

Transgender Youth Care in the New Millennium

Johanna Olson-Kennedy, MD, Medical Director of the Center for Transyouth Health and Development at Children's Hospital Los Angeles, presented to the USC Law and Global Health Collaboration. Dr. Olson-Kennedy has been providing medical intervention for transgender youth and young adults including puberty suppression and cross sex hormones for many years, and is considered a national expert in this area. Her center is the largest transgender youth clinic in the United States.

She began by noting that she's a white cis woman—and that this matters as a part of her practice. Even though she works mostly on the medical side of things, law is definitely relevant; a critical part of her talk centered on medications and medical interventions that are not FDA approved for use with trans populations. She further noted that there are no interventions that are FDA approved for use with trans folks of any age.

Dr. Olson-Kennedy underscored that the history of trans care is very important to understand—the first hormone treatment was in 1920, so we're moving on 100 years. Language is also critical: a lot of people talk about medical intervention as though it is gender transition. This is not gender transition. People transition the way they *wear* their gender. She will use the language of physical gender transition or phenotypic gender transition, and as led that people be very mindful of their language.

She has been engaged in this work for 10 years and loves it—her motivation is the kids with whom she works. Her work can be tremendously empowering, it's also challenging and incredibly important, in this light she discussed the truly significant numbers of trans kids lost to suicide.

Her clinic is seeing increasing numbers of referrals. Over the last six years, their numbers have grown by more than a factor of 10, and they have 850 active patients now. She's talking about youth today because youth are so important, and the important influence that have on trans initiatives around the world. And a quick but related note, she commented on the odd focus on bathrooms happening politically/legally right now in the US—this is mystifying and completely bizarre—nonetheless it's happening and impacting everyone. These rulings (focused on bathrooms) are *extremely* problematic.

She then provided a quick review of key terms, as relevant to peoples lived experience, to the work of health care providers, but also to the law:

Assigned sex at birth is essentially focused on genital anatomy. We check to see: do you have a male gender anatomy? If yes, you're male. If no, you're female. Intersex/DSD: we don't deal with that well, but this is basically the check that is commonly done.

Gender identity is a person's basic sense of themselves. Dr. Olson-Kennedy likes to discuss gender identity as an abacus, because people don't always place themselves in one spot on the spectrum, so a slider/abacus makes more sense with more nuance. Our expectation is that if you have assigned male sex at birth you will have a male gender identity. This is not always the case.

Gender expression is how we choose or are able to portray ourselves, in name, clothing, hair, etc. In the early 1900s, people talked about gender with clothing and work, because there weren't hormone treatments. Trans women were often arrested for breaking laws, e.g. impersonation and disturbing the peace. For trans masculine folks, that was opposite. Trans masculine folks said "look I'd be disturbing the peace if I dressed like a woman." Society has feelings about men expressing themselves as women. This is still true today. The experience of trans masculine and trans feminine folks is dramatically different at a basic societal level. On that note, she commented on how we lump together LGBTAI, mixing identity, sexuality and biology in ways that are problematic.

Culturally, we *teach* you how to express your gender identity. If you start looking at ideas, e.g. a little boy playing with a rocket toy and little girl playing with an easy bake oven, it becomes clear how we want people to be as a society. She gets a lot of calls saying “I think my kid has gender confusion.” We have a cis-normative environment and these are the messages people are getting. It’s also important to discuss sexual and romantic attraction, but “who you are and who you wanna get with” are distinct, and we should treat them as such.

For a long time, this was generally talked about as “normal” vs. trans. Real woman vs. trans woman. That language does not make an equal playing field. Now, more people from the community are saying “why are we saying trans or non-trans?” So cis refers to adjacent, and trans refers to across.

Regarding youth, when do we begin to gender people? So early! Dr. Olson-Kennedy shared a story that when she was pregnant, Barbara Walters wanted to interview her about her work. The producer came and asked her “is it a boy or girl?” and she thought “I don’t think you understand the work I do.” It was really unnerving for the producer to not be able to “close the loop” on the gender of her unborn child, and that’s really important—this is so culturally ingrained.

What happens when people don’t fit? See: howtobeagirlpodcast.com

This video shows what gender dysphoria in childhood can feel like. More and more the concept of socially transitioning is proving to be unbelievably helpful. These little kids who were not able to make friends, do school, pay attention, deal with anger outbursts, with treatment they have improved so much. Gender dysphoria is widely described as persistent physical emotional distress, and not always expressed as being related to genitals or secondary sex characteristics. Trans feminine kids often ask: “when is this gonna fall off?” It’s different for trans masculine kids in the early stages; there is nothing there to hate. Of course experiences vary, but for the most part genital distress in girls is in early childhood. But then for trans masculine kids, they go through puberty and there is something to hate. These trans trajectories are different. Trans feminine people receive messages of shame from a very early stage. That is super important because we know when people take in messages of shame over and over, that leads to people who have chronic anxiety, depression, suicidality, things that become barriers to health and to trans care specifically.

So what are the approaches that people are employing? Some places still practice “reparative therapy.” This ranges from “cold shoulder” to shock therapy to professional shaming. It’s not legal in CA for licensed practitioners, but it is done in religious institutions. Others employ a “wait and see” approach or a mixture of allowed transition, but the problem with “you can do whatever you want in our house but not outside” is a message of shame, you can’t be yourself outside the house. Finally there is an affirmative model, that is supportive, and might include social transition.

What is important to know is that parental suppression is most likely to lead to an anxious, angry child, and a child at risk for serious negative health outcomes. Parental affirmation of a child’s exploration of gender and flexibility may lead to a fearful parent but a happy, well-adjusted child. A word on social transition: it’s extremely helpful, and reversible. We are super quick to give a five year old psychotropic medication but won’t let them wear a dress. This is ridiculous. What is the bad outcome here? “We might make them trans.” Ridiculous. Psychotropic medication does impact brain development. Wearing a dress does not.

So, as to the question of “when you know.” There are so many more important questions, but really, we don’t allow for a reasonable range of ages here. If you talk about it when you’re 3 you’re “too young to know.” If instead you talk about it at 14, “why weren’t you talking about it when you were younger?” There are many factors that influence capacity and situatedness; it’s exceptionally rare for people to talk about this in childhood. Just because you didn’t talk about this when young doesn’t mean you’re less trans—this is so important to understand.

For early asserters: some have socially transitioned, some have not. In kindergarten, gender policing from peers starts happening. Bullying starts. Before that, kids just love what they love. Here are some supportive treatment options:

- Pre-pubertal youth: no medical intervention
- Peri-pubertal asserters: GnRH analogues, maybe puberty blockers
- Post-pubertal asserters: Adding gender-affirming hormones.

Puberty is awful for most trans kids. We know that there is a much higher risk of depression, anxiety, self-harm, social isolation, high-risk sexual behavior, and maladaptive coping. If we can get people into care, we can help.

Dr. Olson-Kenned suggested that the most common question is who is *actually* transgender? People are worried that somebody will change their mind. If you walk away with one thing from today's presentation, make it this: people are not making a decision about their gender. They are making a decision about what to do with it if it doesn't match their sex at birth. You don't wake up one morning and say it's Tuesday and I'm gonna be trans. This is a process whereby people solidify their gender identity. All of this happens at a different pace for every person. But when people say "what are your protocols," it makes her crazy, you can't support people by doing it this way! Other key points:

- Hormones don't cause cancer. There is great data from Europe. No increased incidences of any other cancers.
- Adolescent brain development: adolescence is the time of pruning. Reward centers are lighting up. Perceived reward is big driver of activity. This is why teens get into so much trouble. Think about it, there is no reward for being a trans person! In most places, society tells trans people: they are abominations to god, suicide is common, they are portrayed as sexual predators, this is *not trendy*. What's trendy is gender bending. Blowing away the binary. That's archaic and old and young people today are standing in solidarity. Some adolescents are doing this by presenting themselves in different ways. But those young people are *not in distress*. There are some kids that come in and say "I want hormones." They sometimes stop. Hormones aren't a trigger. They are painfully slow. People don't just randomly want to do this, or go through a second puberty.

Medically, we are taught "first do no harm." *Doing nothing can in and of itself be harmful!* We have to get people into care early. This is extremely problematic. Trans folks of color are our highest risk population and need support. To walk out your door as an identifiable trans person? This is risky. It's not ok that it's only accepted (and even there to some degree) for white kids. Trans folks of color, particularly trans women, face considerable problems here, but it's even worse in other parts of the world. Early treatment offers numerous benefits:

- Improves family functioning.
- Gives the gift of selective disclosure.
- Hormones save lives.

To accomplish this, we must work together and collaboratively.

This was a full hour presentation and with time so short, Q and A happened at the end of the session. The Law and Global Health Collaboration would like to thank Dr. Olson-Kennedy for sharing her time and expertise, and for her engagement in this important work.