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In a two part module on gender care for youth, Dr. Scott Liebowitz clearly explains the recent trends, ethical debates, and best practices for care of trans and gender diverse youth. Dr. Liebowitz is a board certified child and adolescent psychiatrist. He's also a speaker, writer, and educator who is internationally known for specializing in the care of transgender and diverse, which he calls TGD children and adolescents.

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We are particularly thrilled to have him join us in this certificate, given his work from 2016 to 2024 as the Medical Director of Behavioral Health for the Thrive Gender Program at Nationwide Children's Hospital in Columbus, Ohio. Thrive has become the largest embedded therapy and assessment model of any pediatric gender clinic in the United States. Dr. Liebowitz was also the co-lead of the Adolescent Chapter for the 2022 World Professional Association for Transgender Health.

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Also known as WPATH Standard of Care, eighth edition. And he currently serves on the Board of directors for WPATH. Across his two modules Dr. Liebowitz immerses us in the contemporary trends and debates about healthcare for trans and gender diverse youth. Including a local analysis of laws, debates, politics and practices here in Ohio, where he practiced for many years.

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He mobilizes the concept of gender as dimensional and on a spectrum to develop both gender literacy and gender care literacy in healthcare practitioners. In this way, he directly takes the problems of the gender binary from my introductory module into practice, underscoring that the population of trans and gender diverse youth continues to change quite rapidly. I would like to frame these modules through a longer historical lens provided by the scholar Julian Gilll Petersonâ€™s

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ground breaking book, Histories of the Transgender Child, which was published in 2018. In this book, Dr. Gilll Peterson shows how medical archives of the 20th century are full of trans persons asking for and increasingly receiving healthcare. And this clearly includes trans kids. While there's a lot of general societal energy these days around how new the phenomenon of trans kids is, Gilll Peterson's exquisitely careful archival work shows this simply is not true.

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Drawing on Dr. Gilll Petersonâ€™s scholarship, I want to elaborate a three part framework for Dr. Liebowitz as modules. First, I will talk through what she describes or argues for a medical definition of gender that emerged in the 1940s and 50s to shore up the collapse of the sex binary. Secondly, I will discuss what she describes as the gap between the medical industry and clinical practices.

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The history of healthcare for trans and gender diverse youth across the 20th century speaks to this gap. And third, I want to talk about a cautionary tale, which is the difficult tie of early trans healthcare to eugenics.

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The first important framework is about the medical definition of gender. Dr. Gilll Peterson develops a very surprising

account of the concept of gender out of her archival work. She argues that the concept of gender emerges inside the medical industry of the United States in the 1940s and 50s as a powerful tool to shore up the social binary system. Across the early 20th century, medical research and practices in areas like chromosomes, morphology, and endocrinology,

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they all slowly began to show that the framework that we approach sex, biological sex as binary. That framework was deeply flawed. Gilll Peterson shows in detail how, as that sex binary falls apart as a cohesive system and theory across that early 20th century in medical practices and research, the concept of gender stepped in to shore up the binary structure.

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She describes explicitly gender as what she, from her own text says is, quote, a medical device mobilized to face the potential conceptual collapse of binary sex. This is a strikingly different understanding of gender from the one Dr. Lebowitz puts forward in this module as dimensional and a spectrum. This shows us that the medical understanding of gender continues to develop and change, often really at a very fast pace.

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The second framework that I want to discuss for a moment draws attention to the gap between categories developed by the medical industry and the sprawling array of clinical practices that we find in the histories of healthcare for trans and gender diverse youth across the 20th century. As Dr. Lebowitz will explain, the Diagnostic and Statistical Manual, the DSM of 1980 introduced a diagnostic category explicitly about trans kids.

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That category is called the gender identity disorder of childhood. While the entrance of gender identity disorder into the DSM three is often seen to open up trans healthcare and research, as I discussed in the module of Nathan Levitt on Trans Primary healthcare, Dr. Liebowitz confirms that this particular category about trans childhood actually closed the window for adolescent care, and yet that care persists.

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So how is that happening? Dr. Gilll Peterson shows, first of all, how healthcare for trans kids is not new. She tells a range of stories from the archives to show this. She tells us about Val, a trans girl who lived in rural Wisconsin around 1930 whose parents arranged for her to attend school as a girl, including, quote unquote, special arrangements for toilet.

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So the bathroom issue is not new. She also tells us about the scores of letters that teenagers wrote to John Money's clinic at Johns Hopkins University in the 1970s, including evidence that teenage trans boys and girls successfully access gender affirming surgeries in the 1970s. While Gill Peterson fully agrees with Dr. Liebowitz that the 1980 DSM three diagnostically rendered adolescent trans healthcare far more tenuous, she also underscores that the practices of clinics continue to find ways to offer the best possible healthcare for all patients.

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She shows repeatedly that the gap between the medical industry and the sprawling network of clinics is the site in which actual best practices of healthcare have always and continue to occur. She also repeatedly argues that post 1980 post, the emergence of that category in the DSM, that we are neither in any a coherent period of history about trans kids,

00:08:49:02 - 00:09:01:04

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nothing has coagulated in those 45 years, nor certainly are we in something, something new.

00:09:01:06 - 00:09:36:16
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The third framework for these modules that I want to introduce to you is what I call a cautionary tale about the ties of early iterations of trans healthcare to eugenics. As I elaborated in the introductory module, the gender binary carries the histories of settler colonialism and the transatlantic slave trade. From this perspective, we can follow the thread of racialization through scientific racism, sexology, and eugenics all the way further into endocrinology.

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For example, the first endocrinologist to work with trans patients, Harry Benjamin, was born and educated in Germany and then, after immigrating to the United States in 1913, continued to travel between the United States and Germany and Austria, where the frameworks of both sexology and eugenics informed his work in endocrinology. As Gill Peterson elaborates, the long shadow of eugenics hovers over these medical definitions and practices of gender.

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For example, she explains that the Tanner scale, which is used clinically to assess the so-called development of gender in prepubescent children and adolescents, is, as she puts it, quote, lifted without acknowledgment from the turn of the century, eugenic

00:10:30:15 - 00:10:52:05
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anthropometry producing an ascending teleological scale of normal phenotypes. Close quote. This means that the clinical assessments of gender continue the long debunked concepts of scientific racism and eugenics that offer gradient types gradients of human types.

00:10:52:06 - 00:11:27:02
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You'll recall from the introductory module, where you know the white is always at the top and the black is always at the bottom. If that's being caught up into how we are assessing gender in the clinic, we need to become quite cautious about this kind of haunting of eugenics and its many effects. The racialization of gender can, for example, all too easily reproduce old stereotypes, for example, of hypersexualized black and brown women and men, both trans and cis.

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Gill Peterson also sadly gives ample evidence from the archives the treatment of trans kids in the 20th century skews very strongly towards the treatment of white trans kids. Black and brown trans children and adolescents are far more often subjected to harsher forms of confinement in mental and carceral institutions, as well as to street violence, all of which we continue to see in the 21st century.

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I hope these three frameworks prepare you for the exciting work of Dr. Liebowitz. In these two modules. As you learn about more contemporary trends and debates about best practices for trans and gender diverse youth, please keep in mind Gill Peterson's emphasis on the practices of the clinic. She encourages healthcare practitioners to listen to trans kids who have, as she shows, always existed.

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She also encourages you to ground medical care in trans kids desires, which they do know how to articulate. And finally, she encourages us all to abandon binary models of gender development and transition, which are tied to that

very dark and persistent eugenics. As with all the modules in this certificate, the lessons you learn from Dr. Liebowitz will improve all forms of your healthcare, and it will especially encourage you to rethink and transform pediatric medicine at its foundations.

00:13:03:16 - 00:13:07:00
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Enjoy these fantastic two modules.

0:12
[Scott Leibowitz] In the 3rd and final section of this module, I will address the ethical considerations across child and adolescent development.

0:21
I'll start by reviewing the four basic concepts around the biomedical ethical framework that everyone is well acquainted with.

0:29
Autonomy or what the patient wants.

0:32
Beneficence, which is what's good for the patient now and in the future non-maleficence, which is what's bad for the patient now or in the future.

0:42
And then justice, thinking about what is right for that person in the context of what's right for everybody.

0:50
As it relates to gender care, this could be broken down into autonomy being the desire for gender medical treatments.

0:59
The beneficence means feeling comfortable in one's body and having level of harmony as a result of that.

1:09
Non-Maleficence is about recognition of the limited evidence and the attempt to prevent any regret or harm that might happen from the treatment.

1:18
And then justice means that trans people have the right to be perceived as they identify similarly to the rest of society.

1:31
So in order to be able to navigate this complex set of concepts, that is where multidisciplinary care comes into play for trans youth.

1:43
More perspectives means an improved ability to weigh ethical principles in the absence of strong evidence.

1:51
Evidence for the benefits of gender affirming care come from the programs that have multidisciplinary involvement, and the variations in resources geographically mean that guidelines need to be flexible,

since including multidisciplinary perspectives may not always be possible based on the resources where the care is being delivered.

2:16
I'll first start with puberty suppression.

2:20
On the screen you'll see male puberty and female puberty.

2:25
What puberty suppression does for trans youth is it presses a pause button once a young person has entered puberty.

2:33
So Tanner stage 2 would be when they are entering puberty, Tanner one is they are pre pubertal and Tanner 5 is when they are completely have a mature physical body of an adult.

2:47
Historically, once young people enter puberty, if they have had a history of gender diverse expression as a child and that intensifies with pubertal onset, we can suppress puberty using a GNRH analog gonadotropin releasing hormone agonist and that buys time to extend the period of exploration.

3:12
By preventing irreversible changes from that young person's endogenous puberty, you are reducing psychiatric risk since their body is not evolving or physically developing into the mature body of the sex that they do not identify as.

3:31
And if that young person then were to receive hormone care after a few years on puberty suppression, what that does is it helps promote A lifelong appearance of the the physical characteristics associated with the gender they identify as, not the gender associated with their assigned sex at birth, minimizing the need for invasive procedures.

3:57
So a an assigned male at birth or a trans girl would not go through male puberty.

4:04
She would not get broad shoulders, deepening of her voice, facial hair, and a trans boy or assigned female at birth would not develop a breast tissue and would not develop a period or a menstrual cycle that would be difficult for them to go through.

4:23
It sounds like it's all benefit, but it's important to think about the significant limitations and risks.

4:31
Puberty is a time when bone development must take place.

4:36
Bone density accrues, and if we are blocking puberty during a crucial period of time, we need to be understanding the impact on bone development.

4:45
That being said, there is data that demonstrates that when these young people do ultimately get their hormone treatment, that their bone density accrues and that they catch up in in their bone health.

5:01
Brain development is a hypothetical, not proven limitation.

5:06
But if we think about brain development during adolescence, hormones are trophic on executive functioning and they are also important for helping people think through cognitive development.

5:18
They are helpful in helping adolescents develop skills of inhibition and planning.

5:25
And so if we are delaying the impact of hormone development on the developing brain, one must ask is that something that has long term negative outcomes or not?

5:35
The good news is that initial data from the Amsterdam clinic shows that when young people do get their hormones after they've received puberty blockers, that they do not have any significant impairment in their executive functioning.

5:53
But this specific issue is why it's really important that we can't have people taking puberty blockers alone.

6:02
Passed around the age of 14, which is the latest period in time when a typical cisgender kid would be going into puberty if they were in the later stage of the ideal physiological window of puberty.

6:16
Another important topic is related to sexual health and the and the reproductive system.

6:23
When we suppress puberty, we are also suppressing genital growth and particularly for the transgender girls.

6:31
Should that girl ultimately in the future decide that she wants to have a vaginoplasty or gender confirmation surgery, Surgeons have indicated that that puberty suppression can impact or limit the

amount of tissue that they can use to perform the surgery and optimally have that young woman have ideal sexual health later on.

6:56
So these are important decisions that families are facing at very at ages that could be as young as age 12 or 11 when kids do go into puberty.

7:08
And lastly, the reproductive system and fertility is impacted if a young person goes directly from puberty suppression onto hormones and had started the blockers before they were able to experience gematogenesis or to have spermatogenesis, for example.

7:28
So these are important topics to to be thinking about.

7:32
And I'd like you to ask yourself, is using puberty suppression appropriate for the purposes of creating an ideal appearance, ideal appearance in quotes as a man or woman?

7:46
Why or why not?

7:48
So when would puberty suppression be appropriate and what is the main use for it as far as medical and surgical decision making goes?

8:01
Gender hormones have historically been provided at age 16.

8:05
I will get into the history of that in the subsequent module.

8:08
But with the use of puberty suppression, the Endocrine Society guidelines in 2017 recommended flexibility to start hormones younger with the goal of getting young people sex hormone exposure if they were on puberty blockers at a time that they should.

8:27
So the upper limit of physiological puberty, as I mentioned, is age 14.

8:33
It would be appropriate to start hormones at around that younger age.

8:37
Because of this compelling reason, the Endocrine Society guidelines were very clear that mental health assessment is indicated for adolescents to appreciate their decision making capacity before starting gender affirming hormone treatment.

8:53
The evidence for hormones is evolving.

8:55
I did provide for you an overview of the evidence with few longitudinal studies.

9:00
Mostly cross-sectional or survey hormones include testosterone for trans boys and estrogen for trans girls.

9:09
These two hormones produce many of the secondary sexual characteristics of 1's experienced or affirmed gender.

9:18
There is sufficient evidence of psychological benefit and relief in adults and there are known medical and potential psychiatric risks.

9:27
And I say this to say that we can mitigate for those risks.

9:32
We can monitor labs and we can it's important for people to be connected and get the the recommended tests at the recommended intervals by their doctor.

9:45
This is the longitudinal study in the Netherlands that looked at 55 young people, 22 trans females, 33 trans males and took them and evaluated their mental health over three different time points.

9:59
When they started pubertal suppression, when they started their hormones, and then when they one year post surgery.

10:06
And these were the average ages for when those milestones took place.

10:12
Interestingly enough, they the averaging age for those starting puberty suppression was 13.6, which many have said was probably past the point that young people entered puberty, so they may have been in Tanner 3 or Tanner 4 by that point.

10:28
They assessed 10 indicators of psychological functioning using various psychological measures.

10:33
They also included gender scales, including the Gender Dysphoria Scale from Utrecht and the Body

Image scale and found 30% to 7% clinical range decrease on the YSR and ASR, which are measures of psychopathology.

10:49
So decrease in level of psychopathology and that trans women experience greater satisfaction on body image scales.

10:56
There are methodological limitations, as there are with every other study, and I'd urge you to go read that study and critically think about it yourself.

11:05
And with 55 kids over that span of 7 to 8 years, is that sufficient to apply, you know, to generalize to today's population of young people coming in for treatment?

11:20
So back to our perspectives diagram, there are those that say minors just can't appreciate the irreversible effects that these treatments have.

11:31
And then there are others that will say we have to ensure that they go through a correct puberty first and foremost.

11:37
It doesn't matter.

11:39
And my argument would be that the truth lies somewhere in the middle.

11:45
Surgery is very much a controversial subject when it comes to minors.

11:51
I should first start by saying that not all individuals with gender dysphoria even seek surgery.

11:57
Most surgical interventions are reserved for 18 plus.

12:01
So when people are older and able to go through and appreciate the the the pre op care, the post op, all of the things necessary for the surgical outcome to be optimized.

12:13
There are many surgical options that do exist.

12:16

However, for youth historically, pre political culture and political climate, chest masculinization or top surgery for trans masculine patients was the only surgery that minors would be receiving.

12:33
Gender surgery, when indicated, is medically necessary, and the evidence is rather weak in this age group, but it's evolving.

12:42
And I pointed out that there were four studies that contributed to the overall literature for surgery in minors.

12:52
So what about age?

12:53
Are there any age criteria that we should be applying when thinking about different treatments?

13:00
Well, there would be reasons why we should include ages in any set of guidelines, so they could give you a general guidepost.

13:06
And if you include the age in the guidelines, then it prevents an insurance company or others from coming up with arbitrary age policies.

13:15
But there are also challenges by by including ages and guidelines because it is arbitrary.

13:21
There will never be a study that sorts out or has one group go who are 15 year olds as opposed to 17 year olds.

13:31
That's just not the type of study that can be can be done.

13:34
And there's always going to be outliers within age groups reinforcing a very one-size-fits-all approach.

13:41
And the minute ages are thought of, then that's the only thing people go to when they're thinking about these decisions.

13:48
So if you say people must be 14 years old in order to start treatment, the problem with that is that a lot of people then think, OK, when I'm 14, I can start treatment and that does not account for all the other factors involved in the decision making process.

14:05
So age, well, it's all relative.

14:08
Not every 14 year old approaches decisions the same and not every 17 year old approaches decisions the same.

14:15
And one can also say that for adults.

14:19
So moving into assessment and diagnostic clarity, this is a tricky debate because there's been really 2 ends of the spectrum an the pendulum has really swung very widely on this issue.

14:35
Back in the 80s and 90s, trans people were often, and I'm referring to adults were often faced with having to go to therapy for a certain amount of time.

14:46
They were often told that they had to live as the gender that they identify As for a certain period of time, which all reinforced the idea that they had to prove their identity to a mental health professional.

14:59
This was very difficult and challenging because that can create distrust in the in the relationship and many people might not say what they're truly feeling because they're they know that they're being evaluated under a very false premise or circumstance.

15:14
So there's been a push by the trans community to move away from that and have termed that type of practices gatekeeping.

15:23
The challenge with that is if you go all the way to the other direction and then you eliminate any form of assessment or therapy or any form of mental health inclusion in the in, in the process.

15:36
How can you appreciate the young person in particular?

15:40
And I, I refer mostly to minors, but how can you understand their decision making capacity or their maturity level for their age?

15:49
And so really that keeping that pendulum swinging in the middle is about assessing individualized needs.

15:56
And that's where this debate lies.

15:59
So on one side of the debate, you have people saying the wait list is way too long.

16:04
So I can't sit on a wait list to be assessed.

16:08
I need to move quickly.

16:10
And there are other people that will say, well you must mandate X amount of years of therapy before you can even consider any form of treatment.

16:19
And humans are complex and the complexity lies somewhere in the middle.

16:25
Is there evidence to actually doing an assessment?

16:29
Well that that's a tough study to do.

16:31
But what we can say is that the largest body of evidence for the long term benefits of gender affirming medical treatment.

16:39
The study that I showed you was done in a clinic that has a very comprehensive extended assessment approach, so many sessions extended over time.

16:49
So if we're going to say that the treatment for minors, that gender affirming medical treatment is evidence based, we have to be thinking about how did they even collect the evidence in the 1st place.

17:01
And so those youth that ultimately were on those treatments that were proven to be beneficial went through a very extended process of understanding their psychological functioning, their emotional maturity, and their approach to complex decisions.

17:18
So there are a wide variety of protocols that exist in different clinics, each with different staff resources regarding the level of assessment and who completes it.

17:30
Assessment can really create 2, 2 competing perspectives in the clinical relationship.

17:38
So the patient on one hand would say I know my body and I know what I need going back to that autonomy principle, whereas the doctor might say, well, I need to understand your experience before I can prescribe going back to that non maleficence principle.

17:55
And as in the rest of medicine, the truth lies somewhere in the middle and it's a weighing of all perspectives.

18:04
It's not about assessing a young person's gender.

18:08
Rather we assess how well the young person knows themselves and how gender integrates into their overall identity development.

18:17
This is where it's important for us to understand.

18:19
Can they even appreciate the concept of detransition and regret?

18:24
And I bring this up because it's an important trend to Note 3 recent studies have been done looking at detransition and regret of earlier treatments.

18:36
One study done by a de-transitioner in Germany in 2022 looked at 237 de-transitioners.

18:44
92% interestingly were designated female at birth, 65% of whom had medically transitioned.

18:52
And if you look at the experience and understand what they say about their decision to start treatment in the 1st place, 45% felt under informed about health consequences and 60% of them experienced regret.

19:07
So not everybody regretted their decision.

19:11
Also looking at the age at the time that they had made their initial decision, it was over the age of 18,

not during adolescence or younger, not during a time when their families were in charge and there was more oversight over the decision.

19:28
And so that's really interesting to note.

19:30
The second study done here in in the United States looked at 100 individuals, all of whom de transitioned after taking medical and surgical treatment.

19:41
Again, very high level of designated females at birth.

19:45
Comparatively, 55% felt they did not receive adequate medical or mental health assessment, and 38% felt that past experiences of trauma or poor mental health is what led them to feel gender dysphoria in the first place.

20:00
And then a third study by MacKinnon.

20:02
Kinnon, who is in Toronto, he who is a trans masculine person himself, doing research on detransition and regret.

20:13
He did qualitative interviews of 28 individuals and analyzed the themes of what those participants had said.

20:21
92% had started their medical transition old when they were older, when they were not minors.

20:28
And some of the themes that come through were about how binary the gender assessments were and how linear the transitions were emphasized.

20:36
So people not realizing that perhaps their identity felt somewhere in the middle and that had not been explored and they were afraid to ask for chest surgery only they thought they might need to get hormones in order to get chest surgery.

20:52
Others were dissatisfied with informed consent approach and had decisional regret.

20:58
So they were not provided with appropriate expectations about the effects of treatment.

21:03
Or they felt that their providers were trying too hard and believed that their transition would help with everything.

21:10
And then others had said that they wished there could be more support for individualized care pathways and that providers really need to be thinking about the complexity of gender instead of offering fixed approaches promoting self reflection away from influences.

21:29
It's difficult to study regret and detransition.

21:32
Regret is more complex than yes.

21:34
No, you might regret a decision, but you don't regret an outcome or vice versa.

21:40
And there are huge pressures not to regret something once you've invested so much time in educating and telling people about your experience.

21:48
So a lot of shame can come about from that.

21:51
And it's also difficult studying detransition because how do you even define who a detransitioner is?

21:58
That word alone brings up a lot of emotion for people.

22:01
And some people don't want to come forward and call themselves a detransitioner because they know that their experience is being used to deny other people care.

22:11
Therefore, reaching those populations is very difficult.

22:16
There's also been emerging data on adolescent identity shifts over time.

22:21
And so this is research out of DC, the DC National Children's Hospital Gender clinic, that show different shift profiles of young people.

22:31
So there are some people who request treatment and then they no longer request it.

22:35
Then there are people who request no longer request, but request again.

22:39
And that is the most common shift profile.

22:42
And you can see these different shift profiles.

22:45
What's really interesting is they found that non binary youth were more likely to shift in their decision or desire for treatment.

22:54
So ask yourself, is it even appropriate to raise the concept of regret and detransition to trans adolescents seeking medical treatment?

23:03
Why or why not?

23:08
And the reason why this is so emotionally difficult for people to talk about is because many people say they're all going to regret and D transition.

23:19
But then on the other hand, the equal and opposite reaction is regret is rare and D transition really only happens because of stigma when the truth really does lie somewhere in the middle.

23:31
So the final part of this third section is about the timing and and the psychiatric concerns.

23:38
As I've indicated, the population's changed over time.

23:42
There's a heterogeneous group of young people who are seeking care.

23:45
They have different resilience and maturity profiles, they have different gender profiles, and they have different psychiatric or psychological profiles.

23:53

The question that we need to ask for each of these three categories, how emotionally mature is the young person for their age in terms of their decision making capacity?

24:05
To what degree do the sought after treatments address their core identity as a particular gender?

24:12
And then what is the relationship between their gender and their mental health?

24:17
And I'll elaborate on that.

24:20
So the presence of Co occurring mental health condition like depression, anxiety, there's a relationship between gender and their mental health issue that we as clinicians need to decipher.

24:33
There are mental health experiences that might come from one being gender dysphoric in the 1st place.

24:39
There are others that come from the stigma of being a gender diverse minority.

24:45
There are others that are completely distinct from gender dysphoria or stigma, such as one's pet dying.

24:51
There are other mental health experiences that might need prioritizing first, which may be important more for their path to authenticity.

25:00
So if their emotional reactivity is very high or their rigid thinking is impacting their overall functioning, can they approach these big decisions appropriately?

25:13
And then there are other experiences that might impact their identity development and the ways in which they can conceptualize gender and what that even means for them.

25:23
So again, the relationship between mental health and gender can fall into two overarching competing viewpoints.

25:32
There are those that would say these young people need to be fully stable before they can move forward with treatment.

25:38
And then there are others that reinforce the idea that the mental health problems all go away with treatment and the truth lies somewhere in the middle.

25:48
So I'll leave you with the foundational principles of approaching the Co occurring mental health entities that exist for gender diverse youth.

26:01
It's important to prioritize gender and gender care literacy before making decisions that will be addressed in the second module.

26:10
Co occurring mental health concerns often have multiple sources and it's important to understand them.

26:17
Understanding long term decision making requires stabilization of acute Co occurring mental health entities.

26:25
Supporting gender dysphoria through psychological and social means can happen simultaneously.

26:31
So one does not necessarily need to start an irreversible treatment in order for us to help figure out how to support them on a psychological and social level.

26:42
Supporting gender dysphoria through reversible treatments such as menstrual suppression can happen simultaneously while addressing the the most important priorities in their mental health.

26:55
The focus should be on decision making factors and identity development, not on determining a person's gender and the family

27:03
work is important and and is crucial to the treatment involved since parents are the consenters in in minor treatment frames.

27:16
So I want to just say that we can never predict the future and nor can we predict the future in other areas of medicine, but we can protect the integrity of the decision making process by discussing all of these issues and ensuring that our patients have a developmentally appropriate understanding of the key concepts when they make these decisions.

27:41
Thank you very much.

0:11
Welcome to the two modules on gender care for youth.

0:15
This is a very important topic and has become one of significant public interest in more recent times.

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My name is Doctor Scott Leibowitz and I'm a child and adolescent psychiatrist, and I am the board member for the World Professional Association for Transgender Health, also known as WPATH.

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I was the lead author for the adolescent chapter of its 2022 Standard of Care 8th Edition revision guidelines.

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I've also served in three multidisciplinary gender clinics in academic pediatric centers in Boston, Chicago, and Columbus between 2008 and 2024.

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Boston was the first pediatric multidisciplinary gender clinic serving trans youth in the country, and I am proud to have started my career in that program.

1:07
Now I'm an educator, trainer, and consultant on these issues, and This is why I'm very excited to bring to you these modules.

1:16
I want to make an important disclaimer.

1:18
The contents of this presentation contain information and recommendations about gender care for minors.

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It is important to be aware of local, state, and country laws where you practice to understand the legalities of the recommendations and guidance in this presentation.

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For this course, I will be teaching 2 modules, each of which will have reflective thought exercises interspersed throughout the presentation.

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I am including suggested readings and a few key studies for you to review either before or after the presentations.

1:55
The first presentation is on the ethical dilemmas in the care of transgender and gender diverse youth

and the second presentation is more clinical in nature entitled the World Professional Association for Transgender Health's Standard of Care Best Practices for transgender and gender diverse youth.

2:13
The first presentation on ethics is broken into 3 sections.

2:17
Trends with trans and gender diverse youth in clinical practice.

2:21
Why transition in adolescence, which is a section on the justification as to why making important care decisions in adolescence may be indicated over universally deferring those decisions to adulthood, and then the specific ethical considerations across child and adolescent development.

2:40
The second module has four sections, also with reflective thought exercises interspersed throughout the presentation.

2:48
First, I will provide you with an overview of the history of gender care for minors entitled The Evolution of Gender Care for Minors.

2:55
I will then introduce the concept of gender literacy developed by the University of Minnesota Institute for Gender, Gender, and Sexuality.

3:04
The following and longest section of the second module will review the West Path Standard of Care.

3:09
8th Edition Child and Adolescent chapter recommendations.

3:13
Lastly, I will end with an overview of the political climate and its involvement and intrusion into gender care, discussing some of the effects of those efforts experienced by patients, families, and providers alike.

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In these modules, my hope is that you will be able to think about issues related to gender care for minors through a different lens and perspectives.

3:39
While supporting young people living authentically is a very important endeavour and associated with positive mental health outcomes, it's also important to understand adolescent identity development and decision making when approaching care decisions that may be irreversible.

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It's also important to think about gender as one aspect of a person and not the entire aspect of that person.

4:04
Therefore, I would encourage you to approach the reflective thought exercises with the goal of appreciating different perspectives on the issue at hand and conveying your understanding of the complexity of each of those issues.

4:19
Thank you again for registering to take these modules.

4:22
I hope you will find them enlightening and thought provoking.

4:26
It is a pleasure to bring my experience to you and to translate it into something that you can apply to your practice no matter what discipline you are a part of.

0:11
[Scott Leibowitz] Today's outline for this first module includes 3 sections, as I indicated earlier, trends, why transition in adolescence and then the ethical considerations.

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We have 5 learning objectives today.

0:25
The first, By the end of this presentation, you will be able to recognize the trends in the field of gender care for minors and their relevance for clinical practice.

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I want you to be able to summarize the latest and most salient ethical debates in the field of gender care for minors.

0:42
I'd like for you to understand the effects of medical treatments used for gender care in minors.

0:49
Recognize the relevance and importance of understanding the trends on detransition and regret in the field of gender care for minors and to understand the evidence base and its clinical relevance in the approach to managing gender dysphoric adolescence.

1:06
The first section, Trends with transgender and gender diversity is in clinical practice.

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Many people are asking the question what comes first, gender dysphoria or psychopathology?

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And you can think about these issues through two different frameworks.

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The first framework minority stress says that those that discrimination and victimization as a gender minority status leads to mental health challenges.

1:37
So stigma is the mechanism through which people's mental health challenges come about.

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However, others will claim that there is psychological and psychiatric issues leading vulnerable identity, fragile individuals to find comfort and connection in a trans community.

1:59
So mental health challenges through the means of searching for connection and and support lead someone to feel trans.

2:08
And I think in any field that's extremely complex, we have to be thinking about things in different perspectives.

2:17
And the image on the screen that you can see, if you were to look at the left wall, you would see an orange circle with a shadow of a square in the middle of it.

2:28
And if you said that's what I see, you would be true.

2:31
It would be true.

2:33
The people looking at the right side of the image on the right wall will see a round blue circle with a blue round darker shadow in it.

2:44
And they would say, well, that's what I see on the right wall and they would be true.

2:50
They that would be true for them as well.

2:53
But the real important thing to note is that the full truth, the total picture lies somewhere in the middle.

3:00
And that's where multiple perspectives really play a role in understanding the total truth.

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The challenge is when each person says that their truth is the total truth and have an absolute narrative for what they believe the truth to be.

3:16
And I'm going to walk you through the various debates and dilemmas, including the the minority stress as opposed to social connection seeking philosophies that are driving the way people think about youth and gender diversity.

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Talking about psychopathology and gender incongruence and dysphoria is difficult because trans people have been and they continue to be invalidated and erased with their identities being described as delusional.

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That's why it's really difficult to think about the idea that a particular psychopathology might lead people to identify as transgender.

3:59
So ask yourself, is it possible that there are some psychologically vulnerable adolescents who might find comfort living as a different gender and then seek hormones, when in fact something different and more difficult to delve into might be causing them to experience discomfort instead?

4:23
Would that have been the same answer 10 years ago?

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And I ask you to reflect on that.

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Well, let's look at the trends.

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In the last two decades, adolescent referral numbers have surpassed child referrals presenting to gender clinics around the world and that happened sometime in the late in the early to late twenty 10s.

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There's also been a trend where there's been an inversion of the sex ratio who is presenting to clinics.

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So what historically was more designated males at birth presenting to clinics and younger children brought to clinics by their parents is now reversed.

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Now we see more designated females at birth being brought to their to the clinics and typically later on in adolescence.

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But this study from Amsterdam in Toronto published in 2015 highlights that.

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And anecdotally, clinics around the country can tell you that this sex ratio has inversed.

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There's also been an expanded concept of what we think about gender, from a dichotomous polls of gender, from categories of male and female or male or female, to a more dimensional approach to gender, thinking about gender as a spectrum or along a continuum of femininity and masculinity.

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There's also been an increase in the American providers and clinics serving these youth.

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So in 2007, as I mentioned in my intro, there was only one clinic in a pediatric academic Medical Center in the United States, Boston Children's Hospital.

6:07
Now in 2025, there's somewhere between 50 and 100 clinics in pediatric academic and medical centers, although I would question how many are operating the way they once were operating, given the political movement.

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There's also been variations in the way that the care is delivered and the models applied by each clinic.

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Some clinics have resources to only provide mental health services, others only medical services relying on outside mental health, and other clinics have support for both, and the model of care really impacts the outcomes of the clinic and who can get what service.

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The ethical debates are broken down into the following categories.

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I'm only going to focus in on the adolescent ethical debates, not the debate in childhood which is related to social gender transition alone.

7:04
In adolescence, the debates largely fall into 4 categories, Puberty suppression and the complexity around the decision, hormones, medical and surgical treatments, which are more irreversible treatments and decision making that adolescents may or may not have their ability to think about irreversible effects.

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Then the degree to which assessment and diagnostic clarity is provided, that is also considered to be a debate.

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And then the final debate would be around the timing and when there are psychiatric or psychological challenges that might impact that timing, in which should we be providing these young people with services quicker?

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Should we be holding off?

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So you can see this can be very complex.

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Those who are approaching the treatment decisions and the care, the existence of care in all or nothing lens are focusing in on one of two error types.

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So those people who believe that the care should be banned are typically taking the approach of wanting to prevent a type 1 error, so treating someone when the person shouldn't get treatment.

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And those people believe that their concern is over regret and fertility.

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So all the young people will regret their care and their fertility will be impacted and with therefore it's a it's a mistake to continue on with these types of treatments.

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However, the people that are trying to eliminate type 2 errors would say, wait a minute, we can't not get people treatment who need the treatment.

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And the concern for that those people would have is that if you delay these decisions or if you don't get people the care that they will have worsening mental health, and it will delay their ability to live an improved quality of life or live authentically.

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And anyone that is advocating exclusively for a Type 2 error not to take place is advocating for less barriers and less guardrails to care.

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My opinion is that this is a discussion on how to provide the care, not a decision or discussion on whether to provide the care, since in the rest of medicine we aim to prevent and minimize both error types simultaneously, not exclusively one.

9:46
So bringing back to our diagram, on one hand you have those who will say these are all vulnerable teens searching for identity.

9:56
And then you'll have others who will say, well, the stigma is the reason why these young people have mental health issues.

10:02
And I would say that the truth lies somewhere in the middle.

10:06

There will be some people who fall into one category, some people who fall into another, some people experiencing both.

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And we need to decipher case by case.

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Which applies to who?

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So ask yourself, should we exclusively see all of the difficulties that a trans youth faces through just the lens of minority stress?

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Why or why not?

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These are topics that we cannot avoid discussing.

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Regret, detransition, peer influence, fertility, decision making, autism and gender, various family perspectives and gatekeeping.

0:12
[Scott Leibowitz] Next, I'm going to talk to you about why transition in adolescence.

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Ask yourself, are adolescents too young to make permanent decisions?

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Why or why not?

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Well, let's break down the importance of of why we need to make these decisions in the first place.

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I'd like to start by talking about the biological basis of gender identity development.

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There are biological contributors to gender identity development, and we can look at hormone influences, genetic influences, and brain structure research to understand these various contributors to identity development.

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So take hormone influences as the first example.

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We can look to individuals with congenital adrenal hyperplasia who in utero experience increased exposure to testosterone.

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And various research, along many across many decades, would demonstrate that higher levels of testosterone exposure are likely to impact a gender diverse expression of a young person later on in life.

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That being said, not every young person or not every fetus exposed to high levels of testosterone experience a different gender identity later on in life.

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However, it is more likely to impact gender diverse expression.

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That being said, these data also show that it can lead to higher levels of gender dysphoria, which suggests A hormonal influence on the developing brain during pregnancy.

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There's other data that you can look at, other differences of sex development.

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Other differences of sex development there.

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For example, the Kreukels ET al.

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2018 paper looked at 1000 / / 1000 participants from 14 European centers and 5% of those participants experienced gender changes, 4% meaning most of them.

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80% of that group experienced those gender experiences, gender diverse identities prior to their pubertal changes taking place.

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And then there's case report of an XY infant who was raised female who with congenital and with complete androgen intensitivity syndrome, showing that perhaps androgen receptor signalling is not necessarily needed for male identity development.

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Point being, we can look at these known entities and appreciate and study the impact that hormones might have on one's growing or developing gender identity.

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Genetic factors also play a role.

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And we can look at the concordance rate and see that concordance rates are higher in minozygotic twins as opposed to dizzygotic twins.

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We can even understand sex hormone gene polymorphisms.

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So this study from 2019, the Foreman study compared 380 trans women to 344 CIS men and looked at polymorphisms in 12 genes.

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Several allele combinations represented involving the androgen receptor in the in the trans women, which points to another genetic underpinning of gender identity development.

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Heritability studies, whole exome gene sequencing and polymorphisms in receptor genes have all demonstrated A genetic contribution to gender identity development.

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And then neurobiology and brain imaging, which are difficult studies to perform.

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These are also demonstrating emerging evidence of biological factors impacting gender identity development.

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So the the challenge with the neuroimaging studies is 1, you have to have these studies take place before the person were to receive treatment because we need to exclude the impact that the treatment itself had on their brain.

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And two, they're very expensive.

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And we should note we never want to look for a definitive reason or a or an objective test to determine a person's identity experience.

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These are not meant to try to figure out who is or is not transgender.

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Rather, these are important studies to look at the underlying and underlying mechanisms for gender identity development.

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It's thought that it's a combination of biological and environmental influences that can impact any one person's gender identity development.

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In addition to the biological factors impacting gender identity development, we have well known and well accepted data that show that when CIS kids or all kids go through puberty pubertal changes too early or too late, they experience difficulties and challenges with their mental health.

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So kids going into puberty too early can have delinquent behaviors, aggression, depression, anxiety, low self esteem, and kids going into puberty too late for the ideal window can experience depression, anxiety, substance abuse, and disruptive behavior disorders.

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Suggesting that going through physical puberty development during the normal range of physiologically appropriate time to experience those changes is important for long term mental health.

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And this slide is mostly about known theories within childhood and adolescent identity development.

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What we know is that when young people have a misalignment between any area or any different set of developmental processes, for example, they are more advanced cognitively, but socially they are less advanced for their age, or there's a gap between their emotional development and their psychological development, etcetera.

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That is leads to worse mental health outcomes.

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However, when these developmental processes are aligned in adolescence for a given age, there is improved mental health outcomes.

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And the point of me mentioning this to you is to say physical development taking place during adolescence.

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During this time when adolescents are exploring their identities, understanding their bodies, understanding their sexual romantic attractions, figuring out how they fit in the world, understanding how they can distinguish themselves from their parents and their peers, and forming their own morals and ethical approach to to life decisions, having these developmental processes aligned is more puts them on a more likely path to having positive mental health outcomes.

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This is the evidence based specifically for trans youth who have gone and received medical and surgical treatment.

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And I'll point out that while this is a growing list and each study certainly comes with its own methodological limitations, when you look at it in total, it's important to note there is an evidence base.

8:03
And since the fields not been in existence for for decades and decades and decades, the evidence base has to start somewhere.

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And so it's evolving.

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I'll walk you through this.

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So these specific orange studies are ones that that the young people had gone through surgery later on in life.

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So that's important to to note this study, the De Vries ET al, 2014 study, which I will talk about in more detail, and you have it in one of your assigned readings.

8:36
This is the longest study that followed young people from puberty blockers through hormone treatment, through surgery in Amsterdam's clinic in the Netherlands, demonstrating positive psychological outcomes and quality of life outcomes having gone through those processes, those treatments.

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This study is something that's important to note because there's challenges with the way the scale they use was validated.

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So it's about chest dysphoria and they came up with a, a non validated scale to measure chest dysphoria, which is something that we have to look at the details of the study to truly appreciate the benefits and its contribution to the overall literature.

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This (Van Der Miesen et al. 2018) is a high high quality paper, one of the higher quality papers that was known that was noted to be high quality evidence in systematic review that compared internalizing symptoms between trans and CIS youth of the two sexes who received puberty suppression.

9:44
Also published from Amsterdam.

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This study (Tordoff et al., 2022) is a shorter longitudinal study which has been criticized for making the claim that gender care improves mental health.

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But the kids didn't improve.

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Simply, the kids didn't.

10:00
Their care didn't get worse.

10:02
And sometimes it's important for us to note that the outcome measures need to be defined.

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Gender care may not lead to an improved mental health outcome, but that doesn't necessarily make it the wrong decision since other factors may be impacting a young person's mental health after they receive gender care treatment.

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This study (Bungener et al. 2020) is the only one to look at sexual and romantic behaviors after young people have been on puberty, bucker's hormones, and surgery.

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These (Green et al., 2022 & Turban et al. 2022) are retrospective survey data that really only report on associations, so it's difficult to infer causation and correlation in a in a retrospective survey.

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These studies (Strang et a., 2022, Grannis et al., 2021, Morningstar et al., 2022, Grannis et al., 2023) are studies that looked at cognitive factors by involving neuroimaging.

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Specifically, this study Olsavsky ET al, 2023 done here in Columbus.

11:00
This is the first study to look at the differential impacts of medical treatment as opposed to the contributions of parent and peer support, showing that both were important for young people's mental health.

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The Chen and Olson Kennedy et al study are more recent studies looking at the effects of gender affirming hormone treatment on young people.

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And they described a concept called appearance congruence and indicated that when hormones and puberty blockers led to an increased appearance congruence.

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So their appearance is congruent with their stated and felt gender identity that that was the mechanism for which people experienced benefit from treatment.

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These four studies were done in Central Ohio at Nationwide Children's Hospital.

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And that's important to note.

12:02
And then looking just at the total picture of the studies, you can see not, there's not going to be an answer from anyone study, but the collective understanding we gather from these studies and the studies that will come in the future all contribute to the the direct evidence as to benefit of these treatments in adolescence.

12:24
So let's situate what that all means.

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The evidence is evolving and preliminarily demonstrates psychological and psychosocial benefit on certain metrics in certain populations.

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In the short term, we do need to be careful about overstating benefit.

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There's variation in representativeness and generalizability, and it's very difficult to account for many factors.

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So what mental health treatment were the young people getting?

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How much family support were they receiving?

12:55
How long were they on treatment?

12:57
When did they start treatment?

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Where was their body at physically when they began treatment?

13:03
We also need to be careful about requiring high quality evidence to justify treatment.

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In no other field of medicine does one have a plethora of randomized control trials that are double-blind.

13:17
In order to move forward with treatment decisions.

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We also need to understand that this is a population that's changing over time, and the research doesn't always measure the dimensionality of gender.

13:32
So a study that was published in 2014 that was longitudinal in nature had young people enter that study a decade earlier and was the trans and gender diversity youth who were seeking care in 2005, for example.

13:49
Do they seem to be the same demographic characteristics as the trans and gender diversity youth who are receiving care or presenting for care in 2025, twenty years later, and as I mentioned already, the different outcomes, the quality of life, cognitive outcomes, psychiatric and psychological Wellness, romantic and sexual Wellness.

14:13
What's the relevance of the mental health outcomes, especially when there's no one study that measures the impact of gender on mental health and life satisfaction?

14:23
It's a very difficult outcome to study.

14:27
Also, the larger ends come from the population surveys, whereas the cohort and the longitudinal and cross-sectional studies have low ends.

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So you can see there's benefits and limitations to the interpretation of each of these studies.

14:44
One report that was developed in the United Kingdom that's become very controversial, especially here in the United States but also around the world, is called the Cass Report, which was published in 2024.

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It was called for by the United Kingdom's National Health Service to review independently their one gender clinic called the Tavistock GIDS Clinic.

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This was in response to a person who was dissatisfied with their treatment, who ultimately regretted their care and detransition and felt that the service had wronged her.

15:21
Therefore, this independent review was called for.

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There were six systematic reviews done, and what the report did find is that centralized gender care without the provision of wider mental health services doesn't meet the needs of the population since

some people need more mental health support prior to making medical decisions, whereas other people making medical decisions is important in order for their mental health care to improve the quality of evidence should lead the field to take a careful and cautious approach.

16:00
That's a major outcome from the Cass report.

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What's interesting is that people are using the Cass report to justify political bans on treatment.

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However, the Cass report does not have or does not recommend a ban on treatment.

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And in fact, the Cass report has its own limitations.

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There was no consensus done.

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There was no experts interviewed and they took the approach that an independent review was appropriate for this field when there's in no other field of medicine with the guidelines or a report not factor in those who are deeply involved in the care for decades and decades.

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So there are limitations to this report.

16:47
I only bring it up because it's become a very large subject of conversation and it also lacks a road map for addressing access.

16:59
The England system and the Tavistock clinic really had exponential increase in the amount of young people that presented to their clinic and they couldn't necessarily meet the needs without expanding resources.

17:13
So these are what the systematic reviews for the Cass report looked, looked like they were a puberty suppression systematic review and a hormone systematic review, gender affirming hormones.

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I won't get into the details of this, but you can look at this the Cass report yourself.

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It's included in your in your handouts.

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And again, I asked you to just look at this report from a critical lens.

17:39
I don't want you to think about the report as having all of the answers, especially considering the limitations that the report comes with.

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But what we do need to go back to is the fact that there is going to be multiple perspectives on a complex matter.

17:56
So there are those who say that minors are too young to make permanent decisions, and then there are others that will say respect what the teenager says.

18:04
They all know who they are.