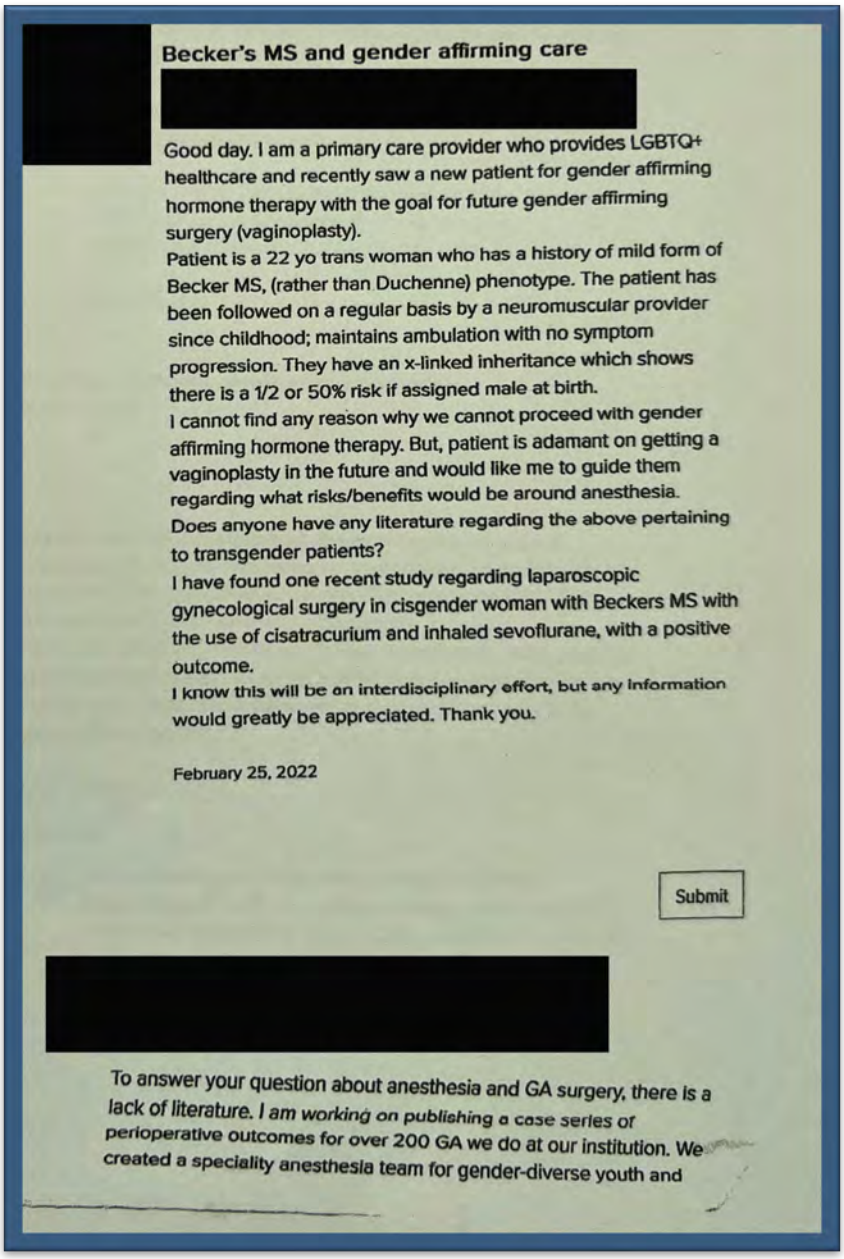
[redacted]

I will have to go back into my records to figure out what we estimated the military costs would be back before they made the decision to cover services. There was a cost study by the Palm Center that I was asked to review before they sent it to the DoD. I did and I thought their figures were wrong and told them so. If I recall right, I thought they were estimating too high. But it could be the other way. But they probably weren't so very wrong that it really mattered. Especially because it does not matter how little is spent on transgender care: as far as the public is concerned even a dime per person is too much.

...

7) SURGICAL RISK AND PRIOR HEALTH CONDITIONS

a) WPATH members discuss the risk for a patient that has Becker Muscular Dystrophy (BMD) to undergo transition surgery



Becker's MS and gender affirming care

[redacted]

Good day. I am a primary care provider who provides LGBTQ+ healthcare and recently saw a new patient for gender affirming hormone therapy with the goal for future gender affirming surgery (vaginoplasty).
Patient is a 22 yo trans woman who has a history of mild form of Becker MS, (rather than Duchenne) phenotype. The patient has been followed on a regular basis by a neuromuscular provider since childhood; maintains ambulation with no symptom progression. They have an x-linked inheritance which shows there is a 1/2 or 50% risk if assigned male at birth.
I cannot find any reason why we cannot proceed with gender affirming hormone therapy. But, patient is adamant on getting a vaginoplasty in the future and would like me to guide them regarding what risks/benefits would be around anesthesia.
Does anyone have any literature regarding the above pertaining to transgender patients?
I have found one recent study regarding laparoscopic gynecological surgery in cisgender woman with Beckers MS with the use of cisatracurium and inhaled sevoflurane, with a positive outcome.
I know this will be an interdisciplinary effort, but any information would greatly be appreciated. Thank you.

February 25, 2022

Submit

[redacted]

To answer your question about anesthesia and GA surgery, there is a lack of literature. I am working on publishing a case series of perioperative outcomes for over 200 GA we do at our institution. We created a speciality anesthesia team for gender-diverse youth and

developed Enhanced Recovery after Surgery ERAS and anesthesia management guidelines for chest reconstruction, phalloplasty, metoidioplasty and vaginoplasty procedures. There are risks with transgender patients who have co-exisiting morbidities such as DM and may affect anesthesia and pain management. Please feel free to reach out to me to discuss more.

March 1, 2022

Comment

[redacted]

Thank you for your response. I just may take you up on your offer! I will be in touch. Are the EAS and anesthesia management guidelines are accessible to folks outside of the organization?

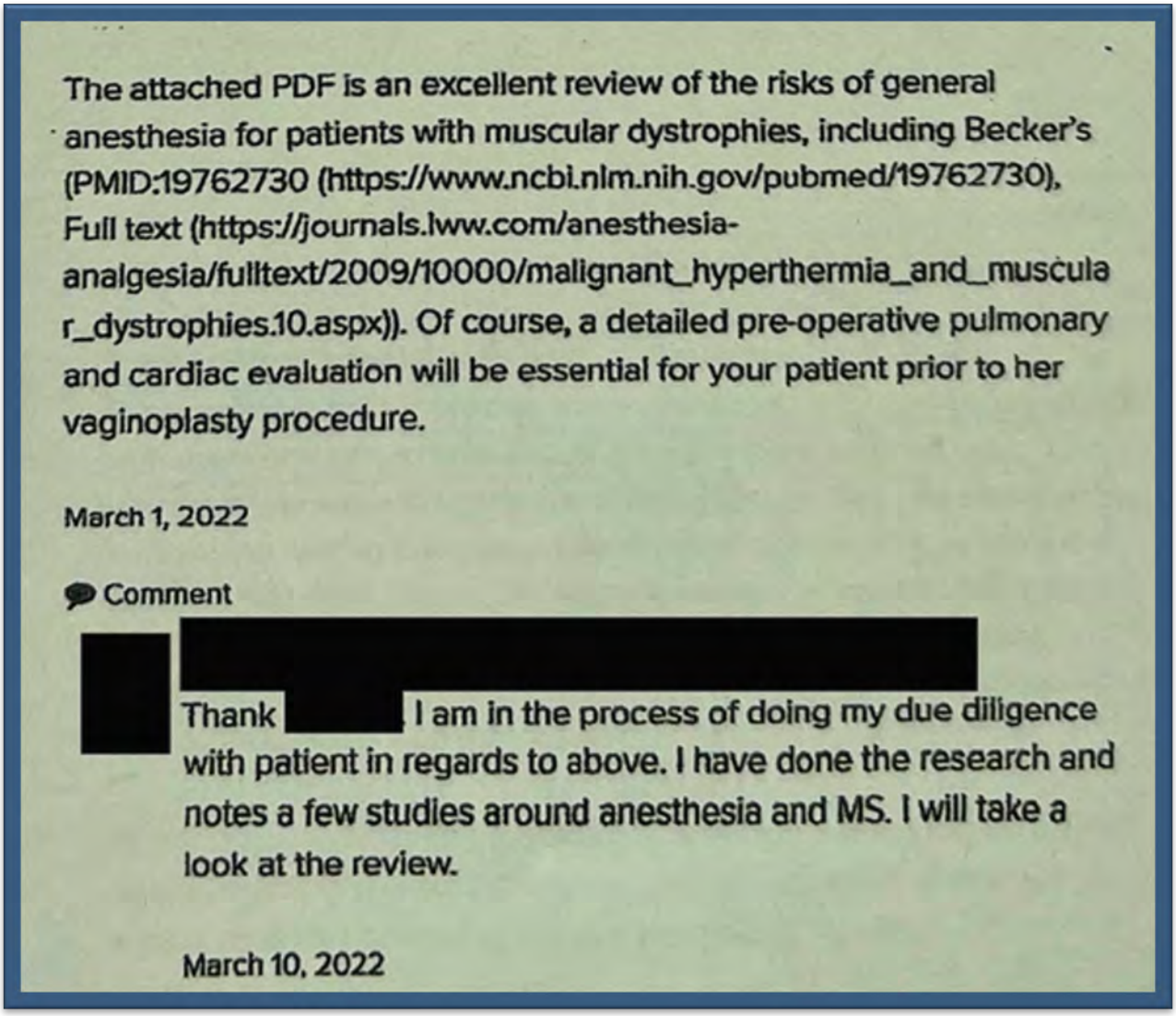
March 10, 2022

[redacted]

Please see our attached article (and link) the Gender Affirming Surgical Program (GASPP) in the Department of Anesthesiology, Critical Care and Pain Medicine at Boston Children's Hospital has done to advance the perioperative care for transgender youth.

A Single Center Case Series of Gender-Affirming Surgeries and the Evolution of a Specialty Anesthesia Team (https://www.mdpi.com/2077-0383/11/7/1943)

March 31, 2022



The attached PDF is an excellent review of the risks of general anesthesia for patients with muscular dystrophies, including Becker's (PMID:19762730 (https://www.ncbi.nlm.nih.gov/pubmed/19762730), Full text (https://journals.lww.com/anesthesia-analgesia/fulltext/2009/10000/malignant_hyperthermia_and_muscular_dystrophies.10.aspx)). Of course, a detailed pre-operative pulmonary and cardiac evaluation will be essential for your patient prior to her vaginoplasty procedure.

March 1, 2022

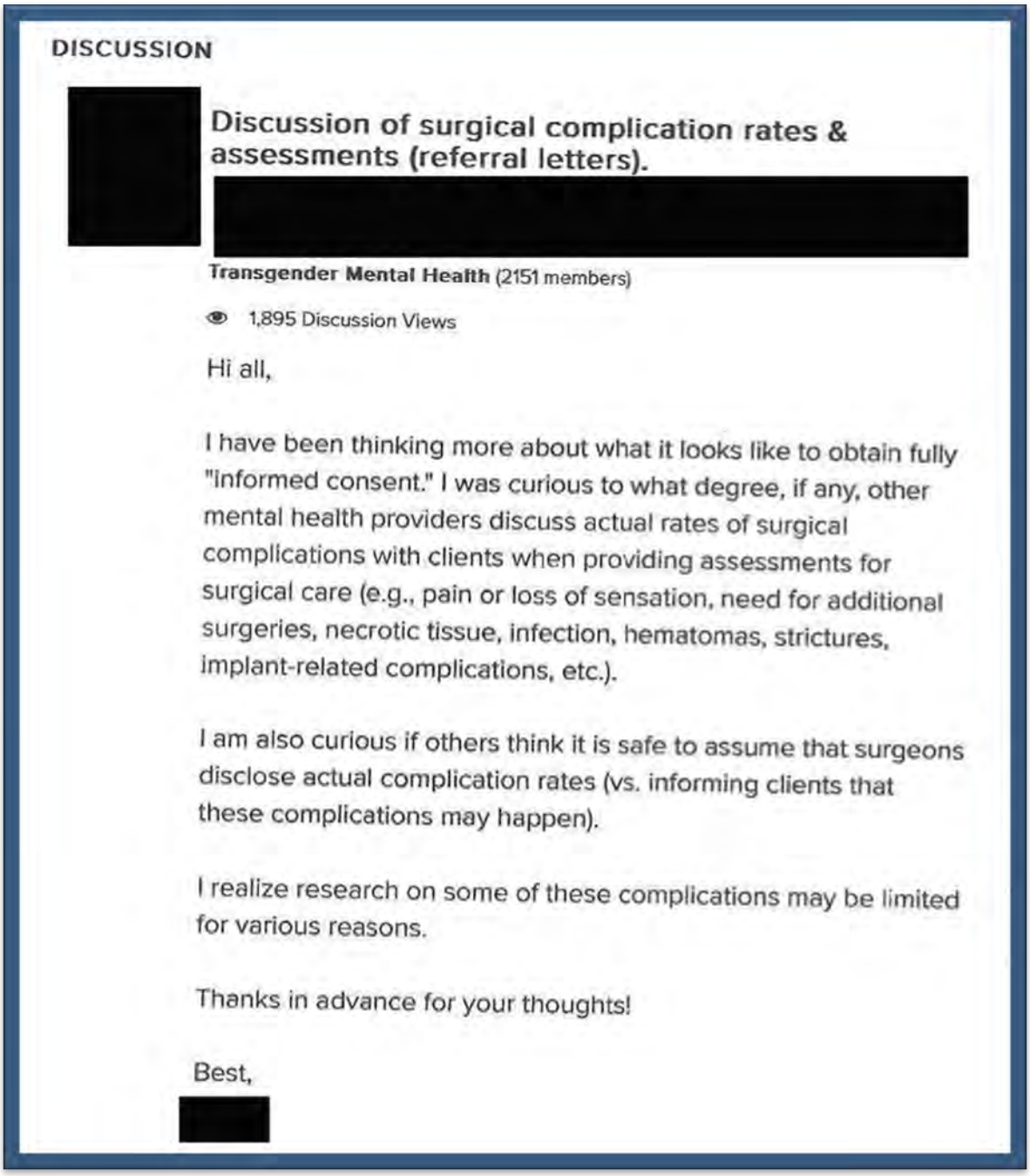
Comment

[redacted] Thank [redacted] I am in the process of doing my due diligence with patient in regards to above. I have done the research and notes a few studies around anesthesia and MS. I will take a look at the review.

March 10, 2022

8) COMPLICATION RATES AND INFORMED CONSENT

a) A WPATH member poses questions regarding standards for informed consent and the reality of complication rates



DISCUSSION

[redacted]

Discussion of surgical complication rates & assessments (referral letters).

[redacted]

Transgender Mental Health (2151 members)

1,895 Discussion Views

Hi all,

I have been thinking more about what it looks like to obtain fully "informed consent." I was curious to what degree, if any, other mental health providers discuss actual rates of surgical complications with clients when providing assessments for surgical care (e.g., pain or loss of sensation, need for additional surgeries, necrotic tissue, infection, hematomas, strictures, implant-related complications, etc.).

I am also curious if others think it is safe to assume that surgeons disclose actual complication rates (vs. informing clients that these complications may happen).

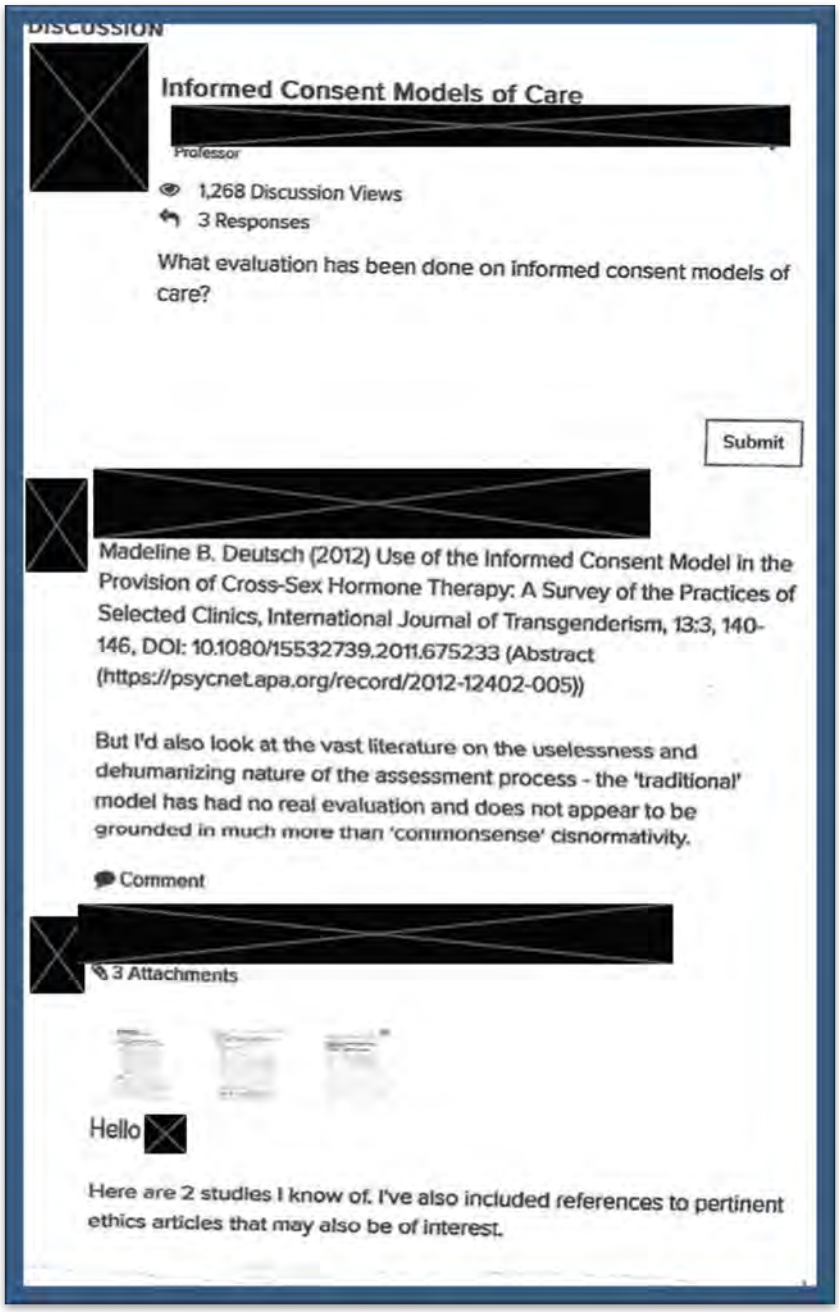
I realize research on some of these complications may be limited for various reasons.

Thanks in advance for your thoughts!

Best,

[redacted]

b) A WPATH member explains that the traditional model of informed consent is cis-normative



DISCUSSION

[redacted]

Informed Consent Models of Care

[redacted]

Professor

1,268 Discussion Views

3 Responses

What evaluation has been done on informed consent models of care?

Submit

[redacted]

Madeline B. Deutsch (2012) Use of the Informed Consent Model in the Provision of Cross-Sex Hormone Therapy: A Survey of the Practices of Selected Clinics, International Journal of Transgenderism, 13:3, 140-146, DOI: 10.1080/15532739.2011.675233 (Abstract (https://psycnet.apa.org/record/2012-12402-005))

But I'd also look at the vast literature on the uselessness and dehumanizing nature of the assessment process - the 'traditional' model has had no real evaluation and does not appear to be grounded in much more than 'commonsense' cisnormativity.

Comment

[redacted]

3 Attachments

Hello [redacted]

Here are 2 studies I know of. I've also included references to pertinent ethics articles that may also be of interest.

- Deutsch MB. Use of the informed consent model in the provision of cross-sex hormone therapy: a survey of the practices of selected clinics. Int J Transgenderism. 2012 May;13(3):140-6. (Abstract (https://psycnet.apa.org/record/2012-12402-005))

...

Read more

Comment

[redacted]

1 Attachment

Hi[redacted]

I also recommend:

Clark, B. A., & Virani, A. (2021). This wasn't a split-second decision": An empirical ethical analysis of transgender youth capacity, rights, and authority to consent to hormone therapy. Journal of Bioethical Inquiry, 18(1), 151–164. (PMID:33502682 (https://www.ncbi.nlm.nih.gov/pubmed/33502682), Full text (https://link.springer.com/article/10.1007/s11673-020-10086-9))

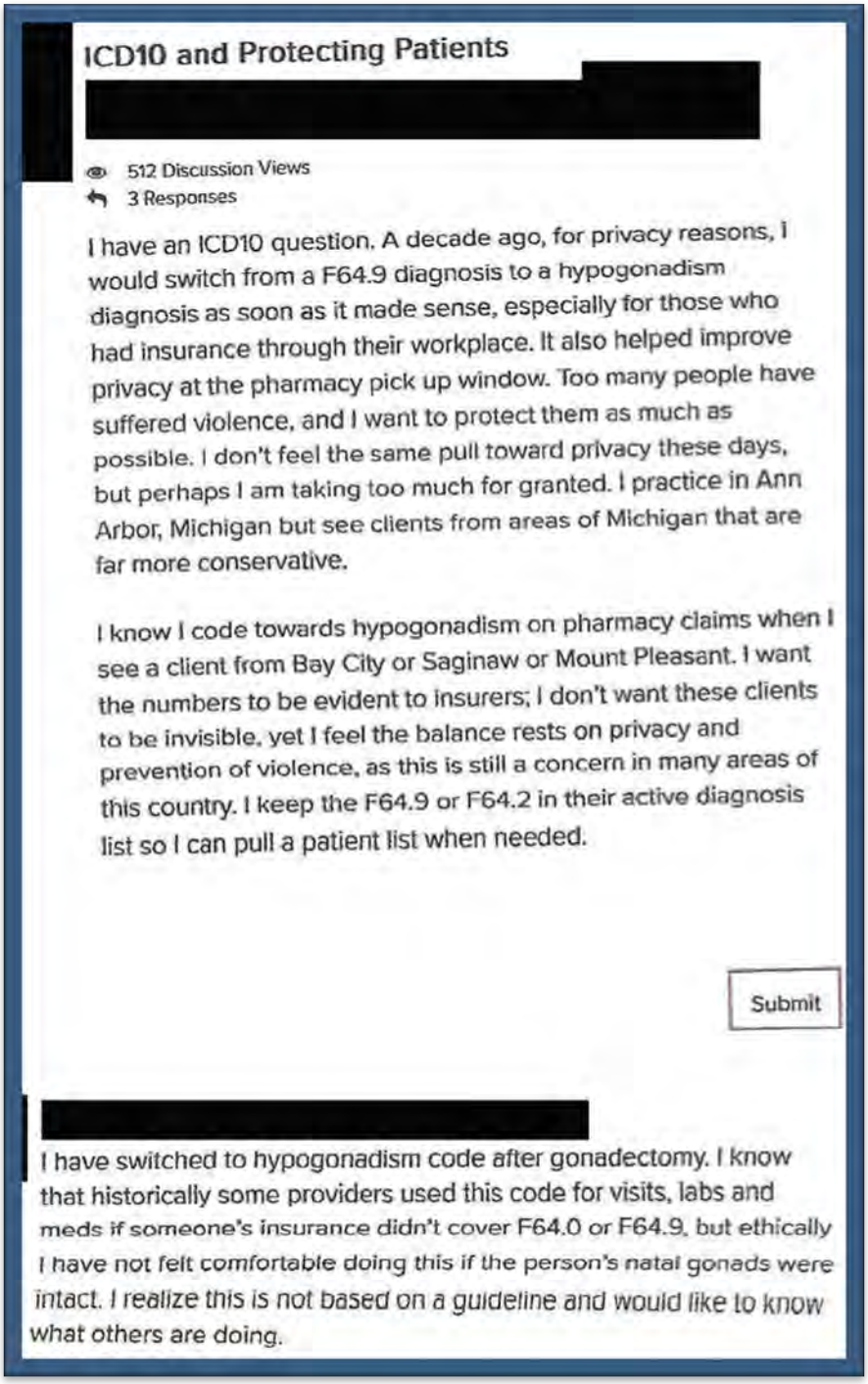
...

Read more

Comment

9) INSURANCE IN GENDER MEDICINE INTERVENTIONS

a) A WPATH member expresses concerns regarding data privacy in conservative areas



ICD10 and Protecting Patients

[redacted]

512 Discussion Views
3 Responses

I have an ICD10 question. A decade ago, for privacy reasons, I would switch from a F64.9 diagnosis to a hypogonadism diagnosis as soon as it made sense, especially for those who had insurance through their workplace. It also helped improve privacy at the pharmacy pick up window. Too many people have suffered violence, and I want to protect them as much as possible. I don't feel the same pull toward privacy these days, but perhaps I am taking too much for granted. I practice in Ann Arbor, Michigan but see clients from areas of Michigan that are far more conservative.

I know I code towards hypogonadism on pharmacy claims when I see a client from Bay City or Saginaw or Mount Pleasant. I want the numbers to be evident to insurers; I don't want these clients to be invisible, yet I feel the balance rests on privacy and prevention of violence, as this is still a concern in many areas of this country. I keep the F64.9 or F64.2 in their active diagnosis list so I can pull a patient list when needed.

Submit

[redacted]

I have switched to hypogonadism code after gonadectomy. I know that historically some providers used this code for visits, labs and meds if someone's insurance didn't cover F64.0 or F64.9, but ethically I have not felt comfortable doing this if the person's natal gonads were intact. I realize this is not based on a guideline and would like to know what others are doing.

[redacted]

What happened to endocrine disorder NOS as an alternative?

Comment

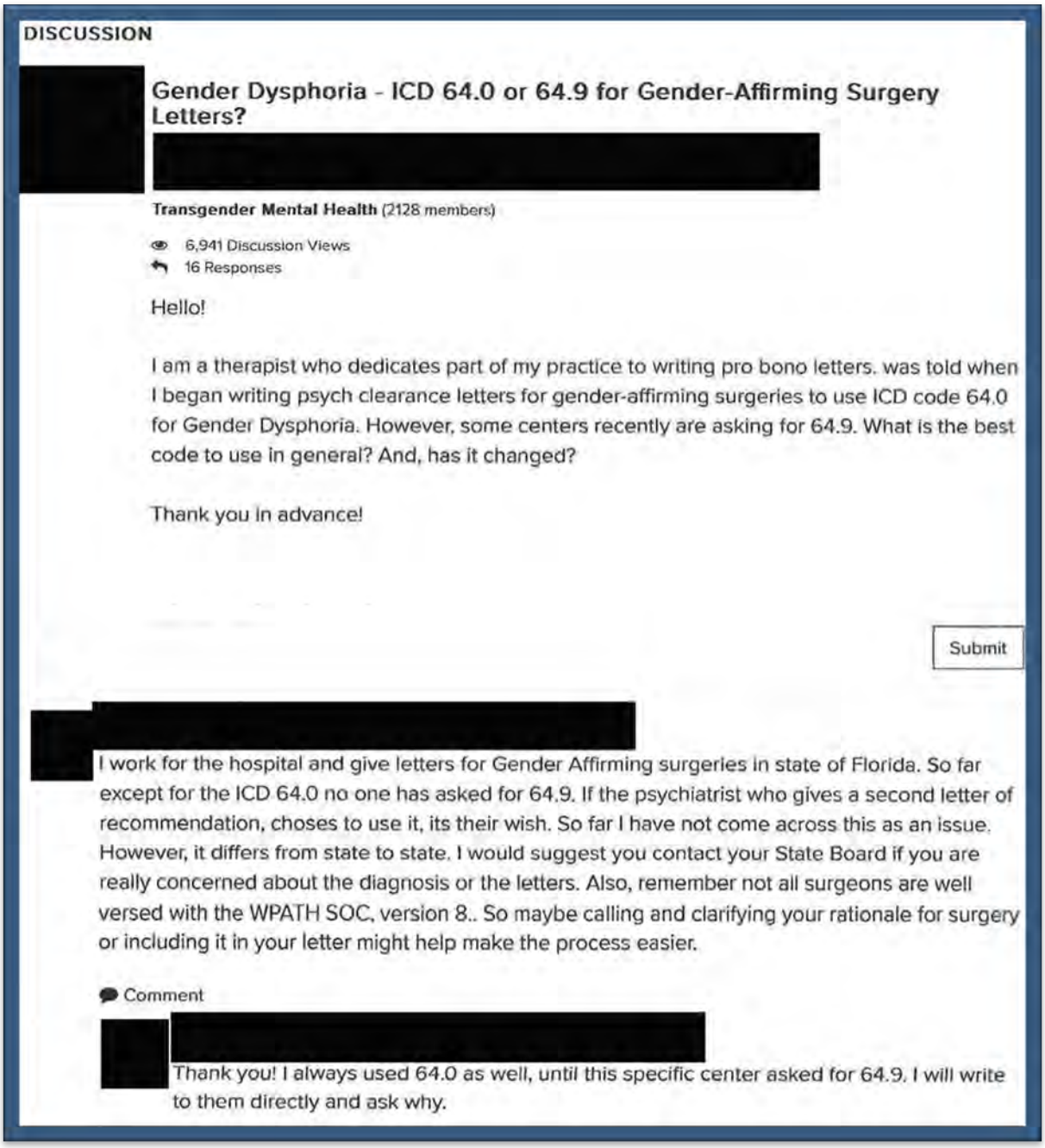
[redacted]

This is challenging to navigate - while the hypogonadism and endocrine disorder NOS are helpful to offer privacy and safety, justifying these codes to an insurer frequently results in an insurer pushing back for lab work justifying low testosterone or low estrogen at certain intervals (usually with an annual PA for controlled substances). For someone on long-term hormone therapy, justifying this is nearly impossible without going off of their hormones for a period of time to meet an insurer's required lab levels for coverage.

I would advise asking your patients directly about their comfort, explaining to them the logistical issues associated with obtaining medications (i.e. coding, concerns with privacy), and creating a course of action in collaboration with the patient. Presuming that a patient has coverage for gender-affirming care in their plan, I would consider keeping gender dysphoria-related ICD-10 coding (most insurers will not require bloodwork for this diagnosis) and advising requesting meds through their insurer's preferred mail order pharmacy - this negates potential conflict or safety issues with a less affirming pharmacist in their area. Another benefit of a mail-order option is that a patient can obtain a 90 day supply of their meds, also reducing potential pharmacist-patient contact.

Comment

b) WPATH members discuss how to classify gender dysphoria using ICD for insurance benefits



DISCUSSION

[redacted]

Gender Dysphoria - ICD 64.0 or 64.9 for Gender-Affirming Surgery Letters?

[redacted]

Transgender Mental Health (2128 members)

6,941 Discussion Views
16 Responses

Hello!

I am a therapist who dedicates part of my practice to writing pro bono letters. was told when I began writing psych clearance letters for gender-affirming surgeries to use ICD code 64.0 for Gender Dysphoria. However, some centers recently are asking for 64.9. What is the best code to use in general? And, has it changed?

Thank you in advance!

Submit

[redacted]

I work for the hospital and give letters for Gender Affirming surgeries in state of Florida. So far except for the ICD 64.0 no one has asked for 64.9. If the psychiatrist who gives a second letter of recommendation, choses to use it, its their wish. So far I have not come across this as an issue. However, it differs from state to state. I would suggest you contact your State Board if you are really concerned about the diagnosis or the letters. Also, remember not all surgeons are well versed with the WPATH SOC, version 8.. So maybe calling and clarifying your rationale for surgery or including it in your letter might help make the process easier.

Comment

[redacted]

Thank you! I always used 64.0 as well, until this specific center asked for 64.9. I will write to them directly and ask why.

[redacted] Insurance isn't taking 64.0 for me.

Comment

[redacted] Interesting!

[redacted] Did it used to?

[redacted] It may have to do with wording. F64.0 in the DSM is Gender dysphoria in an adult or adolescent but in ICD-10 its title is Transexualism and F64.9 is gender identity disorder, unspecified. If you're reading diagnostic criteria in both the DSM and ICD 10, F64.0 is the most accurate but F64.9 isn't inaccurate. I know in our EMR if you search the diagnosis with DSM title it only comes up as F64.9 I end up manually coding F64.0 and then modifying language to match DSM.

Comment

[redacted] "F64.0 is the most accurate but F64.9 isn't inaccurate" - that is exactly the thesis statement here! I wonder if we can list two F diagnosis to cover all bases.

[redacted] This tracks with what I have noticed as well. My EHR will list Dual role transvestism, and my staff cannot figure out how to change the wording in our system. So I have moved to using F64.9 more often for that reason.

[redacted] It sounds like you are writing for gender care services that specify they want a diagnosis. As my writing style for letters has evolved over the years, I have made an effort not to use a diagnosis when sending information to insurance companies. And so far, I haven't been contacted and asked for a diagnosis. Instead, my letters read something like "X meets the recommended World Professional Association for Transgender Health (WPATH) Standards of Care guidelines for the type of surgery he is pursuing." Then I outline all of the criteria and provide information to support that the person fits the criteria.

Comment

[redacted] Interesting [redacted] I did not know they would be approved without the diagnosis!

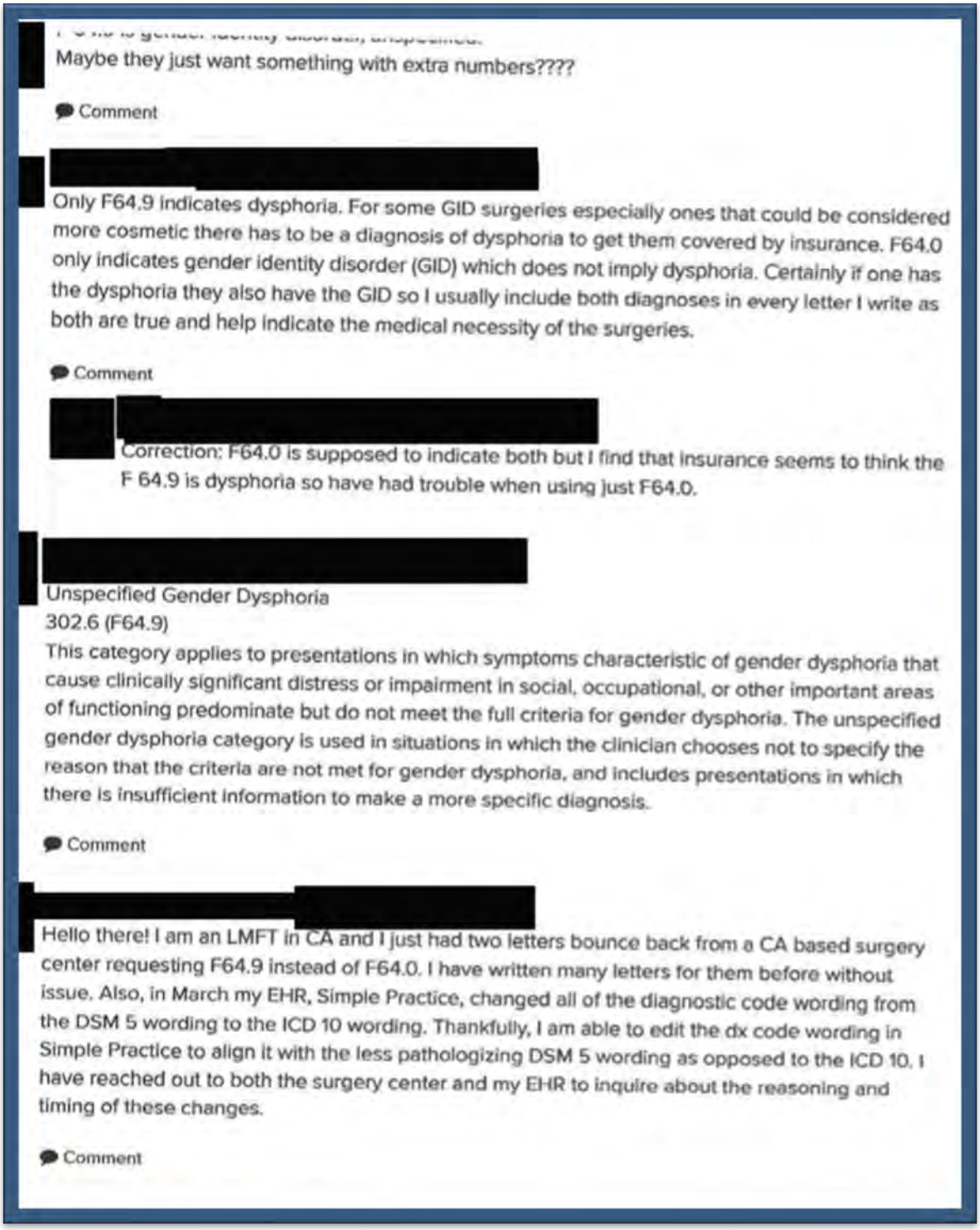
[redacted] LPC-MHSP in Tennessee here.

I've so far (fingers crossed) never had a letter rejected (mostly BCBS, United). I've never this far used F64.0–"Transsexualism" if I'm remembering correctly—as it hasn't yet described clients I've seen seeking letters. I've been using F64.9, which in some electronic health care systems (I've called mine about this and griped about it to them) automatically defaults to "Gender Identity Disorder" but in the coding of DSM-V, I see as being "gender dysphoria in adolescents and adults." So I put that title in with the proper F64.9. So far so good.

In my letters I've been specifically identifying both the ICD-10 code for insurance purposes and...

Read more

Comment



Maybe they just want something with extra numbers????

Comment

[redacted]

Only F64.9 indicates dysphoria. For some GID surgeries especially ones that could be considered more cosmetic there has to be a diagnosis of dysphoria to get them covered by insurance. F64.0 only indicates gender identity disorder (GID) which does not imply dysphoria. Certainly if one has the dysphoria they also have the GID so I usually include both diagnoses in every letter I write as both are true and help indicate the medical necessity of the surgeries.

Comment

[redacted]

Correction: F64.0 is supposed to indicate both but I find that insurance seems to think the F 64.9 is dysphoria so have had trouble when using just F64.0.

[redacted]

Unspecified Gender Dysphoria
302.6 (F64.9)
This category applies to presentations in which symptoms characteristic of gender dysphoria that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for gender dysphoria. The unspecified gender dysphoria category is used in situations in which the clinician chooses not to specify the reason that the criteria are not met for gender dysphoria, and includes presentations in which there is insufficient information to make a more specific diagnosis.

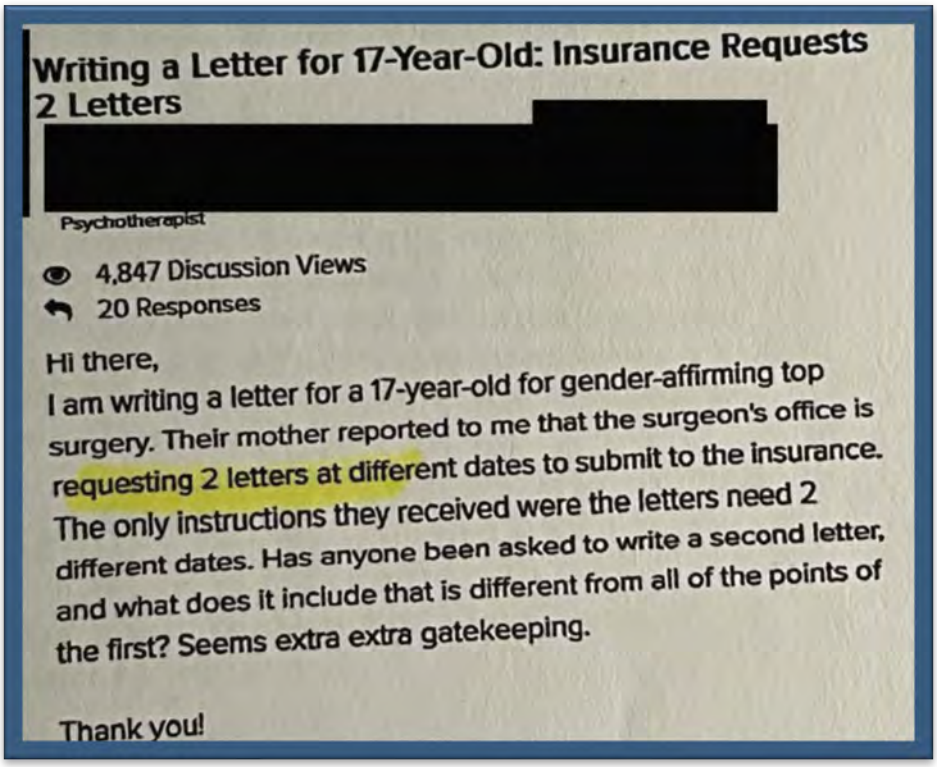
Comment

[redacted]

Hello there! I am an LMFT in CA and I just had two letters bounce back from a CA based surgery center requesting F64.9 instead of F64.0. I have written many letters for them before without issue. Also, in March my EHR, Simple Practice, changed all of the diagnostic code wording from the DSM 5 wording to the ICD 10 wording. Thankfully, I am able to edit the dx code wording in Simple Practice to align it with the less pathologizing DSM 5 wording as opposed to the ICD 10. I have reached out to both the surgery center and my EHR to inquire about the reasoning and timing of these changes.

Comment

c) WPATH members characterize a two-letter requirement for transition surgery as gatekeeping



Writing a Letter for 17-Year-Old: Insurance Requests 2 Letters

[redacted]

Psychotherapist

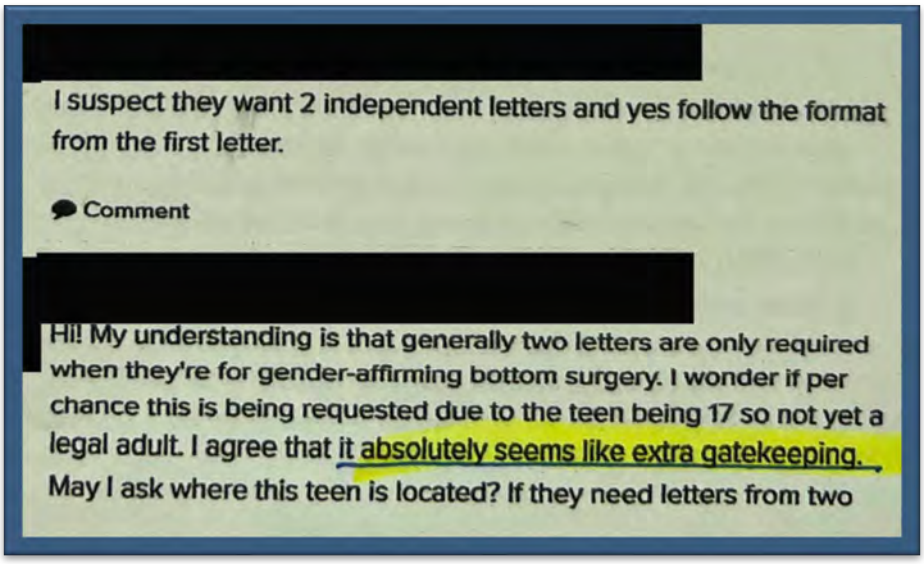
4,847 Discussion Views

20 Responses

Hi there,

I am writing a letter for a 17-year-old for gender-affirming top surgery. Their mother reported to me that the surgeon's office is requesting 2 letters at different dates to submit to the insurance. The only instructions they received were the letters need 2 different dates. Has anyone been asked to write a second letter, and what does it include that is different from all of the points of the first? Seems extra extra gatekeeping.

Thank you!



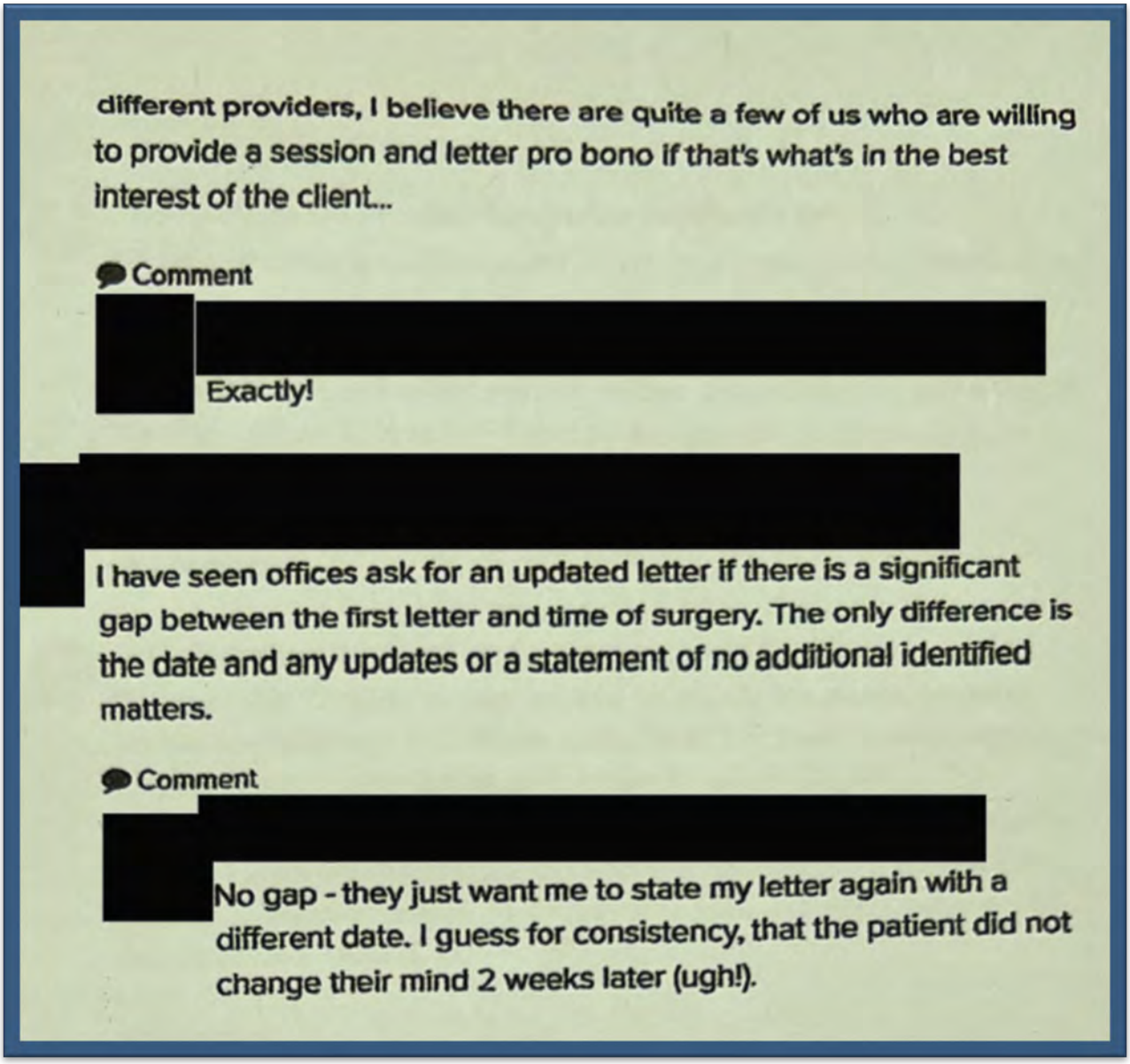
[redacted]

I suspect they want 2 independent letters and yes follow the format from the first letter.

Comment

[redacted]

Hi! My understanding is that generally two letters are only required when they're for gender-affirming bottom surgery. I wonder if per chance this is being requested due to the teen being 17 so not yet a legal adult. I agree that it absolutely seems like extra gatekeeping. May I ask where this teen is located? If they need letters from two



different providers, I believe there are quite a few of us who are willing to provide a session and letter pro bono if that's what's in the best interest of the client...

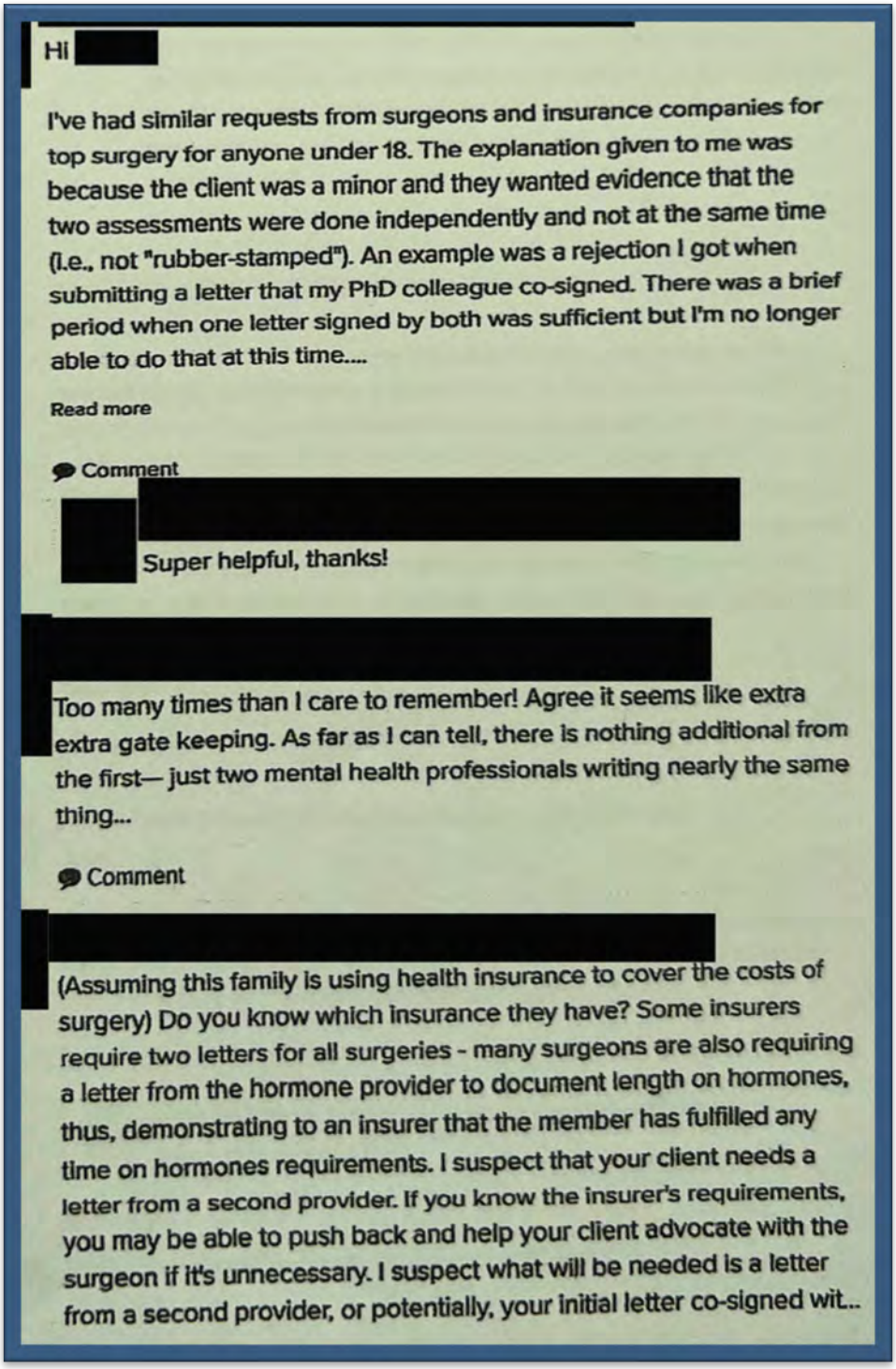
Comment

[redacted] Exactly!

[redacted] I have seen offices ask for an updated letter if there is a significant gap between the first letter and time of surgery. The only difference is the date and any updates or a statement of no additional identified matters.

Comment

[redacted] No gap - they just want me to state my letter again with a different date. I guess for consistency, that the patient did not change their mind 2 weeks later (ugh!).



Hi [redacted]

I've had similar requests from surgeons and insurance companies for top surgery for anyone under 18. The explanation given to me was because the client was a minor and they wanted evidence that the two assessments were done independently and not at the same time (i.e., not "rubber-stamped"). An example was a rejection I got when submitting a letter that my PhD colleague co-signed. There was a brief period when one letter signed by both was sufficient but I'm no longer able to do that at this time....

Read more

Comment

[redacted]

Super helpful, thanks!

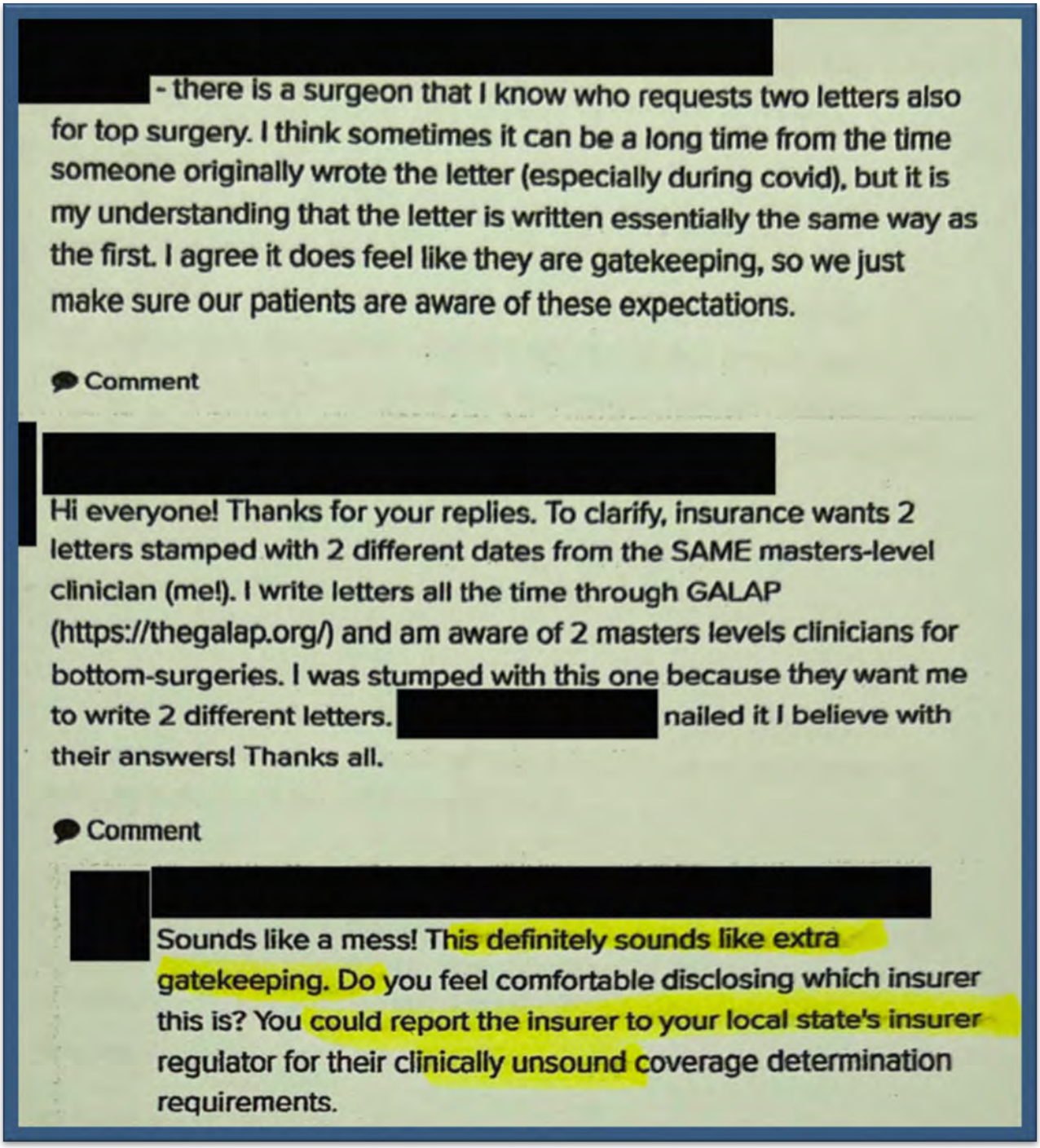
[redacted]

Too many times than I care to remember! Agree it seems like extra extra gate keeping. As far as I can tell, there is nothing additional from the first— just two mental health professionals writing nearly the same thing...

Comment

[redacted]

(Assuming this family is using health insurance to cover the costs of surgery) Do you know which insurance they have? Some insurers require two letters for all surgeries - many surgeons are also requiring a letter from the hormone provider to document length on hormones, thus, demonstrating to an insurer that the member has fulfilled any time on hormones requirements. I suspect that your client needs a letter from a second provider. If you know the insurer's requirements, you may be able to push back and help your client advocate with the surgeon if it's unnecessary. I suspect what will be needed is a letter from a second provider, or potentially, your initial letter co-signed wit...



[redacted] - there is a surgeon that I know who requests two letters also for top surgery. I think sometimes it can be a long time from the time someone originally wrote the letter (especially during covid), but it is my understanding that the letter is written essentially the same way as the first. I agree it does feel like they are gatekeeping, so we just make sure our patients are aware of these expectations.

Comment

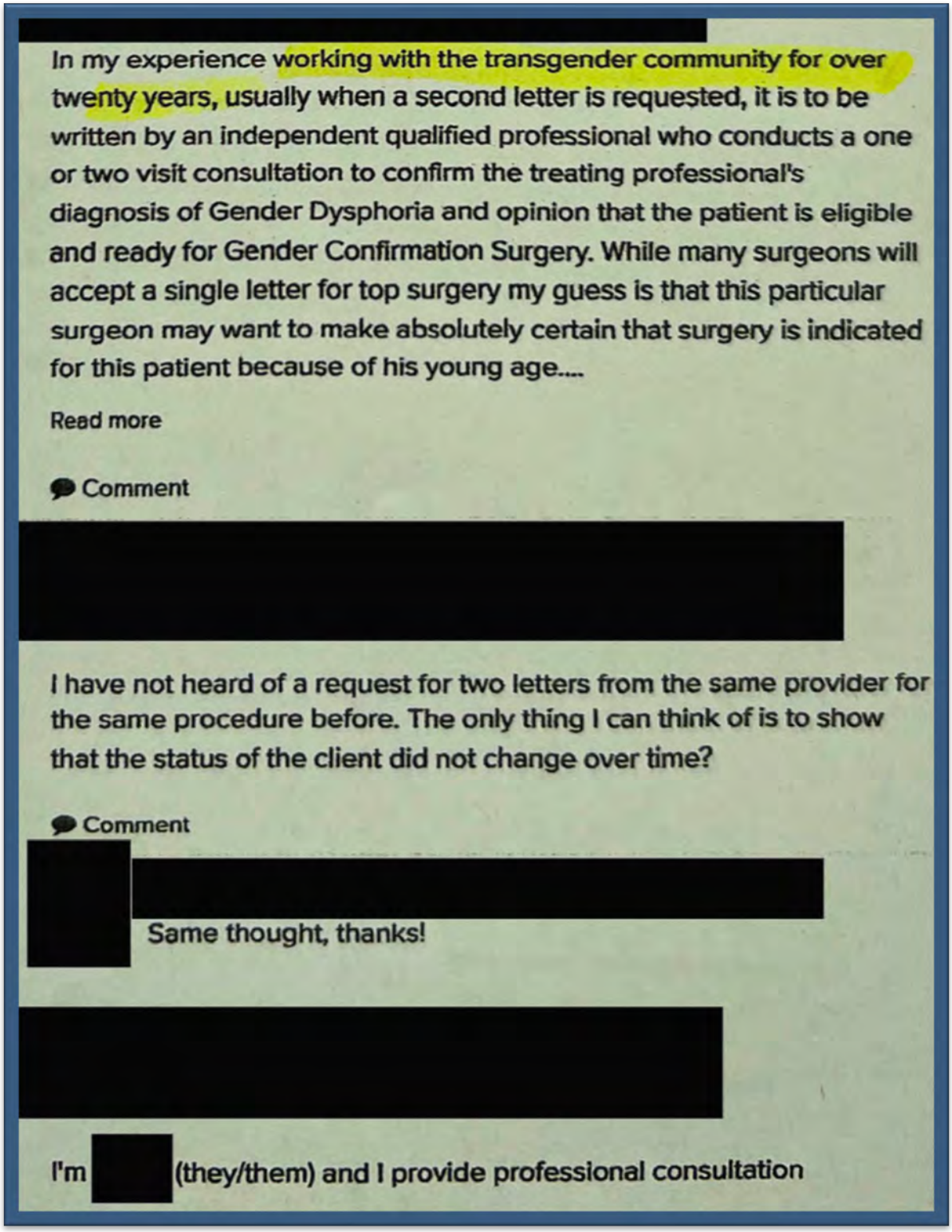
[redacted]

Hi everyone! Thanks for your replies. To clarify, insurance wants 2 letters stamped with 2 different dates from the SAME masters-level clinician (me!). I write letters all the time through GALAP (https://thegalap.org/) and am aware of 2 masters levels clinicians for bottom-surgeries. I was stumped with this one because they want me to write 2 different letters. [redacted] nailed it I believe with their answers! Thanks all.

Comment

[redacted]

Sounds like a mess! This definitely sounds like extra gatekeeping. Do you feel comfortable disclosing which insurer this is? You could report the insurer to your local state's insurer regulator for their clinically unsound coverage determination requirements.



[redacted]

In my experience working with the transgender community for over twenty years, usually when a second letter is requested, it is to be written by an independent qualified professional who conducts a one or two visit consultation to confirm the treating professional's diagnosis of Gender Dysphoria and opinion that the patient is eligible and ready for Gender Confirmation Surgery. While many surgeons will accept a single letter for top surgery my guess is that this particular surgeon may want to make absolutely certain that surgery is indicated for this patient because of his young age....

Read more

Comment

[redacted]

I have not heard of a request for two letters from the same provider for the same procedure before. The only thing I can think of is to show that the status of the client did not change over time?

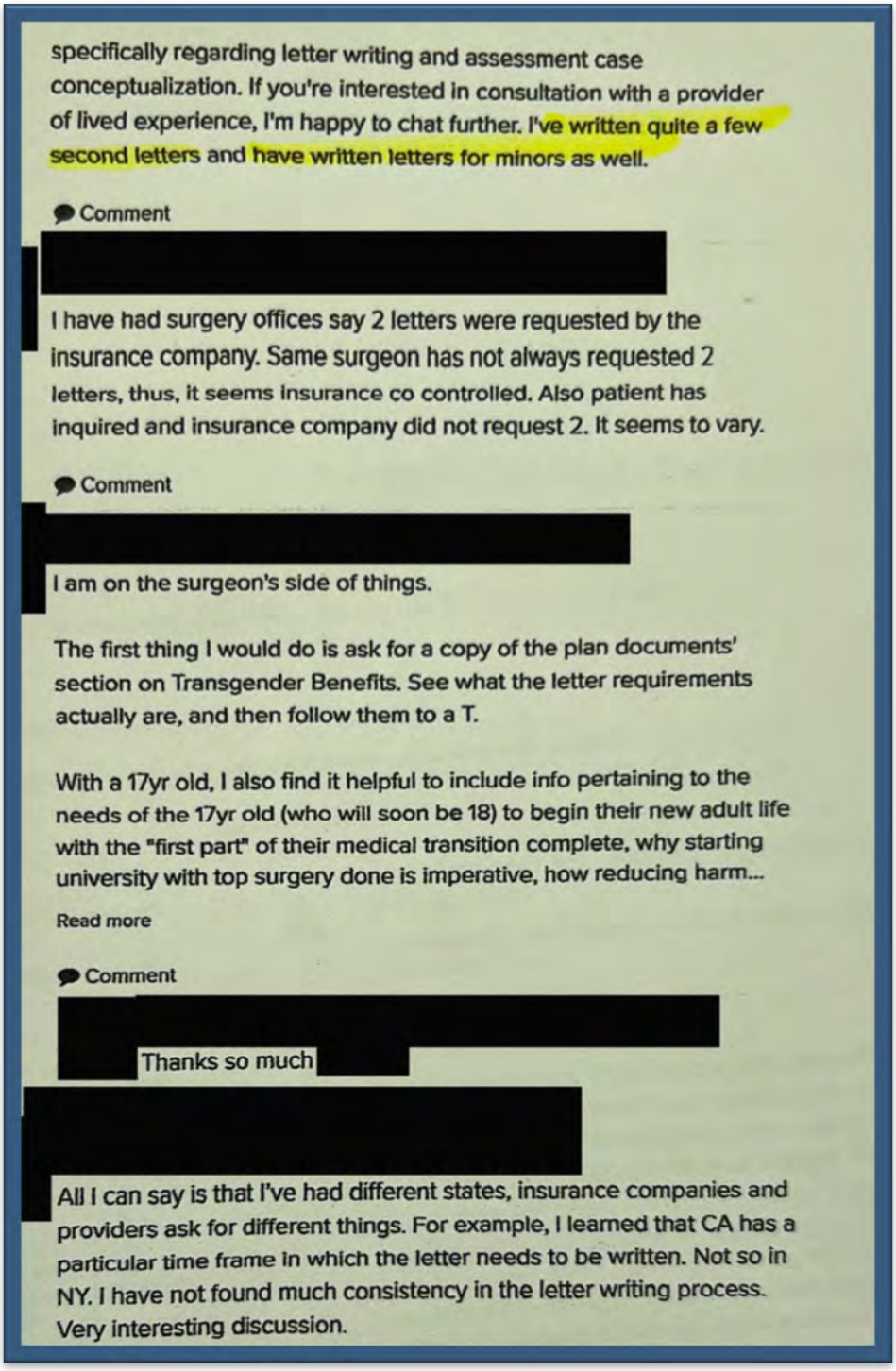
Comment

[redacted]

Same thought, thanks!

[redacted]

I'm [redacted] (they/them) and I provide professional consultation



specifically regarding letter writing and assessment case conceptualization. If you're interested in consultation with a provider of lived experience, I'm happy to chat further. I've written quite a few second letters and have written letters for minors as well.

Comment

[redacted]

I have had surgery offices say 2 letters were requested by the insurance company. Same surgeon has not always requested 2 letters, thus, it seems insurance co controlled. Also patient has inquired and insurance company did not request 2. It seems to vary.

Comment

[redacted]

I am on the surgeon's side of things.

The first thing I would do is ask for a copy of the plan documents' section on Transgender Benefits. See what the letter requirements actually are, and then follow them to a T.

With a 17yr old, I also find it helpful to include info pertaining to the needs of the 17yr old (who will soon be 18) to begin their new adult life with the "first part" of their medical transition complete, why starting university with top surgery done is imperative, how reducing harm...

Read more

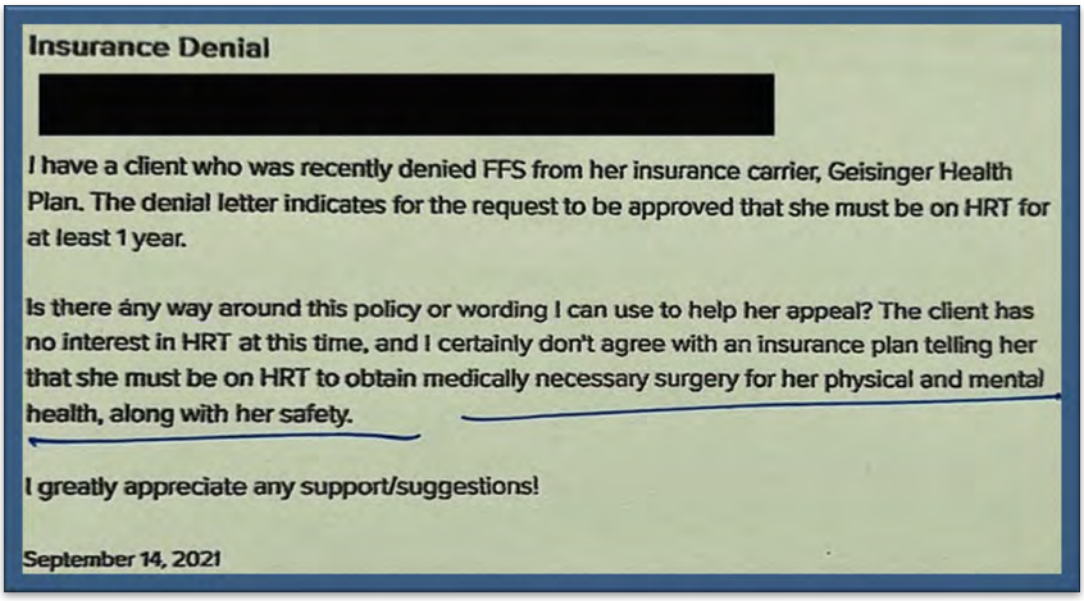
Comment

[redacted]

Thanks so much [redacted]

All I can say is that I've had different states, insurance companies and providers ask for different things. For example, I learned that CA has a particular time frame in which the letter needs to be written. Not so in NY. I have not found much consistency in the letter writing process. Very interesting discussion.

d) A WPATH member states that surgery is necessary for mental and physical health despite insurance denial, seeking a way to circumvent the insurance policy



Insurance Denial

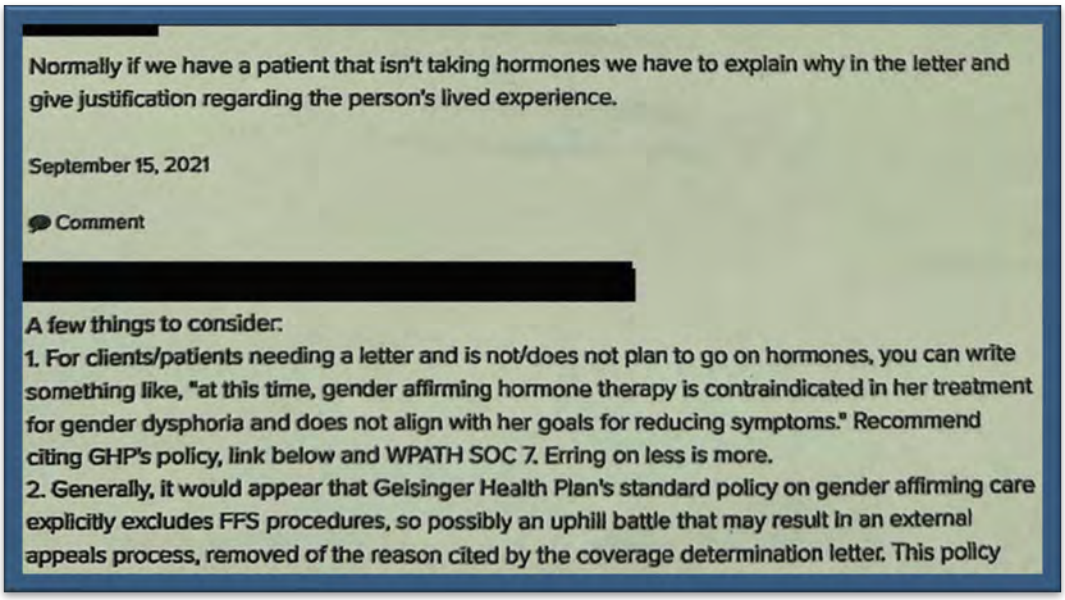
[redacted]

I have a client who was recently denied FFS from her insurance carrier, Geisinger Health Plan. The denial letter indicates for the request to be approved that she must be on HRT for at least 1 year.

Is there any way around this policy or wording I can use to help her appeal? The client has no interest in HRT at this time, and I certainly don't agree with an insurance plan telling her that she must be on HRT to obtain medically necessary surgery for her physical and mental health, along with her safety.

I greatly appreciate any support/suggestions!

September 14, 2021



[redacted]

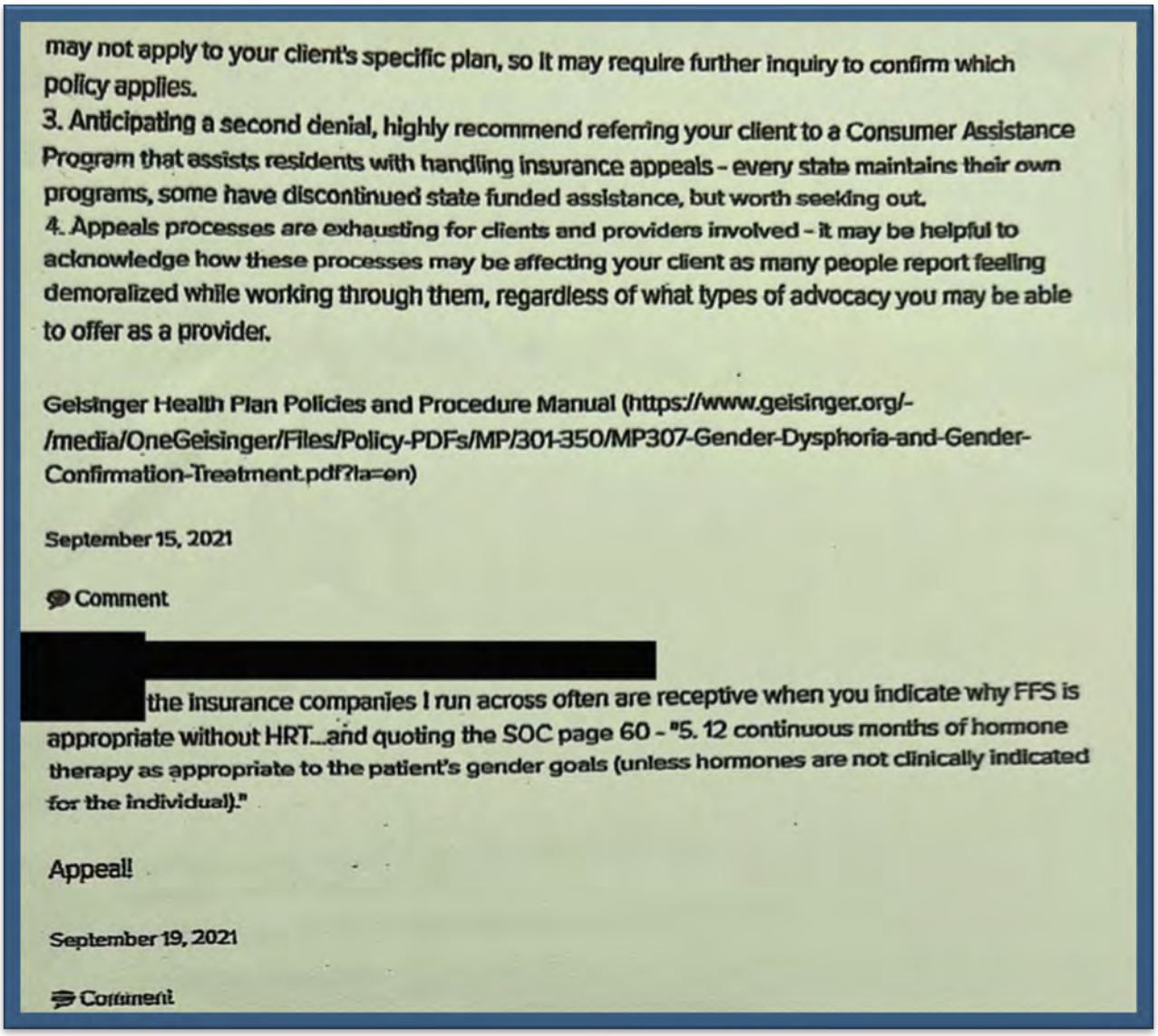
Normally if we have a patient that isn't taking hormones we have to explain why in the letter and give justification regarding the person's lived experience.

September 15, 2021

Comment

[redacted]

A few things to consider:
1. For clients/patients needing a letter and is not/does not plan to go on hormones, you can write something like, "at this time, gender affirming hormone therapy is contraindicated in her treatment for gender dysphoria and does not align with her goals for reducing symptoms." Recommend citing GHP's policy, link below and WPATH SOC 7. Erring on less is more.
2. Generally, it would appear that Geisinger Health Plan's standard policy on gender affirming care explicitly excludes FFS procedures, so possibly an uphill battle that may result in an external appeals process, removed of the reason cited by the coverage determination letter. This policy



may not apply to your client's specific plan, so it may require further inquiry to confirm which policy applies.
3. Anticipating a second denial, highly recommend referring your client to a Consumer Assistance Program that assists residents with handling insurance appeals - every state maintains their own programs, some have discontinued state funded assistance, but worth seeking out.
4. Appeals processes are exhausting for clients and providers involved - it may be helpful to acknowledge how these processes may be affecting your client as many people report feeling demoralized while working through them, regardless of what types of advocacy you may be able to offer as a provider.

Geisinger Health Plan Policies and Procedure Manual (https://www.geisinger.org/-/media/OneGeisinger/Files/Policy-PDFs/MP/301-350/MP307-Gender-Dysphoria-and-Gender-Confirmation-Treatment.pdf?la=en)

September 15, 2021

Comment

[redacted] the insurance companies I run across often are receptive when you indicate why FFS is appropriate without HRT...and quoting the SOC page 60 - "5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless hormones are not clinically indicated for the individual)."

Appeal!

September 19, 2021

Comment

10) LIVED EXPERIENCE GUIDELINES FOR TRANSITION

a) WPATH members discuss potential vaginoplasty in elderly patient

DISCUSSION

[redacted]

12 mo lived gender requirement for gender affirmation surgeries

[redacted]

2,712 Discussion Views

7 Responses

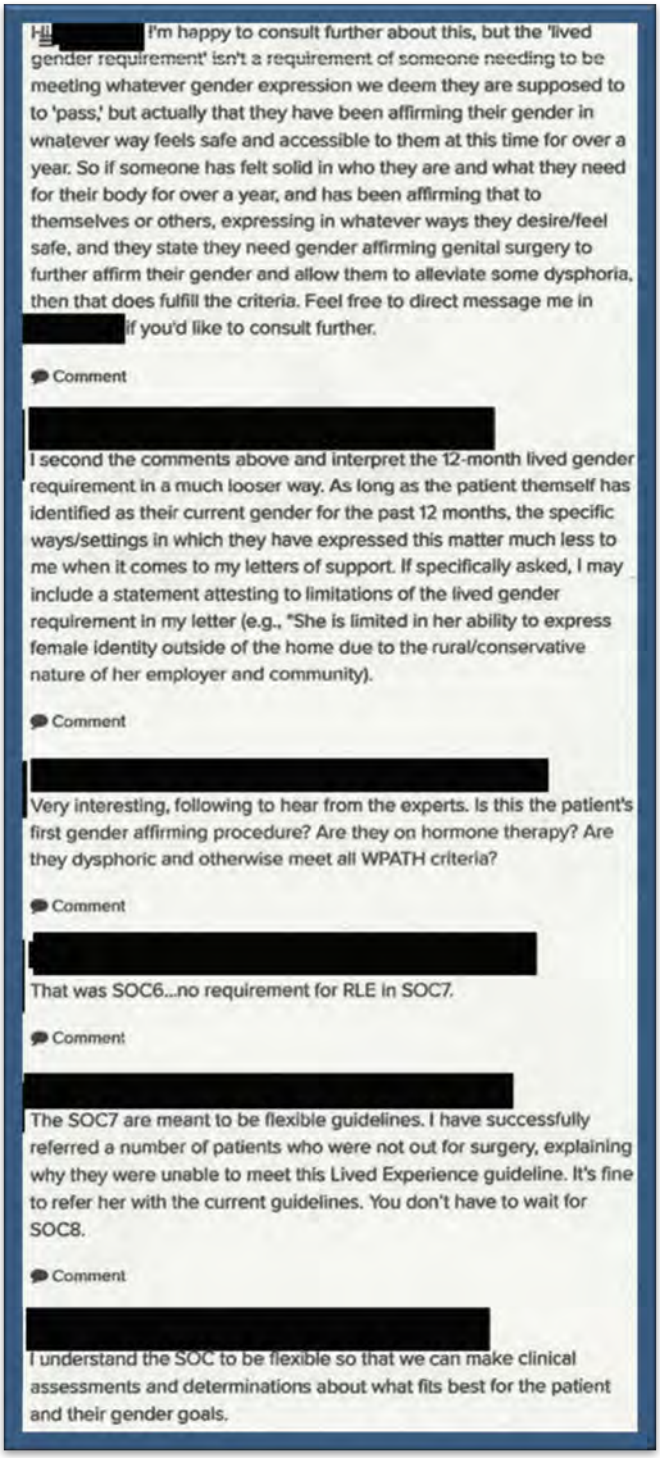
I have an 79yo assigned male at birth patient with a lifelong nonbinary/female gender identity requesting a limited depth vaginoplasty. Patient does not meet the 12 mo lived gender requirement of WPATH SoC version 7 because they are not comfortable socially transitioning at this age in front of their children and rural community. Does anyone know whether SoC v8 will soften the 12mo lived gender requirement? We'll find out end of Dec when it comes out, but at age 79, time is of the essence.

Submit

[redacted]

Does "12 months living in gender role" necessarily have to be interpreted as "12 months of being out as trans in absolutely every possible setting"? Plenty of trans people socially transition in some settings and present as their assigned gender at birth in other settings for logistical reasons (e.g. employment discrimination, family issues). I'm assuming the patient has been "living" in her identified gender at home and/or to certain select people (healthcare professionals? support group? trans friends?) for a long time, even if she's not out to the majority of the people in her community.

Comment



Hi [redacted] I'm happy to consult further about this, but the 'lived gender requirement' isn't a requirement of someone needing to be meeting whatever gender expression we deem they are supposed to to 'pass,' but actually that they have been affirming their gender in whatever way feels safe and accessible to them at this time for over a year. So if someone has felt solid in who they are and what they need for their body for over a year, and has been affirming that to themselves or others, expressing in whatever ways they desire/feel safe, and they state they need gender affirming genital surgery to further affirm their gender and allow them to alleviate some dysphoria, then that does fulfill the criteria. Feel free to direct message me in [redacted] if you'd like to consult further.

Comment

[redacted]

I second the comments above and interpret the 12-month lived gender requirement in a much looser way. As long as the patient themself has identified as their current gender for the past 12 months, the specific ways/settings in which they have expressed this matter much less to me when it comes to my letters of support. If specifically asked, I may include a statement attesting to limitations of the lived gender requirement in my letter (e.g., "She is limited in her ability to express female identity outside of the home due to the rural/conservative nature of her employer and community).

Comment

[redacted]

Very interesting, following to hear from the experts. Is this the patient's first gender affirming procedure? Are they on hormone therapy? Are they dysphoric and otherwise meet all WPATH criteria?

Comment

[redacted]

That was SOC6...no requirement for RLE in SOC7.

Comment

[redacted]

The SOC7 are meant to be flexible guidelines. I have successfully referred a number of patients who were not out for surgery, explaining why they were unable to meet this Lived Experience guideline. It's fine to refer her with the current guidelines. You don't have to wait for SOC8.

Comment

[redacted]

I understand the SOC to be flexible so that we can make clinical assessments and determinations about what fits best for the patient and their gender goals.

[redacted]
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Comment

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Comment

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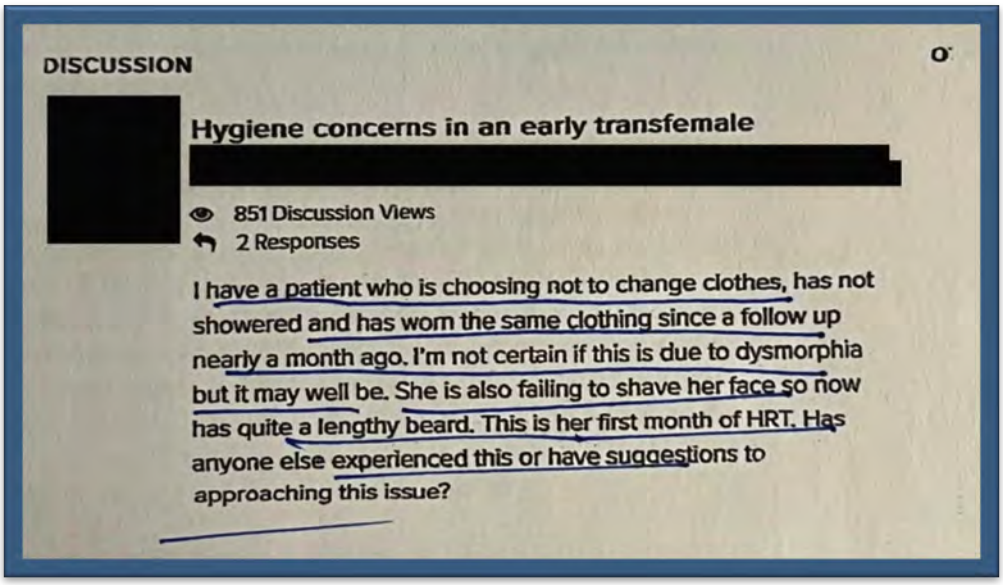
Comment

[redacted]
I understand the SOC to be flexible so that we can make clinical assessments and determinations about what fits best for the patient and their gender goals.

11) HYGIENE CONCERNS

a) WPATH members discuss lack of hygiene in a patient after hormone replacement therapy (HRT)



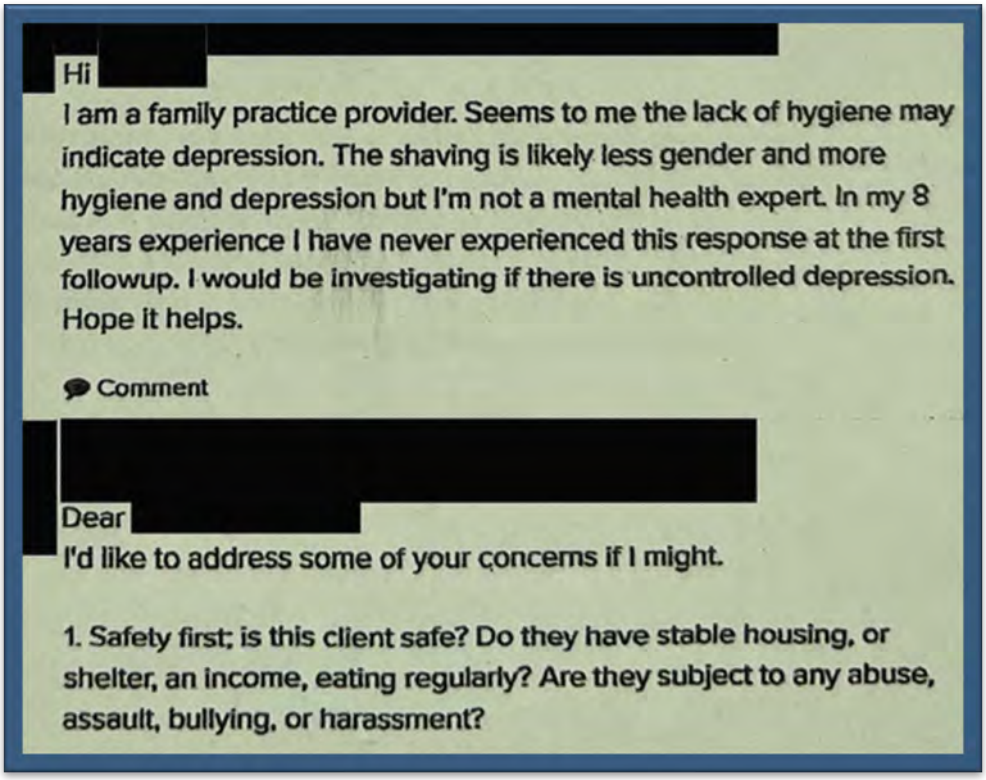
DISCUSSION

[redacted]

Hygiene concerns in an early transfemale [redacted]

851 Discussion Views
2 Responses

I have a patient who is choosing not to change clothes, has not showered and has worn the same clothing since a follow up nearly a month ago. I'm not certain if this is due to dysmorphia but it may well be. She is also failing to shave her face so now has quite a lengthy beard. This is her first month of HRT. Has anyone else experienced this or have suggestions to approaching this issue?



Hi [redacted]

I am a family practice provider. Seems to me the lack of hygiene may indicate depression. The shaving is likely less gender and more hygiene and depression but I'm not a mental health expert. In my 8 years experience I have never experienced this response at the first followup. I would be investigating if there is uncontrolled depression. Hope it helps.

Comment

[redacted]

Dear [redacted]

I'd like to address some of your concerns if I might.

1. Safety first; is this client safe? Do they have stable housing, or shelter, an income, eating regularly? Are they subject to any abuse, assault, bullying, or harassment?

2. Secondly, when you say "early", is this early in the therapeutic process, early in transition, or early in your work with her? I ask because each requires different answers. I'm going to answer "early in work with you." You've diagnosed GD or were referred by someone who had, yes? You've probably done an assessment and BDI; is this person experiencing elevated levels of frustration, anxiety, or depression? Do they have a history of suicidality? There are so many triggers that can push the associated symptomology of gender dysphoria into crisis; have any of these occurred?

3. Regarding the unchanged clothing, does this person have much of a wardrobe? It is very common for Trans folk to maintain THREE wardrobes, particularly Trans women, one of male drag for situations where they are not out, one of female garb matching their gender identity for spaces they're able to present authentically, and garments, usually female, but of an androgynous cut that may be worn anywhere. She may not have many clothes in the second category. She may be very early in transition, still struggling with self-acceptance and cycling through stages of clothing purges.

4. Poor hygiene instantly brings to mind safety again, as in risk of self-harm, elevated depression, suicidality, but also safety as in no stable housing or access to shower facilities or laundry, or not out in housing situation and therefore constrained in dressing space and options due to fear of violence.

5. Has she been diagnosed with dysmorphia? GD diagnostics do contain elements of dissatisfaction ranging to disgust with natal biology matching gender designation at birth rather than actual experienced/lived gender/gender identity but aren't usually referred to with the term "dysmorphia" unless that is a separate diagnosis specific to particular areas of anatomy. Usually, gender dysphoria includes a critical focus upon genitalia or any prominent and visible secondary sex characteristic of GDAB biology. For Trans women, this includes beard shadow, shoulder width, hand size, chin prominence, laryngeal promontory, or other features which may be difficult to alter or conceal and therefore particularly stressful at this stage.

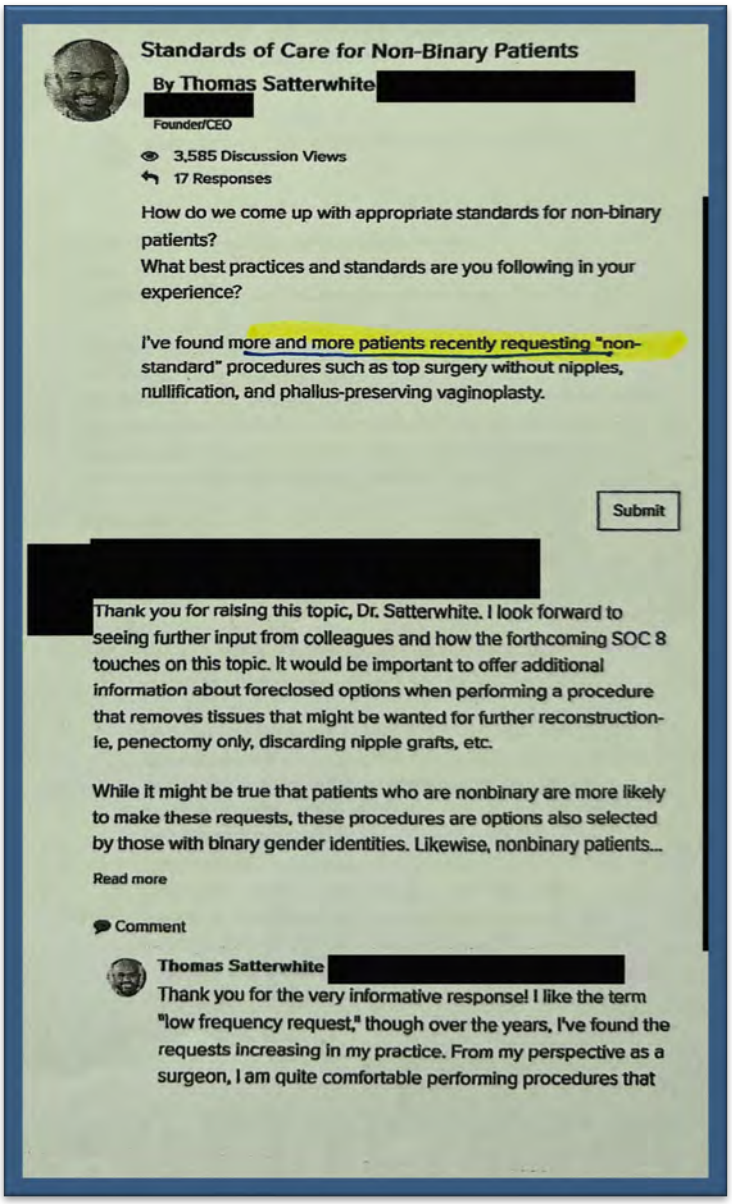
6. Again, with the cessation of shaving, does she have access to adequate shaving supplies and safe space to use them? Or is it possible that this is part of a struggle with self-acceptance and might represent a "flight into masculinity" paradigm? Also, remember race can figure as well. Black Trans women often have different issues managing beard growth, skin appearance, hair and removal methods, and may require elements that could be expensive or unavailable, such as specialty depilatories suitable for multiple skin types.

7. Frequently in the very early days of GAHT, folks experience a boost of positivity, hopefulness, find it easier to regulate, and often describe this concrete and tangible action forward as "gender euphoria." This can be true even if circumstances such as work or family may prevent them from presenting in their experienced gender and may have to continue living part or full time in their GDAB gender presentation.

I hope some of these observations prove useful.

12) NON-STANDARD MEDICAL PROCEDURES

a) WPATH members discuss appropriate standards of care for nonbinary patients, particularly when they request non-standard procedures



Standards of Care for Non-Binary Patients

By Thomas Satterwhite [redacted]

Founder/CEO

3,585 Discussion Views

17 Responses

How do we come up with appropriate standards for non-binary patients?
What best practices and standards are you following in your experience?

I've found more and more patients recently requesting "non-standard" procedures such as top surgery without nipples, nullification, and phallus-preserving vaginoplasty.

Submit

[redacted]

Thank you for raising this topic, Dr. Satterwhite. I look forward to seeing further input from colleagues and how the forthcoming SOC 8 touches on this topic. It would be important to offer additional information about foreclosed options when performing a procedure that removes tissues that might be wanted for further reconstruction- ie, penectomy only, discarding nipple grafts, etc.

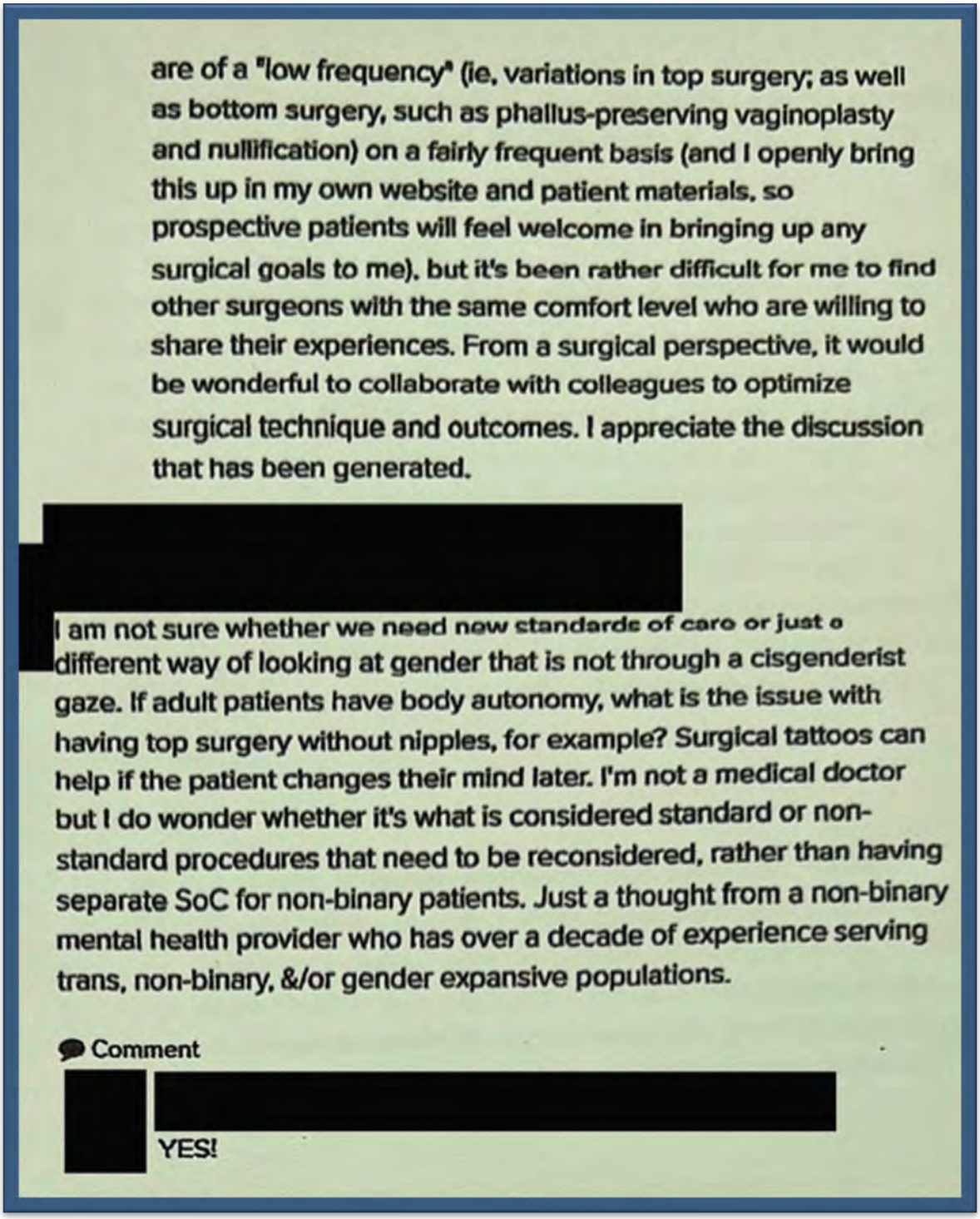
While it might be true that patients who are nonbinary are more likely to make these requests, these procedures are options also selected by those with binary gender identities. Likewise, nonbinary patients...

Read more

Comment

Thomas Satterwhite [redacted]

Thank you for the very informative response! I like the term "low frequency request," though over the years, I've found the requests increasing in my practice. From my perspective as a surgeon, I am quite comfortable performing procedures that



are of a "low frequency" (ie, variations in top surgery; as well as bottom surgery, such as phallus-preserving vaginoplasty and nullification) on a fairly frequent basis (and I openly bring this up in my own website and patient materials, so prospective patients will feel welcome in bringing up any surgical goals to me), but it's been rather difficult for me to find other surgeons with the same comfort level who are willing to share their experiences. From a surgical perspective, it would be wonderful to collaborate with colleagues to optimize surgical technique and outcomes. I appreciate the discussion that has been generated.

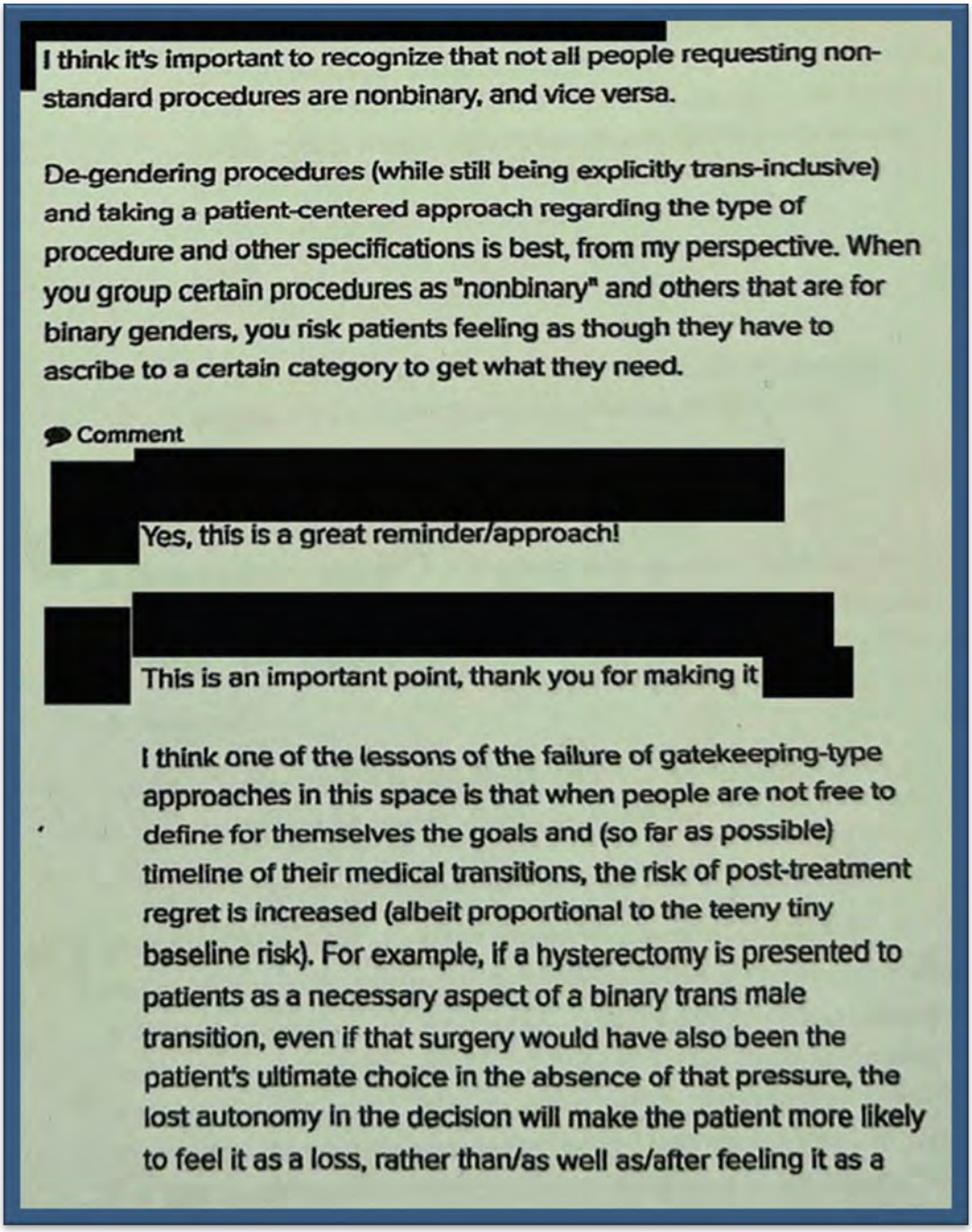
[redacted]

I am not sure whether we need new standards of care or just a different way of looking at gender that is not through a cisgenderist gaze. If adult patients have body autonomy, what is the issue with having top surgery without nipples, for example? Surgical tattoos can help if the patient changes their mind later. I'm not a medical doctor but I do wonder whether it's what is considered standard or non-standard procedures that need to be reconsidered, rather than having separate SoC for non-binary patients. Just a thought from a non-binary mental health provider who has over a decade of experience serving trans, non-binary, &/or gender expansive populations.

Comment

[redacted]

YES!



I think it's important to recognize that not all people requesting non-standard procedures are nonbinary, and vice versa.

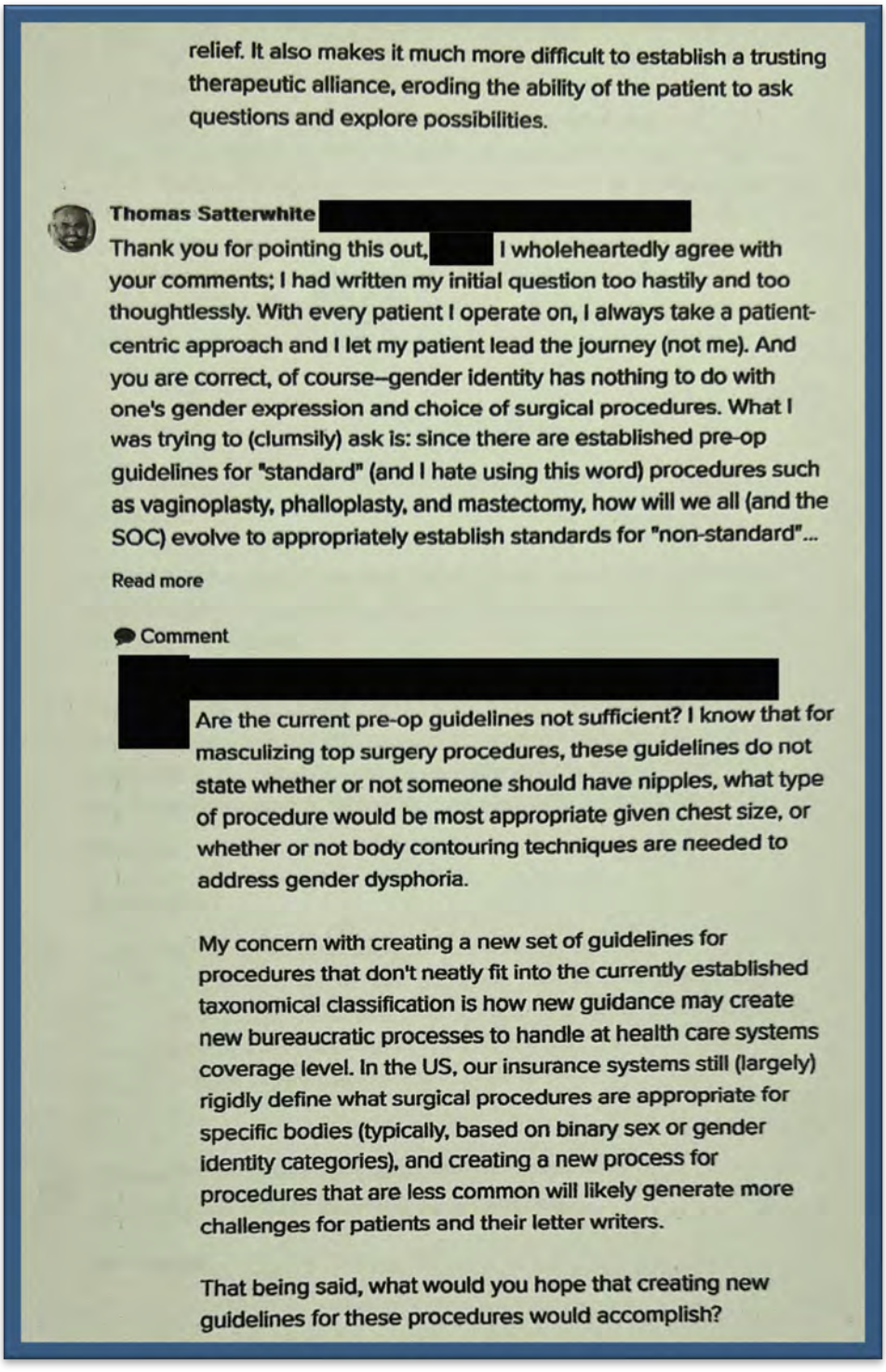
De-gendering procedures (while still being explicitly trans-inclusive) and taking a patient-centered approach regarding the type of procedure and other specifications is best, from my perspective. When you group certain procedures as "nonbinary" and others that are for binary genders, you risk patients feeling as though they have to ascribe to a certain category to get what they need.

Comment

[redacted] Yes, this is a great reminder/approach!

[redacted] This is an important point, thank you for making it [redacted]

I think one of the lessons of the failure of gatekeeping-type approaches in this space is that when people are not free to define for themselves the goals and (so far as possible) timeline of their medical transitions, the risk of post-treatment regret is increased (albeit proportional to the teeny tiny baseline risk). For example, if a hysterectomy is presented to patients as a necessary aspect of a binary trans male transition, even if that surgery would have also been the patient's ultimate choice in the absence of that pressure, the lost autonomy in the decision will make the patient more likely to feel it as a loss, rather than/as well as/after feeling it as a



relief. It also makes it much more difficult to establish a trusting therapeutic alliance, eroding the ability of the patient to ask questions and explore possibilities.

Thomas Satterwhite [redacted]

Thank you for pointing this out, [redacted] I wholeheartedly agree with your comments; I had written my initial question too hastily and too thoughtlessly. With every patient I operate on, I always take a patient-centric approach and I let my patient lead the journey (not me). And you are correct, of course--gender identity has nothing to do with one's gender expression and choice of surgical procedures. What I was trying to (clumsily) ask is: since there are established pre-op guidelines for "standard" (and I hate using this word) procedures such as vaginoplasty, phalloplasty, and mastectomy, how will we all (and the SOC) evolve to appropriately establish standards for "non-standard"...

Read more

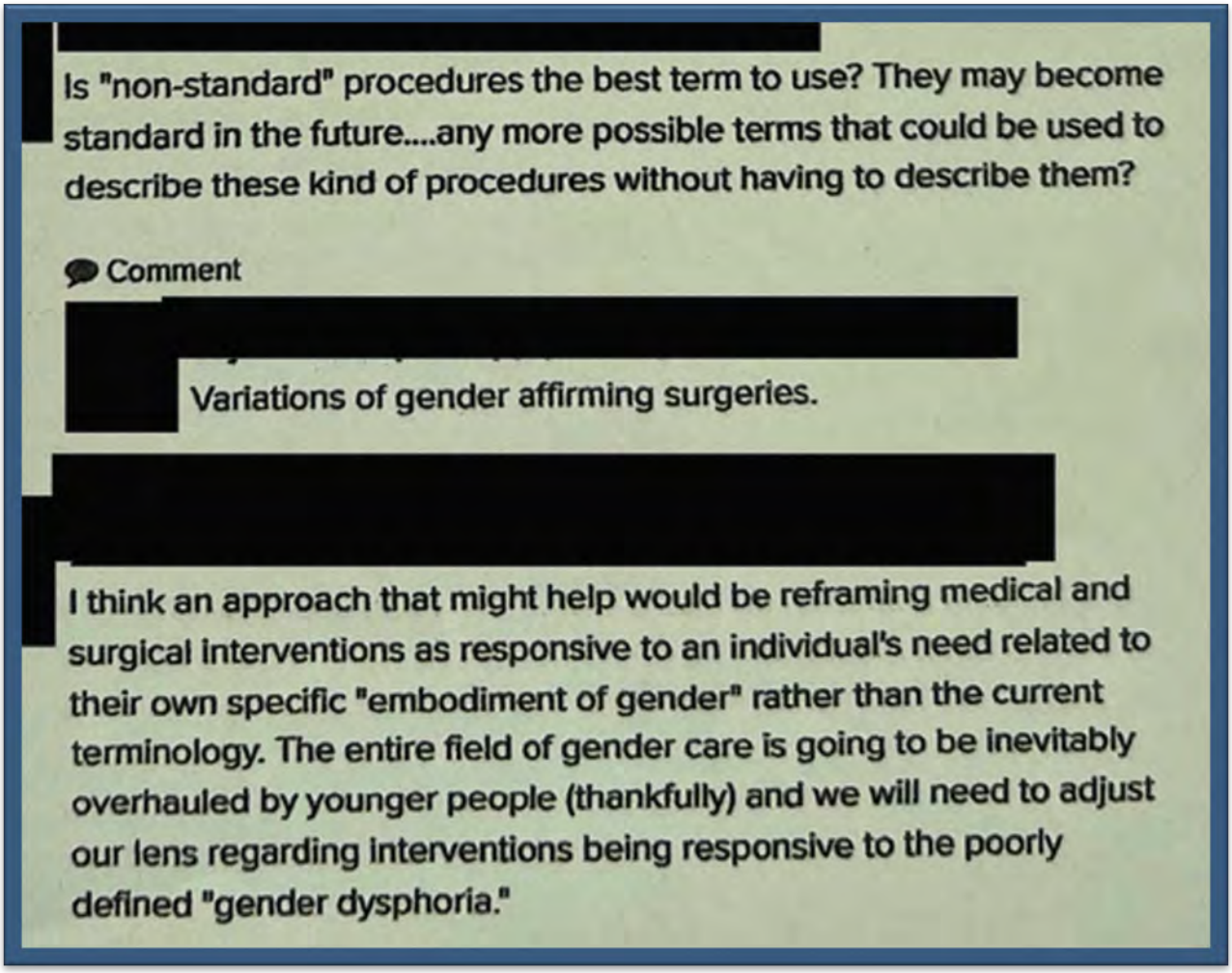
Comment

[redacted]

Are the current pre-op guidelines not sufficient? I know that for masculizing top surgery procedures, these guidelines do not state whether or not someone should have nipples, what type of procedure would be most appropriate given chest size, or whether or not body contouring techniques are needed to address gender dysphoria.

My concern with creating a new set of guidelines for procedures that don't neatly fit into the currently established taxonomical classification is how new guidance may create new bureaucratic processes to handle at health care systems coverage level. In the US, our insurance systems still (largely) rigidly define what surgical procedures are appropriate for specific bodies (typically, based on binary sex or gender identity categories), and creating a new process for procedures that are less common will likely generate more challenges for patients and their letter writers.

That being said, what would you hope that creating new guidelines for these procedures would accomplish?



[redacted]

Is "non-standard" procedures the best term to use? They may become standard in the future....any more possible terms that could be used to describe these kind of procedures without having to describe them?

Comment

[redacted]

Variations of gender affirming surgeries.

[redacted]

I think an approach that might help would be reframing medical and surgical interventions as responsive to an individual's need related to their own specific "embodiment of gender" rather than the current terminology. The entire field of gender care is going to be inevitably overhauled by younger people (thankfully) and we will need to adjust our lens regarding interventions being responsive to the poorly defined "gender dysphoria."