Today’s “Genderation” of Youth: The Clinical Approach to Gender Diverse and Transgender Youth Across Development

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Disclosures

This presentation is based on a partnership between Scott Leibowitz, MD

-&-

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STAND UP TO BULLYING FROM #DAY1
TERMINOLOGY
Terminology - Sex

- Sex
  - Refers to anatomy differences in genitalia and internal reproductive system organs (gonads) that determine sex, typically male or female
  - Typically used at birth to assign a certain gender.
Terminology - Gender Identity

• Gender Identity
  • refers to a person’s personal sense of self as male, female, aspects of maleness and/or femaleness, or neither
  • Typically develops with language around age 3 years old
**Terminology - Gender Expression**

- **Gender Expression**
  - refers to how someone **expresses** their gender through dress, speech, mannerisms, and behavior.
**Terminology - Sexual Orientation**

- **Sexual Orientation**
  - Describes the gender (or sex) of the person who someone is attracted to or aroused by romantically and/or sexually
  - Sexual behavior does not automatically imply sexual orientation
  - Sexual identity does not automatically imply sexual orientation
### Deconstructing the Binary

<table>
<thead>
<tr>
<th>SEX</th>
<th>GENDER IDENTITY</th>
<th>GENDER EXPRESSION</th>
<th>SEXUAL ORIENTATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;What our Body Has&quot;</td>
<td>&quot;Who we are&quot;</td>
<td>&quot;How we act&quot;</td>
<td>&quot;Who we are attracted to&quot;</td>
</tr>
<tr>
<td>Male Anatomy</td>
<td>Male</td>
<td>Masculine</td>
<td>Attracted to males</td>
</tr>
<tr>
<td>Female anatomy</td>
<td>Female</td>
<td>Feminine</td>
<td>Attracted to females</td>
</tr>
<tr>
<td>Both</td>
<td>Aspects of both</td>
<td>Genderqueer</td>
<td>Attracted to both</td>
</tr>
<tr>
<td>Neither</td>
<td></td>
<td></td>
<td>Attracted to all</td>
</tr>
</tbody>
</table>

#### SEX
- Male Anatomy
- Female anatomy
- Both

#### GENDER IDENTITY
- Male
- Female
- Aspects of both
- Neither

#### GENDER EXPRESSION
- Masculine
- Feminine
- Genderqueer

#### SEXUAL ORIENTATION
- Attracted to males
- Attracted to females
- Attracted to both
- Attracted to all

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**THRIVE GENDER PROGRAM**
**NATIONWIDE CHILDREN'S**
*When your child needs a hospital, everything matters.*
Disorder/Difference of Sex Development (Intersex)

- Disorder of sex Development
  - When something occurs differently in the development of typical anatomy that make up a person’s genitalia or reproductive system
  - There are many different types of DSDs
  - Parents may struggle in knowing whether to raise their baby as a boy or a girl
  - When the baby gets older, they may have no questions about their gender identity
Lesbian, Gay, Bisexual, Straight

• Gay
  • When someone is attracted to a person of the same gender/sex, usually referring to males

• Lesbian
  • When a female is attracted to another female

• Bisexual
  • When a person is attracted to both genders

• Straight
  • When a person is attracted to a person of the opposite gender/sex
Gender Nonconforming/Diverse

• **Gender Nonconforming/Diverse** - refers to when people’s outward gender expression is different from what society would expect them to be based on their assigned gender
  - Example: male wearing makeup
  - Example: female with a very short masculine hairstyle
  - Not all people who are gender nonconforming are transgender

• **Gender Conforming** - when people’s outward gender expression is the same as what society would expect
Cisgender vs Transgender

**Cisgender**
- When someone’s sex anatomy matches their gender identity (majority of the population)
- A person with a penis feels like a male.
- A person with a vagina feels like a female

**Transgender**
- When someone’s sex anatomy doesn’t match their gender identity (minority of the population)
- A person with a penis doesn’t feel like a male.
- A person with a vagina doesn’t feel like a female
A. A marked incongruence between one’s experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least six of the following eight indicators, **AT LEAST ONE OF WHICH MUST BE CRITERION A1:**

1. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one’s assigned gender)
2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to wearing of typical feminine clothing
3. A strong preference for cross-gender roles in make-believe play or fantasy play
4. A strong preference for toys, games, or activities stereotypically used or engaged in by the other gender
5. A strong preference for playmates of the other gender
6. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities
7. A strong dislike of one’s anatomy
8. A strong desire for the primary and/or secondary sex characteristics that match one’s experienced gender.

B. The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning
DSM 5: Gender Dysphoria- Adolescence and Adulthood

A. A marked incongruence between one’s experienced/expressed gender and assigned gender, of at least 6 months duration as manifested by at least **TWO** of the following:

1. A marked incongruence between one’s experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics)

2. A strong desire to be rid of one’s primary and/or secondary sex characteristics because of a marked incongruence with one’s experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)

3. A strong desire for the primary and/or secondary sex characteristics of the other gender.

4. A strong desire to be of the other gender (or some alternative gender different from one’s assigned gender)

5. A strong desire to be treated as the other gender (or some alternative gender different from one’s assigned gender)

6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one’s assigned gender)

B. The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning

**Specifiers:**

1. Post Transition Specifier- if individual has transitioned to living in the desired gender and has undergone (or preparing to) have at least one medical procedure

2. Disorder of Sex Development Specifier: if there is a DSD as well
Newer Terminology

- **Agender** – Individuals who experience no specific gender at a certain point in time.

- **Genderqueer** – More common in adolescents; referring to those who defy all categories of culturally defined gender and prefer to self-identify as gender-free, gender neutral, or completely outside gender. The term transcends the male-female gender binary and/or sexual orientation identity labels. (Ehrensaft 2012)

- **Pansexual** – A colloquial term used by youth who are attracted to individuals along all lines of the gender spectrum- not necessarily within the male-female gender binary.

- **“Dysphoria”** – short for “Gender Dysphoria” which Transgender adolescents use referring exclusively to gender dysphoria

- **Gender fluid** – when an individual experiences different genders at different points in time

- **AFAB/AMAB** - Assigned (female/male) at birth
GENDER
IDENTITY &
PSYCHIATRY

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NATIONWIDE CHILDREN’S
When your child needs a hospital, everything matters."
Sex, Sexuality, and Gender Identity in Mental Health Practice

• All individuals have a specific sex anatomy, gender identity, gender expression, and sexual orientation that contribute to their psychological and emotional wellbeing.

• These issues may or may not be contributing to the challenges that they are presenting with in a behavioral/mental health setting (e.g. a transgender depressed person isn’t always depressed because they are transgender).

• All mental health clinicians an important role in helping the patient integrate these aspects of self into healthy emotional and physical development.

• Clinicians play an important role in multidisciplinary collaboration, particularly when physical interventions are indicated for gender dysphoria.
Shift in Conceptualizing Diagnosis—Previously considered “Gender Identity Disorder” which pathologized the *identity*, not the underlying mind-body discrepancy, and now classified as Gender Dysphoria

Shift in Models of Care—In adults, care models have shifted from “Gatekeeping Model” to an “Informed Consent” model

Shift in Behavioral Health expectations—previous need to experience a “Real Life Experience” for predefined period of time.

- Now think about it in terms of “eligibility” and “readiness”
Clinical Service Trends for Youth

- **Adolescent referrals are increasing and surpassing child referrals** for first time in 30 years (Wood, Sasaki, Bradley, Singh et al., 2013)

- **Inversion of sex ratio** - Increasing trend of birth assigned females presenting at higher rates than birth assigned males (Aitken et al., 2015) - 748 adolescents combined from Amsterdam and Toronto

- **Increase in clinics serving these youth** (Hsieh & Leininger, 2014)
  - 2007: one clinic in a pediatric academic medical center in the U.S.
  - 2018: approximately 50 clinics in pediatric academic medical centers

- **Variation in models of care delivery**
  - Some clinics based within mental health division
  - Other clinics based within medical/pediatric/endo division
  - Others based across both mental health AND medical divisions
RELEVANCE
Trans Visibility in the Media

2014, the year of... transgender visibility

We’ve all been living under a rock to have missed the explosion of transgender visibility. Recently, from Janet Mock’s explosive interview with Paris Mcdonald in the Suits of the T.M.E. public transition here in the UK, trans people have been generating headlines like no one’s ever been able to keep up with it anymore. Every day brings some new story about a trans person who people have never had the chance to do before; every day some milestone is reached. Good.

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When your child needs a hospital, everything matters.”
National Transgender Discrimination Survey 2015
James SE et al., 2016

- **Negative Experience in Health Care setting**: 33% of the sample reported a negative experience in a health care setting related to being transgender

- **Pressure to transition back**: 18% of individuals discussing their gender identity with a professional reported the provider tried to stop them from being transgender

- **Lack of provider knowledge**: 24% of the sample reported having to teach their medical providers about transgender care
Barriers to Accurate Prevalence

- **Lack of Data Collection**: (Deutsch et al., 2013)

- **Pervasive Discrimination which impacts:**
  - Fear of Disclosure
  - Lack of Visibility
  - Lack of Access to Care
Prevalence in the United States
Williams Institute, 2016

Looked at Behavioral Risk Factor Surveillance System (BRFSS)

19 states specifically asked the question

0.6% of the adult U.S. population is transgender

1:167
# Gender Nonconformity in Childhood and Psychiatric Vulnerability

<table>
<thead>
<tr>
<th>Study</th>
<th>Outcome</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roberts et al. 2012</td>
<td>PTSD, Child abuse</td>
<td>Gender nonconformity (top decile) predicted almost twice as high risk for lifetime PTSD.</td>
</tr>
<tr>
<td>Roberts et al. 2013</td>
<td>Depression</td>
<td>Gender nonconformity (top decile) led to 26% mild-mod depression in young adulthood compared to 18% of those who were gender conforming children. Abuse and bullying accounted for half of the increased prevalence of depressive symptoms in those youth.</td>
</tr>
<tr>
<td>Toomey et al. 2010</td>
<td>Psychosocial adjustment</td>
<td>Victimization in school of 245 LGBT young adults fully mediates the association between gender nonconformity in adolescence and life satisfaction in adults</td>
</tr>
<tr>
<td>Birkett et al. 2009</td>
<td>Bullying and victimization</td>
<td>LGB and questioning youth are more likely to report bullying, homophobic victimization</td>
</tr>
<tr>
<td>Nuttbrock et al. 2010</td>
<td>Major depression</td>
<td>Looked at the effects of interpersonal abuse on 571 MtF transgender persons in NYC. In adolescence, this abuse led to higher rates of MDD.</td>
</tr>
</tbody>
</table>
Percent of the first 97 patients presenting to the Boston Children’s Hospital GeMS clinic for medical hormone interventions grouped by degree of psychiatric compromise. Spack et. al, Pediatrics March 2012
Developmental Overview

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GENDER-DIVERSE CHILDREN

GENDER-QUEER/QUESTIONING

CISGENDER GAY, LESBIAN, BISEXUAL ADOLESCENTS

SEXUAL IDENTITY

GENDER NONCONFORMITY

PREPUBERTAL SOCIAL GENDER TRANSITION

PUBERTAL SUPPRESSION

CROSS-GENDER HORMONES

SURGICAL

TRANSGENDER ADOLESCENTS of all SEXUAL ORIENTATIONS

PUBERTAL AROUSAL BEHAVIORS SOCIAL ROLE

INFANCY TODDLER PRESCHOOL CHILDHOOD PRE-ADOLESCENCE ADOLESCENCE

0 2 4 6 8 10 12 14 16 18
# Gender Identity - Biological Factors

<table>
<thead>
<tr>
<th>Factor</th>
<th>Associated Entity</th>
<th>Main Conclusion</th>
</tr>
</thead>
</table>
| In Utero Hormonal Exposure | CAH in XX 5αRD in XY CAIS in XY           | • Higher amount of gender dysphoria than would be expected in the general population (Dessens, Slijper, Drop, 2005; Berenbaum & Bailey, 2003)  
  • Increased Androgen Exposure more likely to affect gender role and sexual orientation than gender identity (Meyer-Bahlburg, Dolezal, Baker et al., 2006)  
  • Not solely connected with prenatal androgen exposure. (Rosenthal, 2014) |
| Genetics                | Twin studies Specific Genes                | • Higher concordance (39.1%) in MZ twins than in DZ twins (0%) (Heylens, DeCuypere, Zucker et al, 2012)  
  • No conclusive evidence on specific genes |
| Brain structures        | INAH-3 BSTc (bed nucleus of striae terminalis) | • INAH-3- perhaps sexual orientation dimorphic (Byne, Tobias, Mattiace, et al, 2001)  
  • MtF have female-typical size of BSTc in some studies (Zhou, Hofman, Gooren, Swaab, 1995; Kruijver, Zhou, Pool, et al., 2000)  
  • BSTc is not sexually dimorphic until puberty |
| Brain Morphology        | Grey Matter White matter Odorous steroids  | • Putamen larger in MTF than males, another study inconclusive (Luders, Sanchez, Gaser et al., 2009; Savic & Archer, 2011)  
  • Hypothalamic blood flow in response to steroid odors is sexually dimorphic (Berglund, Lindstrom, Dhejne-Delmy, Savic, 2008)  
  • Limitations are that the brain is plastic and unknown whether the results are a consequence of experience |
Societal Understanding of Gender

Yet...

Gender is a societal construct and gender differences are experienced by humans.

There are many individuals who are non-binary or gender fluid.

We live in a binary world and the science is limited.
So is it biological or environmental?

IT IS COMPLEX.
Several research studies done over the past few decades
- Looked at whether children would ultimately be transgender once they go through puberty
- Some used older categories of children who were more gender nonconforming but not necessarily transgender in the first place
- Research shows that many children who are gender diverse will not be transgender later in life
- Clinically we cannot predict with 100% certainty who will be who, so should not treat a specific child as a research study
Pre-pubertal Social Gender Transition: Cross-sectional Mental Health Outcomes
(Pediatrics, Feb 2016 Olson, Durwood, DeMeules, McLaughlin)

- Community sample of 73 children who have already socially transitioned, aged 3-12 vs two control groups (49 siblings, 743 nonsiblings)
  - Mean age 7.7 y/o, 22 birth females, 51 birth males
- Parents completed anxiety and depression measures (NIH short forms for anxiety/depression)
- Mental health outcomes equal to controls and siblings
- However, long-term research on this has not been published
Gender nonconformity
Behavior phenomenon

- more difficult to distinguish -

Gender dysphoria
Identity phenomenon

Childhood factors:

- Children think more black-or-white
- Lack of mature bodies in children make it harder to know
- Identities are more reinforced by environment

Gender Variance in Childhood

INFANCY  TODDLER  PRESCHOOL  CHILDHOOD  PRE-ADOLESCENCE  ADOLESCENCE

0  2  4  6  8  10  12  14  16  18
Gender nonconformity
Behavior phenomenon
-easier to distinguish-

Gender dysphoria
Identity phenomenon

Adolescent Identity Consolidation
- Can think hypothetically
- Maturing body
- Sexual identity exploration

GENDER VARIANCE

0  2  4  6  8  10  12  14  16  18

INFANCY  TODDLER  PRESCHOOL  CHILDHOOD  PRE-ADOLESCENCE  ADOLESCENCE
CLINICAL PRACTICE
Eliciting a child’s gender narrative

Questions

Meaning of gender to the child
• “Tell me what it means to be a boy and what it means to be a girl.”
• “Is it possible to be something other than a boy or a girl?”

Specific Questions about the child
• “Are you a boy or a girl [or whatever child says above]?”
• “What’s it like for you when you are with boys or girls who are different types of boys or girls than you are?”
• “Can boys like [list things child associates with girls]?”
• “Can girls like [list things child associates with boys]?”
• “What types of activities and toys do you like to do and play with?”
• “Do you like to have friends who are boys, girls, or both?”

Based on Child Gender Identity Interview- Zucker 1993
<table>
<thead>
<tr>
<th>Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reinforcing stereotypes</strong></td>
</tr>
<tr>
<td>“Man up, Jonny.” “Girls aren’t supposed to get dirty.”</td>
</tr>
<tr>
<td><strong>“Boxing in” a gender-variant child</strong></td>
</tr>
<tr>
<td>“When you are older, you will be able to take medicine and have surgery that will make your body a girl.”</td>
</tr>
<tr>
<td><strong>Healthy open-ended gender language</strong></td>
</tr>
<tr>
<td>“We will love you and support you no matter who you are.”</td>
</tr>
</tbody>
</table>
Three Approaches?  
“Trinary Conceptualization”

• **Lessen gender dysphoria**
  • Historically used active attempts to lessen the gender dysphoria with therapy approaches designed to “change the feelings” but largely viewed as unethical

• **Wait-and-see**
  • Intermediate position that doesn’t make an active effort to lessen either gender dysphoria or encourage cross-gender behavior
  • “watchful-waiting approach” approach

• **Support desired transition**
  • Encouragement of a social transition to a cross-gender role and identity
  • Changing names, school attendance, dress in an assumption that gender dysphoria will persist (or intensify) with puberty

Zucker 2008
Three Approaches?

“Trinary Conceptualization”

- **Lessen gender dysphoria**
  - Historically using attempts to lessen gender dysphoria with therapy and interventions that “change” gender were largely viewed as unethical

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- **Support desired**
  - Encouragement of a social transition to a cross-gender role and identity
  - Changing names, school attendance, dress in an assumption that gender dysphoria will persist (or intensify) with puberty

Zucker 2008
Prepubertal Social Gender Transition

Favorable aspects

- Helps their distress if they are currently distressed not living as the gender they feel most comfortable as
- Helps to affirm and support a child’s desire to live in other gender
- Allows a child who may be transgender in the future to live authentically from an earlier age

Possible challenges

- Unknown to what degree this might “box in” a child who is exploring their gender
- If the child is told to keep their body a secret, it can be difficult for someone that young
Multidimensional Family-Based Affirming Model

**Internal**
- Develop strengths in the child
- Maximize child’s capacity to be flexibility when appropriate
- Address other challenges the child might be going through
- Maintain safety and maximize child’s ability to perceive danger

**External**
- Promote acceptance and healthy exploration without presumptions of future outcomes
- Help parents understand how to navigate their own feelings
- Work with schools, community resources, and other institutions in child’s environment
- Intervene proactively when potential harm is detected
Pubertal Advancement

Nobody likes The Puberty Fairy.
World Professional Association for Transgender Health, SOC 7

Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People

The World Professional Association for Transgender Health
Adolescent Clinical Assessment Aims

- Degree of gender dysphoria and its impact
- Stability and persistence over time
- Gender Development history from childhood
- Relationship with developing sexual identity
- Co-occurring psychiatric issues
  - Does it impair the diagnostic understanding of gender dysphoria?
  - Or is it a manifestation of untreated gender dysphoria?
- Understanding degree of physical maturation
- Strengths and resilience factors
- Decision-making around physical (medical/surgical) interventions
- Parent/Caregiver/social supports
- School climate assessment
- Community resources and connectedness
Pronouns and Name use

- **Name preference:** Some patients prefer to use a different name than the legal name listed in the medical record

- **Pronoun use:** Some patients prefer to use different pronouns than the gender listed in the medical record

- **Situation dependent:** Pronoun and name use depends on each child and each family. Sometimes the patient wants the clinician to use one set of pronouns/name when parents are not in the room, and a different set of pronouns/name when the parents are in the room
Exploration of Gender Issues

**Gender Identity**
- Underlying motivations
- Degree of insistence
- Degree of wavering and reasons for this
- Anticipated body changes
- Intimacy and Sexuality
- Reproductive understanding
- Regret in the future

**Gender Expression**
- Pronouns
- Name use
- Gender Markers
- Clothing
- Breast padding(binding)
- Makeup
- Mannerisms
- Activity preference
- Voice

**Environment**
- Family rejection/support
- Victimization and isolation
- Peer acceptance/bullying
- Awareness of others’ perceptions and reactions to anticipated body changes

**Coping**
- Internalized transphobia
- Internalized homophobia
- Degree of resilience and connectedness
- Degree of maturity and consolidation of identity
- Degree of other aspects of identity are being focused on
Gender Transition: Competing Demands

On one hand:
- Degree of Identity consolidation
- Benefits of medical interventions
- Benefits of no medical interventions
- Timing of medical interventions when appropriate
- Patient struggles

On the other:
- Degree that identity and role behavior are being conflated
- Risks of medical interventions
- Risks of no medical interventions
- Degree of psychiatric stability and correlation to dysphoria
- Family struggles
Pubertal Suppression (GnRHa) Premise

- Presses a “pause” button on Tanner 2 (+) for gender exploration
- Meant to extend the diagnostic period
- Reduces anxiety and depression
- Promotes lifelong appearance of affirmed gender (connected to healthier outcomes, Lawrence 2003)
- Minimizes need for invasive procedures
Pubertal Suppression Limitations

- Need to monitor bones
- Hormone effects on brains
- Unknown impact on surgery later on for transfemales
- Reproductive system
Sex Hormone Treatment

- In the past, provided at age 16 if meeting “eligibility and readiness” criteria
  - New Endocrine Society Guidelines from 2017 provide flexibility to go younger *with compelling reason*
  - Mental health assessment *required* for adolescents
- Testosterone for birth females and estrogen for birth males
- Produces many of the secondary sexual characteristics of affirmed gender
- Strong evidence of psychological relief in adults
- Monitoring of labs is important
## Cross-Sex Hormone Criteria

<table>
<thead>
<tr>
<th>Focus</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Persistence</strong></td>
<td>Persistent, well documented gender dysphoria</td>
</tr>
<tr>
<td><strong>Consent</strong></td>
<td>Capacity to make a fully informed decision and to consent for treatment</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td>Age of majority in a given country or parent consent</td>
</tr>
<tr>
<td><strong>Well-controlled</strong></td>
<td>If significant medical or mental health concerns are present, they must be reasonably well-controlled.</td>
</tr>
<tr>
<td><strong>Psychiatric and medical issues</strong></td>
<td>If significant medical or mental health concerns are present, they must be reasonably well-controlled.</td>
</tr>
</tbody>
</table>
Cross-Sex Hormone Effects

### Table 1A: Effects and Expected Time Course of Masculinizing Hormones

<table>
<thead>
<tr>
<th>Effect</th>
<th>Expected onset</th>
<th>Expected maximum effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin oiliness/acne</td>
<td>3–6 months</td>
<td>1–2 years</td>
</tr>
<tr>
<td>Facial/body hair growth</td>
<td>3–6 months</td>
<td>3–3 years</td>
</tr>
<tr>
<td>Scalp hair loss</td>
<td>&gt;12 months</td>
<td>Variable</td>
</tr>
<tr>
<td>Increased muscle mass/strength</td>
<td>6–12 months</td>
<td>2–5 years</td>
</tr>
<tr>
<td>Body fat redistribution</td>
<td>3–6 months</td>
<td>2–5 years</td>
</tr>
<tr>
<td>Cessation of menses</td>
<td>2–6 months</td>
<td>n/a</td>
</tr>
<tr>
<td>Clitoral enlargement</td>
<td>3–6 months</td>
<td>1–2 years</td>
</tr>
<tr>
<td>Vaginal atrophy</td>
<td>3–6 months</td>
<td>1–2 years</td>
</tr>
<tr>
<td>Deepened voice</td>
<td>3–12 months</td>
<td>1–2 years</td>
</tr>
</tbody>
</table>

### Table 1B: Effects and Expected Time Course of Feminizing Hormones

<table>
<thead>
<tr>
<th>Effect</th>
<th>Expected onset</th>
<th>Expected maximum effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body fat redistribution</td>
<td>3–6 months</td>
<td>2–3 years</td>
</tr>
<tr>
<td>Decreased muscle mass/ strength</td>
<td>3–6 months</td>
<td>1–2 years</td>
</tr>
<tr>
<td>Softening of skin/decreased oiliness</td>
<td>3–6 months</td>
<td>Unknown</td>
</tr>
<tr>
<td>Increased libido</td>
<td>1–3 months</td>
<td>1–2 years</td>
</tr>
<tr>
<td>Decreased spontaneous erections</td>
<td>1–3 months</td>
<td>3–6 months</td>
</tr>
<tr>
<td>Male sexual dysfunction</td>
<td>Variable</td>
<td>Variable</td>
</tr>
<tr>
<td>Breast growth</td>
<td>3–6 months</td>
<td>2–3 years</td>
</tr>
<tr>
<td>Decreased testicular volume</td>
<td>3–6 months</td>
<td>2–3 years</td>
</tr>
<tr>
<td>Decreased sperm production</td>
<td>Variable</td>
<td>Variable</td>
</tr>
<tr>
<td>Thinning and slowed growth of body and facial hair</td>
<td>6–12 months</td>
<td>&gt;3 years</td>
</tr>
<tr>
<td>Male pattern baldness</td>
<td>No regrowth, loss stops 1–3 months</td>
<td>1–2 years</td>
</tr>
</tbody>
</table>

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*Adapted with permission from Herbst et al. (2009), Copyright 2009. The Endocrine Society.*

Complete removal of male facial and body hair requires electrology, laser treatment, or both.

SCOTT LEIBOWITZ, MD
THRIVE GENDER PROGRAM
NATIONWIDE CHILDREN’S
When your child needs a hospital, everything matters.”
Future Regret and Fertility Concerns

“I will never ever want children.”

-is different from-

“I don’t want children now, don’t think I will want children when I’m older, but I realize that I may change my mind because I’m just a teen.”
## Surgical Overview

<table>
<thead>
<tr>
<th>Population</th>
<th>Surgery Options</th>
</tr>
</thead>
</table>
| **MtF**    | 1. Breast/chest surgery: mammoplasty through implants  
             2. Genital surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, vulvoplasty  
             3. Nongenital, nonbreast interventions: facial feminization, liposuction, lipofilling, voice surgery, thyroid cartilage reduction, gluteal augmentation, hair reconstruction |
| **FtM**    | 1. Breast/chest surgery: subcutaneous mastectomy, creation of a male chest  
             2. Genital surgery: hysterectomy/salpingo-oophorectomy, reconstruction of the urethra, metoidioplasty/phalloplast, vaginectomy, scrotoplasty, implantation of erection or testicular prostheses  
             3. Nongenital, nonbreast: voice surgery (rare), liposuction, lipofilling, pectoral implants |
Gender Confirming Surgical Interventions in Youth

- Not all individuals with gender dysphoria seek surgical interventions
- Most surgical interventions are reserved for the 18+ population
- Many surgical options exist
- Gender confirming surgery, when indicated, is medically necessary
- Mental health assessment important
- Testosterone is strongly recommended for at least one year in an adolescent age group, per WPATH SOC7, before top surgery
## An Ideal Gender Clinic

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Potential Role</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Psychology team</strong></td>
<td>Addresses psychological health&lt;br&gt;Assessment and psychometrics&lt;br&gt;Evidence based therapies</td>
</tr>
<tr>
<td><strong>Psychiatry team</strong></td>
<td>Complex psychiatric patients with gender issues&lt;br&gt;Psychopharmacological interventions&lt;br&gt;Assessment for Gender confirming interventions</td>
</tr>
<tr>
<td><strong>Adolescent Medicine</strong></td>
<td>Hormonal interventions- feminizing regimens&lt;br&gt;Menses-suppression&lt;br&gt;Primary Care</td>
</tr>
<tr>
<td><strong>Psychotherapy team</strong></td>
<td>Ongoing therapies&lt;br&gt;Evidence based therapies that are gender informed (TF-CBT, FBT, DBT, ASD)</td>
</tr>
<tr>
<td><strong>Social Work team</strong></td>
<td>Psychosocial support&lt;br&gt;School Advocacy and Community links&lt;br&gt;Linkage between medical team and behavioral health team</td>
</tr>
<tr>
<td><strong>Coordinator</strong></td>
<td>Interacts with families/Advocacy with Name changes&lt;br&gt;Parent supports&lt;br&gt;School Advocacy and linkage to other services&lt;br&gt;Group coordination</td>
</tr>
<tr>
<td><strong>Endocrine team</strong></td>
<td>Pubertal Suppression monitoring&lt;br&gt;Cross Sex Hormone therapy- in particular the masculinizing regimens</td>
</tr>
<tr>
<td><strong>Nursing team</strong></td>
<td>Injections and counseling on medication,&lt;br&gt;Medication related issues/concerns&lt;br&gt;Crisis management in clinic</td>
</tr>
<tr>
<td><strong>Surgical team</strong></td>
<td>Chest surgery</td>
</tr>
</tbody>
</table>
Resources

- Nationwide Children's THRIVE Program - [www.nationwidechildrens.org/thrive](http://www.nationwidechildrens.org/thrive)
- World Professional Association of Transgender Health – [www.wpath.org](http://www.wpath.org)
- The Trevor Project (suicide prevention) - [www.thetrevorproject.org](http://www.thetrevorproject.org)
- Tyler Clementi Foundation- Anti- Bullying resource: [www.tylerclementi.org](http://www.tylerclementi.org)
- Gay Lesbian Straight Educators Network (GLSEN)- School climate resource- [www.glsen.org](http://www.glsen.org)
- Welcoming Schools (Human Rights Campaign) – [www.welcomingschools.org](http://www.welcomingschools.org)
- Trans Youth Family Alliance - [www.imatyfa.org](http://www.imatyfa.org)
- PFLAG (Parents organization for support)- [www.community.pflag.org](http://www.community.pflag.org)
- Trans Student Educational Resources - [www.transstudent.org](http://www.transstudent.org)
- Many books are now available as well:
  - Trans Bodies, Trans Selves, Editors: *Laura Erikson Shroth*
  - Gender Born, Gender Made: by *Diane Ehrensaft*
  - The Conscious Parents Guide to Gender Identity: A Mindful Approach to Embracing your Child’s Authentic Self: by *Darlene Tando*
  - The Transgender Child: by *Stephanie Brill*