We will be starting soon, but in the meantime….  
Web Conference Rules & Etiquette

✓ To see presentation – click on link in meeting invitation

✓ Can hear audio two ways:
  ✓ Dial in by phone
  ✓ Log in via computer

✓ Please limit background noise and conversation
  ✓ Use MUTE button if available
  ✓ **Never** (please, please) use HOLD (avoids practice/center recorded on-hold messages that everyone can hear)

✓ Questions encouraged – only 1 person can speak at a time
  ✓ Identify yourself by name and organization
  ✓ Can use messaging feature to either group or individuals with questions
  ✓ We will open for questions at the end
ACCREDITATION:

- This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of The George Washington University School of Medicine and Health Sciences and Children’s National. The George Washington University School of Medicine and Health Sciences is accredited by the ACCME to provide continuing medical education for physicians.

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- The George Washington University School of Medicine and Health Sciences designates this continuing medical education activity for a maximum of 30 AMA Physician Recognition Award Category 1 Credits™ (total project).
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Caring for LGBTQ Youth: What Providers Need to Know

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With special thanks to David Call, MD

November 14, 2018
Disclosures

• Laura Willing, MD is employed by Children’s National Medical Center and is the Children’s National Site lead for DC MAP

• Lawrence D’Angelo, MD, MPH is employed by Children’s National Medical Center and is the Director of the Youth Pride Clinic

• For the purposes of this talk, neither Dr. Willing nor Dr. D’Angelo have anything to declare
Objectives

- Be able to define concepts and terms related to sexual orientation and gender identity
- Understand the specific mental health disparities and stressors that are unique to LGBTQ youth
- Understand medical risks for and potential interventions to help LGBTQ youth
- Be aware of ways to make one’s practice more inclusive, accepting, and safe for LGBTQ youth
- Learn of various interventions and resources to help LGBTQ youth
What is LGBTQ+?

- Lesbian
- Gay
- Bisexual
- Transgender
- Questioning
- And More.....

- Generally speaking, used as an acronym to include groups of individuals who’s sexual orientation differs from heterosexual attraction or gender identity differs from the gender they were assigned at birth...
Why is this important for pediatricians?

• Increased visibility of LGBTQ individuals, including youth
• Increased discussion of LGBTQ rights
• Being on the front line of healthcare you may be one of only trusted adults a child may feel safe to talk to about their sexuality or gender identity
• Previous studies show approximately 3% of students in high school identify under LGBT identities
• LGBTQ youth face a number of health disparities due to increased and unique stressors
  • One’s sexual orientation or gender identity is NOT pathological
### AT CNHS - HOW MANY YOUTH ARE WE TALKING ABOUT?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>60,000</strong></td>
<td>At Children’s, this was the estimated number of Adolescent patients who sought care in FY 2013 throughout the Health System</td>
</tr>
<tr>
<td><strong>2,040</strong></td>
<td>Patients therefore likely identifying as LGBT 3.4% (based off of 2012 Gallup Poll, likely a conservative measure of prevalence)</td>
</tr>
<tr>
<td><strong>6,000</strong></td>
<td>Upper limit estimate: Patients likely with “exclusively same-sex attraction” (Kinsey’s 10% rule)</td>
</tr>
</tbody>
</table>
GENDER DEVELOPMENT

Between ages 1 and 2
- Conscious of physical differences between sexes

At 3 years old
- Can label themselves as girl or boy

By age 4
- Gender identity is stable
- Recognize that gender is constant
Terminology

• Sexual Orientation: who you are attracted to
• Three dimensions of sexual orientation
  • Sexual self-identification
    • Gay
    • Lesbian
    • Homosexual
    • Bisexual
    • Asexual
    • Pansexual
  • Sexual behavior
  • Sexual attraction/fantasy
• Not to be confused with gender identity
  • Gender identity, sexual orientation, and gender expression are all independent of each other
Terminology

• Sex: one’s biological status assigned at birth as male or female based on reproductive organs
• Gender: behavioral, cultural, psychological traits typically associated with one’s sex
• Gender Identity: internal sense of who one is, being man, woman, something else
• Gender expression: external representation of one’s gender identity, how one communicates gender identity
Terminology

• Gender non-conforming: extent to where gender expression/identity differs from cultural norm for one’s sex
• Transgender: umbrella term for individuals where gender identity/expression does not line up with one’s gender assigned at birth
• Cisgender: individual who’s gender identity is in line with the gender assigned at birth
• Transboy/affirmed male: child assigned female at birth with the gender identity of male
• Transgirl/affirmed female: child assigned male at birth with gender identity of female
Terminology

- **Genderqueer**: neither male nor female; or in between male and female
  - Non-Binary: often used to refer to those who identify outside of the binary of Male/Female
- **Gender non-conforming/variant**:  
  - Could refer to individuals who expresses gender in way that doesn’t conform to society/culture definition of how male/female should be but still identifies with natal sex  
  - Transgender individuals could also be considered gender non-conforming
- **Other Terms**  
  - Genderless/Agender  
  - Two-Spirit  
  - Third Gender  
  - FTM/MTF  
  - Genderfluid  
  - .......
The Gender Unicorn

Gender Identity
- Female/Woman/Girl
- Male/Man/Boy
- Other Gender(s)

Gender Expression/Presentation
- Feminine
- Masculine
- Other

Sex Assigned at Birth
- Female
- Male
- Other/Intersex

Sexually Attracted To
- Women
- Men
- Other Gender(s)

Romantically/Emotionally Attracted To
- Women
- Men
- Other Gender(s)

To learn more go to: www.transstudent.org/gender

Design by Landyn Pan
Important to Note:

• One’s sexual orientation or gender identity are not “diagnoses” or “pathological”
  – DSM-5 changed terminology from “Gender Identity Disorder” to “Gender Dysphoria” to focus on the distress
  – Gender non-conforming behaviors are NOT disordered
  – In ICD-11, WHO will move Gender Incongruence out of Mental Disorders to Sexual Health Conditions

• One’s sexual orientation or gender identity do not inherently cause mental health issues, but they can arise more readily due to the increased stress LGBTQ individuals face
Minority Stress

- Stigma, prejudice, and discrimination create stressful social environment that leads to mental health problems in stigmatized minority groups
- 3 processes of minority stress relevant to LGB individuals:
  - External, objective stressful events/conditions
    - Violence, bullying, teasing
  - Expectations of such events and vigilance the expectation requires
    - Hiding identity out of fear of harm
  - Internalization of negative social attitudes
    - Decreased self esteem, depression, self harm

Factors to Consider

• Issues around disclosure
  • Who to come out to and when?
  • Consider issues around safety and privacy

• Bullying/Harassment
  • Connect youth to support organizations

• Barriers to Care
  • Ensure safe spaces
  • Educate other staff to ensure respecting patient’s identity

• Impact of Family and Social Support
Suicidality

- Multiple studies have shown that LGB youth are more likely to attempt suicide compared to heterosexual peers (Marshal, et al. 2011)
- Meta-analysis of 19 studies that reported rates of depression and/or suicidality in SMY and Heterosexual youth (with mean age <18yo)
- On average 28% of SMY reported a history of suicidality vs 12% of heterosexual youth
- Safren and Heimberg study found that 58% of LGB youth that reported a suicide attempt indicated that they “really hoped to die” vs. only 33% of heterosexual youth that reported a suicide attempt.

Suicidality

• 2007 study (Grossman and D’Augelli) interviewed sample of transgender identified youth/young adults

• 45% seriously thought of suicide
  – Higher rates of physical/verbal abuse by parents

• 26% had history of suicide attempt

• No difference between groups based on sex assigned at birth or affirmed gender

Grossman AH and D’Augelli AR. Transgender Youth and Life Threatening Behaviors. Suicide And Life Threatening Behavior. 37 (5) October 2007 527-537.
Substance Use

• Meta-analysis of 18 studies looking at substance use between sexual minority youth vs. heterosexual youth
  • Odds of substance youth in LGB youth 190% greater than heterosexual youth
    • 340% greater in bisexual youth
    • 400% greater in females
  • Effects vary based on type of drug
    • Heavy alcohol OR 1.34 for recent use
    • Marijuana OR 1.56
    • Cigarettes OR 2.76
    • Injection Drug Use OR 2.87
    • Cocaine OR 3.27

School Absenteeism

• 6 month longitudinal study showed sexual minority youth have more excused and unexcused absences from school
  • Higher levels of depression and anxiety on rating scales
  • Higher depression and anxiety correlated with more unexcused absences in sexual minority youth, but not heterosexual youth
    • Heterosexual youth may find more support in school environment vs sexual minority youth may find teasing or bullying
    • Unexcused vs excused: explaining to parents or teachers the problem at school may risk disclosing their identity

Burton CM, Marshal MP, and Chisolm DJ. School Absenteeism and Mental Health Among Sexual Minority Youth and Heterosexual Youth. Journal of School Psychology. 2014. 52 (1) 37-47.
Safety at School

• Only 1 in 7 lesbian or bisexual females and 1 in 5 gay or bisexual males feel a high degree of safety in their school (Eisenberg & Resnick, 2006)

• LGB youth nearly 5x likely to miss school because of fear of safety, 4x likely to have been threatened with weapon on school property (Garofalo et al., 1998)


Safety at School

• GLSEN National School Climate Survey 2010-11 academic year
• 705 transgender students
  – 75% endorsed regular verbal harassment
  – 32% endorsed regular physical harassment (pushed, shoved)
  – 17% endorsed regular physical assault (punched, kicked, injured with weapon)

Haven’t things gotten better?

• CDC report released Aug 2016 looking at health risks of LGB high schoolers
• >40% contemplated suicide, 29% report suicide attempt in last 12 months
• Up to 5x more likely to use illegal drugs
• 60% report being so sad or hopeless they stopped doing some of their usual activities
• LGB students more likely to report:
  – Being forced to have sex (18 vs 5%)
  – Experience sexual dating violence (23 vs 9%)
  – Experience physical dating violence (18 vs 8%)
  – Being bullied at school or online (34 vs 19% at school, 28 vs 14% online)

What can you do?

• Post LGBT friendly materials (rainbow flags, safe zone stickers/posters)
• Adding options on intake forms for more than just “male”, “female”
  • Include “transgender”, “other”
  • Include “preferred pronoun”, “preferred name”
• Ask again when parent is out of the room
  • And discuss confidentiality
• Talk with ALL staff to ensure everyone is sensitive
  • National transgender discrimination survey found 19% refused care due to gender identity, 28% harassed in the medical setting, 2% physically assaulted in the office

In Practice

• Never ASSUME
  • When it comes to labels/terms
    • Don’t be afraid to ASK
    • Roll with various definitions
  • Social History
    • In younger kids, can talk about “crushes”
    • Can start by asking about friends/others, “Are people you know in school starting to date?”
    • Don’t assume everyone is heterosexual: avoid “Do you have a girlfriend/boyfriend?”
    • Go beyond the labels of just “gay” vs. “straight”, ask if a label even feels right
    • In adolescents, ask about sexual experiences, don’t be afraid to go there
      • Definitions of “sex” vary (touching, kissing, oral sex, vaginal sex, anal sex)
In Practice

- Ask about chosen name/pronouns
  - When child is alone ask again and ask if they feel comfortable using it in front of their parents
  - Think of Gender as a “mosaic” of identities
- Level of Disclosure
  - Who knows and who doesn’t know
  - Pros/Cons of disclosure in various settings
- Safety
- Social Media Safety
  - Get a sense of how and why youth are using it
    - Often the one place they can find other kids like them
  - Use of dating/”hookup” apps
Family Support/Rejection

- Ryan, et al through the Family Acceptance Project surveyed a number of Latino and Non-Latino LGB adolescents to identify 106 specific behaviors that families/caregivers use to express
  - acceptance (ie finding positive LGBT role models, welcoming their LGBT friends/partners) vs.
  - rejection (ie verbal harassment, physical violence, exclusion from family activities, and preventing access to LGBT community)
- LGB young adults that reported higher levels of family rejection (compared to LGB peers with no/low levels of family rejection) were
  - 8.4 x more likely to report suicide attempt
  - 5.9 x more likely to report high levels of depression
  - 3.4x more likely to use illegal drugs
  - 3.4x more likely to report unprotected sexual intercourse

Ryan C, PhD; Huebner D, PhD; Diaz RM, PhD; and Sanchez J. Family Rejection as a Predictor of Negative Health Outcomes in White and Latino Lesbian, Gay, and Bisexual Young Adults. *Pediatrics*. 2009; 123; 346-352.
Family Acceptance

- Following the child’s lead
- Communicate/talk about it/engage
- Correcting/defending child in family/public situations
- Advocacy in school
  - Talking with teachers/staff
  - Bathrooms
  - Sports teams
  - GSA’s
Fostering Acceptance

• Respect
  • Consider how everyone in the family is treated, are there different levels of attention
    • Don’t forget siblings
  • Intervene/no tolerance of bullying/teasing

• Showing support
  • Allowing your child to express themselves
  • Consistency
    • Does the child want you to use name/pronouns in all settings
  • Communication
    • Ask questions when you don’t understand
    • Don’t assume!
    • Offer opportunities to talk about it, don’t just wait for them to come to you.
Social Transition

• Social Transition
  • Reversible Intervention
  • Can include changing one’s
    • Name
    • Pronouns
    • Way of gender expression (hair, clothes, makeup, etc)
    • In some/all settings
  • Every child is different
    • No ONE path for a child that identifies as transgender
  • Can be a show of support and affirmation
  • Also, need to discuss issues surrounding
    • Potential for teasing/bullying
    • Disclosing/Coming out to friends, family
The Goals of LGBTQ Adolescent Health Care

Same as for all adolescents:

• To promote healthy development
• To promote social and emotional well-being
• To promote and ensure physical health
Barriers to Care for LGBTQ Youth: Provider Attitude

• Lambda Legal survey through partner organizations, 4,916 LGB respondents, 2009
  – Almost 8% of LGB and 27% of transgender and gender nonconforming reported being denied care because of their identity/orientation
  – 11% reported that providers refused to touch them or used excessive precautions
  – Transgender and gender-nonconforming respondents reported facing discrimination and barriers to care 2-3 times more frequently than LGB respondents
Discussing Sexuality in Clinical Encounters

• Due to discrimination and fear, many LGBTQ youth have difficulty accessing health care, and if they do get care, it is rarely as an acknowledged LGBTQ youth

• Sexuality and Gender Orientation are "invisible" aspects of these youth unless discussions about these topics are open, honest and non-judgmental

• Asking about these topics normalizes the notion that there is a range of sexual orientations and gender identities
Asking about Sexual Attraction

• How can you respectfully ask about sexual orientation?

✓ If you had a crush on someone, would it be a boy, girl, neither or both?

✓ Are you sexually attracted to guys, girls, or both?

✓ When you think of yourself in a relationship is it with a guy, a girl, or both?
Asking About Sexual Behaviors

• Need to be sensitive AND specific

Younger Children and Early Teens
  Have you held hands or cuddled?
  Have you kissed or touched each other’s private parts?
  Have you ever done anything more than that?

Older Teens
  Have you ever had: oral sex, vaginal sex, anal sex?
  Are your partners men, women, or both?
  During your most recent sex, which parts went where?
  Did you put your penis in his/her vagina, butt, or mouth?
  Did you take his/her penis in your vagina, butt, or mouth?
What do we know about LGB Youth Sexual Behaviors

<table>
<thead>
<tr>
<th>Category</th>
<th>GLB Youth</th>
<th>Heterosexual Youth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ever Had Sexual Intercourse</td>
<td>81.70%</td>
<td>44.10%</td>
</tr>
<tr>
<td>Sexual Intercourse &lt; Age 13</td>
<td>26.90%</td>
<td>7.40%</td>
</tr>
<tr>
<td>3 or More Partners</td>
<td>55.40%</td>
<td>19.20%</td>
</tr>
<tr>
<td>Alcohol or Drug Use at Last Sexual Episode</td>
<td>34.70%</td>
<td>13.30%</td>
</tr>
</tbody>
</table>
Consequences of Sexual Behavior in LGBTQ Youth

• 4 times the rate of all STIs
• Currently account for 70% of all new cases of HIV in youth
• 2/3 of all cases of syphilis diagnosed in MSM (36% of these cases have met their partner(s) online)
• HIV prevalence is upwards of 19% in some MSM sub-populations
Diagnoses of HIV Infection Among Male Adolescents and Young Adults, by Age Group and Transmission Category, 2016—United States and 6 Dependent Areas

<table>
<thead>
<tr>
<th>Transmission category</th>
<th>13–19 years</th>
<th></th>
<th>20–24 years</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>Male-to-male sexual contact</td>
<td>1,321</td>
<td>92.7</td>
<td>5,595</td>
<td>91.6</td>
</tr>
<tr>
<td>Injection drug use (IDU)</td>
<td>15</td>
<td>1.0</td>
<td>88</td>
<td>1.4</td>
</tr>
<tr>
<td>Male-to-male sexual contact and IDU</td>
<td>40</td>
<td>2.8</td>
<td>188</td>
<td>3.1</td>
</tr>
<tr>
<td>Heterosexual contact(^a)</td>
<td>42</td>
<td>3.0</td>
<td>234</td>
<td>3.8</td>
</tr>
<tr>
<td>Other(^b)</td>
<td>6</td>
<td>0.4</td>
<td>6</td>
<td>0.1</td>
</tr>
<tr>
<td><strong>Total(^c)</strong></td>
<td><strong>1,424</strong></td>
<td><strong>100</strong></td>
<td><strong>6,111</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Note. Data for the year 2015 are preliminary and based on 6 months reporting delay. Data have been statistically adjusted to account for missing transmission category.

\(^a\) Heterosexual contact with a person known to have, or to be at high risk for, HIV infection.

\(^b\) Includes hemophilia, blood transfusion, perinatal exposure, and risk factor not reported or not identified.

\(^c\) Because column totals for numbers were calculated independently of the values for the subpopulations, the values in each column may not sum to the column total.
Adolescents and Young Adults Aged 13–24 Years Living with Diagnosed HIV Infection by Sex and Transmission Category, Year-end 2015—United States and 6 Dependent Areas

Male
N = 28,467

- Male-to-male sexual contact: 81%
- Heterosexual contact: 3%
- Injection drug use (IDU): 1%
- Male-to-male sexual contact & IDU: 3%
- Perinatal: 11%
- Other: 1%

Female
N = 8,494

- Diagnosis, %: 48%
- Diagnosis, %: 5%
- Diagnosis, %: 42%
- Diagnosis, %: 5%

Note. Data have been statistically adjusted to account for missing transmission category. “Other” transmission category not displayed as it comprises 1% or less of cases.

*a Heterosexual contact with a person known to have, or to be at high risk for, HIV infection.
*b Includes hemophilia, blood transfusion, and risk factor not reported or not identified.
HIV in Transgender Individuals

22% is the estimated HIV prevalence among transgender women (2013 meta-analysis (Baral et al.)).

- 28% of transgender women had HIV infection (4 studies), but only while 12% of transgender women self-reported having HIV (18 studies) ((Herbst et al.)

- 56% of black/African American transgender women are HIV positive (vs. 17% of white or 16% of Hispanic/Latina transgender women).

- Among the 3.3 million HIV testing events reported to CDC in 2013, the highest percentages of newly identified HIV-positive persons were among transgender persons.

- Although HIV prevalence among transgender men is relatively low (0-3%), much higher in transgender men who have sex with men
Question

Jovan is an 19 yo male who admits to “hooking up” with guys he meets on the internet several times a month. He rarely has the same partner. How often do you recommend he be screened for STIs?

A. Annually
B. Every month
C. Every 9 months
D. Every 3-6 months
E. None of the above
Screening for urethral, anal, and pharyngeal GC and Chlamydia annually BUT as frequently as every 3-6 months in patients with history of previous STIs or history of multiple or anonymous partners.

Similarly, screening for HIV and Syphilis is recommended at least annually and as often as every 3-6 months for same reasons.
Reproductive Health in Bisexual and Lesbian Women

• Often overlooked

• Using data from the 2006-2010 NSFG of Self-identified bisexual, lesbian, and heterosexual women aged 15-20 we find that LBQ women often have:

  – A younger age at heterosexual debut than strictly heterosexual women
  – More male as well as female sexual partners
  – More likely have been forced sex by male partner

• Greatest use of EC and highest frequency of abortion among bisexual young women
**Question**
In addition to regularly screening Jovan for STIs, what medication should you also prescribe for him?

A. Daily Doxycycline  
B. Benzathine Penicillin injections every 3 months  
C. Daily Truvada  
D. Post-sexual contact doses of doxycycline and Truvada  
E. None of the above
What is PrEP (Pre-exposure Prophylaxis)?

- Once daily tablet containing 2 drugs: emtricitabine/tenofovir disoproxil fumerate (TDF-FTC)
- Marketed as TRUVADA for PrEP™ vs. Truvada® for treatment
- FDA approved in 2012 for adults that are HIV uninfected
- FDA expanded indication in May 2018 to include adolescents at risk for HIV acquisition who are at least 35 kg (78 lbs)
- >90% reduction of HIV transmission among high risk HIV uninfected patients who are adherent to taking the medicine
Risk Behaviors that SHOULD Facilitate Provider Discussion with all Youth about PrEP Use

• Unprotected sex (vaginal, anal or oral) with someone of unknown HIV status or known HIV+ status in past 6 months
• Having “multiple” sexual partners
• Having prior bacterial sexually transmitted infections (STI) i.e. syphilis, chlamydia or gonorrhea in past 6 months
• Having sex after drinking alcohol or taking drugs
• Develop a plan for STI prevention and contraception or safer conception
• Increase self-efficacy for adherence
  – Link to daily habits; Disclose PrEP use to a trusted person; Use alarms
• Reinforce that PrEP is a responsible choice
• PrEP is highly effective if taken as prescribed
• If you forget to take a tablet, take it as soon as you remember
• PrEP tablets can be taken any time of day, with or without food
Key Counseling Messages: Effectiveness

• Develop a plan for STI prevention and contraception or safer conception
• Increase self-efficacy for adherence
  – Link to daily habits; Disclose PrEP use to a trusted person; Use alarms
• Reinforce that PrEP is a responsible choice
• PrEP is highly effective if taken as prescribed
• If you forget to take a tablet, take it as soon as you remember
• PrEP tablets can be taken any time of day, with or without food
Key Counseling Messages: Safety

• “PrEP is safe, with no side effects for 90% of users”
• “About 10% of people who start PrEP will have some short-term, mild side-effects”
  – GI symptoms (flatulence, nausea, weight loss) and headache
    • Remind that “start up syndrome” usually resolves in 4 weeks
    • Counsel to take medication with food
    • Prescribe PRN anti-emetics
    • Offer close follow up: MONTHLY vs. quarterly
  – Slight, reversible bone mineral density risk
    • Noted during first 6 months without progression; resolves 6 months after discontinuation
    • Maximize calcium intake
• “PrEP is effective even if you are taking hormonal contraceptives, gender affirming hormones or non-prescription medications”
And a few words about........

Transgender Youth
DSM 5 diagnostic criteria for Gender Dysphoria

Table 2. DSM-5 Criteria for Gender Dysphoria in Adolescents and Adults

A. A marked incongruence between one’s experienced/expressed gender and natal gender of at least 6 mo in 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 designated gender)
5. A strong desire to be treated as the other gender (or some alternative gender different from one’s designated 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 designated gender)

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

Specify if:

1. The condition exists with a disorder of sex development.
2. The condition is posttransitional, in that the individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one sex-related medical procedure or treatment regimen—namely, regular sex hormone treatment or gender reassignment surgery confirming the desired gender (e.g., penectomy, vaginoplasty in natal males; mastectomy or phalloplasty in natal females).

Reference: American Psychiatric Association (14).
Gender Dysphoria in Adolescents

• Few medical and mental health providers treating adolescents provide services to this population
  ✓ Lack of knowledge
  ✓ Inadequate and inconsistent patterns of insurance coverage
  ✓ Personal discomfort on the part of the professionals

• Delaying proper diagnosis can lead to significant psychological consequences

• Window of optimal psychological evaluation and endocrinologic management occurs during adolescence
Etiology of Gender Dysphoria

• Neither biological nor psychological studies provide a satisfactory explanation for GD

• There is no comprehensive understanding of hormonal imprinting on gender identity formation.
  – Role for sex steroids and receptors?
    • Prenatal androgenization and male identity
  – Genetic mechanisms
    • One study from 2011 reported that identical twins were more likely to be concordant for GD than fraternal twins
  – Maternal immunization against the H-Y antigen and birth order
    • Immunization of some mothers to Y-linked antigens by each succeeding male fetus
  – Neuroanatomic and neurofunctional studies
    • Postmortem
    • Live brain-imaging studies
Transgender Youth - Epidemiology

• In Adults, 0.53% (1/186) of population self-identify as Transgender (Crisman et al, AJPH 2017;107:213-215)

• The prevalence of gender variant behavior and GD in childhood and adolescence are evolving

• Social/cultural climates: prevalence increases as acceptance increases

• Perspective of who is defining the condition (surgical/medical management vs self report )

• Difference in natal sex transitioning
  Adults - 3x more likely to be male to female
  Childhood - the sex ratio is close to 1:1
  Youth Pride Clinic female to male/male to female is 3 to 1
Management of GD in Adolescents

- Multidisciplinary effort with a focus on hormone therapy:
  - Diagnostic assessment
  - Psychotherapy or counseling
  - Real-life experience
  - Hormone Therapy
  - Surgical therapy

- Not every individual with GD feel the need to masculinize or feminize their body
Treatment Options for Transgender Youth

• Physical Interventions
  • Fully reversible
    – GnRH agonists to suppress estrogen and/or testosterone
    – Medroxyprogesterone/spironolactone
  • Partially reversible
    – Hormonal intervention to feminize or masculinize the body
  • Irreversible
    – Surgical procedures
Criteria for Puberty Suppressing or Gender Affirming hormone therapy

In order for adolescents to receive puberty suppressing or gender affirming hormone therapy, the following minimum criteria must be met:

• 1. The adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed);

• 2. Gender dysphoria emerged or worsened with the onset of puberty;

• 3. Any co-existing psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed

• 4. The adolescent has given informed consent and, particularly when the adolescent has not reached the age of medical consent, the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process.
Gender Care Within Children’s National Health System

• Gender and Sexuality Development Program – Department of Psychiatry (Drs. David Call and Laura Willing)

• Gender Treatment Program – Division of Pediatric and Adolescent Gynecology (Dr. Veronica Gomez-Lobo)

• Youth Pride Clinic – Division of Adolescent and Young Adult Medicine (Drs. Larry D’Angelo and Tonya Katcher)

• Proud Clinic – Department of Genetics (Drs. Veronica Gomez Lobo and Eric Villain)
Gender and Sexuality Development Program

• Provide psychosocial evaluations of children and teens who may be struggling with issues around sexual orientation and gender identity
  – Screening and management of co-occurring conditions
• Provide psychoeducational support for both youth and their families
• Support groups for both youth (pre-pubertal, pre-teen, adolescent) and parents
• Guidance and support around social and medical transitions
  – Referrals for medical interventions (puberty suppression, cross-sex hormones, surgical) when appropriate
• 202-476-5980
Youth PRIDE Clinic

• Provides primary, secondary and tertiary care for LGBTQ Youth

• Services include gender counselling, STI treatment and prevention (including PrEP), and Gender Affirming Hormone Therapy


• 202-476-2178
Resources

- DCMAP
- PRIDE Clinic
- Gender and Sexuality Development Program
- American Academy of Pediatrics Section on Lesbian, Gay, Bisexual and Transgender Health and Wellness
  - Policy statement, resource guide, handouts for children and families, more webinars!
- Gender Spectrum [www.genderspectrum.org](http://www.genderspectrum.org)
  - Resources for youth, families and providers
- PFLAG DC (Parents, Families & Friends of Lesbians & Gays)
  - [www.pflagdc.org](http://www.pflagdc.org)
- SMYAL (Supporting and Mentoring Youth Advocates and Leaders)
  - [www.smyal.org](http://www.smyal.org)
  - Provides recreations/social/support groups for youth
  - Peer education and leadership development
Resources

• Family Acceptance Project [http://familyproject.sfsu.edu/](http://familyproject.sfsu.edu/)
  • Publications and videos promoting family acceptance

• Lead with Love [http://www.leadwithlovefilm.com/](http://www.leadwithlovefilm.com/)
  • Free video documentary of parents journeys of acceptance
  • Support for Parents

• GLBT National Youth Talkline [www.glbthotline.org](http://www.glbthotline.org)
  • Free phone support line and online chat for youth to have safe discussions

• Trevor Project [www.thetrevorproject.org](http://www.thetrevorproject.org) 1-866-488-7386
  • Suicide prevention hotline for LGBT youth
DCMAP

• **Mental Health Access in Pediatrics**
• Based on a **highly successful child psychiatry access model**
• Staffed by an **interdisciplinary team** from Children’s National and MedStar Georgetown University Hospital
• **Live phone consultation** with child MH experts (psychiatrists and/or therapists, depending upon consultation question)
• Brief, **time-limited follow-up** services as clinically indicated
• Mental health **training and education**
Using DCMAP Services

• **Free!!**
• Contact about **any** issue pertaining to mental health
• M-F, 9am – 5pm; call back within 30 minutes
• **Call** 1-844-30-DCMAP (1-844-303-2627) or complete **consultation request form** ([www.dcmap.org](http://www.dcmap.org))
• Provide basic information about your question/patient and we will connect you with the appropriate team member
Questions?

- lwilling@childrensnational.org
- ldangelo@childrensnational.org
To Earn CME Credit

1. Watch 2-Hour Webinar (You’ve already done this if you reached this slide! 😊)

2. Complete CME Attestation Form
You must fill out this form by no later than **Wednesday, December 5th.** Once you have completed this form your information will be turned into the George Washington University Office of Continuing Education in Health Professions.

3. Complete GWU CME Evaluation Form
This form will be sent out by the George Washington University Office of Continuing Education in Health Professions.

*Please note you must complete all 3 steps in order to receive CME credit.*