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Common Questions Parents Ask.

Questions from audience - April 10, 2018

Q. Where can I find more facts regarding bullying?
Dr. Caretto: GLSEN has statistics on bullying and resources to combat bullying.

Q. With all that happens to teens hormonally, is it the best time to transition?
Dr. Shumer: Every case should be considered individually, but for some teens, hormonal transition can be very helpful. These are decisions where we may wish it would be possible to wait until adulthood, but sometimes that is not in the best interest of the young person. Adolescence is a time when the body starts making sex hormones, and if those sex hormones are causing the opposite changes from the child's gender identity, this can cause worsening of distress.
This is assessed with the mental health provider and doctor carefully, and options to intervene during adolescence may be recommended depending on the child's individual situation.

Dr. Caretto: Not doing anything is not a neutral intervention. When kids are very distressed about their gender presentation and that dysphoria is insistent, consistent, and persistent then a transition may bring great relief and prevent self harm. A social transition is fully reversible.
The timing of a social transition should be solely driven by the child's needs, not the school calendar, what is convenient for the parents, nor the agenda of a therapist.
In the case of an hormonal transition, all teens want to experience pubertal changes at the age when it is most appropriate and they can share the experience with peers so contragender hormones as a teen is perfect timing. Again, in cases where the teen is clearly transgender, not allowing hormonal transition until age 18 is withholding medical care and is cruel.

Q. Is there a correlation between sexual abuse and being gender expansive?
Sara Wiener: There is no research that indicates a connection between sexual abuse and a difference in one's gender identity.

Q. What are puberty blockers? Pros/Cons? Will blockers affect a child's understanding of gender identity and sexual preference?
Dr. Shumer: Puberty blockers are medications that pause puberty and are reversible. The goal is to prevent development of potentially distressing changes while delaying any medical decisions about transition. There is not evidence that blockers change a child's gender identity or sexual orientation.

Q. If a FTM trans male child goes directly from puberty blockers to testosterone, thereby going through "male" puberty without first having gone through female puberty, would the odds of being sterile/infertile be the same or different from an individual who started T later, post puberty?

Dr. Shumer: In order to make eggs for fertility purposes, a child needs to go through female puberty. If a trans boy went from blockers to testosterone without going through female puberty, and later wanted to use his body to make eggs, he would need to come off the testosteorne for an extended period of time. We don't have long term data on how the testosterone treatment would affect the chances of making eggs, so in this situation I would discuss the chance of infertility with the patient and family prior to starting testosterone.

Q. I need help with name change process and filling out forms with gender boxes.
Sara Wiener: This is a helpful resource: https://transequality.org/documents/state/michigan

Q. How should we expect schools to handle overnight trips?
Dr. Caretto: Expect that they have no idea how to handle it. The Michigan State Board of Education has guidance for schools, State Board of Education Statement and Guidance, but the document doesn't address that specific question. Each school will come up with their own solution which may be having students room according to gender identity or not, having supervision in rooms, offering private housing, etc.

Q. What happens when they go to college?
Sara Wiener: A trans student who lives in a dorm in college has options, depending on the school. Some colleges have all gender dorms where people of any gender identity live together. Other schools simply allow students to choose the gender of their roommate. Many colleges have policies about rooming, and students with questions about their school's policy should contact the housing office at their school.

Dr. Caretto: A great resource is Campus Pride

Q. What resources or training would you recommend for clinicians/organizations that currently have limited access for trans health?
Sara Wiener: Regarding training for mental health clinicians to learn about working effectively with trans folks, there are many one to two day CEU programs out there, but I recommend taking care to ensure the trainer has an extensive history working with transgender people, and formal training and/or supervision by an experienced gender specialist. It's important to learn from an experienced provider. Child & Adolescent Gender Services at C.S. Mott Children's Hospital, of which I am a part, hosted one conference and may host others in the future. If you are interested in being on our mailing list, email me at sarawie@med.umich.edu
NASW (National Association of Social Workers) in Michigan has held at least two, two day trainings within the last year regarding working with trans people, and I believe future trainings will be posted on their website. Other reputable training resources include Gender Spectrum, WPATH, and Gender Odyssey.

Q. Can you provide any tips on how to approach medical leadership regarding the need for trans health services?
Dr. Caretto: Many statistics and resources can be found on the American Medical Student Association web page.

Q. Please talk about teens – I have 2 grandkids who are transitioning to boys. Is it common for more than one child in a family to be trans? Is this influenced by a sibling or other?
Sara Wiener: Lots of families have more than one child who is cisgender, and similarly, many families have more than one child who is transgender. I suppose that siblings could influence each other's gender identity, but it has been my general experience that people are who they are and influence of others is a minor part of their identity development process.

Dr. Caretto: My dissertation research was on families with more than one gay child. The only influence I would attribute to the sibling would be having built in support for coming out. As Dr. Shumer mentioned in his presentation, gender development is likely influenced by a complex combination of nature and nurture. There may be some genetic component, as evidenced in twin studies, and there is no one common environmental experience identified as causative.

Q. Is testosterone a good idea? Side effects?
Dr. Shumer: Testosterone would be offered to older adolescents who have gender dysphoria. I find that in trans young men who are living as young men and are clear in this identity, testosterone can be a huge benefit. The side effects are all of the changes that occur during male puberty.

Q. I heard no hormones until age 21. Most teens change their minds at 21? Is that true?
Dr. Shumer: The current Endocrine Society Guidelines suggests treatment can be offered younger than age 21 in adolescents with gender dysphoria as diagnosed by a mental health professional. We do not see young people changing their minds about their gender identity once they have identified themselves as transgender insistently, consistently, and persistently and they are in adolescence.

Q. My teen grandkids are on hormones. He is still depressed.
Why? Shouldn't he be happier now?
Dr. Shumer: Unfortunately hormones are not a silver bullet for all of a young person's depression symptoms, and I'd encourage any young person in the process of transition who has ongoing mental health problems to connect with a therapist with expertise in gender identity.

Dr. Caretto: Some individuals are unlucky enough to be both transgender and depressed, needing specialized treatment for two medical issues at the same time. Some people are depressed as a result of the stigmatization of being a member of a marginalized group. Even after transition, hormones, and surgery trans individuals are still not cisgender.
Stress has been shown to have significant and lasting effects on the physical and mental health of minorities, including sexual minorities. I have observed that many trans individuals living in a heteronormative world suffer from PTSD symptoms including anxiety and depression.

Q. What if there are other problems – autism, depression, anxiety?
Should they wait on hormones?
Dr. Shumer: There are many situations that may make it wise to take a slower approach to medical decision making, such as autism or severe depression, however, young people with these issues may benefit from transition depending on the individual case.

Q. What if they change their minds after hormones?
Dr. Shumer: At any point along a transition where a patient is not wanting to continue hormones, they should be stopped. This is not common. We start hormones on patients only after a thorough evaluation and discussion of risks and benefits in an attempt to avoid regret.

Dr. Caretto: Prior to starting medical intervention there is lengthy discussion of possible effects, side effects, and the irreversible nature of some effects. The changes brought on by hormones do not happen overnight. It is suggested that those starting hormones be in therapy to discuss the experience. What little we know about those who do transition back to their assigned gender is that most still have no regret and state that the transition was a necessary and valuable part of their process of coming to understand their gender more fully.

Q. Is this a phase? What's wrong with waiting?
Dr. Shumer: When a young person has consistently and persistently identified as the other gender, it becomes less likely to be a phase. We would suggest waiting on irreversible medical interventions until it is clear that the young person is planning to live as the other gender; at that point, medical interventions can be very helpful and sometimes life saving.

Q. What about surgery? Do most elect surgery? When should it be done?
Dr. Shumer: For some transgender people surgery is desired and important, and for others it is not. Chest surgeries can be done in older adolescents, and genital surgeries are not typically done until closer to age 18 or older.

Dr. Caretto: Most transmasculine individuals (over 66%) who did develop breast tissue will opt for chest reconstruction if medically and financially available. Only a little over 10% opt for genital reconstruction for a variety of reasons (less than ideal outcome, cost, finding it unnecessary in order to feel complete). Over half will eventually have hysterectomy.
Most transfeminine individuals get adequate breast development from contragender hormones though some will still opt for augmentation. Over 60% will have gender affirming genital surgery. A small percentage will elect facial feminization surgeries.

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