

Behavioral Health Webinar Series for Primary Care

Wednesday, February 12, 2020

12:00 – 1:00 PM

Today's 'Generation' of Youth: The Clinical Approach and Ethical Dilemmas Across Development

Presented by: Scott Leibowitz, MD



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Reminders

- This webinar is being recorded.
- We have **muted** all participants.
- **Chat with us during the webinar.** To type a question or comment for the speaker or facilitator, type it directly into the WebEx chat box.



Today's 'Genderation' of Youth:

The Clinical Approach and Ethical Dilemmas Across Development



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NCH Behavioral Health Webinar Series for Primary Care

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Learning Objectives

At the conclusion of this continuing medical education activity, the participant will be able to:

1. Identify the relevant terminology with respect to gender and sexuality constructs.
2. Examine the trends in the field regarding youth across development presenting with gender related concerns.
3. Appreciate an overview of the current ethical dilemmas that exist with respect to clinical decision making for children and adolescents presenting with gender related concerns.



Main Ethical Dilemmas- Gerritse K et al. (2018)

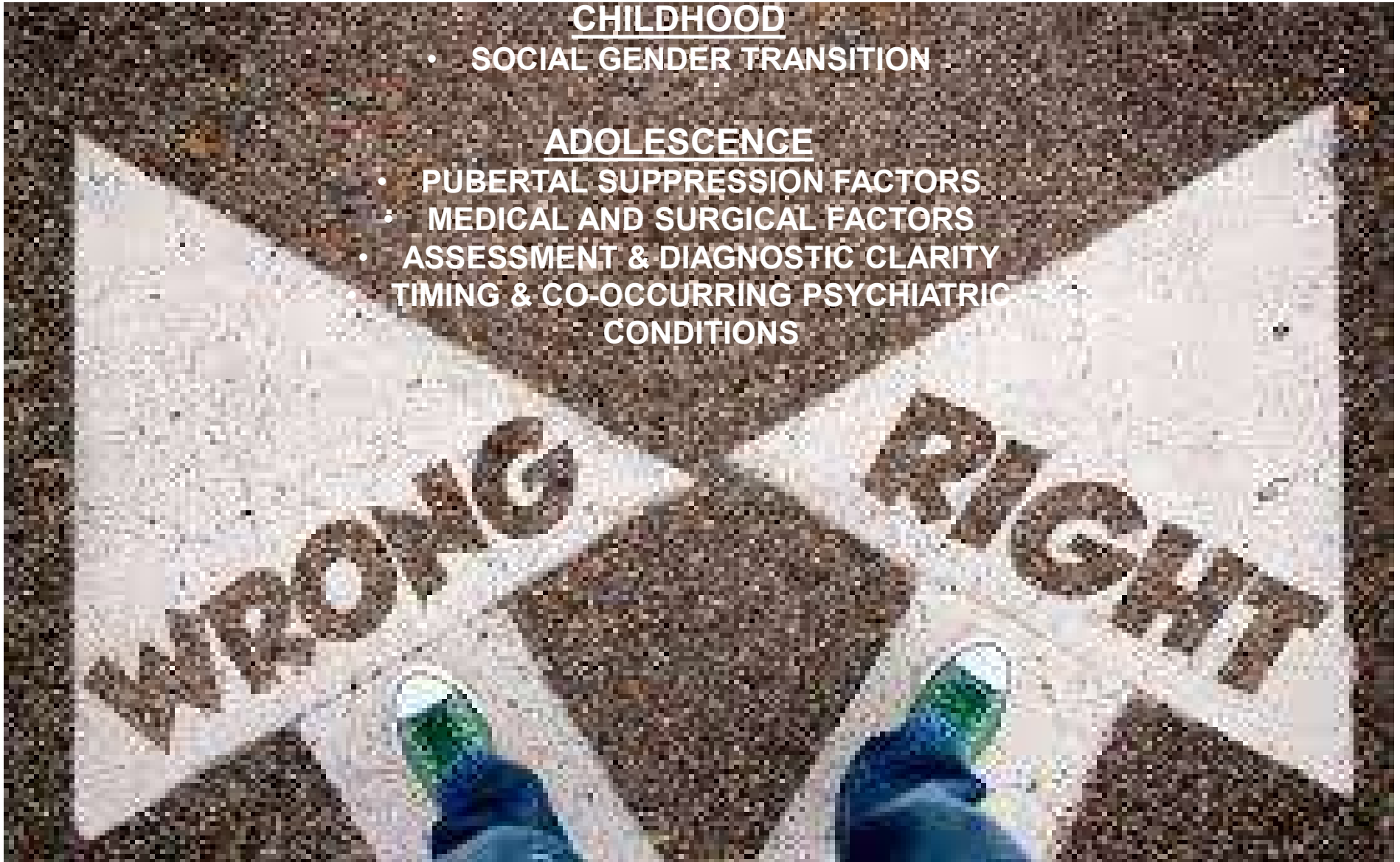
Moral Challenges in Transgender Care: A Thematic Analysis Based On A Focused Ethnography, *Archives of Sexual Behavior*

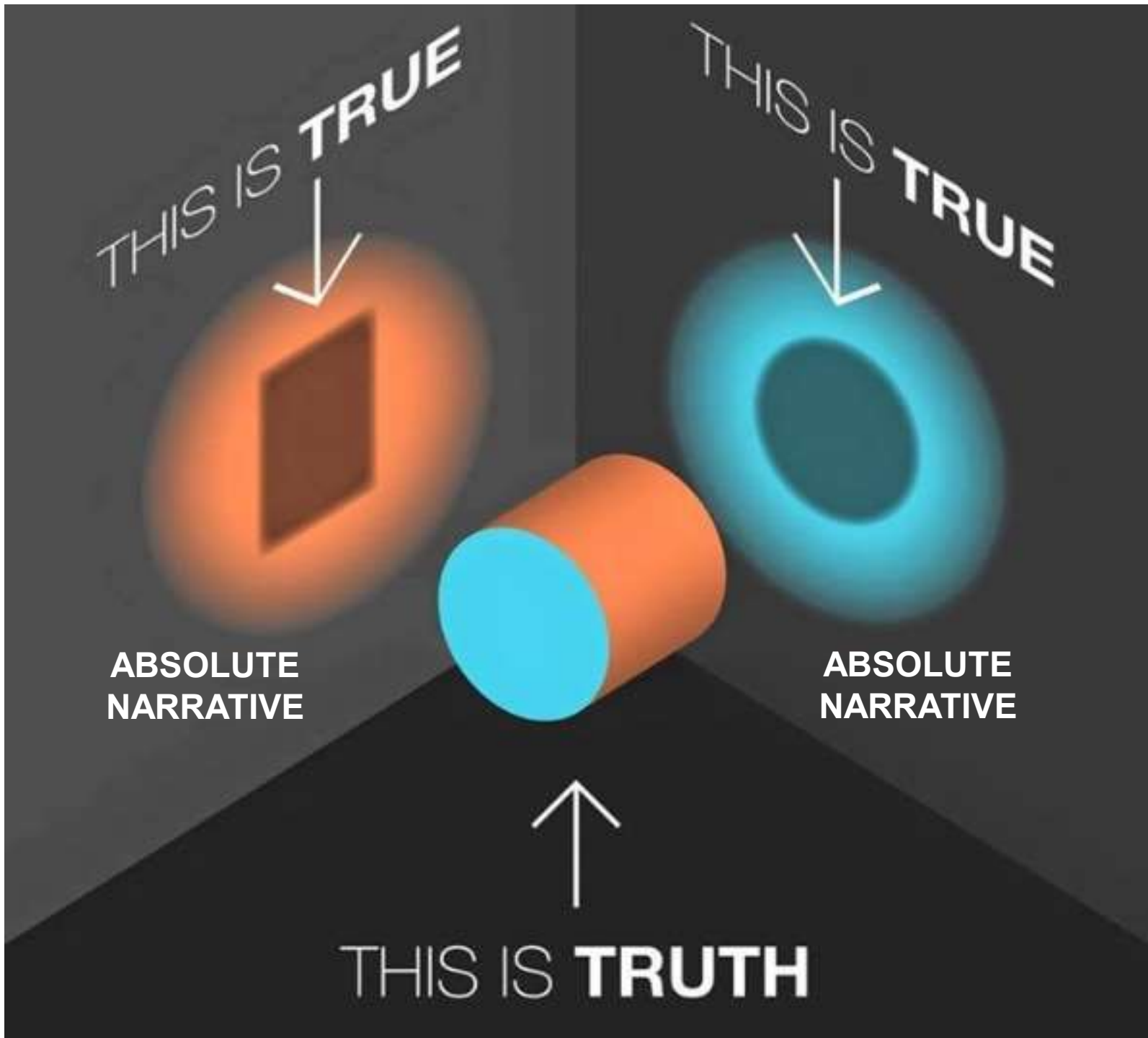
CHILDHOOD

- SOCIAL GENDER TRANSITION

ADOLESCENCE

- PUBERTAL SUPPRESSION FACTORS
- MEDICAL AND SURGICAL FACTORS
- ASSESSMENT & DIAGNOSTIC CLARITY
- TIMING & CO-OCCURRING PSYCHIATRIC CONDITIONS





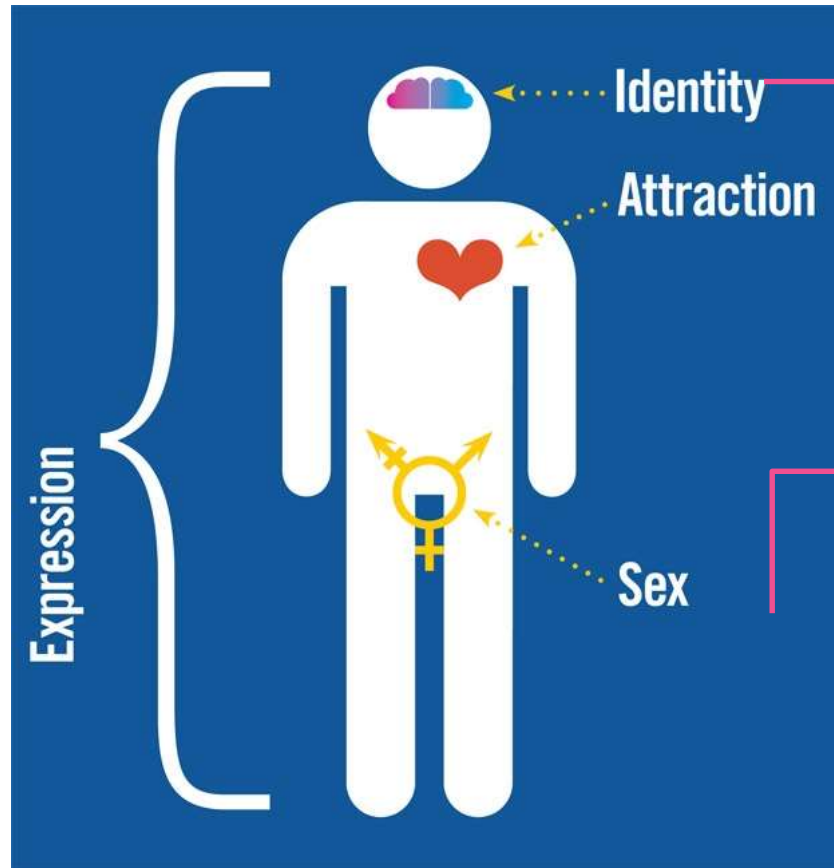
TERMINOLOGY



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Cisgender vs Transgender



•Cisgender

- When someone's sex anatomy matches their gender identity (majority of the population)
- A person with a penis feels like a male.
- A person with a vagina feels like a female

•Transgender

- When someone's sex anatomy doesn't match their gender identity (minority of the population)
- A person with a penis doesn't feel like a male.
- A person with a vagina doesn't feel like a female



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Newer Terminology

- **Agender**
- **Genderqueer**
- **Pansexual**
- **“Dysphoria”**
- **Gender fluid**
- **ASAB/AFAB/AMAB-** Assigned sex (female/male) at birth



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What Ever Happened to just LGBT?



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DSM 5: Gender Dysphoria in children

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration as manifested by at least six of the following eight indicators, **AT LEAST ONE OF WHICH MUST BE CRITERION A1:**

1. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender)
2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to wearing of typical feminine clothing
3. A strong preference for cross-gender roles in make-believe play or fantasy play
4. A strong preference for toys, games, or activities stereotypically used or engaged in by the other gender
5. A strong preference for playmates of the other gender
6. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities
7. A strong dislike of one's anatomy
8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

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



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DSM 5: Gender Dysphoria- Adolescence and Adulthood

- A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration as manifested by at least **TWO** of the following:
1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics)
 2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)
 3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
 4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender)
 5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender)
 6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender)
- B. The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning

Specifiers: 1. Post Transition Specifier- if individual has transitioned to living in the desired gender and has undergone (or preparing to) have at least one medical procedure
2. Disorder of Sex Development Specifier: if there is a DSD as well

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TRENDS



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Clinical Service Trends for Youth

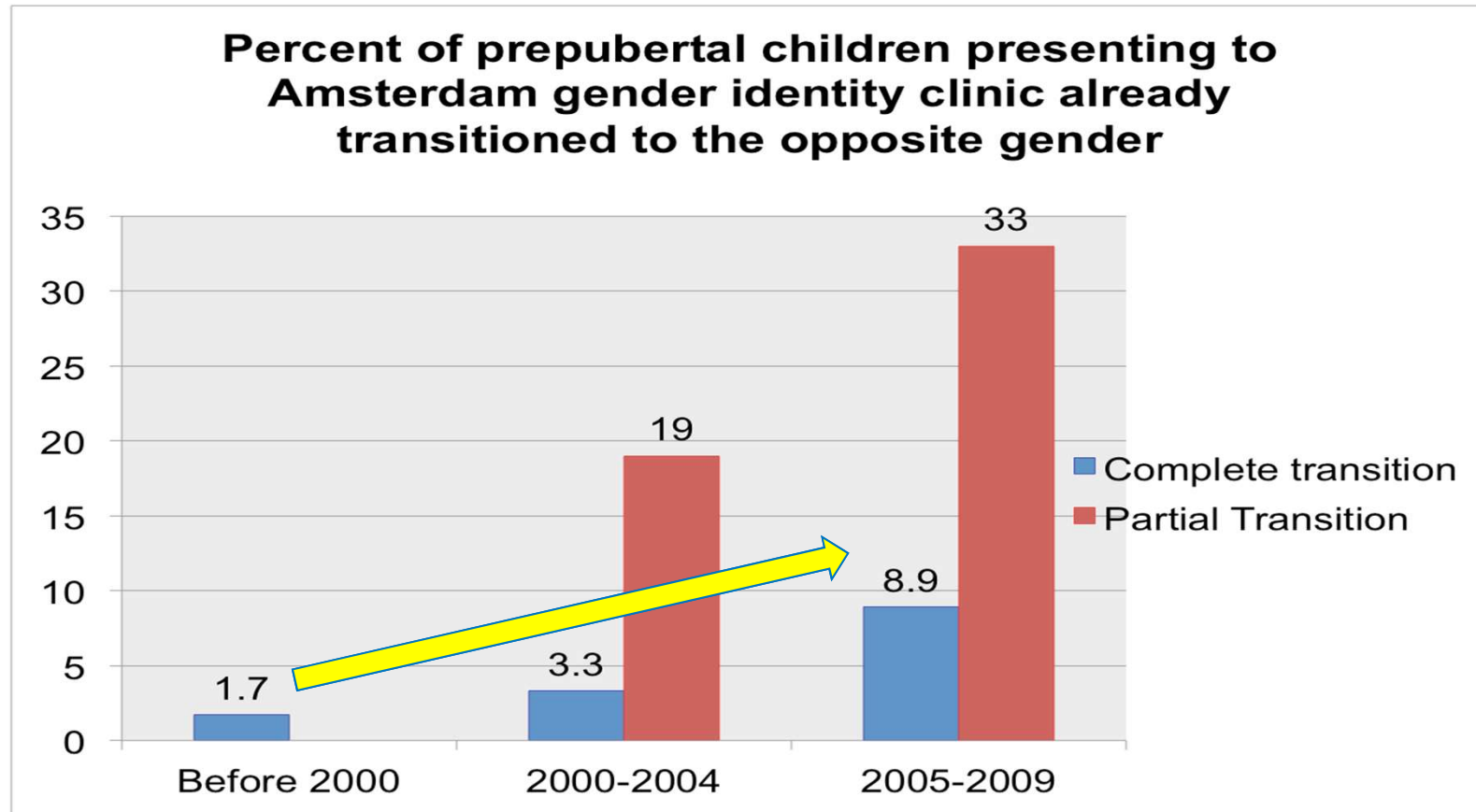
- **Adolescent referrals are increasing and surpassing child referrals** for first time in 30 years (Wood, Sasaki, Bradley, Singh et al., 2013)
- **Inversion of sex ratio-** Increasing trend of females assigned at birth presenting at higher rates than males assigned at birth (Aitken et al., 2015)- 748 adolescents combined from Amsterdam and Toronto
- **Increase in clinics serving these youth** (Hsieh & Leininger, 2014)
 - 2007: one clinic in a pediatric academic medical center in the U.S.
 - 2020: approximately 50 clinics in pediatric academic medical centers
- **Variation in models of care delivery**
 - Some clinics based within mental health division relying on outside medical providers
 - Other clinics based within medical/pediatric/endocrine division relying on community mental health support if available
 - Others based across both mental health AND medical divisions



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Prepubertal Gender Social Transition Trend



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Steensma and
Cohen-Kettenis 2011



Trans Visibility in the Media

- **Social Media- YouTube, Tumblr**
- **Mainstream TV: Transparent, I am Jazz**
- **Magazine Covers**
- **Famous authors**
- **Political Issues & figures in the news**



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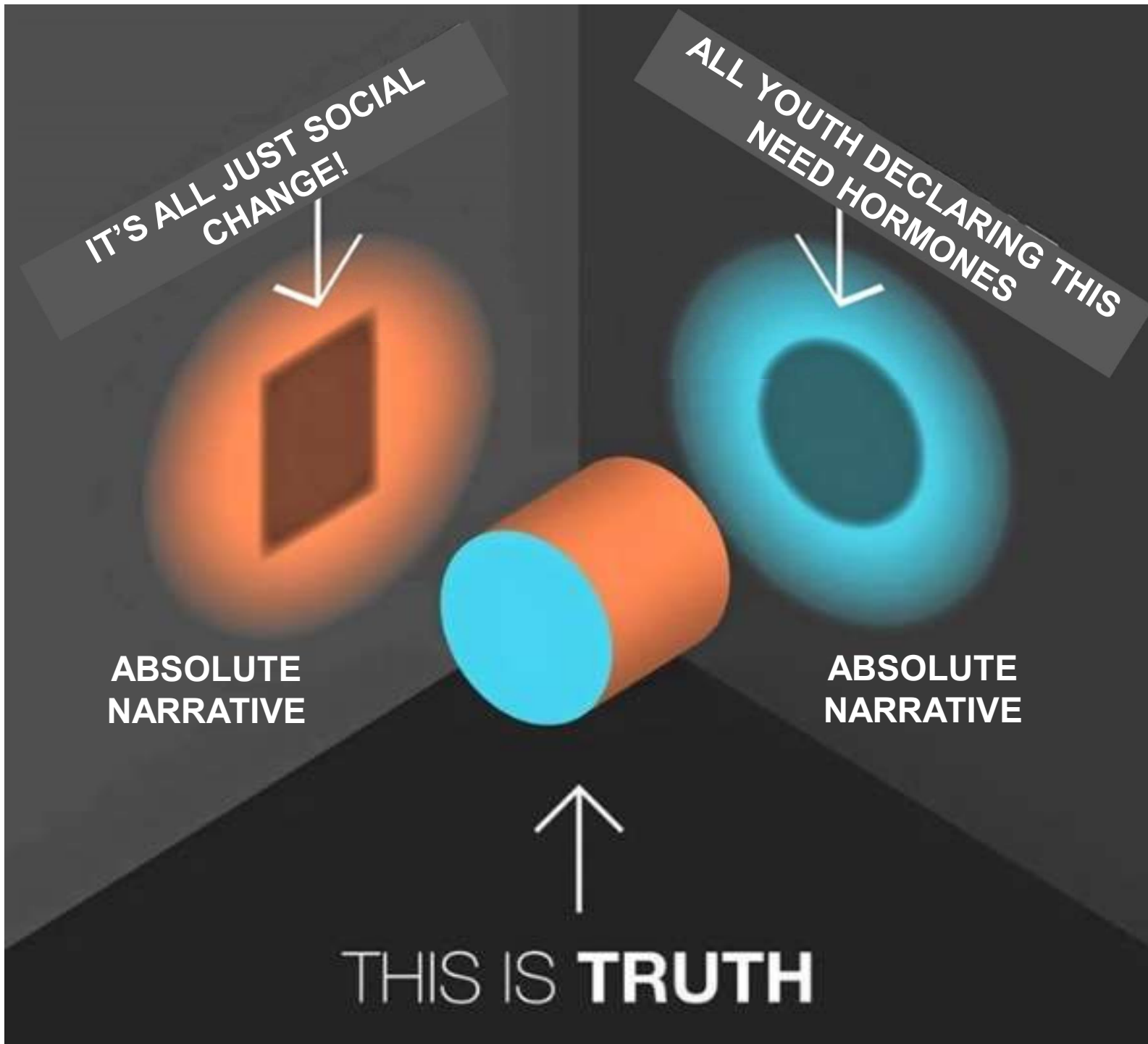
IT'S ALL JUST SOCIAL
CHANGE!

ALL YOUTH DECLARING THIS
NEED HORMONES

ABSOLUTE
NARRATIVE

ABSOLUTE
NARRATIVE

THIS IS **TRUTH**



GENDER DEVELOPMENT



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Gender Identity- Biological Factors

Factor	Associated Entity	Main Conclusion
In Utero Hormonal Exposure	CAH in XX 5- α RD in XY CAIS in XY	<ul style="list-style-type: none">Higher amount of gender dysphoria than would be expected in the general population (Dessens, Slijper, Drop, 2005; Berenbaum & Bailey, 2003)Increased Androgen Exposure more likely to affect gender role and sexual orientation than gender identity (Meyer-Bahlburg, Dolezal, Baker et al., 2006)Not solely connected with prenatal androgen exposure. (Rosenthal, 2014)
Genetics	Twin studies Specific Genes	<ul style="list-style-type: none">Higher concordance (39.1%) in MZ twins than in DZ twins (0%) (Heylens, DeCuyper, Zucker et al, 2012)No conclusive evidence on specific genes
Brain structures	INAH-3 BSTc (bed nucleus of striae terminalis)	<ul style="list-style-type: none">INAH-3- perhaps sexual orientation dimorphic (Byne, Tobias, Mattiace, et al, 2001)MtF have female-typical size of BSTc in some studies (Zhou, Hofman, Gooren, Swaab, 1995; Kruijver, Zhou, Pool, et al., 2000)BSTc is not sexually dimorphic until puberty
Brain Morphology	Grey Matter White matter Odorous steroids	<ul style="list-style-type: none">Putamen larger in MTF than males, another study inconclusive (Luders, Sanchez, Gaser et al., 2009; Savic & Archer, 2011)Hypothalamic blood flow in response to steroid odors is sexually dimorphic (Berglund, Lindstrom, Dhejne-Delmy, Savic, 2008)Limitations are that the brain is plastic and unknown whether the results are a consequence of experience





Challenging biology

Yet...

Gender is a societal construct and gender differences are experienced by humans.

Some children are no longer gender dysphoric later in life and some evidence suggests environment shapes prepubertal children.

There are many individuals who are non-binary or gender fluid yet this exists within how a particular society defines gender.

We live in a binary world that is impossible to control for.



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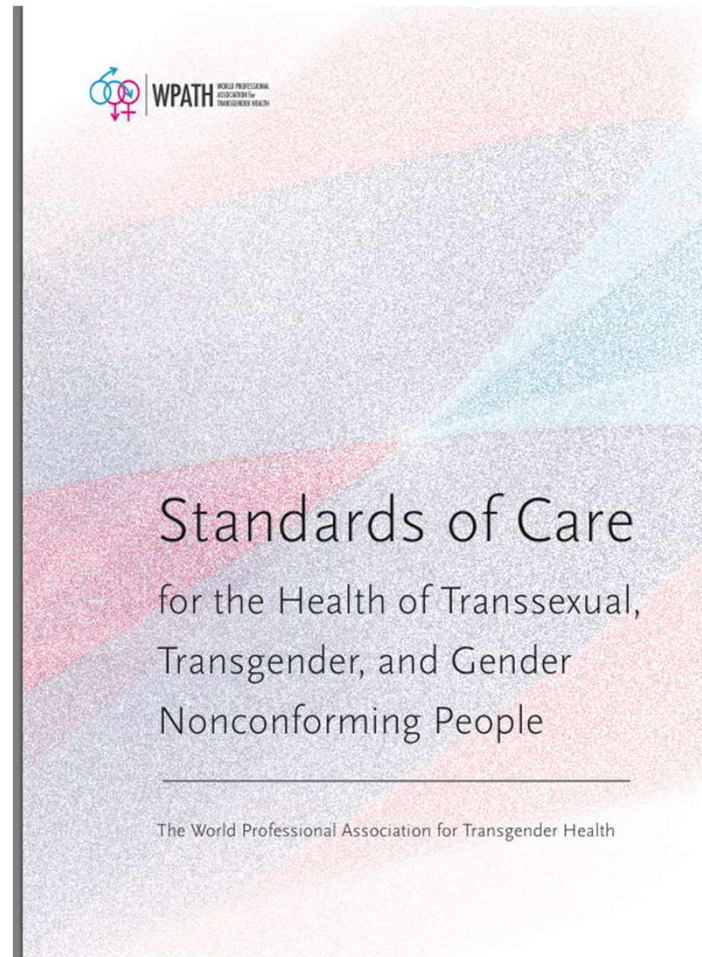


So is it biological or environmental?





World Professional Association for Transgender Health, SOC 7



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ETHICAL CHALLENGES ACROSS DEVELOPMENT



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Main Ethical Dilemmas

CHILDHOOD

- **SOCIAL GENDER TRANSITION**

ADOLESCENCE

- PUBERTAL SUPPRESSION FACTORS
- MEDICAL AND SURGICAL FACTORS
- ASSESSMENT & DIAGNOSTIC CLARITY
- TIMING & CO-OCCURRING PSYCHIATRIC CONDITIONS





Prospective Studies from Childhood

Study	N	M	F	Focus	Persist rate	Hallmarks	Sexual Orientation
Green 1987	66	66	--	Sexual orientation in adolescence for "effeminate boys"	1.5%	Younger kids more comfortable saying cross gender wishes	Gay fantasies- 75% Gay/bisexual behaviors- 80%
Zucker/Braley 1995	45	40	5	Identity outcomes in adolescence for gender dysphoric children	20%	Higher rates of gay sexual orientation than general population	31% desisters were bisexual or homosexual
Drummond 2008	25	--	25	Replication in "masculine girls"	12%	60% met full criteria for GID	32% lesbian/bisexual fantasies 24% lesbian/bisexual behaviors
Wallien/Cohen Kettenis 2008	77	59	18	First to look at nuanced differences in the kids initially	27%	Extreme GD was more associated with higher likely persistence	50% of desister boys identified as gay
Singh 2012	139	139	--	Identity outcomes of gender dysphoria	12.2%	Psychiatric outcome at f/u Replicated extreme finding	61% of desister boys identified as gay in fantasy
Steensma et al 2013	127	59	48	-Predictors of identity outcomes -Looked at narrower age range	37% (50% natal F 29% natal M)	Social transition initially Girls vs boys	75.8% desister boys with homosexual/bisexual fantasies 18.2% desister girls with bisexual fantasies, 0% lesbian fantasies

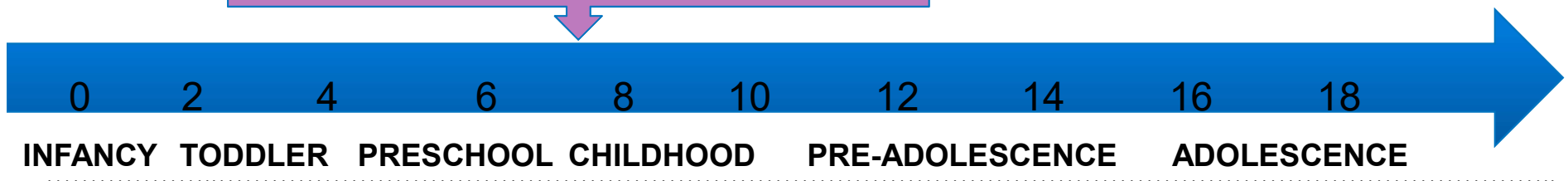


Pre-pubertal Social Gender Transition: Cross-sectional Mental Health Outcomes

(Pediatrics, Feb 2016 Olson, Durwood, DeMeules, McLaughlin)

- Community sample of 73 children who have **already socially transitioned**, aged 3-12 vs 2 control groups (49 siblings, 743 non-siblings)
 - Mean age 7.7 y/o, SD 2.2 yrs
 - 22 birth-assigned females, 51 birth assigned males
- Parents completed anxiety and depression measures (NIH short forms for anxiety/depression) t-score 50 is national mean SD 10.
- Mental health outcomes **equal to controls and siblings**

CROSS-SECTIONAL, Outcome is MH



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Methodological Limitations

PROSPECTIVE

- Lack of inclusion criteria
- Homogeneity
- Clinic referred samples
- Not long enough of time to account for changes
- Range of length in time that they were done
- Variation in ages at T1

CROSS SECTIONAL

- Lack a pre-intervention mental health
- No measure of parent support used
- Therefore no control group of trans children with supportive parents where social transition was not chosen.

INTERPRETATION

More kids will “desist” so prevent a lifelong medical tx and limit those who transition

Kids who socially transition and are supported, will do better, so should transition the children

ABSOLUTE NARRATIVES



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**Gender
Variance in
Childhood**

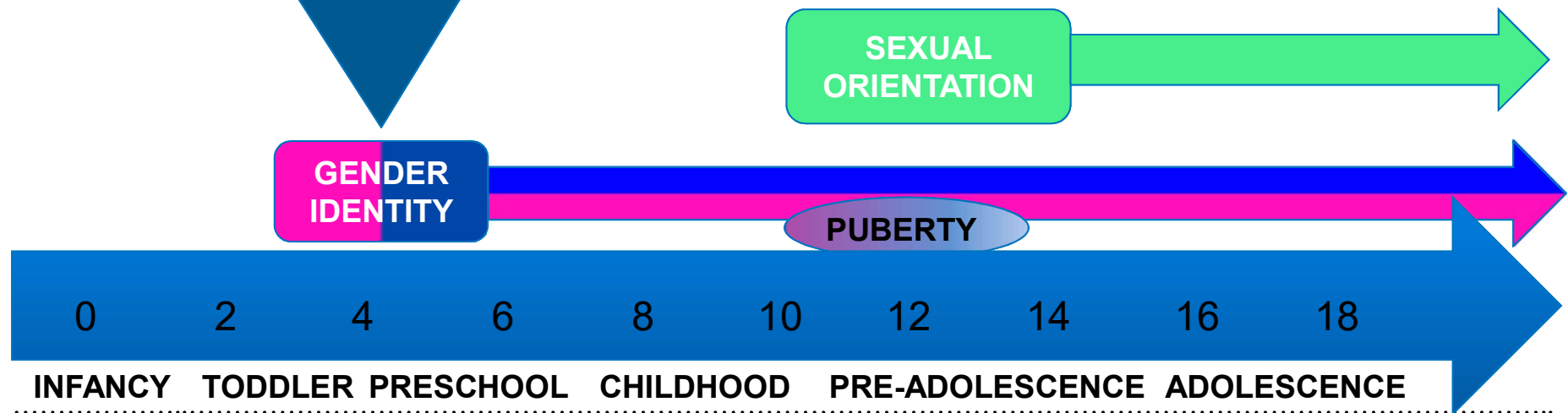
**Gender nonconformity
Behavior phenomenon**

-difficult to distinguish-

**Gender dysphoria
Identity phenomenon**

Childhood factors:

- Cognitive stage of development
- Lack of secondary sexual characteristics in children
- Identity fluidity with high degree of environmental reinforcement



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3 Methods? “Trinary Conceptualization”

- **Reverse gender dysphoria**
 - Limit other gender expression by making child attempt to be able by parents in more aspects of social sex
- **Wait-and-see**
 - Help patient/parents with a proverbial “middle ground”
- **Support ego and social transition**
 - Socially transition the child to another gender in all situations.

Zucker 2008



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Pre-pubertal Social Gender Transition: It's Not about the “What”, it's about the “How”

Emotional Functioning

- Can the child handle this being a “secret”
- Are the benefits to the child's exploration of feeling whole outweighing the negatives of being in denial of anatomy
- How are family members modeling the way the transition should go in front of the child?

Social Functioning

- Are there other co-occurring issues that will put this child more at risk if the social transition is meant to be kept “a secret?” (impulsivity, anxiety)
- Can this child make appropriate friendships and not be preoccupied with the gender transition?

Intellectual Functioning

- Does the child's capacity to learn or academically flourish as the result of living in the affirmed gender, or is the child's mind preoccupied with others finding out?



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Prepubertal Social Gender Transition

Arguments For

- May alleviate immediate psychological distress
- Helps to affirm and support a child's desire to live in other gender
- Allows a child who may be transgender in the future to live authentically from an earlier age

Arguments Against

- Unknown to what degree this influences an identity outcome in the future ("boxing in")
- Introduces the element of keeping sex a potential "secret"
- Unknown challenges exist if a future reverse gender transition (back to gender of natal sex) is desired.



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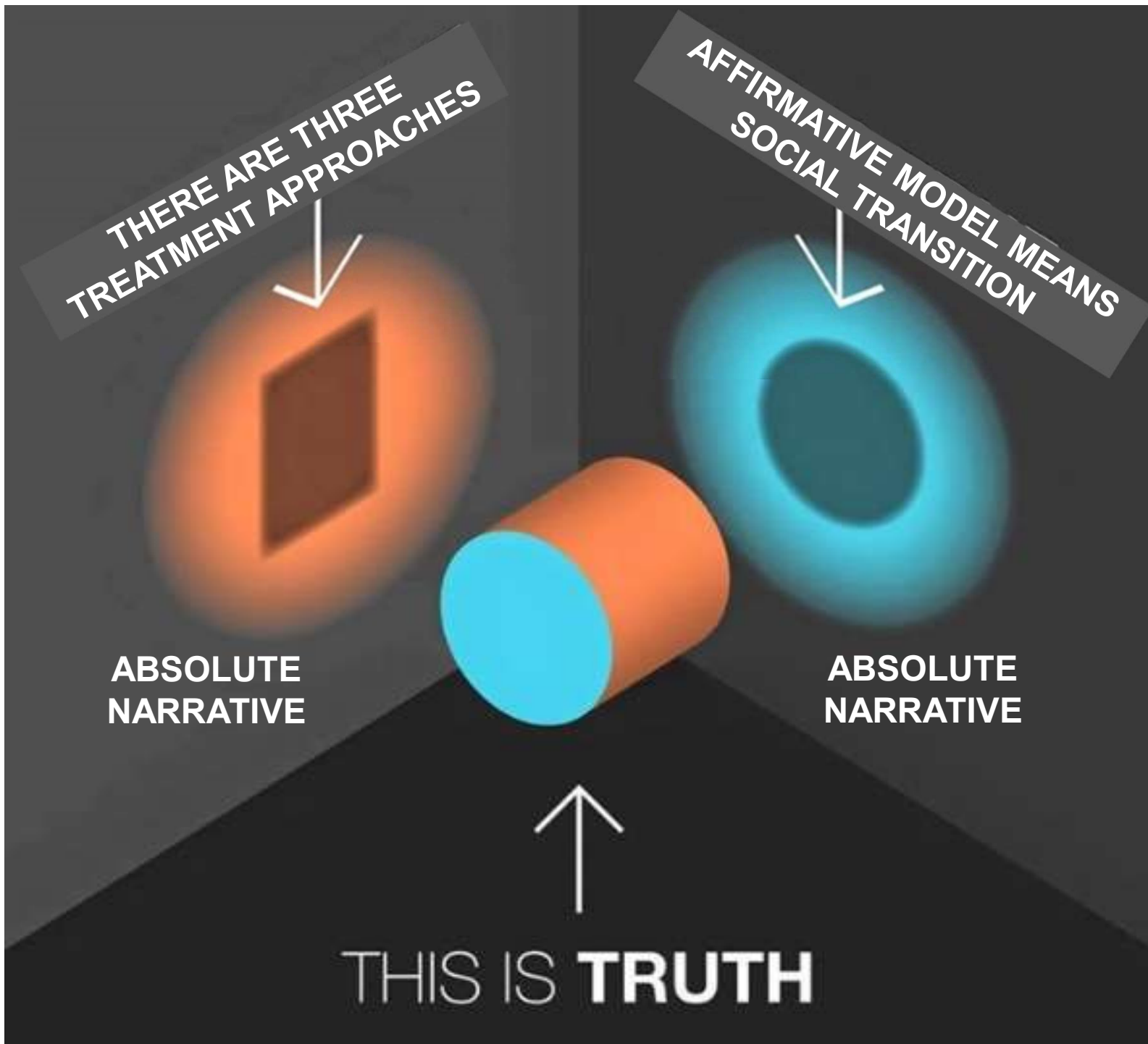
THERE ARE THREE
TREATMENT APPROACHES

AFFIRMATIVE MODEL MEANS
SOCIAL TRANSITION

ABSOLUTE
NARRATIVE

ABSOLUTE
NARRATIVE

THIS IS **TRUTH**



GENDER VARIANCE

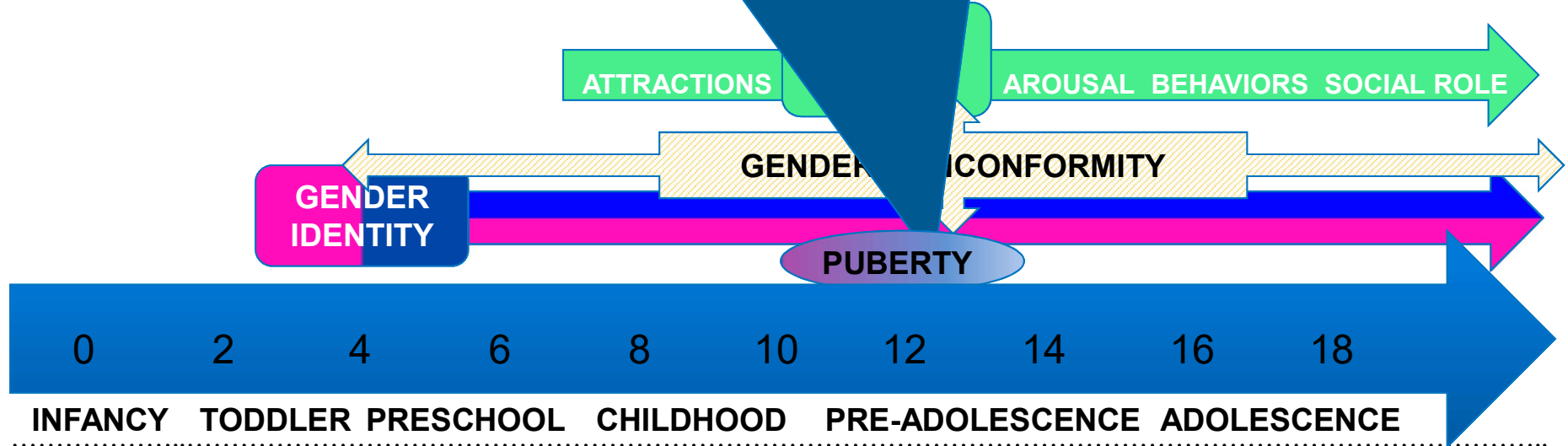
Gender nonconformity Behavior phenomenon

-easier to distinguish-

Gender dysphoria Identity phenomenon

Adolescent Identity Consolidation

1. Changing body
2. Sexual identity exploration
3. Abstract thought



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ADOLESCENCE

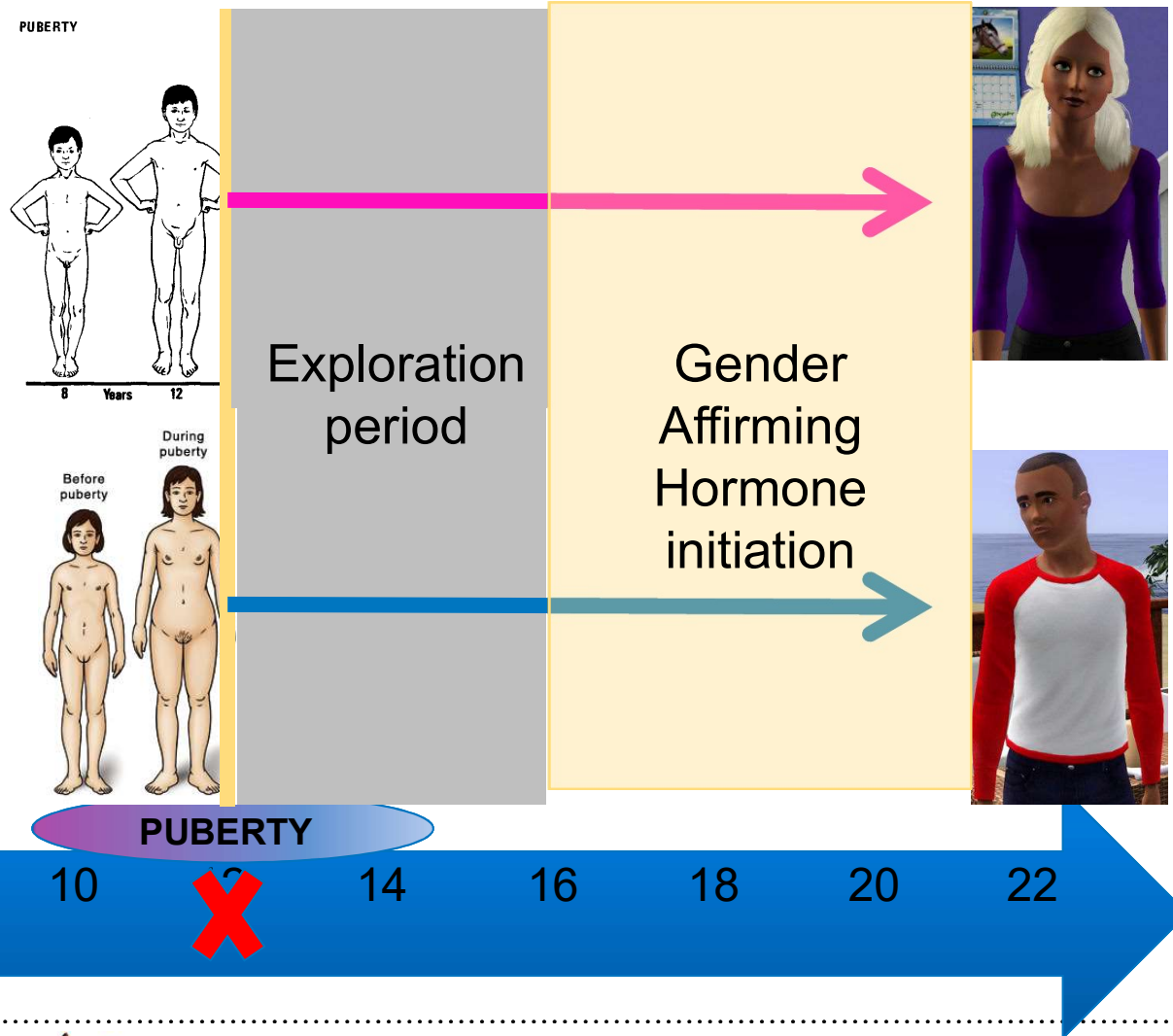
- PUBERTAL SUPPRESSION FACTORS
- MEDICAL AND SURGICAL FACTORS
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- TIMING & CO-OCCURRING PSYCHIATRIC CONDITIONS





Pubertal Suppression (GnRHa) Premise

- Presses a “pause” button on Tanner 2 (+) for gender identity exploration
- Indicated for those with h/o child gender nonconformity that intensifies or remains
- Meant to extend the diagnostic period
- Reduces psychiatric risk
- Promotes lifelong appearance of affirmed gender (connected to healthier outcomes, Lawrence 2003)
- Minimizes invasive procedures

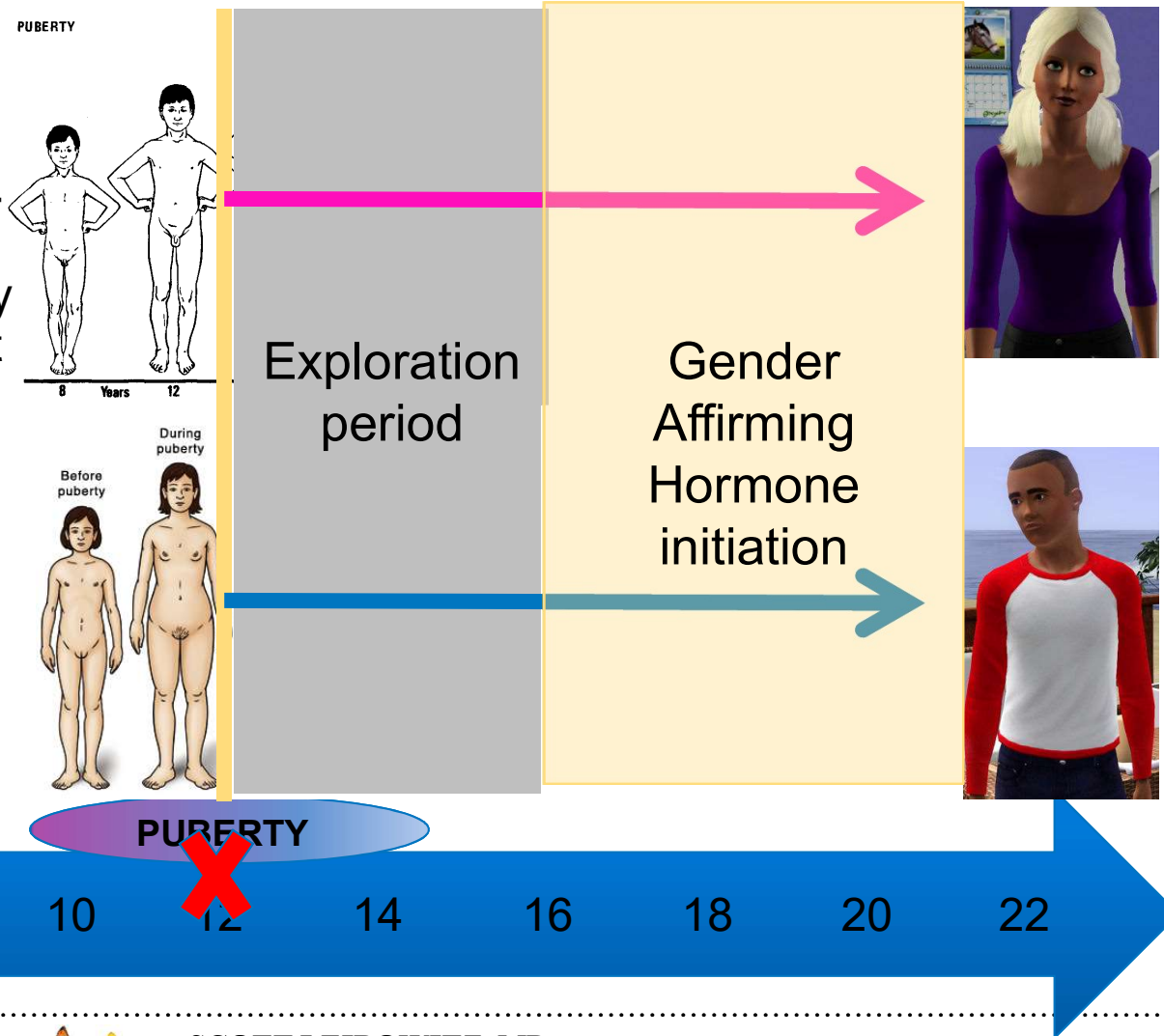


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Pubertal Suppression Limitations

- Bone development (Klink et al. 2015)
- Brain development effects- sex hormones trophic on affective regulation, identity and cognitive development
- Impact on future sexual functioning post-SRS?
- Reproductive system
- Conforming to societal intolerance of nonconformity?



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Pubertal Suppression Clinical Challenges

- Age versus Tanner stage
 - **If age** → may miss advancing puberty in some adolescents
 - **If Tanner stage** → introduces potential need to start cross-gender hormones earlier
- What does “experience a little puberty” mean? Different for sexes
- How long to suppress puberty before the need to introduce a sex hormone (either endogenous or exogenous)?
- Exploration of gender identity issues does not appropriately take place
- Co-occurring neurodevelopmental disorders- ADHD, ASD, Tourettes?
- How important is height?
- Differences in physical outcomes for the sexes



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Gender Affirming Hormone Treatment

- Historically provided at age 16 if meeting “eligibility and readiness” criteria
 - Endocrine Society Guidelines 2017 provide flexibility to go younger (age 14) *with compelling reason*
 - Mental health assessment REQUIRED for adolescents
- Evidence is evolving
- Testosterone for natal females and estrogen for natal males
- Produces many of the secondary sexual characteristics of affirmed gender
- Strong evidence of psychological relief in adults
- Known medical risks and potential psychiatric risks

WPATH GUIDELINES 7th EDITION
ENDOCRINE SOCIETY GUIDELINES 2017



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Future Regret and Fertility Concerns

“I will never ever want children.”

-is different from-

“I don’t want children now, don’t think I will want children when I’m older, but I realize that I may change my mind because I’m just a teen.”

Use clinical tools to help adolescents understand/protect their current decisions from potential future disappointment (e.g. time capsule letter)



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Gender Confirming Surgical Interventions in Youth

- Not all individuals with gender dysphoria seek surgical interventions
- Most surgical interventions are reserved for the 18+ population
- Many surgical options exist
- Gender confirming surgery, when indicated, is medically necessary
- Mental Health providers have historically played a “gatekeeper role”
Same criteria apply in evaluating readiness/eligibility for FtM chest surgery (hormones not a prerequisite but strongly recommended for at least one year in an adolescent age group, per WPATH SOC7)



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Surgical Overview

Population	Surgery Options
Female identified	<ol style="list-style-type: none">1. Breast/chest surgery: mammoplasty through implants2. Genital surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, vulvoplasty3. Nongenital, nonbreast interventions: facial feminization, liposuction, lipofilling, voice surgery, thyroid cartilage reduction, gluteal augmentation, hair reconstruction
Male Identified	<ol style="list-style-type: none">1. Breast/chest surgery: subcutaneous mastectomy, creation of a male chest2. Genital surgery: hysterectomy/salpingo-oophorectomy, reconstruction of the urethra, metoidioplasty/phalloplast, vaginectomy, scrotoplasty, implantation of erection or testicular prostheses3. Nongenital, nonbreast: voice surgery (rare), liposuction, lipofilling, pectoral implants



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Chest Surgery in Transmasculine Youth

Olson-Kennedy et al.,
2018 JAMA Pediatrics

JAMA Pediatrics | Original Investigation

Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults Comparisons of Nonsurgical and Postsurgical Cohorts

Johanna Olson-Kennedy, MD; Jonathan Warus, MD; Vivian Okonta, MPH; Marvin Belzer, MD; Leslie F. Clark, PhD, MPH

IMPORTANCE Transmasculine youth, who are assigned female at birth but have a gender identity along the masculine spectrum, often report considerable distress after breast development (chest dysphoria). Professional guidelines lack clarity regarding referring minors (defined as people younger than 18 years) for chest surgery because there are no data documenting the effect of chest surgery on minors.

- 136 completed surveys
 - 68 post-surgical (50%) | 68 nonsurgical (50%)
 - Age range 13-25 years old
- Chest Dysphoria Scale (21 survey items on multiple aspects of gender)
 - “I worry that people are looking at my chest.”
 - “I participate in life less than others because of my chest.”
- Questions then asked about regret to the surgical cohort
- Questions then asked about interest in chest reconstruction to nonsurgical cohort
- **Strength:** Findings indicate **low regret** among 68 surgical cohort
- **Limitations**
 - How was assessment done to indicate correlation with GD?
 - Construct validity of the scale
 - Unclear other variables: other diagnoses to explain high distress, lack of description of how long post-op the surveys were done, why nonsurgical patients didn't go through with surgery



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CLINICAL APPROACH TO ASSESSMENT



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Adolescent Clinical Assessment Aims

- Degree of gender dysphoria and its impact
- Stability and persistence over time
- Gender Development history from childhood
- Relationship with developing sexual identity
- Co-occurring psychiatric issues
 - Does it impair the diagnostic understanding of gender dysphoria?
 - Or is it a manifestation of untreated gender dysphoria?
- Understanding degree of physical maturation
- Ego strengths and resilience factors
- Decision-making around physical interventions
- Parent/Caregiver/social supports
- School climate assessment
- Community resources and connectedness



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Eliciting an Adolescent's gender narrative

Scenario	Questions
Adolescents with parents in the room	<p>Say: "I will have a chance to ask you these questions without your parent/guardian if you feel that will be helpful."</p> <p>"What name for yourself do you feel most comfortable using?"</p> <p>"What pronoun do you feel most comfortable with me using to refer to you?"</p>
Adolescents without the parent in the room	<p>Say: "Now that we are alone I am going to ask you some more questions."</p> <p>"What name do you feel most comfortable using in private?"</p> <p>"What pronoun should I use to refer to you? Would this change depending on who I am with?"</p> <p>"Is there a gender you feel most comfortable identifying as?"</p> <p>"Are there aspects of the gender you were assigned to that you feel comfortable with? Uncomfortable with?"</p> <p>"Are there aspects of another gender that you feel comfortable with? Uncomfortable with?"</p> <p>"Are there aspects of maleness or femaleness that you relate to?"</p>



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But the main aim is:

GET TO KNOW THE ADOLESCENT AND FAMILY SO THAT WHEN YOU MAKE RECOMMENDATIONS *IN THE FUTURE*, YOU CAN SPEAK TO THE SOPHISTICATION WITH WHICH THE ADOLESCENT UNDERSTANDS:

- **THEMSELVES AS A WHOLE**
 - **THEIR BODY**
- **SEXUALITY AS DISTINCT FROM GENDER**
 - **GENDER ROLES**
- **And WHAT IS NEEDED FOR TRANSITION**



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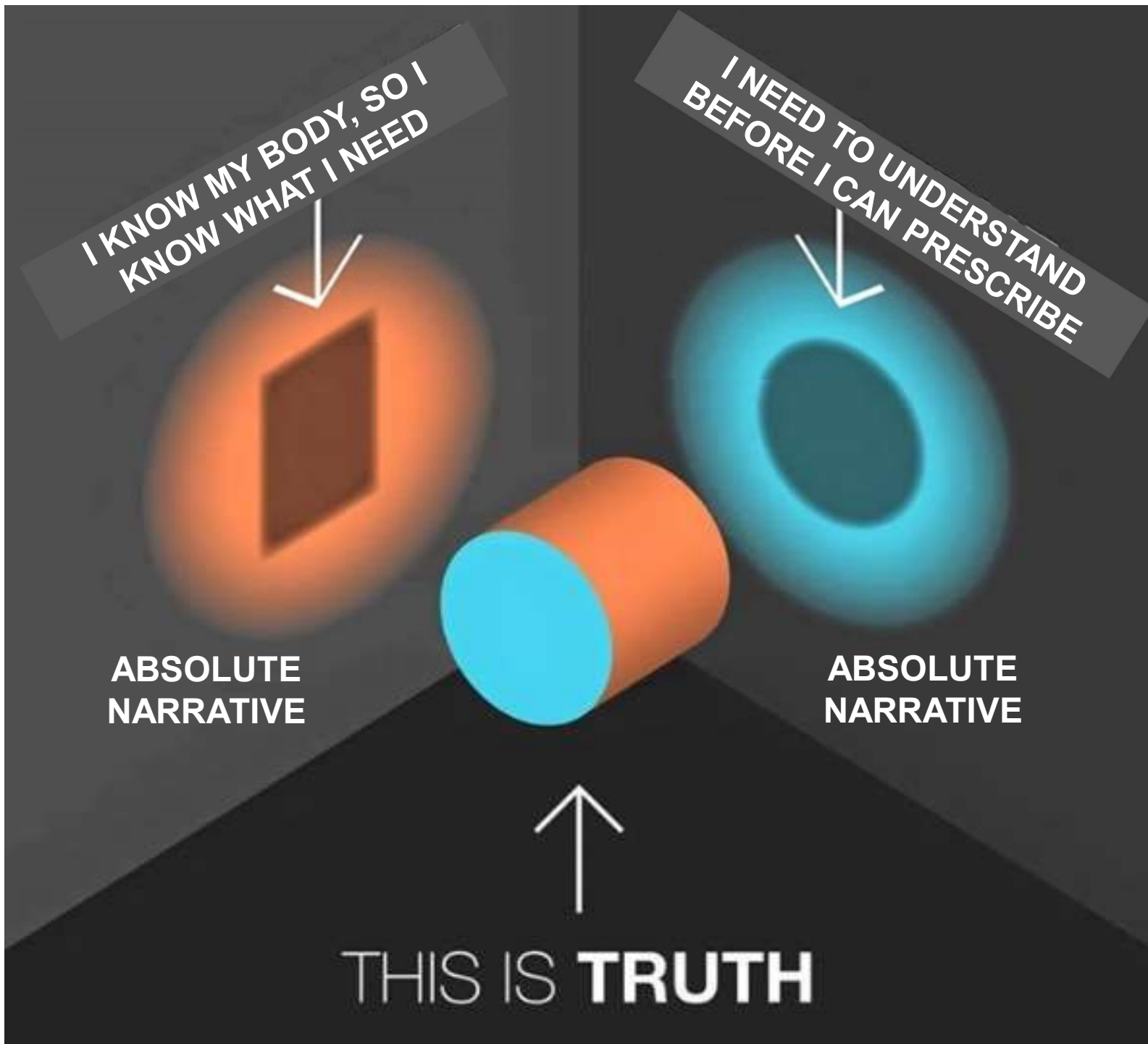
I KNOW MY BODY, SO I
KNOW WHAT I NEED

I NEED TO UNDERSTAND
BEFORE I CAN PRESCRIBE

ABSOLUTE
NARRATIVE

ABSOLUTE
NARRATIVE

THIS IS **TRUTH**





Main Ethical Dilemmas

CHILDHOOD

- SOCIAL GENDER TRANSITION

ADOLESCENCE

- PUBERTAL SUPPRESSION FACTORS
- MEDICAL AND SURGICAL FACTORS
- ASSESSMENT & DIAGNOSTIC CLARITY
- **TIMING & CO-OCCURRING PSYCHIATRIC CONDITIONS**





Heterogeneous Group of Adolescents Seeking Gender Transition

Gender identity factors

- **Opposite gender identified**
- **On the “gender spectrum”**
- **Gender fluid**
- **Ability to distinguish gender identity with sexual identity**

To what degree do the sought interventions address the patient’s core gender identity?

Co-Occurring Psychiatric

- **Depression**
- **Anxiety**
- **Self-injurious Behavior**
- **Suicidal**
- **Psychosis**
- **ASD**
- **OCD**
- **ADHD**
- **Tic Disorders**
- **Substance Abuse**
- **Eating Disorders**

What is the relationship between the gender issues and other psychiatric conditions?

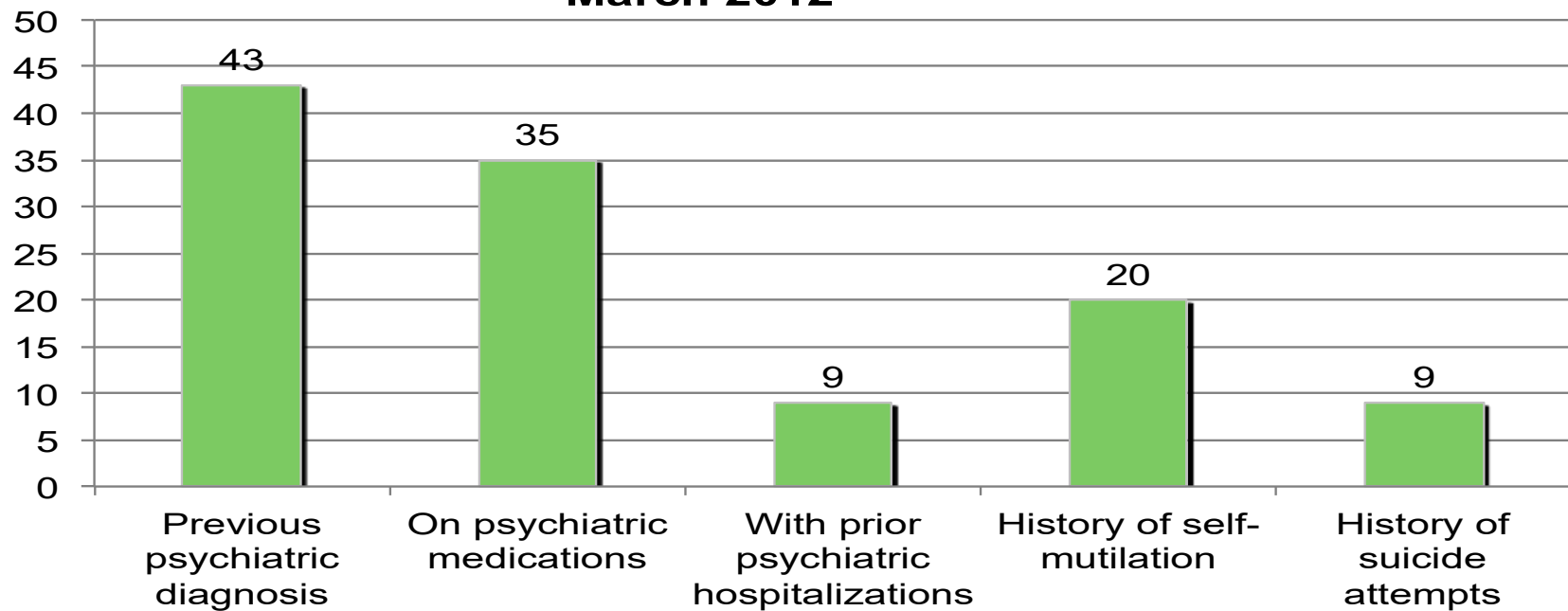


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Adolescent Gender Dysphoria and Co-occurring Psychiatric Illness

Percent of the first 97 patients presenting to the Boston Children's Hospital GeMS clinic for medical hormone interventions grouped by degree of psychiatric compromise Spack et. al, Pediatrics March 2012



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Exploration of Gender Issues

Gender Identity

- Underlying motivations
- Degree of insistence
- Degree of wavering and reasons for this
- Anticipated body changes
- Intimacy and Sexuality
- Reproductive understanding
- Regret in the future

Gender Expression

- Pronouns
- Name use
- Gender Markers
- Clothing
- Breast padding/binding
- Makeup
- Mannerisms
- Activity preference
- Voice

Environment

- Family rejection/support
- Victimization and isolation
- Peer acceptance/bullying
- Awareness of others' perceptions and reactions to anticipated body changes

Coping

- Internalized transphobia
- Internalized homophobia
- Degree of resilience and connectedness
- Degree of maturity and consolidation of identity
- Degree of other aspects of identity are being focused on

Racial Identity

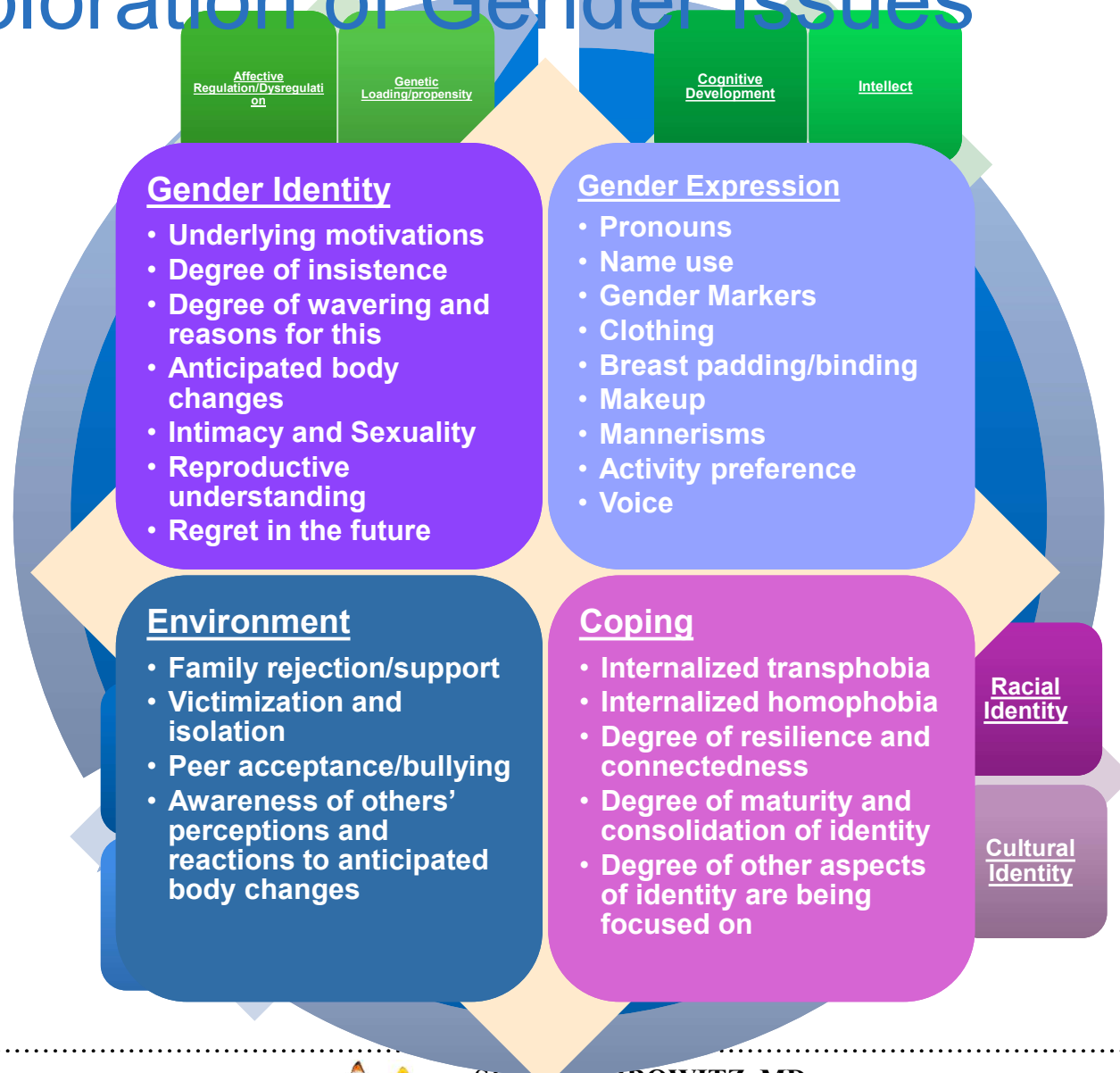
Cultural Identity



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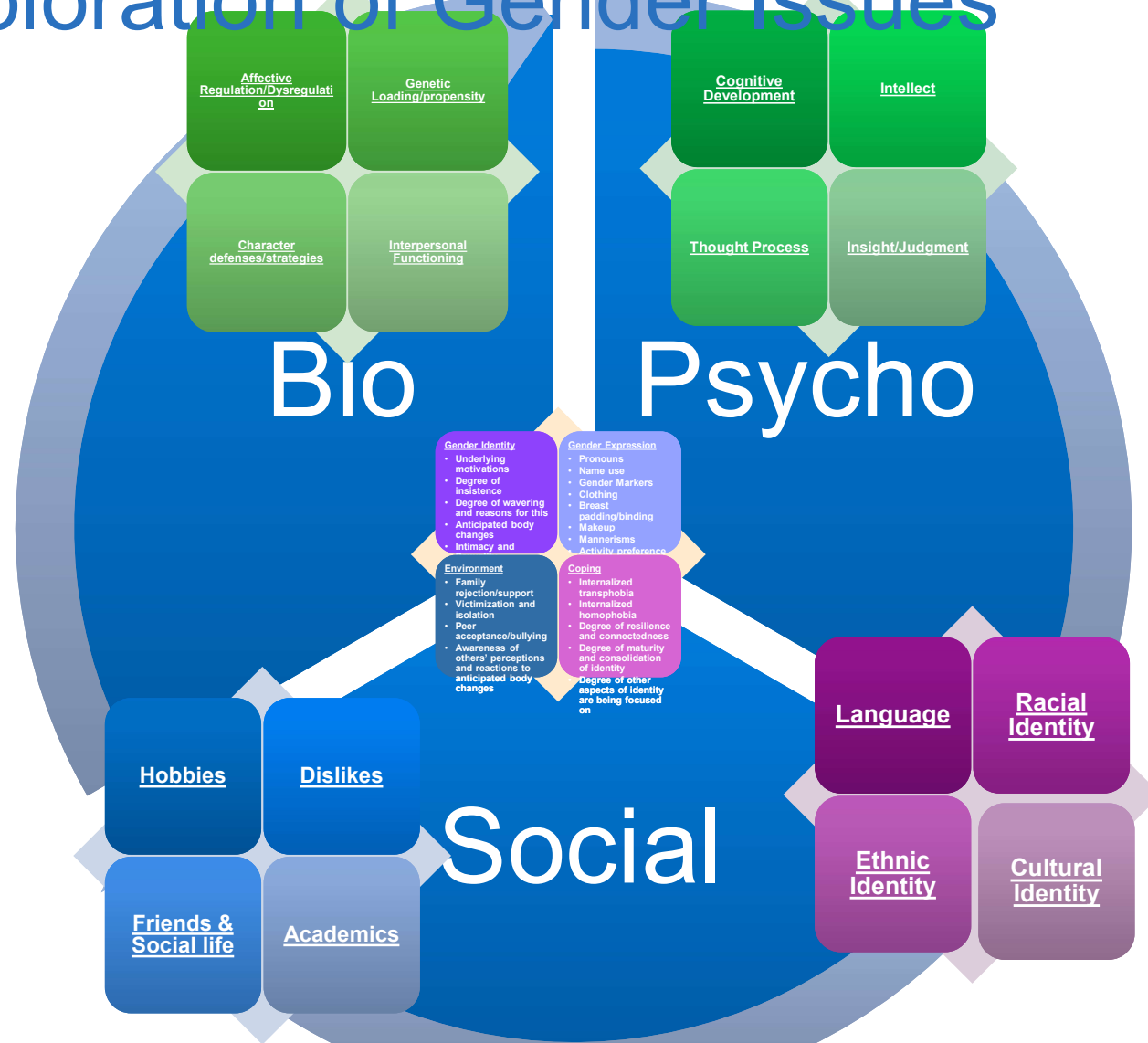
Exploration of Gender Issues



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Exploration of Gender Issues



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Families and Gender Transition

- Pronoun interactions
- Lack of gender nonconformity in childhood, parental perception of something new for them
- Typical Adolescent Individuation
- Rigid and difficult temperament
- Demands for medical interventions
- Guardians/parent disagreement
- Divorced high-conflict parents, custody situations
- Well-intentioned misinformed parents
- Sibling reactions
- Extended family



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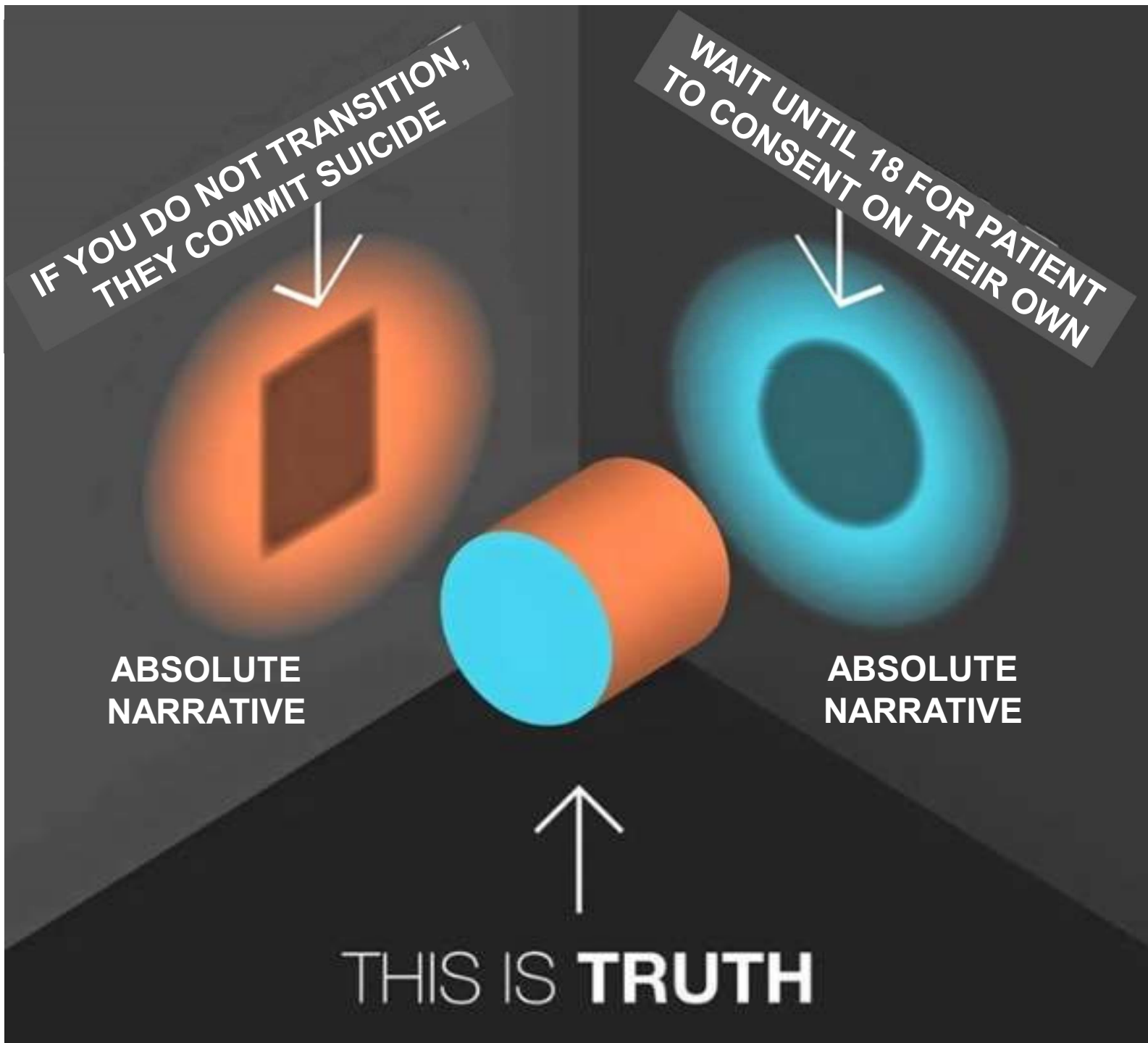


Autism Spectrum Disorder & GD

- **Added clinical challenges when ASD & GD/gender issues co-exist**
 - ASD individuals have challenges with transitions
 - ASD individuals can think more categorically/concretely
 - ASD individuals may not perceive social cues that are important to perceive (i.e. danger in their environment)
- **Is there an overlap?: Controversial subject**
 - Turban & van Schalkwyk 2018 Translations in JAACAP: “no overlap”
 - Strang et al. 2018 & Dutch team response to JAACAP article suggests that there is a higher rate of ASD within clinic-referred samples of gender identity multidisciplinary clinics.
 - Strang et al. 2016: Initial Clinical Guidelines for Co-Occurring Autism Spectrum Disorder and Gender Dysphoria or Incongruence in Adolescents, *Journal of Clinical Child & Adolescent Psychology*, 2016



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Summary:

Gender Transition: Competing Demands



On the other:

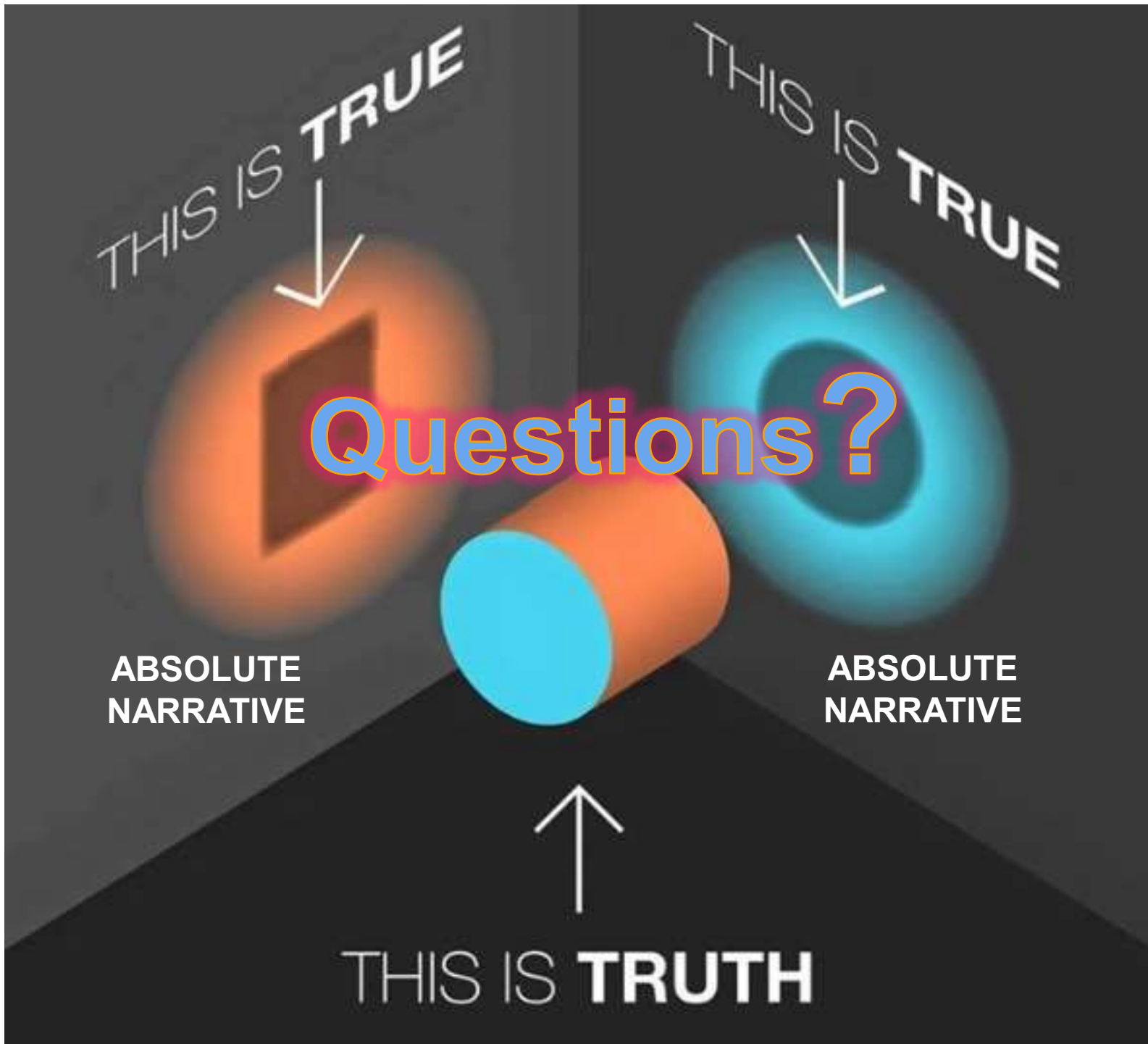
- Degree that identity and role behavior are being conflated
- Risks of medical interventions
- Risks of no medical interventions
- Degree of psychiatric stability and correlation to dysphoria
- Family struggles

On one hand:

- Degree of Identity consolidation
- Benefits of medical interventions
- Benefits of no medical interventions
- Timing of medical interventions when appropriate
- Patient struggles



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Save the date:

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- **June 17** – Sleep Strategies
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- **August 26** – The Pediatrician's Role in School Problems
- **November 11** – Eating Disorders: Restrictive Behaviors

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CME POSTING

Series Name: Behavioral Health Webinar Series for Primary Care
Date: February 12, 2020 / 12:00 – 1:00 PM
Presentation Title: Today's "Genderation" of Youth: The Clinical Approach and Ethical Dilemmas Across Development
Speaker's Name: Scott Leibowitz, MD
Planning Committee: Jennifer White, MD; William Long, MD; Nancy Cunningham, PsyD; Alex Bishara; Amanda Oxenham; Jessica Dudley

Session Objectives:

At the conclusion of this activity, participants will:

1. Identify the relevant terminology with respect to gender and sexuality constructs.
2. Examine the trends in the field regarding youth across development presenting with gender related concerns
3. Appreciate an overview of the current ethical dilemmas that exist with respect to clinical decision making for children and adolescents presenting with gender related concerns.

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