

# Transcript: Identity Evolution

## Workshop held on May 6, 2022

A different recording of a 1 minute and 30 second clip from the panel discussion (which is 1 hour and 22 minutes in total) was leaked into the public domain over a year ago. The video in the WPATH Files is a new recording, has a different layout, and has no connection to the previous leak. The time stamp of the previously released portion of the WPATH video is 23:16 - 24:43. This is the first time the panel discussion has been made publicly available in full.

### Clip 1

**Cecile Ferrando:** Transmasculine patients. And we talk about, you know, early oophorectomy, so early removal of the ovaries and what that means in somebody who is taking testosterone therapy but may not be on testosterone their whole lives. And I simply sort of explain the need to have to supplement, you know, in order to have cardiovascular protection, bone health, good bone health as they get older.

Um, so those are the things that we think about in this cohort of 20 year olds in whom we're removing the ovaries. There's some concern that long term, if they ever stop their testosterone, they could be at, um, um, at metabolic risk, which is just something that needs to be considered. But historically, we have a patient population that also doesn't seek out medical care.

So there's that sort of confounding factor too, which makes it a little bit trickier. Um, but at the end of the day, it's about informed consent. And on my end, I'm just managing patients who have sought out treatment in alternative ways. Um, and that those are, those, those can be pretty challenging.

**Ren Massey:** Thanks, Cecile. Would anybody else like to add some observations?

**Dan Metzger:** I think, you know, when we, when we start people on, um, testosterone or estrogen, uh, you know, we, we try to be as clear as we can, um, about the stuff that's going to be permanent and the stuff that's, that's going to go backwards. So if you started testosterone, your voice is going to change. That's permanent, but you might get more muscly, but then that's not permanent if you were to stop.

Um, I think the thing you have to remember about kids is that we're often explaining these sorts of things to people who haven't even had biology in high school yet. And, and, um, uh, and I know I've, I've heard others in, in this kind of a, in this kind of a setting say, well, we think adults are like really slick biologically.

And in fact, lots of people have very little medical understanding of stuff like that. We just put medical professionals and. mental health professionals take for granted. So I think we have to be, um, more concrete than we think we need to be. Um, short of surgical stuff, you know, I think, I think, um, uh, and the permanent physical changes that happen with testosterone or estrogen, um, you know, you might get some breast development that maybe you would later regret.

Uh, but I think, um, it's reasonably safe to, to be on hormone X for a while and then stop and go back to your, to your natal hormones. Provided you haven't had some sort of a gonadectomy, then, as Cecile mentioned, that's a different issue if you're hormone less, um, so, um, I think that is important, um, for people to know, and I think we also, like, just in general, you know, people want this, but they don't want this, but they want this, but they don't want this from a hormone, and I'm like, well, you know, you might not be binary, but hormones are binary, and so, you know, you can't get a deeper voice without probably a bit of a beard.

It doesn't work that way, or you can't, um, you can't, uh, you know, get estrogen to feel more feminine without some breast development. It, that doesn't, that doesn't work very well. And there are different ways of trying to get around some of these things, but in general, um, you know, when you give a hormone, it's going to do what hormones do.

It's going to act on a receptor, the receptors are everywhere, and you're going to get some sort of a physiologic effect, and it's hard to kind of pick and choose the effects that you want. And, and I know that that's, um, I know that that's, uh, like something that kids wouldn't, wouldn't normally understand because they haven't had biology yet, but I think a lot of adults as well are hoping to be able to get X without getting Y, and that's not always possible.

## Clip 2

**Ren Massey:** Thanks, Dan. Yes, expectations and informed consent. We have a lot of work to do here, even as mental health professionals, um, in my work, I, even before having folks start on hormones, I go over a lengthy, um, information about the effects of the different kinds of hormone therapies, uh, just so they, I have the clarity that they have some sense of understanding what they're going to because even the good hormone docs here in my area.

Don't always take the time, or it's easy for us to make assumptions that people understand. You know, but that estrogen is not going to make somebody's voice go higher. Or if you're a certain age, testosterone is not going to make you taller. So, um, manage expectations, I think is really important. Uh, it looks like Dianne's ready to say something.

**Dianne Berg:** Yeah, I just wanted to piggyback on all of the importance that comes up with the informed consent. Um,

I often see people who, because there's such a backlog of therapists to do some of the mental health therapeutic support, I often see people who have already engaged in some sort of, and this is again with youth, who've already engaged in some sort of medical, um, Intervention. And so one of the things I do is I just kind of I'm sitting with the youth and their parents and I say, Oh, well, so tell me more about what you know about that medical intervention.

And kind of like what Dan was saying, you know, children and young adolescents, we wouldn't really expect them. It's kind of a developmental it's out of their developmental range sometimes to understand the extent to which some of these medical interventions are impacting them. And so I think I, I try to kind of do whatever I can to help them understand best, best I can.

But what really disturbs me is when the parents can't tell me what they need to know about a medical intervention that apparently they signed off for. And so I think informed consent has to happen very differently for parents. That it has to happen for children and early adolescents and adolescents, but it needs to happen and it needs to be a process and, and I think therapists are in a really good position to do that process because we have a lot more time.

with our people than like the 20 to 20 minute medical appointment the way that and that's another problem is the way the medical system works is is there's often very little time. So I think it's really one of our roles is to really do that and to really

suss that out and take quite a bit of time to do that and it's more than just like we certainly provide information but then you kind of have to listen to what the the youth is doing with that information to to kind of not, not catch them, but to pick up on the ways that they're not really understanding what, because they'll say they understand, but then they'll say something else that makes you think, Oh, they didn't really understand that they, that they are going to have facial hair, right?

Because they say something else that makes you think, Oh, they didn't get that point, but they'll say they totally get it.

## Clip 3

**Dianne Berg:** This comment on is that I worked in a, um, an intersex or disorders of sex development clinic for a number of years as the psychologist. And I would come in to the session with the parents and usually these were very young kids. So I wasn't really working with the kids. I was more working with the parents and, and I would come in there after the, after the medical doctor had, after the pediatric endocrinologist had been in there and done, had been in there for an hour and had talked with them.

Um, and. The pediatric endocrinologist came out and said, yeah, they totally get it on board. I don't have any concerns about their understanding. I would go in and I would say, okay, so tell me what you learned from, and they'd just be like, 'We have no idea what they were talking about.' Because they, they feel deferential.

Part of it is that they feel less deferential to the kind of doctor I am than the kind of doctor, the medical doctor is. And so, and because they really are seeking the care, they're just gonna. Say they know when they really, they really aren't picking up on what's happening. And so I think the more we can normalize that it is okay to not get this right away.

It is okay to have questions is, you know, the more we're going to actually do a real informed consent process. Then what I think has been currently happening and that I think is frankly, not what we need to be doing ethically.

**Ben Massey:** Thanks, Dianne. I appreciate those comments. Um, anything you want to add in there, Gaya?

**Gaya Chelvakumar:** I would just say I agree with all the comments that have been made. I think the informed consent process is so important and definitely that it's a process is really important to recognize that it's not one conversation at one point in time that is many conversations over time, um, and that those conversations don't have to stop once the Medicaid and intervention has been started, that those conversations can be ongoing even after the intervention has occurred.

Um, even asking how they feel about changes that are happening and, and having discussions about is this something you want to continue with to not, um, you know, informed consent is such an important piece of starting any intervention and it's so, it's so hard. And I often wonder about what you mentioned, Dianne, about people saying they understand when they don't, just because they're so focused on the intervention that, um, They're afraid to share things that they might not be

understanding about the information we're sharing with them and how, how to address that I think is very, is very important.

I will say just personally my practice, it has evolved, how in the medical setting. I think we have these Conversations and, um, around informed consent has evolved a lot over time as well, just recognizing a couple of different things, you know, that identities may shift and transition needs may shift, um, that also has shifted how we have, I think, conversations around, um, around informed consent and starting an intervention.

But it's so important and just that it's a process and it's a continual conversation, I think, is the biggest thing.

## Clip 4

**Dianne Berg:** And Gaia, I don't know if other people do, but I really struggle with, with, because I kind of want The kids that I work with, whether they're nine to, you know, 13 and looking at puberty suppression or hormones in some ways to be a little pediatric endocrinologist, like I, I want them to understand it at that level, um, in an age appropriate way.

And I struggle with that on one level because it's like, well, when a kid takes diabetic medication, do they have to understand? everything about their pancreas and everything that's happening and all of all of that do we do we do that same process around other medical kinds of things and so is this an unfair So, I just struggle with that line, um, and I just kind of wanted to, to say that because I'm not quite sure what to do about that.

The other thing that, that I, that I really like to do is I like to have the children or the young adult or the young adolescent or the adolescent come up with questions that they have for their medical doctor. So let's, let's, let's write a great question. Write that down. Write that down. We're going to ask that you ask that the next time you come back so that they're, they're really, I think, um, one of the things we have in one of the papers that we published is how important it is to instill a level of autonomy into Okay.

Children and adolescents about their medical care and transgender people about their medical care that they get to be assertive. They get to ask questions. They get to be really well informed. And so we want to start that very young by having children like, ask a question, write down what you think and ask the doctor.

You can ask the doctor. Well, I can't really. Yes, you can. Yes, you can. You get to ask the doctor anything that you want to ask them. Um, and so really instilling that way of thinking about medical care, I think is important.

## Clip 5

**Gaya Chelvakumar:** Important point two is just collaboration between the medical team and the mental health care providers so that there can be also ongoing discussions between team members. So if, when mental health providers are having conversations around expectations around Medicaid, it's just like, Hey, you may want to spend a little more time talking about this, or this is an area that the, there seems to be some confusion about, or parents or child are really, um, concerned about, I think.

In this, in this area of healthcare right now, multidisciplinary care is so important and being able to collaborate with each other is so, is so important and so helpful, um, because sometimes we're not, you know, maybe in the context of a medical appointment, the conversations that need to happen can't happen and then maybe there needs to be further conversations with, with a mental health provider to help make sure parents and children have all the information they need to make the best decisions for themselves.

Yeah, I agree. It's so helpful to be on these on these panels just to hear where everyone's at because I think we all are struggling with how to do this and that in the best way without overburdening our patients and families as well.

**Jamison Green:** But our health care system doesn't If I may jump in here, our health care system doesn't encourage this.

I mean, if you have a clinic, like already, like a university setting where Dianne is, or where Cecile is even, and I'm not sure where you are exactly, Dan, but I know many people providing this care are independent practitioners, and they're referring their clients to surgeons. Uh, across the country and their endocrinologist might be their actual May, they may not never, they may never have a, an endocrinologist.

They may be able to get their hormones prescribed through their primary care provider who doesn't really know necessarily everything about Transcare. They're basically trying to be supportive and you know, our health care system. It leaves us in the lurch all the time. And so to create, I agree that we don't necessarily need to be able to have If you have a known condition, like diabetes, you don't have to understand every nuance about what the insulin is going to do to you in order to give informed consent.

You need, but, because there's so much experience with that. But in this field, this is all new, this is all contentious, and that's where we run into problems. because



everyone's afraid. And I know for a fact, people, even adults, even well educated, older adults, accessing care for the first time, sit down with the person who's going to prescribe their hormones, and they look at an informed consent form that says your hormones are going to do this, this, and this. They don't take any of that in yet because they're so scared that they're not going to get what they need. They, they just so, show me where to sign. Cause I'm, this is my moment, I gotta grab it. And they don't really take in the information.

## Clip 6

**Jamison Green:** And people also are afraid many times about surgery and so they can read other people's descriptions about surgery and they'll miss details or they'll miss the, the, uh, the most important piece of information for them simply because they're afraid to read it. You know, it's just how human beings work.

So I think at the same time we're fighting against The community's desire to have less gatekeeping, less professional intrusion, less spending time in doctor's offices. And how do we manage that and make sure that everybody's got the right level of education to make good decisions for themselves? So this is a problem that we're facing.

And this is where I think some of the detransition comes in. Because the over medicalization, as well as Uh, over binarying, as well as just the pressures that people are under because of the opposition creates a dynamic that's very, very hard for all of us to work in. Trans people and clinicians, very, very hard.

So I think these dialogues are crucial and we need to take them outside of this space ultimately as well.

**Ren Massey:** All right. So I'm, I'm sorry. Did you want to go ahead?

**Dan Metzger:** Good. We can do it after the.

**Ren Massey:** Yeah, I was going to suggest you this great conversation. I have more comments, but I'm like, ah, people probably need a break attendees as well as panelists. So, uh, I've asked for a 12 minute break. And we will reconvene back here and look forward to seeing y'all back here in a little bit. Thanks.

## Clip 7

**Ren Massey:** I think we're pretty close to on time for that 12 minutes. Appreciate everybody being back here. Um, I'm wondering if, uh, well, I wanted to share just a little bit about informed consent. And then after, if anybody else wants to chime in, feel free to. I saw a little bit going on there. I do think that that's a really important part of what we can do to help folks.

Um, in terms of their decision making processes and also, you know, just to start out with, I make it clear to people that I don't have an investment, whether they're youth, whether it's parents. Whether it's adults that I have no investment in what their gender identity is even just because transitioning was right for me doesn't mean that it's right for somebody else.

And that's not a bias that I have. And, um, I hope that that gives people from the start a sense of safety in, um, considering a range of options in, um, in terms of gender identity and gender expression possibilities. Uh, when we do get to talking about, um, hormonal and medical interventions for those who, uh, are considering those options. You know, one important thing I believe is to make sure we address fertility preservation. If you all have looked at the drafts of the standards of care coming out, S. O. C. Eight. Hopefully next month, you'll see, you know, a number of places where it's encouraged and ethical to talk about fertility preservation options. And that's even for youth who are going on puberty blockers, because many of those youth Thank you for nodding heads. Many of those youth will go directly on to affirming hormone therapies, which may eliminate Or will eliminate, you know the development of you know, they're gonads producing sperm or eggs that are going to be able to be usable if they want to be partners with somebody else later in contributing genetic material for reproduction

## Clip 8

**Ren Massey:** I start even with puberty blockers to talk about fertility and a useful tool has been John Strang's TYFAQ, the Trans Youth Fertility Attitudes Questionnaire. It's not necessarily standardized to my knowledge, but it's a mechanism for discussing. There's a parent version and a child, a youth version for discussing some fertility issues just over, I think it's 16 questions.

And then also my informed consent process, I will include, um, as a non medical person, but somebody in the healthcare profession with a lot of. experience and knowledge and G. E. I. S. Under my belt attend all these conferences. Always learn something. I cover the reversible and irreversible effects and the potential risks to the best of my again.

I'm a lay person as far as being not a medical provider. Um, knowledge and I base that on the standards of care seven and we're gonna have the new ones coming out as I mentioned as well as the interim guidelines. Uh, the latest being in 2017. And there are some other resources out there. So, um, I see somebody put a file up there but there Are ways I think we can all go over this.

And also just finally, I'll just add that I go over it with the youth separately from the parents. Uh, and then with the parents separately from the youth, ideally, and then bring them all together. Make sure we're all on the same page of under what we understand. Um, Limitations acknowledged, and, uh, you know, they're often having questions, and I say you have to ask your hormone provider, the consultant you're, uh, going to be meeting with about, uh, certain questions.

So there are certainly, I stay within my lane, but I do think that part of the multidisciplinary nature of this work is being well versed in these things, at least to a certain level, and that's part of why we have a multidisciplinary panel here.

## Clip 9

**Ren Massey:** wants to, I see somebody added the QIFAQ in there. Anybody wants to add any comments on that before we move on and we could potentially start looking at cases in a little bit? Does anybody want to add anything to what I said? Looks like Dan might.

**Dan Metzger:** I, I was just gonna say, you know, like, like it's always a good theory that you talk about fertility preservation with a 14 year old, but I know I'm talking to a blank wall. And the same would happen for a cisgender kid, right? They'd be like, Ew, kids, babies, gross. Or, or the usual SPAC answer is I'm going to adopt. I'm just going to adopt. And then you ask them, well, what does that involve? Like, how much does it cost? Oh, I thought you just like went to the orphanage and they gave you a baby.

No, it's not quite like that. Um, but, um, and I was just trying to find it, but I can't, I can't quickly locate it because I only have is like a picture of a slide, but apparently last week at the Pediatric Endocrine Society, uh, some of the Dutch researchers started, uh, gave some data about, um, young adults who had transitioned and reproductive regret, like regret, and it's there.

Um, and I don't think any of that surprises us. I don't remember any of the numbers or anything. I just, again, I have a picture of a slide. But hopefully this is something that will get published in the next while. But, um, you know, I think, I think now that I follow a lot of kids into their mid twenties, I'm always like, Oh, the dog isn't doing it for you, right?

Yeah, they're like, no, I just found this, you know, wonderful partner and now we're kids and da da da. So I think, you know, it doesn't surprise me, but I don't know still what to do for the 14 year olds. The parents have it on their minds, but the 14 year olds, you just... It's like talking with diabetic complications with a 14 year old. They don't care. They're not going to die. They're, they're going to live forever. Right? So I think, I think when we're doing informed consent, I know that that's still a big lacuna of, of that we're just, we do it. We try to talk about it, but most of the kids are nowhere in any kind of a brain space to really, really, really talk about it in a serious way. I, that's always bothered me, but you know, we still want the kids to. Be happy, happier in the moment, right?

## Clip 10

**Dianne Berg:** I appreciate that much less with a 9, 10 or 11 year old who's, who's, um, who's starting puberty suppression. And like Ren said, if they continue on then, and, and I mean, it's, it's like developmentally not in their space to be able to have, have to think about that. And it shouldn't be, um, right. And so I think it is.

I think it is a real growing edge in our field to kind of figure out how we can, how we can approach that. Um, I'm definitely a little stumped on it.

**Gaya Chelvakumar:** I'll just add one more complication in there is that then if you do have, which doesn't commonly happen, but if you are interested in preserving fertility, then the options for for doing that, depending on age and stage of development also can be. From a medical standpoint, may or may not be possible, but then from a financial standpoint, also may or may not be possible, and that's another complexity to the, adds another layer of complexity to these discussions as well, and that's at any age, I guess.

**Dianne Berg:** And from a social and sexual standpoint, right? Um, in some ways, the stuff that you need to do to be able to preserve your fertility might be beyond kind of what a youth, where a youth is at in terms of their sexual development, and yet.

That's kind of what's needing to happen and, um, yeah,

**Ren Massey:** yeah, I don't think that we have all the answers and I appreciate y'all's comments, bringing, you know, highlighting the nuances and the challenges here. I find a range of. Maturity levels and having thought about this or not having thought about it. Um, again, depending also on the age and the cognitive maturity, emotional maturity.

Um, I still, I know you all do these kinds of things too. I think that it's better to give them the information and have them, Be able to reconcile, like we wish we could afford this, but at this point we can't. And so we will proceed down this avenue anyway, but not later on then find out, Oh, nobody ever told me that I couldn't, you know, do that.

## Clip 11

**Ren Massey:** Like, why didn't somebody tell us? And so I think that there's a shift in the field, but I just think we need the spotlight that, um, it's part of the discussion in the informed consent process for youth as well as adults. Um, And back to the thing I said the very beginning of after the break, part of also trying to make sure people have a sense of I have no investment in where their gender identity or identities land is because that part in this study where people said they didn't go back to the same provider, that that bothers me, I would like people to feel like they can continue with me whoever they are.

Um, if I can help in other issues, you know, a few of the folks I've worked with, it's been, um, some of what Dianne was saying earlier, you know, their sexuality got to clarify some of their gender identity issues. And, um, they, I've been pleased when they've gotten clear. Okay. Maybe I'm not trans, maybe I'm non binary, maybe I'm cis, um, and maybe this was more of a sexuality issue.

And they were willing to continue to work with me as they explored sexuality issues. You know, I want people to feel like they don't have to perform a certain gender to be working with me. Um, that I want to be inclusive and supportive of all aspects of their being, so. All right.

## Clip 12

**Ren Massey:** Any other thoughts before we maybe look at cases? Alright, as, as we shift to cases, then, uh, this is always the tricky part for me to work on.

**Dianne Berg:** I'm sorry, Ren, can we just, Melissa Goldstein is just asking if anyone has great resources for fertility and preservation especially. Oh, Gaia just put it, did you just put it in?

**Gaya Chelvakumar:** I just popped in one article that starts to discuss some of it.

**Ren Massey:** I'm, I'm glad. I think, I think that that's a knowledge, right? And there isn't a ton of, of that existing. So I just wanted to acknowledge that. Yeah. All right. Thank you. Um, it's wonderful how we've got all these wonderful resources here. All right. So, uh, bear with me a second. I am going to try to share screen to, uh, go over some cases that our panelists have, uh, put together.

And this is the part where I always grapple.



## Clip 13

**Ren Massey:** Read the case of DJ. Give me a thumbs up, panelists.

Okay. All right. So I'm wondering if panelists have any comments or thoughts you all want to start with in getting this discussion going around this young person and their experience.

Oh, sorry, Randall. I'll read the next one.

**Dan Metzger:** To me, this is a not an untypical story. I mean, this person's got some significant mental health stuff, which is, you know, that they need to deal with. It sounds like they had an unfortunate sexual traumatic sexual event, which that sounds probably pretty horrible. But to me, this is a kid who, who, who. Um, got a false start and, uh, and, um, maybe it wasn't in a place where they were fully supported or they feel fully supported.

Um, but to me, this is not de transitioning. This is just a kid working through crap. And, um, I mean, I obviously may feel sorry for the kid, but to me, this is not like something that should hit the news as a, you know, a system problem. You know, assuming that this kid's been getting the mental health care that they need.

To me, this is like, not an untypical story. Um, and with a happy ending. So, yay.

## Clip 14

**Dianne Berg:** highlights the importance of having ongoing support and following kids over time, um, so that you're getting as much of the picture as you possibly can. And, and so kind of the important role of, of behavioral health, mental health, um, component. Um, I think, I think oftentimes mental health can get a really bad rap.

Um, in terms of that, we're trying to do things that we're not actually trying to do and, and so I think this is a good case that kind of exemplifies if you're following this kid and meeting relatively recently, relatively, um, often with them, you're going to kind of be seeing this in real time and be going through this with them and be helping them to process and figure out kind of the meaning that it has for them.

Um, And hopefully as you have enough of a rapport, I don't know if it happened in this case, but that it looks like the, the person didn't disclose some of the bullying and the traumatic sexual event until a year later. The hope would be that if we can build enough rapport over time with kids in whatever specialty we have.

That, that we would learn about that in more real time than a year later, and that we would be able to be, you know, kind of just doing it as part of the regular process of checking in about all spheres of life. Um, so it really highlights the importance of that for certain, for certain youth.

## Clip 15

[Ren Massey](#): comment. I noticed an observation or a wish that, uh, therapists involved in able to Help the young person distinguish between the assault and their gender identity. I think, um, that there are times working with young people where they don't even disclose an assault or some type of sexually, Coercive or unpleasant experience.

It may not even have been coercive, but it may be almost like self coerced. They thought they were supposed to do X, and so they, like, I guess this is how people interact sexually, and so they showed up voluntarily, like this other person at

the moment, um, wasn't coercing them, but they were kind of trying to get themselves to learn about sex. And so they may have done things they didn't even feel comfortable with. And so they don't want to talk about it with therapists. So, I mean, um Even good therapists, you know, we're going to be limited at times where we're, uh, we can't get everything that's going on with our kids that we're working with.

And sometimes the adults also don't bring it forward. So, um, it's a, it's a high bar to cross sometimes to try to catch everything that. may be affecting somebody's view of themselves and across domains of their life experiences.

## Clip 16

**Gaya Chelvakumar:** And I'll just echo Brennan and Dianne's statement. I think the case to me just highlights the need for, in addition to continued, you know, ongoing care, but also maybe like leaving the door open, that if this is your decision at this point in time, but that may change and we're, you know, we're here to support you, whatever your decision is, and that you can always, you know, continue to see us continue to see the team, um, you know, keeping, keeping engaged with young people and letting them know that they can, It's okay to change your mind.

It's okay to, to come back and knowing that, um, people sometimes have to disclose things in their own time as well. So that while we hope things are disclosed in real time, sometimes people just aren't in a place to face, to face their trauma and what's going on. And so even more so becomes important, I think, to have that ongoing care.

Um, and even if there is an ongoing care, at least leaving the door open, young people, or adults even, are in a place where they want, where they want to reengage that that door is still open?

**Dianne Berg:** Yeah, there, there was a comment. There was a comment in the chat about, um, sometimes our, our discomfort with asking questions, particularly pertaining to sexuality.

And I, and I think that that's, that's really true. I mean, we have not gotten to the place yet where it's just part of, Every typical kind of area that you inquire about, and I think that that's really important, um, and is, is part of, and, and to not, and to not frame sexuality, I think the other thing that happens with sexuality is it gets framed as negative, all the things that we shouldn't be doing, um, rather than having a positive, kind of positive take on sexuality, and so how with, with youth and, are adults.

Do we just naturally feed that into the conversation? And how do we as clinicians get comfortable with sexuality and sexuality themes? Um, in a society that isn't very comfortable with it, but isn't comfortable with it in appropriate ways is very comfortable with it in some ways that probably aren't very healthy.

And so how do we teach people to do that? I think that's one of the benefits that That I have working in a sexual health kind of clinic that has a gender component to it. And I think that's really important.

## Clip 17

**Ren Massey:** All right, thanks. Going, going, gone. Move on to our next case. Okay, if I can get my screen share to cooperate with me. Ah, here we go. All right. Cases. This is a collective consideration. Several trans men in their late 20s, early 30s have done a range of social and medical interventions. They're now clear that in hindsight, if they had come out ten years later, they may not have taken all the medical transition steps that they did if the option of a non binary identity had been on the table. They don't like to be seen by others as male, but given the physical changes, don't feel like they have a choice. There are different intensities of how upsetting this is to them, but a common theme is not likened to be perceived as male by others to the extent they are seen as male. I found this really interesting.

Who would like to jump into this conversation?

**Dan Metzger:** This is a bit beyond my age group, but I think one thing that they could do, uh, medically is to talk with their hormone provider to see if there's a way. I'm presuming these people are still on testosterone, if they are, that they could at least lower the dose to something that's still bone protective and still would make them feel okay, but maybe wouldn't, uh, would less stimulate, uh, you Like facial hair growth or or the other kinds of things.

I mean, their voice is not going to change, obviously, but, uh, there might be some room to play with the testosterone dosage just to make things a little bit less, uh, um, less masculine.

## Clip 18

**Cecile Ferrando:** Um, so I think this is about goal setting. Um, so you know, while I'm a surgeon, I do a lot of testosterone implants for patients. So I do testopel implants. Um, and, um, when I talk to a lot of patients, the majority of the patients I see, they are seeking, um, realization, masculinization. So I dose them to sort of physiologic levels.

Um, but I have sort of this, um, cohort of patients that is seeking sort of, you know, underdosing, but wants testosterone, um, supplementation. Um, so we sit and we talk about. The goals of therapy, understanding whether, you know, I have to explain to them that sometimes underdosing can, um, will not lead to cessation of menses, which is sometimes the actual goal, like not virilization, but cessation of menses.

And so, in those situations, we talk about, you know, what other things we can do that, um, that may not have sort of either feminizing effects, you know, a lot of our, Transmasculine patients don't want to be on oral contraceptive pills, etc. So sometimes I'll underdose testosterone in a pellet form. Um, and also, um, place an IUD in those patients.

And so it's really sort of about discussing what their goals are. I'm now seeing younger patients. So not necessarily patients who were dosed on, on doses of testosterone and who are now working backwards. But I have a couple of patients in their twenties who. Sort of err on the side of the masculine side on the spectrum, but don't want to be fully masculinized.

So I'll underdose them as well. And, you know, I think that there's a physiologic component to this improving their, their sort of state of being and giving them a sense of wellbeing. But also I think that there's this component of, um, I feel like I'm taking some steps towards masculinization, but not completely.

So that makes me feel good. And I think that there's. Also, I think we, um, uh, actually to this crowd, I'm not gonna say undervalue. I think, um, uh, people in my, um, from where I'm coming from undervalue the importance of giving a patient a sense of control of their transition and their care plan, which is not a foreign concept when we talk about.

You know, paternalism and autonomy, but certainly when it comes to this type of care, allowing patients to have some control over what it how their transition is or what it is, is really important. So even in patients who've been on high dosing who

want to work backwards, but like Dan just pointed out, sometimes you can't reverse everything.

Right. So there's some masculinization that will have already have occurred, but perhaps just the giving a patient the sense of being able to control what's going to happen down the road is really important.

## Clip 19

**Cecile Ferrando:** testosterone dosing. For me it's easier in the pellet form because you can really sort of dose to certain levels. It's in my, from my experience, easier to control than intramuscular and subcutaneous dosing. But it's about goal setting and discussing and so much can just come from a discussion of I understand that what your goals are and let me see if I can help you achieve them.

Certainly that conversation is easier when it comes to hormones than it is surgery.

**Dianne Berg:** There are a little bit, I think what it comes up, what comes up for me is helping people to explore socioculturally what it means to be masculine, feminine, male, female, um, because there's kind of the internal sense of it and then there's also the the way that that gets perceived in the world and It sounds like for some of, for some of these folks, like, for whatever reason, it's more about how they're being perceived by others and maybe, maybe kind of what others are then attributing to them or assuming about them because they're, they're interpreting them as male when maybe that's those things, those, those aspects of maleness are not what they, aspire to or what they want.

And so I think it's, it's, it's all about kind of that, that therapy around what does it mean in our culture to be kind of, what does gender, what does gender mean in our culture? And how is that going to play out for how you see yourself and how others see you? So it's kind of those deeper, those deeper conversations.



## Clip 20

**Ren Massey:** I just want to add something here. I appreciate what you were just saying, Dianne. One of my adjustments with my transition was, um, losing, um, automatically being perceived as safe. by females who I was meeting for the first time. And, uh, it was a very strange experience to be walking in a parking lot, you know, following a woman out in the parking lot from the grocery store, and to realize, oh, she's looking over her shoulder to, like, see, am I following her?

Am I a threat? Or to be in an elevator and... have, you know, somebody kind of scoot just about as far away as they can. And, um, it, it was, it was, it was a loss, candidly, not to be, uh, perceived or assumed to be safe anymore. Um, so I can easily see that some of these things would be, um, really distressing, um, social impacts of, um.

Being perceived as masculine in our culture. So, looks like you wanted to say something there.

## Clip 21

**Dianne Berg:** Around kind of the other way too, right? I mean, so many of my trans feminine adult and even adolescent clients, um, Talk a lot about They they they hear about it theoretically, but it's not until it happens that they really get it like not being paid Not being given as much airtime as they Become perceived as a woman.

Um, you know kind of all the the things that feminists have been saying for a really long time, I think, start to become more clear to people. And, and I think those are some losses or just some, some realizations around how gender plays out in, in sociocultural spaces. And And kind of what is that going to mean and how does how what meaning does that have for people.

So I think it, I think it goes both ways because gender is such a powerful mediator, whether we like it or not, it's such a powerful mediator of sociocultural spaces and interactions and environment.

**Ren Massey:** Yeah, I'm going to add to that, you know. A lot of us are youth or focused or heavy in our practices. Um, or young adults and, and minors.

Um, but One of my mentees, who I think is on this, um, meeting today and some other folks have talked to me about, you know, and I've even had clients as well who were adults who were assigned male at birth and found the loss of privilege and safety that they experienced in the world, um, was really disturbing.

And particularly some of the older folks. Um, we're actually, um, de transitioning, re transitioning for, for reasons of fitting in not just either around job stuff, but sometimes to be able to go into assisted care facilities with less hassle. And a greater sense of safety. So I think there are other issues, again, outside pressure sometimes, it may not even be the internal experience, that we need to be able to be aware of supporting people for in different contexts that we may be encountering.

## Clip 22

**Ren Massey:** So um, yeah, one of the thing I would like to highlight on this case, I think that it underscores that from the in the outset, we also may help people explore more non binary options. You know, I have a young person I'm working with right now, um, who's been on blockers for about two years. Mother's anxious for the kid to come off.

Pediatric endocrinologist is saying maybe go a little longer. Um, and the kid is vacillating. Um, really not wanting facial hair. Um, but... about having menstrual cycles and kind of vacillates about whether breast development, chest development bothers them or not, and which pronouns they use. And we all know that chest surgery is pretty inevitable, or at least it looks like that, because that has consistently been a bothersome thing.

So, is there more, um, benefit of staying on blockers or letting the kid... switch back to their endogenous estrogen? Or is it better to go low dose testosterone or what? You know, and at what point in time? So, um, if the kid doesn't want facial hair, but maybe doesn't mind their chest growing and they're planning on having chest surgery anyways.

So we may want to, you know, be creative in how we help folks approach these. Situations that are complex.

## Clip 23

**Ren Massey:** All right. So, um, I'm going to shift to the next one. I see we got a few other comments on, yeah, what people wanting. And being perceived male can happen very fast. Yes. All right. Let me try to get my screen to cooperate again. Okay. I'm going to read case three in S. 14 years, 11 months, assigned male at birth who identified as female preferred by previous mental health provider for gender dysphoria in the past year.

No significant medical history. Gender history and initial presentation, patient reported that a year prior to presentation a friend came out as bisexual and patient reports it clicked. Hey, that's what I'm feeling. Did not initially share this with anyone, but then six months later told mom about being bisexual.

Felt this confused mom. Around the same time, patient also reported feeling, looking pretty, cute and pretty. wearing female clothing. Reports always having felt this way, but never acted on the impulse to express self using feminine clothing. Patient reports that one month after school started, came to the conclusion they were trans.

Patient disclosed to an online friend first then told girlfriend who encouraged patient to tell mother. When patient told mom about identifying as transgender reports that mom's reaction was unsurprised. Patient had been trying out different names and eventually chose the name Nora. Patient reported feeling dysphoric and that sadness goes hand in hand with dysphoria.

Patient reported interest in starting gender affirming hormones but felt the gender affirming surgery was scary. Felt that mother was supportive of starting hormones, but father was not, and this could be a barrier. Extensive mental health history, starting at age 4, including aggression, ADHD, oppositionality, depression, anxiety, and challenges with behavior.

hospitalizations.

At 15 years, 10 months, the family is open to the patient starting spironolactone, but not ready to provide consent for estrogen. The patient's excited to start medication. Patient continued to follow the mental health provider two or three month intervals. At six month follow up after starting spironolactone, patient started, uh, reported that they felt more male and was feeling comfortable with he him pronouns.

Reported that I felt like a boy who wants to, I feel like a boy who wants to wear nail polish. Patient wanted to stop spironolactone and not interested in pursuing estrogen at this time. Plan for patient to continue to follow the mental health provider. Has follow up appointment in two weeks.

## Clip 24

**Ren Massey:** Anybody want to jump in here?

**Dan Metzger:** I, I'm, so again, another kind of happy ending. Kids happy. Um, parents are happy. I, I, I think it's important to remember that not all kids are as smart as every other kid or as in tune with their bodies or minds or minds of kids.

## Clip 25

**Dan Metzger:** sophisticated as other kids. Some kids like just get things and some kids don't and it takes a little bit longer. And the point is just because you're 15 doesn't mean you know everything. And I, I, I mean, I talk to this all the time, right? You're 15. That's great. But, um, you're probably going to know more than when you're 16.

You actually better know more when you're 16 than when you're 15. So I think it is kind of important to get, uh, uh, And this is our, you know, what our, what our assessors do is to get a level of sort of capacity of not just able to consent for stuff, but like they're understanding where they are. And do they understand that there's a difference between sexuality and gender and being trans and, and, and being, you know, cross dresser.

Um, that, that, that there's more than one way of. You know, liking nail polish. You don't have to be a girl to like nail polish. You can just be a boy and wear nail polish, whatever. So I think, you know, when these kinds of kids are working with their mental health professional, I think it is important for somebody to also really see, well, like, this is a kid that's kind of, not changed, but, you know, well, it's changed their direction three or four times within a short period of time.

That's not somebody you're going to want to rush in to do something permanent with. You're going to want to make sure that the kid, Really is starting to, you know, I have a clear direction of where they're heading before you do something and as well, you know, to make sure that the family are coming along with the kid.

## Clip 26

**Gaya Chelvakumar:** I will also add that like an anti androgen like spironolactone is a nice place to start because it's something that probably is not going to give you, you know, irreversible changes. And so, you know, if needed to help kind of clarify needs and goals and identity, it's a nice, nice medication to use.

**Dan Metzger:** Yeah, I would second that, you know, like if this was a kid that was clearly binary and, and wanting to move forward, you know, then we would probably use Lupron because Lupron works better. It's way more expensive. But I think Lupron without a plan of moving towards estrogen for this kid would just make this kid feel crappy, probably because he's, she, sorry, is well through puberty.

Um, so she's probably just going to feel like whatever a teenage kid would feel when they have their testosterone taken away, kind of, you know, whatever, menopausal. So I, I think, um, Just to, just to, just to affirm, I think Spyro is a really good way to go because it's harmless. It's cheap. It works to, for the beard.

It's not going to prevent the bigger boy changes that happen with male puberty, but, um, it is a nice way to kind of ease into things and often, um, for families, for, for parents that are kind of holding back, it's a nice way to move forward. That's, you know, affordable, cheap, safe, and reversible.

**Dianne Berg:** I'm noticing a lot of stuff in the chat, but I think the medical people could maybe address that kind of comes from how fast testosterone maybe works and does low dose affect that can just noticing that.

**Dan Metzger:** Yeah, so it's true. I mean, we all, you know, Adult men all have the same testosterone levels, but there's clearly a different range of like how hairy you are or how fast you go bald or whatever.

And it doesn't have to do with your testosterone levels. It may have to do a bit with your testosterone receptors and a million other things that you inherit, um, in your genes. So, so, you know, I, I always kid the Persian, the Persian kids that come and see me, I'm like, don't even look at the bottle. You're going to get a beard.

Like, because we know it's going to happen really fast, and then some of the poor Asian kids, you know, they try forever, they could barely get a mustache going, like their brothers, and so, um, you know, but everybody's the same level, it's all the same dose, so, um, you, you, you do have to let people know that just because



you're taking dose X is not, doesn't mean you're going to get results Y to, to, to the same extent.

And the same is true, of course, for, for, for, for girls taking estrogen, you know, breast

## Clip 27

**Dan Metzger:** Level. Level provided your estrogen levels more or less in the normal range, in a, you know, in a normal range. It has much more to do with other genetic factors and body weight and stuff like that.

**Ren Massey:** Alright, great. So I think we have time maybe to go into one more case and um, then we may have some time for some concluding comments. Let's see. The biggest challenge is always there, the technology. Actually, the technology user is the biggest challenge. Okay, case four. An AMAB person assigned male at birth, who is now 13, who early on identified as binary trans girl and took all social transition steps.

Medically, the client is on Lupron and she's not been in a rush to start estrogen. However, she's been very invested in doing so at some point in the future. Within the last six months, this youth has begun to identify more as non binary, trying out different pronouns and names. She's very avoidant to have any discussions about what the shift toward non binary gender identity may or may not mean in terms of the decision she's always thought she would make in terms of medical transition.

When brooch will shut down and no longer engage. Have had some success processing when discussions are framed from an embodiment lens.

**Dianne Berg:** I can say a little bit about this case. I'm not sure whether it's one that I submitted and it just got kind of morphed and changed, um, which is totally fine. Um, but I think the thing that comes up for me, if it is kind of based on one of the cases is, um, But it was very difficult to, to kind of, um, the youth always kind of had it in their mind how their transition was going to work.

I'm going to do this. So I'm going to do this. So I'm going to do this. Then I'm going to do this. And, and it was all a very binary related kind of transition process and how they were thinking about it. And then as they, as they began to kind of try on. Different non binary identities and, and,

um, they started to kind of talk to people, uh, at least with the, with the, um, kid that I worked with.

## Clip 28

**Dianne Berg:** Where we kind of got to was a general not wanting to talk about things because they were just kind of at that place. But also that they really thought that if they said anything about this and really delved into it, it would mean that their options for any of that medical transition that they had always thought they were going to do would be off the table.

And so they were like, I can't, I don't want to explore that the non binary shift, because if I explore that, that means that I'm never going to be able to get estrogen or I'm never going to be able, and it was kind of like having some education around. No, it doesn't mean that what it means is we are trying to meet your embodiment goals.

And if your embodiment goals are such that you need a certain type of medical intervention, then you need that medical intervention and we can move forward with that. And you don't have to be afraid that, um, That your identity is going to drive necessarily drive your medical decision. It's more about your embodiment goals are going to are going to drive some of the medical decision making.

And so I don't know. That's kind of how we were able to get through that impasse. Um, So I don't know what other people kind of have to say about that. But, um, embodiment is certainly a concept that I'm using a lot more of with my adolescence and Children.

## Clip 29

**Dan Metzger:** I, you know, like sort of 13 and a half is sort of our, like a kind of cut off where we, where we're okay to do hormones, if everything, it seems like it's going to work. Um, but I always told the kids, God, you're 13, you don't know everything. Um, I don't expect to know everything. And this is like a journey and you're going to take us, you know, we're coming along for the ride.

And, you know, we start this, it doesn't mean you have to continue. It doesn't mean you have to go up. every single time you come, I'm going to ask you what you want to do with your hormones. Are you happy where they are? And kids do shift with time. A lot of the, particularly the non binary kids, um, um, think that they want to be initially more vascularized than they end up wanting to be.

And they find that there's a happy dose that's gotten rid of their periods or whatever, and that they're happy on that dose. And they don't necessarily want to push forward as they had thought that they might at the beginning. So. I think it's important that you just lay that out right at the beginning.

You do not, you do not have to have all the answers. You know, even an 18 year old, you do not have to have all the answers. Let's work with all we got today, and you keep letting me know, and I'm going to keep pestering you, you know, what do you want to do about this? What do about this? Or you're not ready to make any decisions, you don't even want to talk about it today.

Fine, let's just leave it in the same. And I think the kids need that space to, to know that A, they're in charge. Uh, B, I'm a little bit pushing them to think about it, like, by asking them, and, and C, you know, they have permission to go backwards, stay where they are, go forwards to, to whatever degree, and, um, and I think that, uh, I think that the kids, um, I think there are kids who are a little bit timid at the beginning, and they don't feel, they can, I, I feel that there is a group of kids who say they're non binary because they're not, Really ready to go full on.

And as they go, they actually find, no, this is working for me. I'm, I really actually do want to go to the, to the end of the binary there. But, um, I think, I think you just got to let kids have that, that permission to do that.

## Clip 30

**Ren Massey:** I'll just add in that, uh, this actually reminds me of a successful 30 something I have, um, you know, who's, uh, very accomplished in their field and is, uh, was first aware in the last few years really more about their gender identity and, um, thinking, you know, they were identifying as a woman. Uh, and when the first came really more open to their awareness about six months ago.

Um, took him a couple months to call me, then a couple months on my waiting list. And I've been seeing the person, I don't know, a couple months now. And They were hesitant to acknowledge maybe a non binary space might be good, maybe a fluid space might be good. And it's hard to tell how much feels true to their gender versus how much is external factors, and that's kind of stuff we're sorting through with time.

Um, and I think they're feeling some relief to know that there are a range of medical options, and we're not, The, the fortunate thing is this person is not in a rush rush and has some ways of being able to express, um, their feminine side, uh, with their significant other and friends and, and one of their family members, uh, from their family of origin.

But, um, I, I, my main point is in adults as well as young people. I mean, mature, more mature adults, like 30 somethings.

All right, so if we don't have any other comments on this one, actually, I would really like it if we could get to the next case and then we could close up.

## Clip 31

**Dianne Berg:** I'm just noticing that Jameson is telling us that we should talk, look more at the chat. Jameson, is there a particular thing?

Jason: I was just wanted to draw your attention to the Q& A box as well as the chat. There are questions in the Q& A stream as well as in the chat. So just, just to make sure that.

**Dianne Berg:** Thank you. I didn't even know about that.

Jason: Yep. Yep. I've answered a few, but, um, the clinical ones I can't.

**Dianne Berg:** Okay. While we look at the q amp a there's a couple coming up in the chat just about that embodiment discussion. Yes. It's, it's a, it's a growing edge for me. And so I certainly don't want to. To misspeak, but my understanding and what I'm trying to kind of incorporate in my clinical practice is in some ways moving away from, um, what is your identity and therefore because you have this identity, you're going to want to do these particular medical interventions to change your body, not having it be as identity driven, because I think that's been the historical basis of kind of how things have operated.

And instead, regardless of your identity, What, what do you think about your body and what do you want your body to be able to be and how do you feel in your body and, and what's going to help your, your, you feel better about being in your body and how do we address some of that? Um, regardless of what your identity is, and that might mean medical, that might mean lifting weights, that might mean eating better, I mean, there's a whole range, but it just kind of goes shifting your thinking from identity driven interventions to more, um, for some people, more body driven interventions.

It is kind of my, is what I would try to say about that.

## Clip 32

**Ren Massey:** Kind of related to that, Dianne, there are some questions about co occurring diagnoses or considerations in the Q& A section, and I would just say it's hard to do it justice in a little bit of time here, but, you know, when there are co occurring conditions of any type, I am more cautious and take a slower approach in terms of.

Um, questions to in considering both identity and embodiment. Um, and, you know, may ask people and encourage people to look at things from all of those kinds of perspectives. Um, and maybe try to get creative in asking them to. You know, just as an example, who is somebody who you'd like to look like who, um, not somebody who's a TV star who's super attractive, but just like kind of an average looking person, you know, um, so that we're not engaging in a fantasy realm of transition expectations with like facial hair, no facial hair, chest of wet socks, flat, brown, small, wet.

And, um, sometimes those discussions. are very helpful, especially with folks who may struggle with the identity piece. Um, and, uh, I think that also just we have to be careful when we recognize there are folks who may have things that make understanding identity uh, more fluid or complex or more challenging.

So I just Take a lot more caution. That's what I would say.

Alright, um, I'm going to try to get us to that very last one.

## Clip 33

**Dianne Berg:** Not wanting to take up more space, but since other people aren't jumping in, I think it just speaks to the importance of the intersection between sexuality and gender and how, um, I think that the field of gender, it feels like the fields are very separate as someone who's in both of ASAC certified person.

I'm, you know, I go to a lot of the sexuality conferences that are starting to care more about gender and I think in the gender conferences. There's there's very little focus on actually sexuality and so I think for me this case just Exemplifies a way that they intersect and I think there's lots of ways that they intersect and I know that WPATH is gonna do a specialty thing on sexual pleasure which I think is awesome and And so I think just for me, I want to, I just want to point out that that, that intersection, we don't, we don't often do a good job with that.

And I think that's someplace that we could, that we could be doing better.

**Dan Metzger:** You know, I totally agree. And I'm sure putting a kid on a blocker at age nine, and then letting them get to the age of whatever, when they're developing a sexual identity, can that be. Uh, cannot be great, right? So I think I think that the other people brought this up that we are to a degree robbing these kids of that sort of early to mid pubertal sexual stuff that's happening with their with their cisgender peers.

That's not happening because we've got the one loop running and their you know, their brains are just not thinking that way. There's no, you know, they're getting older and smarter about, you know, math, but they're not learning how their body works. They're learning how to masturbate because they don't, because they don't have the urge to do that, right?

And all of a sudden they're, you know, they're, they're way many years behind their peers trying to like figure their sex stuff out.



## Clip 34

**Ren Massey:** Yeah, I'll, uh, add somebody asked when that sexual health workshops going to be, um, we're in the process of developing a number of new workshops this year. Um, as we're updating the foundations curriculum for Montreal, where we'll present the SOC eight, um, based, uh, foundations course for the first time.

Uh, in the meantime, we have a number of. Uh, workshops this summer, including the one Dianne referred to on sexual health, and I believe it's going to be July 29th. Um, I'm pretty sure that's the date we got lined up in, uh, I'm trying to remember. I think it's like eight to 11 Pacific time, 8:00 AM to 11 Pacific time.

But, um, I'm, I'm not gonna bet my life on that. Um, but um, we also have. Some other comments about sexuality and neuroticism, not neuroticism, eroticism. Um, and, uh, you know, I think that that is some of the complexity of gender and sexuality. Both. being processes of discovery and evolution, um, for a lot of, you know, tweenagers and teenagers.

And, uh, so it's not surprising sometimes that they need some help discerning those things. Looks like you wanted to say something, Dianne.

**Dianne Berg:** Well, I think for adults, historically, if, if people with some sort of gender. Identity have, have, have mentioned anything about their sexuality, it, um, or if they there's always been, at least I have had many clients tell me, I did not tell you the truth about, about a lot of things about my sexuality, because I figured if I told you that.

You would gatekeep and assume it was a fetish or assume it was, um, you know, some of the terms that we no longer are using. And so I think there is a huge historical context. To to sexuality being seen as a being seen in a way that does act that does create barriers access to access to care, and I just want I think it's very important that we acknowledge that historical context, um, and that we work against that historical context, um, by talking more about positive sexuality and pleasure and that that they can go together and that it's okay.

Um, and not create barriers to care because people have that belief that that's what we're going to do.

## Clip 35

**Jamison Green:** Yes, and gender and sex are two different things, but gender informs your sexuality tremendously. And, uh, no matter who you are, trans people, cis people, male, female, non binary, all those things are really informative to each other. And when you deny any aspect of it, you are limiting yourself. Uh, to a certain extent, you're, you're cutting off parts of yourself if you pretend it doesn't exist.

And clinically, we've been told, trans people have been told historically, Oh no, don't talk about that. So, it's really, really something that our professions need to combat. Thank you, Dianne. That's good.

**Ren Massey:** All right, so I'm going to end with a question. I'm going to stop my screen share here, and I'm going to bring this up to my panelists really quickly.

If anybody has any closing thoughts, one question that we didn't get to was steps to support folks who have regret or interventions. I think it's such a new area. We don't have data on it. to my knowledge, but it looks like a lot of folks are looking for support and I would say we need to normalize their exploration just as we would normalize people considering transitioning to a gender different than what they were assigned at birth and to get them supports to do that.

Um, and again, try not to other, other people in the process, not to marginalize or. Put down other people. If other folks have a quick comment.

All right, that that's to be continued in our ongoing growth in the field. I want to thank all of the attendees. Uh, I appreciate the great input, the questions, the comments, the exchange, the thought provoking, um, dialogue among all of us. I want to thank the production staff, Mike Evans and Cheryl Field.

Y'all are awesome. And our WPATH staff as well, Tricia, Kat, Rebecca. Wayne and Jamie. Uh, I see Tricia, Kat, and Rebecca doing the heavy lifting today. And then I thank all of my colleagues for being here and the thought you put in in advance and for taking part in this conversation to try to advance health care for our trans and gender questioning clients.

Thank you.