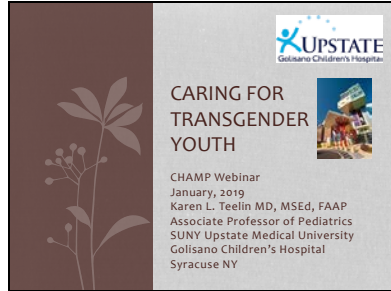


Slide 1



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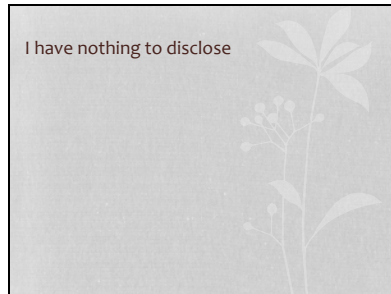
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Slide 2



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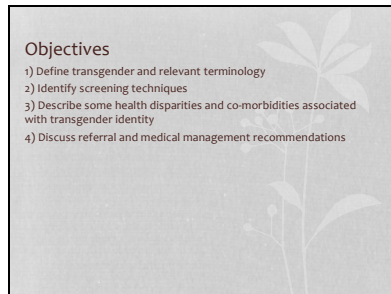
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Slide 3



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Slide 4

Outline

- Introduction and Definitions
- Prevalence and Etiology
- Health Disparities
- Making the Office Friendly
- Medical Care
  - STI screening
  - Pubertal suppression
  - Gender affirming hormones



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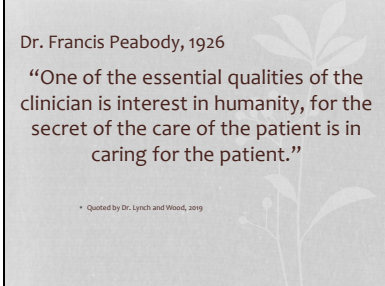
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Slide 5

Dr. Francis Peabody, 1926

“One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient.”

• Quoted by Dr. Lynch and Wood, 2019



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Slide 6

Definitions



Note: There are no specific medical interventions for transgender children prior to puberty



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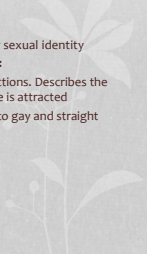
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Slide 7

LGBTQ

- **L, G, B** refer to sexual orientation or sexual identity
- **Sexual orientation / Sexual identity:**
  - Pattern of romantic or sexual attractions. Describes the gender of the persons to whom one is attracted
  - An internally applied label. Applies to gay and straight individuals
- **T:** transgender, trans
- **Q:** questioning or queer




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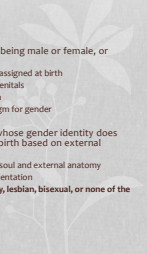
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Slide 8

Gender definitions

- **Gender identity:** A person's internal sense of being male or female, or neither or both
  - For most people, gender identity matches the sex assigned at birth
  - Gender identity may not match chromosomes or genitals
  - Gender identity is separate from sexual orientation
  - Social science research reveals a nonbinary paradigm for gender
- **Transgender or trans** – a term for someone whose gender identity does not match the gender they were assigned at birth based on external anatomy or chromosomes
  - Mismatch/incongruence between the brain/heart/soul and external anatomy
  - Gender identity is different/distinct from sexual orientation
- A transgender person may identify as straight, gay, lesbian, bisexual, or none of the above
  - Reported throughout history and cultures
  - Not simply a social construct




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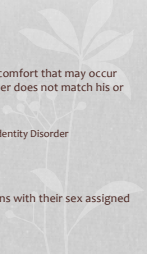
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Slide 9

Gender definitions

- **Gender dysphoria (GD):** Distress or discomfort that may occur when a person's internal sense of gender does not match his or her sex assigned a birth.
  - A DSM 5 diagnosis
  - It replaces the DSM IV diagnosis, Gender Identity Disorder
- **Gender incongruence**
- **Gender body divergence**
- **Cisgender:** a person whose gender aligns with their sex assigned at birth.




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Slide 10

**Definitions**

- **Transgender male**
  - A term to describe someone whose sex assigned at birth was female, but who identifies as a male.
  - Also called female-to-male (FTM)
  - FTM, f2m: Female-to-male, or transman
- **Transgender female:**
  - A term to describe someone whose sex assigned at birth was male, but who identifies as female
  - Also called male-to-female (MTF)
  - MTF, m2f: Male-to-female, or transwoman



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Slide 11

- **Gender diverse or gender nonconforming:** A person whose identity, behavior or appearance does not match cultural and societal stereotypical expectations for what is appropriate for his or her assigned gender.
- **Gender queer or nonbinary** = a term for someone who identifies as something other than male or female, or who doesn't identify exclusively as male or female.
- **Gender fluid:** a person whose gender identity shifts / varies over time
- **Gender expansive**
- **A gender**

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Slide 12

**Definitions**

- **TGNC:** Transgender and gender nonconforming. Used to identify all gender minority or gender diverse patients
- **GSM:** Gender and sexual minorities

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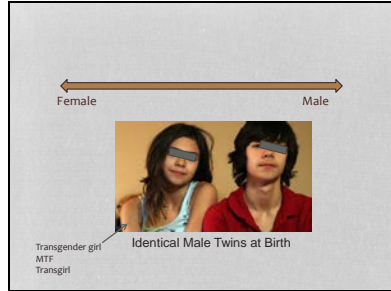
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Slide 13



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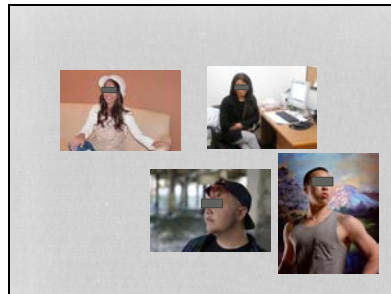
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Slide 14



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Slide 15

**How to conceptualize gender and sexual variations**

- Young children often exhibit very gendered choices in terms of toys, games, clothing choices (even when raised in a gender neutral environment). This is not because they have looked at their genitals and decided on their gender, but rather it comes from inside.
- Variability is a normal part of biology
- Different does not mean abnormal or bad
- Diversity in gender identity and expression are normal aspects of the human condition and of human biology
- Gender differences have been described throughout history
  - Written about at least since late 1800s
- Provider role to advocate for marginalized or minority populations

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Slide 16

Questions about transgenderism

- What causes it?
- How common is it?
- At what age does it present?
- Short answer – we don't know



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Slide 17

Etiology of transgenderism: hypotheses

- Androgens:
  - Role of prenatal and possibly postnatal androgens in gender identity development is supported by studies of disorders of sexual development, e.g. CAH
  - Prenatally, genitals develop prior to maximal hormone saturations → potential for disconnect or mismatch?
- Anatomic/ neurobiologic
  - MRI studies have reported brain differences in transgender individuals vs controls, supporting a neurobiologic basis for transgenderism
- Genetic susceptibility?
  - Supported by twin studies
- Disproportionately found in autistic children\*

\*de Vries AL, et al. Autism Spectrum Disorders in gender dysphoric children and adolescents. J Autism Dev Disord. 2010.  
Koenig H et al. Increased gender variance in autism spectrum disorder and attention-deficit hyperactivity disorder. Arch Sex and Behav. 2010.

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Slide 18

MRI studies

- 1) Structural brain differences between the sexes – transgender individuals have brains that match their affirmed gender. (Simon L et al. PLoS One. 2013)  
Prior to hormone treatment
- 2) Hypothalamic activation to odorous steroids dependent on sex differs in adult transwomen vs adult cisgender men. (Berglund H et al. Cereb Cortex. 2015)
- 3) Adolescents with gender dysphoria had MRI activation responses similar to those of their affirmed gender and not to sex assigned at birth. (Suzuki SM et al. Front Endocrinol. 2014)

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## Slide 19

Twin studies – monozygotic twins

- Gender dysphoria has a 39.1% concordance in monozygotic twins
- Based on 23 identical twins with at least one with gender dysphoria
- This concordance rate is considered strongly suggestive of a genetic influence
  - Type 1 diabetes mellitus has 50% concordance for monozygotic twins

\* Heylens G et al. Gender identity disorder in twins: a review of the case report literature. J sex med. 2012.

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## Slide 20

Transgender Identity:  
What age does it present?

- Age of presentation varies
- It can present as young as 2 years old, when children first begin to talk and to express preferences regarding clothes, hair, and toys.
- Some or most young children with gender differences do not grow up to be transgender adults.
- Gender dysphoria that is insistent, consistent and persistent is likely to persist.

\* It may present during puberty, which can be an extremely distressing time for transgender children. GD often worsens after onset of puberty.

- Gender identity is unlikely to change after puberty
- GD may present during adolescence or adulthood

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## Slide 21

How Common Is It?

- Prevalence estimates vary and have been increasing over the last decade.
- Recent estimates range from 0.3% of the adult population to 2.7% of adolescent population (included gender nonconforming). (Trevor Project)
- Consistent data: Non-heterosexual orientation 15.9%
- Current data suggests about 1% of youth may be transgender.

\* De Vries AL, et al. What the primary care pediatrician needs to know about gender incongruence and gender dysphoria in children and adolescents. Pediatr Clin North Am. 2016;63(12):1913-1939

- \* Shields JP et al. J Adolesc Health. 2013.

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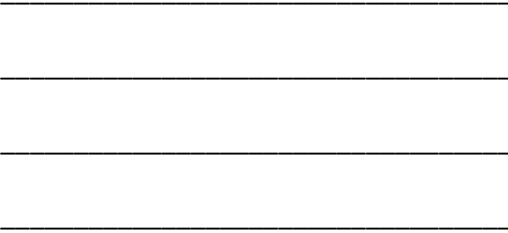
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Slide 22

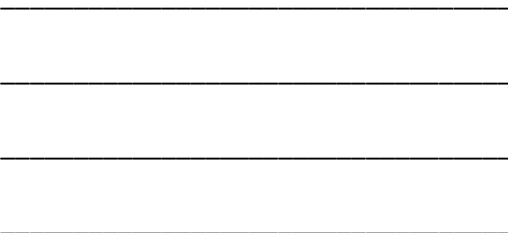
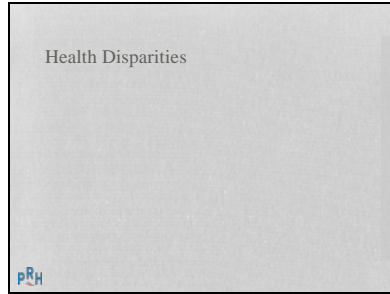
Sexual Orientation and Gender Identity of Middle School Students

Table 1  
Mean, standard deviation, and gender identity of middle school students, enrollment included

Sexual Orientation	Demographic	Mean (SD)	Standard Deviation	Female	Male
Gay/Lesbian/Bisexual	Female	1.25 (0.42)	1.00	1.25	1.25
Gay/Lesbian/Bisexual	Male	1.25 (0.42)	1.00	1.25	1.25
Gay/Lesbian/Bisexual	Total	1.25 (0.42)	1.00	1.25	1.25
Transgender	Female	1.25 (0.42)	1.00	1.25	1.25
Transgender	Male	1.25 (0.42)	1.00	1.25	1.25
Transgender	Total	1.25 (0.42)	1.00	1.25	1.25
Questionable	Female	1.25 (0.42)	1.00	1.25	1.25
Questionable	Male	1.25 (0.42)	1.00	1.25	1.25
Questionable	Total	1.25 (0.42)	1.00	1.25	1.25
Not Specified	Female	1.25 (0.42)	1.00	1.25	1.25
Not Specified	Male	1.25 (0.42)	1.00	1.25	1.25
Not Specified	Total	1.25 (0.42)	1.00	1.25	1.25
Total	Female	1.25 (0.42)	1.00	1.25	1.25
Total	Male	1.25 (0.42)	1.00	1.25	1.25
Total	Total	1.25 (0.42)	1.00	1.25	1.25

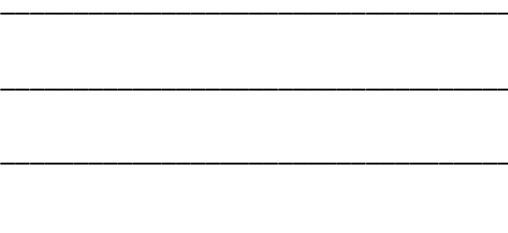


Slide 23



Slide 24

- Health Disparities
- Being a member of a gender minority group does not inevitably lead to health disparities
  - Stigma associated with gender minority status leads to psychological distress and stress, worsened by internalized transphobia, problems with self-image and self-esteem, social isolation and rejection, which may be accompanied by an increase in risk behaviors
  - We know that stress in childhood is associated with negative health outcomes
  - Resiliency pro-diversity model: early identification, resources, connection, support, and a change in cultural appreciation for diversity





Slide 25

**Transgenderism and Autism**

- **Transgender youth:** (at least 4 studies)
  - Study at a gender clinic in the Netherlands: prevalence of autism was **9.4%** (de Vries et al., J Autism Dev Disord, 2016)
  - Smaller studies:
    - **23% (North America)** (Schumer DE et al. LGBT Health, 2016)
    - **26% (Finland)** (Kataja-Heleno R et al. Child Adolesc Psychiatry ment Health, 2013)
    - Prevalence of autism in the general population is about 1.5%
- **Youth with autism:** (at least 3 studies)
  - **5-4%** gender variance (Straug et al, Arch Sex Behav, 2014)
  - **4%** (US National Database for Autism Research) (May T et al, Int J Transgen 2017)
  - Prevalence of transgender in the general population unknown; estimated at about 1%

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Slide 26

**Transgenderism and Autism**

- Clinical guidelines have been published in the psychology literature for treatment of co-occurring ASD and GD
  - Journal of Clinical Child & Adolescent Psychology, October 2016
- **Suggestions:**
  - Gender specialists should work with ASD specialists
  - Gender referrals should be screened for ASD
  - Youth with ASD should be screened for gender issues
  - Youth with GD and ASD should not be denied treatment
- **Challenges:**
  - GD sometimes dismissed as a trait of ASD (an over-focused or unusual interest)
  - ASD may be missed if social difficulties are viewed as stemming from GD
    - Gender identity concerns may lead to social awkwardness, for example if there has been insufficient opportunity to develop a sense of self, identity, social belonging, and acceptance
  - Diagnosis of GD is challenging in an adolescent with weaknesses in communication, self awareness, and executive function

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Slide 27

**LGBTQ Health Disparities**

- **School / Bullying / discrimination / harassment / homicide**
  - Especially for transgender women of color
  - 2 articles and a commentary in May 2018 Pediatrics
- **Anxiety and Depression, including suicide and NSSI**
- **Eating disorders**
  - Desire to adhere to perceived ideals of experienced gender
  - Some kids may stop eating to avoid pubertal changes
  - Trevor Project; 54% of LGBTQ surveyed reported they had been diagnosed with an eating disorder (1034 youth age 13-24)
- **Substance abuse**
- **Homelessness**
- **Intimate partner violence**
- **Job discrimination leads to economic disparities**
- **Sexual health:** HIV in transgender females, especially transgender females of color

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Slide 28

### Transgender Health Disparities

- Student survey of 9<sup>th</sup> and 11<sup>th</sup> graders, n=81,885
- Trans/gender fluid/ non-conforming: n=2,168 (2.7%)
- Risk behaviors significantly higher among transgender than cisgender students
- Protective factors
  - Family connectedness
  - Student-teacher relationships
  - Feel safe in community

	Transgender	
Alcohol use	23%	17%
No condom at last sex	51%	38%
No birth control at last sex	46%	25%
Depressive symptoms	58%	31%
Self-harm past year	54%	14%
Truancy/absenteeism	61%	20%
Physical bullying	25%	12%
Relational bullying	52%	32%
Physical/re-based assault	35%	5%

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Slide 29

### Many transgender individuals avoid medical care

- 33% have had negative healthcare experiences
- 23% avoided care due to fear of mistreatment
- 40% are out to all of their medical providers

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Slide 30

### Parental support mitigates psychiatric comorbidities

• Caitlyn Ryan, Family Acceptance Project

Research conclusions:

- Family reactions that are experienced as rejection by the child contribute to serious health concerns and inhibit the child's development and well being
- Rejecting families tend to become less rejecting over time, and access to accurate information is critical in this process

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Slide 31

**Parental Acceptance**

**"When my daughter was little I spent so much time fussing over how she looked I should have been concerned about how she felt. We didn't know about transgender - but I know how sad and depressed she got right before middle school. The school helped us find a counselor and that's when we found out how hopeless she felt. I wanted to make sure she wasn't rejected by others, but instead, I was the one rejecting her. I'm so grateful I could change things before it was too late."** Brianna, mother of 12-year-old transgender youth



• <https://familyproject.sfasu.edu/sites/default/files/familySupportForGBTChildrenGuidance.pdf>

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Slide 32

**Family Acceptance Project**  
Ryan & Diaz 2011

- Recognize that parents and caregivers who are seen as rejecting their LGBT child are motivated by care and concern to help their child "fit in," have a "good life," and be accepted by others
- Support the need for families to be heard and understood
- Understand that parents and families experience their lack of knowledge about LGBT issues as inadequacy that feels disempowering and shameful
- Beyond building a strong alliance between families and providers, family awareness of the consequences of their behavior is the most important mechanism of change

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Slide 33



Socially transitioned transgender children who are supported in their gender identity have developmentally normative levels of depression and only minimal elevations in anxiety, suggesting that psychopathology is not inevitable within this group. Especially striking is the comparison with reports of children with GID; socially transitioned transgender children have notably lower rates of internalizing psychopathology than previously reported among children with GID living as their natal sex.

PRH 33

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Slide 34

**How to proceed when parent(s) disagree?**

- No easy answers
- Families are also experiencing a transition / journey process/ loss
- Ensure that everyone has a chance to express their concerns
  - What is he most worried about? Validate father's experience and concerns. Many children experiment with gender identity and gender expression, and do not turn out to be transgender
- Provide information and data:
  - "Parents have little influence over their children's gender identity, but extensive influence over their children's gender health" (Diane Ehrensaft, PhD)
  - "Being transgender or gender-nonconforming is a matter of diversity, not pathology." (WPATH SOC7)
  - MRI studies have supported anatomic differences: Structural brain differences between the sexes - transgender individuals have brains that match their affirmed gender
- We are all on the same side, motivated by care and concern for the child, and we all want to facilitate the development of a happy, healthy, well-adjusted adolescent

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Slide 35

**Sexual and Reproductive Health**

- **Transgender Females**
  - Increased prevalence of HIV
  - All transgender women: 27.7%; black transgender women: 56.3%
- **Transgender males**
  - Few studies
  - Prevalence of HIV and risk behaviors are low among transgender males
  - CDC STD Treatment guidelines now have a transgender section
  - Screen based on anatomy and behavior
    - Remember that transgender females may retain a functioning penis
    - Remember that transgender males are at risk for PID, etc.
    - Case reports of pregnancies in transgender males

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Slide 36

**Screening and Improving the Office Experience**

- Knowing the prevalence and the health disparities, how do we make our offices welcoming to best serve these youth?



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Slide 37

**Making the Office Friendly**

- Forms
- Preferred name and pronoun
- Signs – include non discrimination policy that includes protections for gender minorities
- Train staff
- Bathrooms
- Try to use gender neutral language:
  - They/them, we, people, everyone, patients, folks



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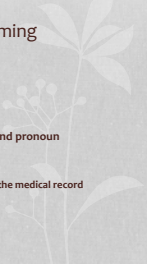
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Slide 38

**Making Your Office Welcoming**

- Forms
  - Offer options for gender:
    - Transgender male
    - Transgender female
    - Other
- Inquire about and use preferred name and pronoun
  - What name would you like me to use?
  - What pronoun do you use?
  - Document preferred name and pronoun in the medical record



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Slide 39



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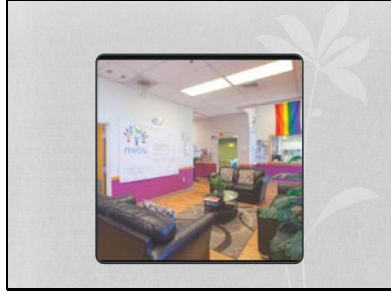
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Slide 40



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Slide 41



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Slide 42



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Slide 43



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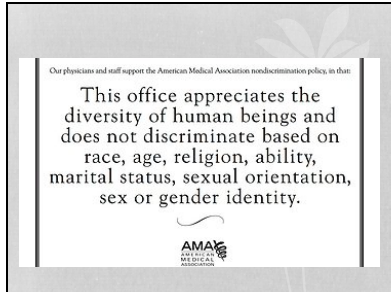
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Slide 44



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Slide 45



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Slide 46

**History & Screening**

- What name would you like me to use?
- What pronoun do you use?
- What is your gender identity?
- Do you have any questions or concerns about your gender?
- Do you think of yourself as a girl, a boy, neither, or something else?
- What name or pronoun fits you?
- When were born they said you were a girl. Do you feel like a girl?

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Slide 47

**More about screening**

- Avoid assumptions
- Remember that individuals are more than their gender
- Affirm the gender but remember to focus on the whole person
- "Ally is a verb."<sup>8</sup>
- A process, not a destination
- Requires ongoing learning, continuing education, and practice

\* From Lynch and Wood, 2019, unpublished work

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Slide 48

**Screening**

The slide displays two educational posters. The first, 'THE GENDER BEAR', features a brown bear character and lists various gender identities and pronouns. The second, 'The Gender Unicorn YSER', features a purple unicorn character and provides a comprehensive list of gender identities, pronouns, and names, along with instructions for use.

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Slide 49

What health care providers can do:

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Infrastructure	Make office accepting, affirming
Training	Work with staff to create a trans-friendly environment
Screen & Identify	All patients, at various points of development All children with mood, behavior, school, problems or with eating disorders or autism
	Become comfortable, take a gender history
Offer primary care	Promote open disclosure and acceptance
Offer referral and resources	Offer gender care and/or referral to gender clinics
Advocacy	Promote diversity in your professional and personal communities

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Slide 50

Gender Affirming Care

- Be extra gentle with physical exam
- Consider deferring parts of the exam
- A word about tucking and binding:

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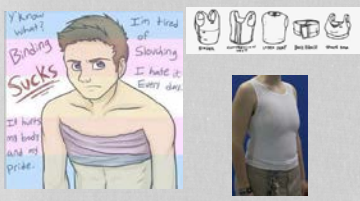
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Slide 51

Binding



The diagram shows a person's torso with a blue band around the chest. Text around the person includes: 'You know what? Binding Sucks', 'It hurts my body AND my pride.', 'I'm tired of Slinking', and 'I hate it Every day.'. To the right are four small drawings of different binding methods labeled 'bra', 'underwire bra', 'band', and 'bandeau'. Below these is a photograph of a person wearing a white tank top.

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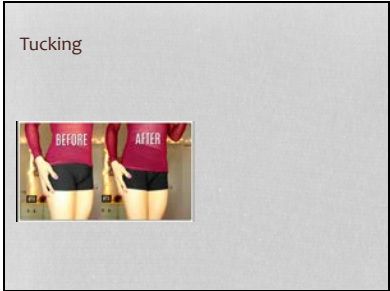
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Slide 52




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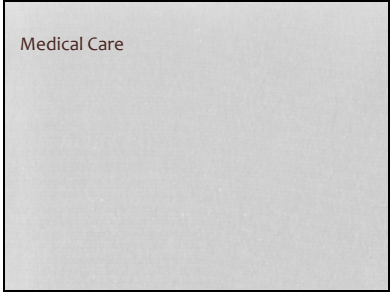
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Slide 53




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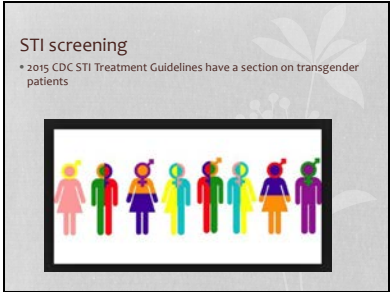
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Slide 54




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Slide 55

**STIs: Transgender Females**

- High risk for HIV
- Remember that transgender females may still have a functioning penis
- Need to ask, and screen based on individual behaviors and risk
- Remember to screen extra genital sites if indicated
- More frequent screening, including syphilis test, may be indicated
- Offer PrEP to transgender females

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Slide 56

**STIs: Transgender Males**

- Few studies
- Remember that adolescent transgender males usually still have a vagina and cervix, therefore are at-risk for vaginitis, cervicitis, and pelvic inflammatory disease.
- Screen based on individual behaviors and risk.
- Follow CDC guidelines for males having sex with males, if applicable
  - More frequent screening, including syphilis, extra-genital sites, HBsAg, HPV vaccine through age 26, consider PrEP for HIV
- Testosterone is not reliable contraception. Transgender males are at risk for pregnancy.

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Slide 57

**Specialized transgender health care**

- 1) Pubertal suppression
  - At Tanner stage 2-3
  - Completely reversible
- 2) Gender affirming hormones
  - Usually age 14-16 at the earliest
  - Increase dose over 2-3 years
  - Partially reversible
- 3) Gender affirming surgery
  - Irreversible



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Slide 58

**Our job**

- Explore the patient's identity and needs
- Individualize treatment
- Provide information
  - What to expect
  - What are the risks
- Prescribe and monitor
- Help navigate the system



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Slide 59

**Medical Management of a Pubertal Child with Gender Dysphoria**

- Once you document Tanner stage 2 and obtain informed consent from the youth and guardian(s), offer GnRH analog for pubertal suppression:
  - Shuts down pulsatile release of GnRH from the hypothalamus, thus stopping the increase of LH/FSH
  - Standard of care, supported by evidence
  - Prevents suffering for the child (current and future)
  - Gives the child more time to explore gender identity
  - Adult physical outcome is improved
  - Reversible, usually well tolerated
  - Cost may be a barrier

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Slide 60

**Why not just wait until they are adults?**

"It is to be remembered that giving, but also withholding endocrine treatment is a momentous and responsible decision. Accordingly, one cannot sidestep the ethical dilemmas by merely avoiding them, especially given the devastating impact puberty can have on this population.

- Allowing puberty to progress in teen's assigned gender is NOT a neutral option

Gooren and De Waal, 1996

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Slide 61

**Relief > Risk or Harms**

- “Despite the understandable concern about potential harm that could be done by early physical medical interventions, it seems currently that withholding intervention is even more harmful for the adolescents’ wellbeing during adolescence and in adulthood.” (de Vries 2012)

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Slide 62

**Transgender Care: Pubertal Suppression**

- Pubertal suppression: reversible treatment
  - GnRH analog: leuprolide IM or histrelin subcutaneous implant
  - Allows for a better final outcome – more “passable”
    - Transgender Males: Prevents breast growth
    - Transgender Females: Prevents voice deepening, Adam’s apple, facial changes
  - Puberty can be distressing or even unbearable for trans kids
- This approach is supported by data
  - Decreased depressive symptoms
  - General mental health functioning improved
  - No subject withdrew from pubertal suppression
  - All went on to cross sex hormone treatment
  - No suicides, no street hormones
  - Risks of not treating are greater than the risks of treating

Guidelines for the Health Care of Transsexual, Transgender, and Gender-Diverse Patients, et al. Eur J Endocrinol. 2016; 175: D4-Vries, et al. J Sex Med. 2012.

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Slide 63

**Leuprolide**

- Has FDA approval for treatment of precocious puberty, uterine leiomyomata (fibroids), endometriosis
- Used off-label for: breast cancer, vaginal bleeding for childhood cancer, fertility treatments, treatment of paraphilia / hypersexuality, and transgender adolescents
- Adverse effects: rare - weight gain, sterile abscess, depression, initial flowering of puberty or withdrawal bleed

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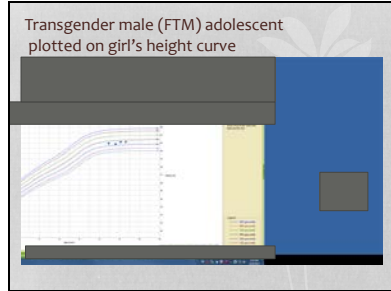
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Slide 64



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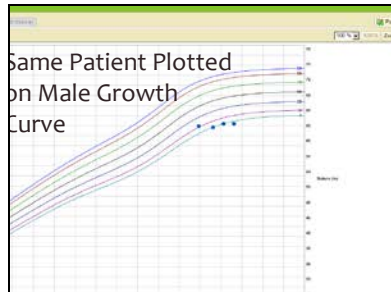
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Slide 65



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Slide 66

**Transgender Care: Sex Steroids**

- Starting at age 14-16: Gender affirming hormone therapy
  - Testosterone for FTM
    - Usually prescribed as an injection q 1-2 weeks
    - May be given at home or by PCP's office
  - Estrogen plus spironolactone for MTF
    - Usually prescribed as tablet or patch, also available as an injection
    - 17-beta estradiol is used, chemically identical to estrogen from a human ovary
      - Different from the ethinyl estradiol used in contraception
  - Spironolactone used as an androgen blocker
    - Potassium sparing diuretic
    - Higher dose has direct anti-androgen receptor activity and suppressive effect on testosterone synthesis
  - AE: hyperkalemia, polyuria, polydipsia, orthostasis
- Increase doses of sex steroids gradually over 2-3 years

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Slide 67

Transgender Care – Mental health letter (MHL)

- Many specialists require a mental health letter from a qualified mental health provider prior to prescribing hormone treatment for transgender youth
- This does not mean all transgender youth have mental health problems
- In our system, signed parental consent required prior to prescribing hormones to transgender youth
- This consent includes conversation about fertility

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Slide 68

What medical changes to expect

- Transgender males – taking testosterone
- Masculinization: acne, male pattern hair growth and balding, increased muscle, fat redistribution, deeper voice, cessation of menses
- Will see an increase in hemoglobin
- EMR may flag as abnormal, but as long as it is within the range of normal for a boy, it is ok and expected



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Slide 69

- Transgender females - taking estrogen & spironolactone
- Feminization: breast growth, fat redistribution, skin softening, decreased acne
- Important not to smoke
- Risk of migraines, mood swings, hot flashes, nausea, weight gain, blood clot
- Monitor potassium
- Estradiol may increase prolactin
- Usually well tolerated
- If growth plates are open, sex steroids will have an affect on height



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Slide 70

Effects of Testosterone

Action	Onset	Max
Male pattern facial/body hair	6-12 mo	4-5 yrs
Acne	1-3 mo	1-2 yrs
Voice deepening	1-3 mo	1-2 yrs
Clitoromegaly	3-6 mo	1-2 yrs
Vaginal atrophy	2-6 mo	1-2 yrs
Amenorrhea	2-6 mo	
Emotional changes/ ↑ libido		
Increased muscle mass	6-12 mo	2-5 yrs
Fat distribution	1-6 mo	2-5 yrs
Tendon weakening		



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Slide 71

Effects of Estrogen

Action	Onset	Max
Breast growth	3-6 months	2-3 yrs
Body fat, muscle changes	3-6 months	2-3 yrs
Softening skin	3-6 months	
Softer, less male pattern terminal hair	6-12 months	> 3 years
1-3 months		
Emotional changes		
Change in libido, erectile dysfunction	1-3 months	3-6 months
Decrease testicular volume	25% see change in 1 yr	50% see change by 2-3 yrs
Decrease sperm production	?	?



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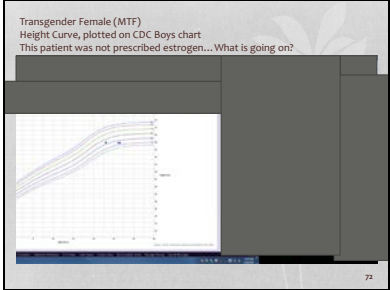
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Slide 72



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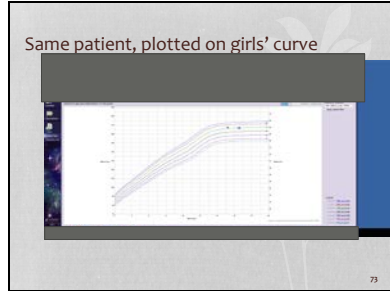
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Slide 73



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Slide 74

**“Do It Yourself Transitions”**

- Two studies, total 578 patients, mostly adults, all > 16 yo
- 25% of transwomen self prescribe estradiol, usually from the Internet
- May also come from friend, relative, street

Meghan N, et al. People with gender dysphoria who self prescribe cross-sex hormones: prevalence, sources, and side-effects knowledge. J Gen Med. 2014  
Rozanski NK, et al. Nonprescribed hormone use and self performed surgeries: “do it yourself” transitions in transgender communities in Ontario, Canada. Am J Public Health. 2015

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Slide 75

**Do-it-yourself (DIY): Why?**

- It's “incredibly hard” to access hormones through traditional channels
- “Either they wouldn't work with my insurance, didn't know enough about transgender HRT to even consider me, kept bouncing me around to different clinics, or just told me to see a therapist or anything”
- “At times I would literally be brought to tears over being rejected so much.”
- When people need to have access to care and they can't get it, they use any means possible. ( Dru Levasseur, Lambda's Transgender Rights Project Director)

Brannaman, CBBin, The Atlantic, “Quality Pharmacies Are Selling Hormones to Transgender People” August 20, 2016

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Slide 76

**Do-It-Yourself (DIY): Why?**

- Lack of access to care
- Stigma and embarrassment, anxiety
- Negative experiences with providers
- Lack of social supports
- Limited financial resources, lack of insurance and/or lack of transportation

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Slide 77

**DIY: How?**  
\*Amy's Quick-and-Dirty Guide To DIY\*  
\*Ellie's Awesome DIY Guide\*



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Slide 78

**Our pediatric transgender clinic**  
**A-GEMS: Adolescent Gender Medical Services**

- Started by Dr. Irene Sills
- Part of nascent Gender Center at SUNY Upstate
- 1 MD, 0.5 NP, 1 RN
- Partnership with therapists at SU
- Approx 250 patients
  - 62% asserted males, 2 nonbinary
  - Ages 6 – 23
  - Must on leuprolide and/or gender affirming hormones
- 75% mental health diagnosis
  - Depression, anxiety, borderline, PTSD, adjustment disorder, OCD, bipolar
- 3% eating disorder
- 7.2% autism



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Slide 79

**Summary**

- Transgender males (asserted males) have a male gender identity but were assigned female sex at birth.
- Transgender females (asserted females) have a female identity but were assigned male sex at birth.
- Transgender identity and sexual orientation are separate concepts.
- Transgenderism is associated with health disparities, but most are not inevitable.
- Making the office welcoming involves updating forms, posting affirming signs, using preferred name and pronoun, and training staff.
- Specialized medical care involves puberty blockers at Tanner 2, then gender affirming hormones starting at age 13-16. There are growth curve changes and changes in some lab values, eg, hemoglobin increases for patients taking testosterone.

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Slide 80

**Transgender Health Care – Resources**

- UCSF website:
  - Guidelines for the Primary and Gender Affirming Care of Transgender and Gender Nonbinary People: [Transhealth.ucsf.edu](http://Transhealth.ucsf.edu)
- Physicians for reproductive health
  - [Phr.org/teen](http://Phr.org/teen)
  - Callen Lorde Community Health Center
    - [www.callen-lorde.org/transgender-health-training](http://www.callen-lorde.org/transgender-health-training)



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Slide 81

**Questions?**



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Slide 82

**Free Local Resources**

- TransParent and TransYouthgroup at our Children's Hospital
- Q Center, funded by ACR Health
- Syracuse University Marriage and Family Therapy
- Sally Curran, volunteer lawyers project

• Resources in Rochester

- Gender Health Services – Golisano Children's Hospital in Rochester, Adolescent medicine. Accepts patients through age 25, and patients may self refer.
- Out Alliance: [www.outalliance.org](http://www.outalliance.org), eg Transparent group third Tuesday of every month 6:30 pm

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Slide 83

**Resources**

- Physicians for Reproductive Health Adolescent Reproductive and Sexual Health Education Program: [www.phr.org/adolescent-reproductive-health](http://www.phr.org/adolescent-reproductive-health)
- Massachusetts Transgender Political Coalition:
- The National LGBT Health Education Center:
- Center of Excellence for Transgender Health:
- Callen-Lorde Community Health Center: [www.callenlorde.org/transgender-health-center](http://www.callenlorde.org/transgender-health-center)

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Slide 84

**Resources**

- World Professional Association for Transgender Health [www.wpath.org](http://www.wpath.org)
- Vancouver Coastal Health Guidelines for Transgender Care [transhealth.vch.ca](http://transhealth.vch.ca)
- The Fenway Guide to LGBT Health, American College of Physicians [www.acponline.org/fenway/guide-to-lgbt-transgender-health/](http://www.acponline.org/fenway/guide-to-lgbt-transgender-health/)
- Center of Excellence for Transgender Health <http://transhealth.ucsf.edu/>
- Transgender Law Center Health Care Issues [www.transgenderlawcenter.org/health-care](http://www.transgenderlawcenter.org/health-care)

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Slide 85



- National Center for Transgender Equality: [www.transgenderequality.org](http://www.transgenderequality.org)
- [www.gayandstraightallianceusa.org](http://www.gayandstraightallianceusa.org)
- [www.transgender.com](http://www.transgender.com)
- Freeing Ourselves: A Guide to Health & Self Love for Brown Bois: [www.transgender.com](http://www.transgender.com)
- The Name Change Project from the Transgender Legal Defense and Education Fund: [www.transgenderlegal.org/workshops/2015/](http://www.transgenderlegal.org/workshops/2015/)
- Transgender Law Center: [www.transgenderlawcenter.org](http://www.transgenderlawcenter.org)
- Health Care Rights and Transgender People: [www.transgenderlawcenter.org/health-care-rights/](http://www.transgenderlawcenter.org/health-care-rights/)

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