My work is focused on LGBT communities and in people of all
ages. And so I'm here to basically make sure that all of
you are aware of what we do and how we do it.
And you can ask questions because we know all of ourselves
that this is an issue that is highly relevant to your work
in the child welfare system.
First, before I talk about what we do, I'd like to offer
you an invitation.
So you have an incredible opportunity to join us in reducing
health disparities.
The health disparities that persist for LGBTQIA people begin
in childhood, and LGBTQIA youth are consistently over represented
in all surveys of the child welfare system.
So I've seen numbers between 25 depending on the survey,
as opposed to one of the general population.
And you can model an extent inclusive practice with all of
the kids that you meet, which also gives you a model and
give parents and caregivers and everyone else model about
what it means to treat a kid in an affirming manner.
And it can make a gigantic difference, both in letting the
child know that they are affirmed, that they are welcome,
that you care and know, and also by helping to shift parents
misconceptions or caregivers misconceptions, and to figure
out how to make sure that the child is safe and Welcome.
Okay.
So the first thing that I wanted to talk about is childhood
development. And so tell me, when do we figure out what our

gender identity is?

Ballpark it.

Okay.

I would say between the ages of three and 6 in that general

area, I feel like a lot of young people are sort of trying

things on or not sure.

And they're fermenting and then think by the time they're

in school, generally, they have that sort of figured out

for themselves, even if they're not verbalizing it, I would

say as a toddler.

Okay.

Thank you for those answers.

And how about when do we figure out our sexual orientation?

Do we actually figured out, or is this something that just

happens? I don't think I ever one day said, okay, this is

what I like.

I think it just came about, but I couldn't tell you when

or how.

That's totally fair answer.

So, Yeah, it's kind of a trick question.

Right.

So that when you look at a book about developmental behavioral

Pediatrics, we thought that gender was very stable by age

about five or 6, but it turns out that it's quite complicated.

So if you think about some sort of traditional linear understanding

from three to 4 months old patients, babies can distinguish

male and female faces.

At six to 8 months old, they can distinguish male and female

voices. And at about 24 to 31 months, as you both suggest,

there's a lot of interest in labeling the gender of things

and people and sort of figuring out which gender of mine,

how does it relate to other people, etc, and particularly

in the ages of three to 5.

It is extreme in terms of gender labeling about who is a

boy and who is a girl.

And obviously, all of this is reinforced by the socialization

right. We give babies different clothes based on their gender,

all of that kind of stuff.

At age five to 6, they start to understand consistency and

stability and gender as they start to understand consistency

and stability and other things.

And then in early puberty, people start to understand attraction

and orientation as the person that spoke.

It sort of comes to you, but it's so much more complicated

than this for so many different people.

So while many people follow this sort of linear path about,

like, well, I sort of always figured out as much as I can

remember that I was one gender or the other some other thing.

And that when I started figuring out sexuality was when I

started in puberty and that I realized who I was attracted

to, et cetera.

But lots of gender diverse kids are Crystal clear at preschool

ages. So when you start talking with kids that are trans

identified and our young people, they are often really like

their parents will say, I knew when they were three or 4,

or they say, I remember when I was 4-5-6-I had this experience.

But for a lot of people, it's way more ambiguous than that.

And so we have patients and I have patients that are sort

of figuring out gender and sexuality as the life course goes

on, including people in their 60?

S and 70?

S who sort of always had these feelings.

And then some life shift happens, and then they start figuring

it out.

Lots of us that are gender and sexual minorities often reflect

and look back on to early life tendencies and think, Oh,

that's it.

I mean, I think it would be lots of there would be lots of

people telling you the story about when I was young, I didn't

fit in with one gender or another, and I did XYZ, etc.

So, Yeah.

So it's tricky.

And for you who are in the child welfare system and dealing

with kids because that process is more complex today because,

frankly, there's more understanding and acceptance of LGBT

communities. And so more kids are thinking, Oh, maybe I should

maybe this is me and a lot of children experiment with all

different kinds of expressions of gender.

I think the first person who answered a question alluded

to that, right, is that a lot of kids play around with gender

and gender identity.

It doesn't mean that a kid is trans.

And so a lot of patients and caregivers, particularly because

of the increased conceptualization and consciousness raising

around gender, when their kid starts playing around with

gender, that parents get really worried because they're like,

Is this, like, a persistent thing?

Do I need to work?

Like, what do I do?

Blah, blah, blah, blah.

And and those fears really warranted.

Right.

Because I think that lots of parents and caregivers want

to support their kids and being who they are, which is honestly

the best thing that you can do to prevent lots of the health

disparities, particularly mental health and suicide that

affect LGBT folks in terms of transgender children and treatment

of transgender children.

However, that the standards of care and what we go by in

our gender farming services is three different notions, one,

persistent gender identity and gender difference, and consistent

over and over and over again, and insistent.

The child's gender identity is continues to be a source of

discomfort and the term gender dysphoria.

Right.

That discomfort between the notion of what gender hand you

were dealt at birth versus how you feel in your head.

And so that analysis is extremely tricky and is often bound

up in lots of other mental health and lots of other developmental
difference. And so the reason why we treat kids in Kids Pride
Clinic with psychological evaluation at the Center of what
we do and at the beginning of what we do is to try and sort
out those differences and to try and really make sure that
we're not offering things to kids that will permanently change
their reproductive abilities, etc, unless they are really
clear that this is who they are and everyone involved is
making a choice that is aligned with that.
The way we do this on the adult side is that once people
are 18, we use an informed consent model which allows the
patient to make the decision to start hormones, if that is
something that they're interested in after an evaluation
and lab work.
And that lens of doing this requires the standard of reasonably
controlled mental health, which is to say, if a person can
genuinely consent to hormones, we generally offer it to people.
But if people are in the middle of extremely labile mental
health situations, then we often pause things for a little
bit. That depends on the provider.
But on the pediatric side, it takes a rock solid evaluation
bio psychologist over the course of time to really decide
to make changes and continue treatment from a hormonal and
medical perspective for children.
So, again, persistent, consistent, consistent.
So that means that you have an incredible opportunity to
support people and being who they are.

Again, the best way to respond to anybody telling you about

any difference they have is to support them is to let the

kid be who they are and to experiment and express and sort

of figure it out.

We are here and our psychology team is here, including for

kids that are uncertain or unsure where there's conflict

between the caregivers and family and the child.

That is the bulk of what we do.

And in fact, lots of people that come to our Kids Pride Clinic

don't end up being treated with either puberty blockers or

hormonal therapy because that initial psychological evaluation

went a different way.

Okay, so these are common questions.

So again, first, about what we do in kids pride.

First, the patient gets evaluated by psychology.

And sometimes this takes a while.

And for kids that are teenagers, this is often a source of

huge frustration because what happens is that the kid will

tell their parents caregivers, et cetera, who they are.

And it takes a while for adults to adjust.

And the kid is sitting there going like, I've been thinking

about this for two years.

When are we getting started?

But the whole thing is that the family system needs to everybody

needs to be aligned, that this is the right decision.

And it makes more sense to take a month or two or 6 or 12

to really get everyone on board and on the same page about

what the goals of care are so that the child is likely to

have the best outcome related to this.

Parents and any custodial figures must consent for treatment

with either puberty blockers or hormones.

And that includes all parents.

So we have had some challenges with one parent being fine

and the other one not being or a custodial parent being okay,

but the bio parent not being okay or that kind of stuff.

And so we also have social workers supporting us.

And obviously, you all are there to help us figure all of

this stuff out in terms of custodial parents and consent.

So Let's talk about timing in terms of blockers versus hormones

and timing of that.

Again, it's a careful and deliberate everyone on board process.

Before puberty, everything is psychological and social.

So there's this notion for trans kids of social transition,

wherein the child starts to live as the affirmed gender in

school and socializing in the world.

And obviously, that's really been changed around with this

pandemic. And so we have tried to think about and trying

to work with kids and families about what does it mean to

live as your gender not only in your house on Zoom, but also

around in the world, because obviously, those experiences

can be wildly different.

So before puberty is a perfect time to refer to us, because

then it allows for a real full conversation with the parents

of the Guardians and preparation for potential intervention.

So this whole thing I can't emphasize more is slow and deliberate

and important.

So I think one of the common misconceptions about gender

affirmation and children is that somehow clinicians who work

with gender diverse youth are for hormones on them.

People start really quickly, all of that kind of thing.

And for us, it really isn't that way.

We really take the psychological and physical health of the

child into questions.

So Let's talk about puberty blockers first.

So first, puberty blockers GnRH agonists are extremely safe.

So in central precocious puberty, what that means is that

a child sex hormones start coming early.

And so they need those hormones to be blocked in order to

continue normal development.

And so these GnRH agonists work to basically block puberty.

So if you think about how that happens, this is going to

be tricky to explain.

The hypothalamus in the brain secretes a hormone called GnRH,

and it works in pulses.

So normal GnRH secretion is up for a few weeks and then down

to put it most simply.

And the hypothalamus signals the anterior pituitary gland,

which is also in the brain, and the anterior pituitary gland

secretes FSH and LH again, during puberty in a pulsate way.

And those two hormones stimulate the gonads to either make

estrogen and progesterone or testosterone.

And usually there's a combination of both in every human

being. So when you put a generate agonist into a child's

body, what that happens is because it's not impulses.

The whole system shuts down and doesn't start functioning,

because the pulses are what makes the hormones be secreted.

By giving this hormone to the child, it basically shuts down

the puberty process.

And so what are the effects of that?

Is basically it's a pause.

You can think about it that way as a puberty pause.

And so it's beneficial in multiple ways.

One is that the symptoms and experiences of puberty are distressing

for. I mean, Let's be honest, anyone, but particularly a

child with gender dysphoria where their body starts developing

in a way that is extremely uncomfortable, et cetera.

And so that first puberty pause allows the patient, again,

to be continuing in social transition and also preparing

to use gender affirming hormones.

So a lot of parents are really concerned and caregivers are

concerned about this, right?

Because our puberty blockers safe, et cetera.

And they are actually exceptionally safe.

And in fact, if a child starts puberty blockers, and then

again, in this process of social transition and gender affirmation

and psychology and all of that, they decide this is not really

the choice I want to make.

Want to do XYZ identifying another way, not start hormones,

etc. Then you just stop the puberty blockers.

And puberty is, I think, as all of us know, relentless.

And so we'll continue on back to the typical way without

harming the child.

And so the problem with pre blockers is that they are exceptionally

expensive. And so we spend a lot of time looking for insurance

companies to approve them.

So kids are on blockers up until the mid teams.

It very much depends on the patient and the sort of judgment

of the endocrinologist.

But mid to late teenage years is when we start people on

affirmative hormones.

And part of that is because hormones do, Besides developing

sex characteristics, lots of other things, like bone growth

heights and vascular and all of it.

So when the child is at an appropriate age, again, that this

happens after several years, if they've been on loppers or

sometimes we get children that come to us when they're 15

or 16.

And so puberty has already begun.

So we start with social transition and then gender affirming

hormones. So Let's talk about the sort of two basic buckets

of hormonal therapy.

Testosterone or masculinizing therapy, is exceptionally effective.

Testosterone is if you give somebody enough testosterone,

eventually you'll be looking at a masculinized person.

And it is extremely effective and it's affordable without

insurance coverage.

I know that in the case of the youth that you're working

with, they have insurance coverage.

We offer it for teams and post Prandial kids as a subcutaneous

injection on the pediatric side.

So often what happens is that the child learns how to vacation.

That's ideal to me.

But sometimes in the expected changes for testosterone, we

have irritability and crabbiness.

We all know teenage boys.

It's that kind of mood swing and potentially increase sort

of anger and emotional lability, increase hair on the face

and body oily and economic skin, increased metabolism and

increased energy.

There is eventually body weight distribution and fat changes.

So for more of a feminized, look to more of a masculine fat

distribution in terms of abdominal fat rather than breast

and hips.

Voice deepening happens pretty reliably in terms of the risks.

The main things are obviously for young children.

This is the most impactful, which is permanent alterations

and fertility.

And so part of the consent process is really to talk through,

you know, these sorts of fertility changes with children

and caregivers as best we can.

Unfortunately, we all know that what you think about what

you want to do about your fertility at 15, maybe different

than what you're going to think about when you're 30.

And if children have gone through puberty, there is an opportunity

for egg storage for masculinizing children and sperm storage

for feminizing children.

Unfortunately, these things are not covered by insurance

and so often people forgo them because of financial constraints.

Other risk of type Asteron includes increased red blood cell

count and physiological, you can think about testosterone

as the hormone that makes stuff.

So it makes oil and acne and red blood cells and energy and

everything, and they can go too high, which is why in children

and adults, we monitor their red blood cell count every three

months for at least a couple of years and then intermittently

afterwards. Because if you're thinking about testosterone

is a masculinizing hormone, the metabolic profile of the

patient will change as well to be more of a male profile,

which means increased risk for diabetes, heart disease and

stroke. And as I'm sure all of you know, the main ways to

prevent diabetes, heart disease and stroke are to not smoke

cigarettes, exercise, manage mood, sleep well, all that kind

of stuff.

So again, before we start testosterone, we can get quite

seriously that there is a persistent, consistent, consistent

gender identity difference.

Okay, then for feminizing hormones, we use Estro dial and

an anti.

Androgen usually it's spironalactone, which is actually a

diuretic or a water pill.

And so the point here is to give the patient estrogen for

feminizing effects and to tamp down the impact of testosterone

on the body.

These medications are old and widely used, and on the pediatric

side, we usually get them by mouth, although there are other

preparations available.

And sometimes as the life course goes on, patients decide

to change from one to the other.

The expected changes are mood and emotional lability.

So think of all of the crabby teenage girls that you know

or have met and also softer skin.

The hair on the body and the face will find out more so on

the body than on the face, decrease metabolism, fat distribution

changes again from the abdomen more to the breasts and hips.

And antiandrogens won't change people's voices, but we do

have speech therapists that work with many of our transgender

patients to do feminizing voice changes without injuring

the vocal cords.

And there are face shape changes.

Sorry, I didn't talk about that in the masculinizing, but

the shape of the patient space will change to a more feminine

one with Estro, dial and antiandrogen and will change to

a more masculine one with a testosterone.

So in terms of estrogen and the anti androgen risks again

here, the permanent fertility changes are of exceptional

import in young people, and those conversations need to be

had. The scariest side effect that is, is most often is blood
clots. And that's also important part of the family history,
which is that if it's known that there is a genetic tendency
towards blood clots in the patient's family, then we have
to have more in in depth conversations about hematology workup
potentially and making different decisions about hormones.
Spironolactone because it is a diuretic water pill can cause
kidney injury and can cause changes in the minerals in the
body. Which is again, why we evaluate patients every couple
of months with labs to make sure that all of that is okay.
And then the long term risks of estrogen include an increased
risk for breast cancer.
So we monitor transfeminine people, particularly when they've
started as kids.
The same as we monitor is gender women, which is mammograms
and screenings as developmentally appropriate.
And for transforming people, there is also an increased risk
of cardiovascular disease and stroke.
Again, prevention for these things is the same as the prevention
for everyone.
So, you know, neither testosterone nor estrogen and anti
androgen are benign.
And so we make serious decisions with children and their
caregivers about taking these life altering medications.
And for transgender children here, even though these medications
all have risks, I just want to emphasize that if a child
is transgender, this is life saving stuff that affirming

someone in their gender, reduces the risk of suicide attempts
and completion, helps with mental health.
All these other things, living in the body that you want
is and the living in the body that you see yourself as being
is an incredibly important part of gender affirmation in
terms of surgeries, these are normally after the patient
is 18, just in custom.
And so masculine patients that are masculinized often get
what's called top surgery, which is a double mastectomy with
shaping of the chest to look in a more masculine way.
There are genital surgeries available for transmasculine
people. One is a fella plasty, which is creation of a penis
that involves it's an extremely elaborate and complex surgery
that involves skin grafting and construction of an external
Palace and is not the choice for everyone.
But there is a fella plastic surgeon now in Cleveland, and
so I have sent patients to him.
The other common surgery is called the Toya plasty, where
there is clitoral growth as a result of testosterone administration.
And so they play to basically cut the connective tissue that
keeps the clitoris next to the body so that a patient can
achieve erections.
And then the other common one is, of course, hysterectomy,
because unused parts are more vulnerable to cancer, another
dysfunction. And so if a patient is not using their uterus
often they elect for hysterectomy.
Let me just say that for transmasculine people, the alterations

and fertility are often less permanent.

So we do know that transmasculine people can and do get,

but it involves a whole elaborate process.

And so fertility.

We often say you should expect your fertility to be permanently

changed and by testosterone.

However, testosterone and estrogen are not birth control.

Feminizing surgeries for trans fermentation include shave

of the trachea feminizing plastic surgery on the face.

Breast surgery for those two, estrogen supplementation has

not given them the breast size that they would desire and

vagina plasty.

There's two vaginal plastic surgeons in Cleveland.

Again, it's a major and complicated surgery, so that requires

additional layers of psychological evaluation and preparing.

Okay, so in summary, LGBTQIA kids benefit from performing

pediatrician. Having a pediatrician who knows who you are,

who believes who you are, including if your parents and caregivers

are not affirming, who you are does really support the child

and support the child's mental health.

I have kids who I met when I was a general Pediatrics resident

at Metro who maintained me as their primary care doctor because

their parents who were more or less affirming, you know,

created a space where my clinic was the only place where

they could be honest about who they are.

And protocols exist for careful assessment and evaluation

of trans and gender doers kids.

It's best to send children to well trained providers.

And so come see us.

And I can give Jen or Corey the links and phone numbers to

our Pride Network website and the contact numbers to schedule

appointments. And we would love to see any kids for whom

this is relevant.