Transgender Adolescent Patients Medical Care

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DISCLOSURES

None

Objectives

- Differentiate assigned sex at birth, gender identity and expression, and sexual orientation.
- Provide initial management strategies for appropriate and competent care to gender-nonconforming patients.

PRH

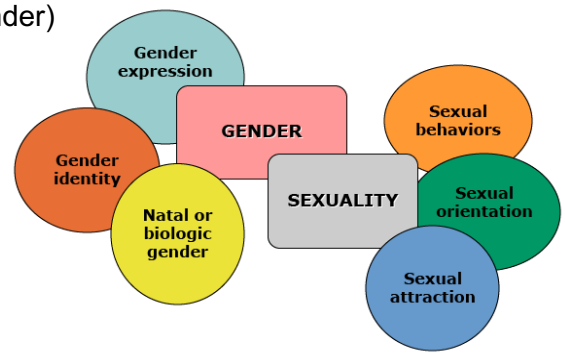
ARSHEP 3

Defining Gender

Assigned sex at birth: Sex assigned at birth; body parts, hormones, biology.

Gender Identity: The understanding of one's self (Female, male, transgender, gender non-conforming, genderqueer, non-binary, gender fluid, cisgender)

Gender Expression: Ways in which a person acts, presents self, and communicates gender within a given culture



Citation: Olson, Forcier

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ARSHEP 4

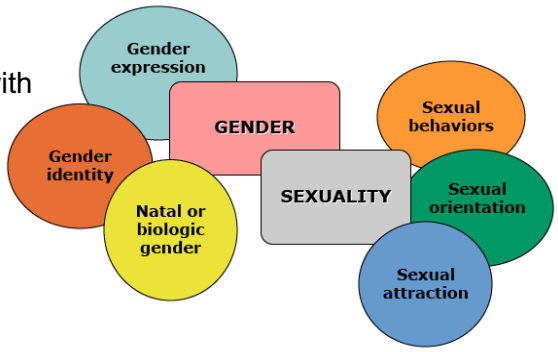
Defining Sexuality

Sexual Orientation/Identity:
Sexual concept of one's self based on feelings, attractions, and desires;

LGBTQ:
Lesbian, Gay, Bisexual, Transgender, Questioning/Queer; Pansexual/Asexual

Sexual Behaviors:
Young Men who have Sex with Men (YMSM)Young Women who have sex with Women (YWSW)

Citation: Olson, Forcier



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Awareness of Gender Identity

Between ages 1 and 2
Conscious of physical differences between sexes

At 3 years old
Can label themselves as a girl or boy

By age 4
Gender identity stable
Recognize gender constant

PRH ARSHEP 6

Pathology Based

DIAGNOSIS of GENDER DYSPHORIA

- Marked difference between expressed/experienced gender and gender others would assign.
- Must continue for at least six months.
- Causes clinically significant distress or impairment in social, occupational, or other important areas of function.
- In children, the desire to be of the other gender must be present and verbalized.
- DSM V Criteria must be met.

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ARSHEP 7

Developmental Perspective

GENDER DIVERSITY

- Gender is universal, normal
- Variance is expected aspect of biology & human development
- Diversity is not deviance
- Improve care
- Impact minority stress
- Advocate for another form reproductive justice
- Advocate, empower vulnerable populations

Patient-centered developmental care—Allows flexibility and clinical judgment

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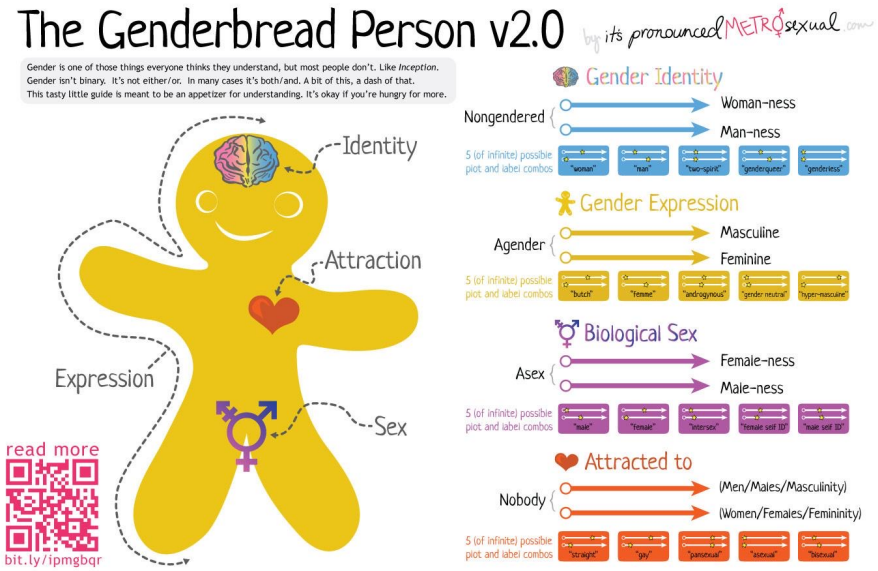
ARSHEP 8

Gender Screening



Phases of Transitioning

Reversible	• clothes, hair, shoes, toys, GnRH analogues
Partially Reversible	• masculinizing and feminizing hormone therapy
Irreversible	• Surgical interventions

GnRH Analogues

- Continuous GnRH secretion
  - Suppress FSH, LH pulses
  - Initial ↑ LH, FSH followed by desensitized pituitary
  - LH, FSH secretion suppressed
- Leuprolide, Triptorelin IM
  - 1,3 and 4 monthly depot preparations
  - 6-month preparation
- Histrelin implant
  - 12 months officially, but can last 24 - 36 month

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ARSHEP 11

Phases of Transitioning

Reversible	• clothes, hair, shoes, toys, GnRH analogues
Partially Reversible	• masculinizing and feminizing hormone therapy
Irreversible	• Surgical interventions

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ARSHEP 12

Pre-Transition Evaluation

Discuss hormones
- Risk, benefits
- Expectations of Hormones/ Surgical goals
- Future **fertility** effects
- The unknown future

Embodiment goals

Testosterone Regiments

- T. Cypionate/ enanthate IM
  - 100-200mg q 2 weeks
  - 50-100mg q week
- Topical Gel
  - 50-100 mg daily
- Patch (not currently available)
  - 2.5-7.5mg daily

Effect	Onset (months)	Maximum (years)
skin/ acne	1 to 6	1 to 2
facial/ body hair	6 to 12	4 to 5
scalp hair loss	6 to 12	
increased muscle mass	6 to 12	2 to 5
fat redistribution	1 to 6	2 to 5
cessation of menses	2 to 6	
clitoral enlargement	3 to 6	1 to 2
vaginal atrophy	3 to 6	1 to 2
deepening of voice	6 to 12	1 to 2

Risks of Masculinizing Hormones

Common

- Initial mood changes, resolved by 3-4 months
- Initial weight gain, re-stabilize after 3-4 months
- Acne
- Male pattern baldness
- Pelvic pain
- Increase in Hgb, Hct

Uncommon

- Liver dysfunction
- TG ↑ HDL ↓ LDL ↑
- Insulin resistance
- Polycythemia

Studies over time indicate that hormones have minimal clinically significant physiologic affects & suggest we can do less labs in future

Lab Follow-Up for Masculinizing Hormone Therapy

- How often
  - Q 3 months initially
  - Then every 6 mo - annual
  - Test according to need
- Testosterone levels
  - Average physiologic levels
  - Goal 400-700 ng/dl
  - Mid-dose levels
- CBC
- CMP
- Lipids

Goals

Dosing & labs by

- Generate desired effects
- Avoid side effects
- Average natal levels

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Management of Side Effects of Masculinizing Hormones

- Finasteride to treat pattern baldness
- Estrogen vaginal cream for atrophy
  - Minimal systemic effects.
  - Psychological factors
- Retinoids, benzoyl peroxide, doxycycline for acne
- Low dose oral minoxidil for sparse hair production?
- Supplemental meds for menstruation suppression?

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ARSHEP 18

Amenorrhea

- A common goal of testosterone therapy
- Often achieved in 6-8 months of consistent therapy
  - 85-100% at 1 year of therapy
- 25% with breakthrough bleeding
  - The longer on T, the more likely to have breakthrough
  - Lack of data on breakthrough patterns
  - Often appear to be idiopathic
- Lack of data on long term maintenance

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Health Care Maintenance for FTMs

- Emotional well-being
- STI testing
  - Consider, don't assume
  - HIV testing
  - Profile may or not mimic WSW profile
- Contraception
- Fertility concerns
- Breast cancer screening
  - Instructions in self breast exam
  - Mammography if breasts accord to cis guidelines
  - Consider use of US
- Pap cancer screening
  - Note FTM on testosterone
  - Atrophy looks like dysplasia

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ARSHEP 20

Contraception

- Transmasculine patients have a pregnancy risk
  - Testosterone not fail-safe contraceptive
  - May continue to ovulate while on testosterone
  - Testosterone may adversely affect development of fetus
  - Consider Nexplanon, progesterone IUD, DMPA, other
  - Avoid assumption—do Family Planning exploration
- 16-31% trans men believe T is contraception
- Frequently not discussed
  - Only 1/3 of clinicians were comfortable discuss
  - Only 70% of OB residencies have formal training.

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ARSHEP 21

Estrogens

- Oral estradiol
  - 2-6mg daily
- Transdermal estradiol
  - 0.1-0.4mg twice weekly
- E. valerate or cypionate
  - 5-20mg IM q 2 weeks
  - 2-10mg IM q weekly

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Effect	Onset (months)	Maximum (years)
redistribution of body fat	3 to 6	2 to 3
decresed muscle mass	3 to 6	1 to 2
softening of skin	3 to 6	unknown
decreased libido	1 to 3	3 to 6
decreased spontaneous erections	1 to 3	3 to 6
breast growth	3 to 6	2 to 3
decreased testicular volume	3 to 6	2 to 3
decreased sperm production	unknown	>3
decreased terminal hair growth	6 to 12	>3

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Estrogen Side Effects

CVA/ MI/ DVT/ PE
Depression
Gall bladder disease
Headaches
Hepatitis
Hyperlipidemia
Loss of libido/ ED
Mood change
Pituitary adenoma (Prolactin > 80)
Sterilization

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VTE

Higher risk with conjugated estrogens (e.g. Premarin)

Safer to use 17-beta Estradiol

Zero to 2.5 increased risk

Transdermal estrogen seems the lowest risk

no increased risk

Weak evidence that sublingual administration is better

Background risk 1.3 per 100,000 in healthy persons

with estrogen about 3 per 100,000

with migraine about 28 per 100,000

Lab Follow-Up for Feminizing Hormone Therapy

- How often
  - Q 3 months initially
  - Then every 6 mo - annual
  - Test according to need
- Testosterone levels
  - Goal <55 ng/dl
- Estrogen level (mid dose)
  - Goal 100-200 ng/dl
- CBC
- CMP
- Lipids
- Prolactin annually

Goals

Dosing & labs by

- Generate desired effects
- Avoid side effects
- Average natal levels

Anti-Androgens

Spironolactone
100-200mg daily

GnRH Agonist (e.g Leuprolide acetate)
variety of regiments as noted previously.

Finasteride and Dutasteride (5-Alpha reductase inhibitors)

1-5mg daily for Finasteride

0.5 mg daily of Dutasteride

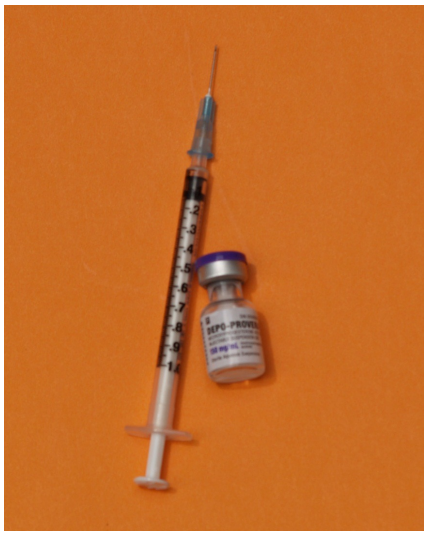
Bicalutamide

50mg PO daily

May have a role as an alternative to GnRH agonists

Progesterone

- No good data in transgender women
- Women's Health Initiative concerns
- No direct evidence that it is harmful in trans women



SERM

- Selective Estrogen Receptor Modulators
  - Raloxifene 60mg daily
  - Tamoxifen 20mg daily
- Binds to estrogen receptors
- Used on osteoporosis and breast CA prevention
- Not studied for use in amenorrhea induction
- No studies for use in gender care, but a theoretical use for those seeking an “androgynous” appearance in AMAB.
- No pediatric dosing

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ARSHEP

Thank You!

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QUESTIONS?

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Mental Health Evaluation Support for Gender Diverse Youth

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June 13, 2024

Purpose and Objectives

PURPOSE *Provide overview of mental health assessment tools for gender diverse youth*

OBJECTIVES

- Define mental health issues that impact gender diverse youth
- Provide tools to assess and evaluate mental health of gender diverse adolescent patients
- Offer supports for gender diverse youth experiencing mental health issues

FINANCIAL DISCLOSURE *None*

Presentation Overview

- Overview of mental health for LGBTQ+ and gender diverse youth
- Stressors impacting mental health of TGNB/gender diverse youth
- Mental health screening assessment tools
- Supportive models of care and therapeutic approaches

6/9/24

Mental Health Statistics

According to the most recent Trevor Project National Survey:

- 39% of LGBTQ+ young people seriously considered attempting suicide in the past year.
  - This includes 46% of transgender and nonbinary young people.

2024 U.S. National Survey on the Mental Health of LGBTQ+ Young People. The Trevor Project. c

Breaking it down: What are the factors playing a part in this?

1. Respect and Recognition of Gender Identity
2. Access to developmentally appropriate GAHT/medical care
3. Family and social support

Respect for Gender Identity – Power of Pronouns

6

PHYSICIANS FOR REPRODUCTIVE HEALTH

2014

Access to developmentally appropriate GAHT & medical care

Having access to hormones and puberty blockers for youth ages 13 to 20 was associated with:

- **60% lower odds** of moderate to severe depression
- **73% lower odds** of self-harm or suicidal thoughts

compared to youth who did not receive these medications over a 12-month period.

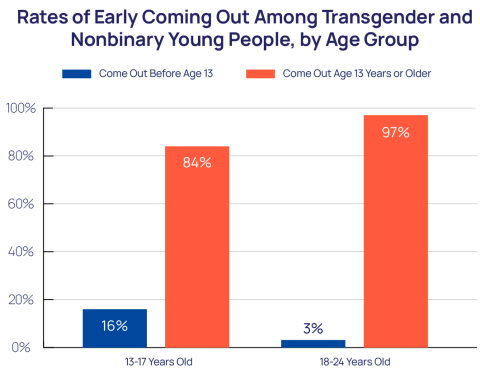
Tordoff et al. Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care. JAMA Netw Open. 2022.

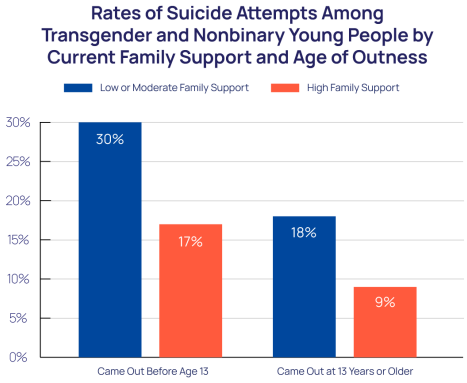
Access to developmentally appropriate GAHT & medical care

Pubertal suppression is associated with decreased behavioral and emotional problems as well as decreased depressive symptoms (de Vries et a., 2011). Prior to pubertal suppression, 44% of youth experienced clinically significant behavioral problems; however, after an average of two years of pubertal suppression only 22% experienced them.

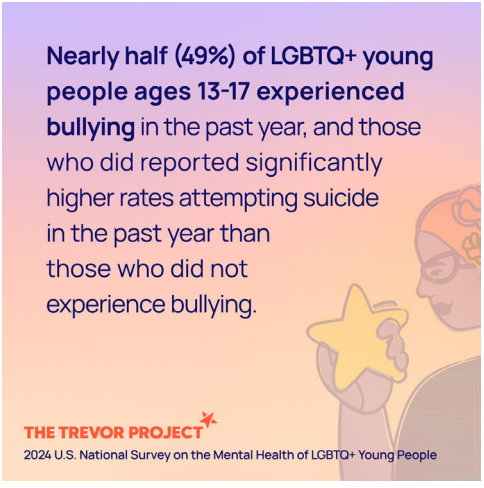
Research on GAHT for youth demonstrates positive effects on body image and overall psychological well-being as well as reduced suicidality. one study of transgender youth demonstrating that after approximately 1 year of treatment the average level of suicidality was 1/4th what it was before treatment (Allen et al., 2019).

Family and Social Support:
Coming Out





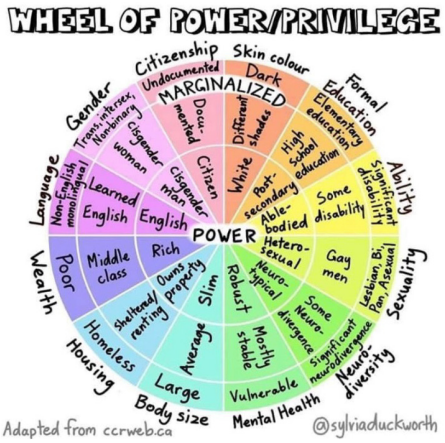
Family and Social Support:
Schools & Peers



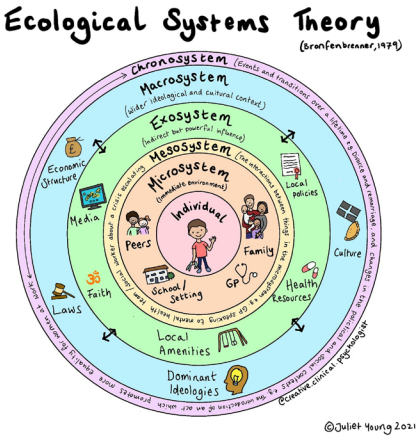
Family and Social Support: Intersectionality

TGNB identities are:

- Diverse
- Impacted by power and privilege and access
- Impacted by race, ethnicity, migration
- Impacted by intergenerational trauma and violence
- Resilient



Family and Social Support: Institutions and Systems



Frameworks:

- Minority Stress
- Ecological Systems Theory

90% LGBTQ Youth report their wellbeing being negatively impacted by the current anti-LGBTQ laws

Social transition & Mental Health

The evidence for social transition builds upon what is already known regarding positive family and social support; that is, family acceptance of LGBTQ youth is associated with positive mental health (Ryan et al., 2010), whereas higher rates of family rejection are associated with the opposite. For example, young adults from highly accepting families attempt suicide at significantly reduced rates compared to those in low accepting families (31% versus 57%) (Ryan et al., 2009). TGNB children who have socially transitioned demonstrate comparable levels of self-worth and depression as non-TGNB children. This has been demonstrated in research that asks parents to report on their child's mental health (Olson et al., 2016) as well as asking the youth themselves (Durwood et al., 2017). Although TGNB youth who have socially transitioned report slightly higher levels of anxiety compared to non-TGNB peers (Durwood, et al., 2016; Olson et al., 2016) the fact that self-worth and depression outcomes are equal is powerful due to the significantly worse mental health outcomes experienced by non-supported TGNB youth. Further, research has specifically shown lower suicidal ideation and suicidal behavior when a TGNB youth's chosen name is consistently used.

Social Transition & Mental Health Starts Early

According to the WPATH Standards of Care 8:

- The only form of gender-affirming care for children before puberty is ***social support***, such as allowing a child to choose clothing, hairstyles, use of a different name that more closely aligns with their gender identity.
- Social support, sometimes called social transition, can help children understand and explore their gender as they grow up and is endorsed by major medical 5 associations.
- Research indicates that children have an understanding of their gender, and their gender in relation to others, beginning as young as 18 months.
- Children benefit from a holistic approach to their well-being, through which providers and parents and/or caregivers take both physical and mental health care into account.

Providing Mental Health Assessments to TGNB/Gender Diverse Youth

Screenings must be:

- Developmentally appropriate
- Culturally competent
- Strengths-Based

Formats:

Self-Administered

Clinician-Administered

Overall Mental Health Screenings for Adolescents

Assessments around gender identity and stressors related to identity development and transitioning

6/9/24

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Psychosocial Assessments

Example: HEEADSSSS

H: **Home** → **homelessness, abuse, lack of acceptance**
E: **Education/Employment** → **absenteeism, drop-outs, discrimination**
E: **Exercise/Eating** → **disordered eating behaviors**
A: **Activities**
D: **Drugs** → **problematic substance use/abuse**
S: **Suicidality/Depression**
S: **Sexuality** → **gender dysphoria, coming out concerns, sexual behaviors**
S: **Safety** → **victimization, IPV**
S: **Strengths**

Mental Health Screening Assessment Tools

- Suicidal ideation
- Depression and anxiety screenings (PHQ2/PHQ9)
- Substance use (S2BI, CRAFFT, BSTAD)
- Circles of support
- Resilience and protective factors

Screening and Assessment Tools Chart | National Institute on Drug Abuse (NIDA) (nih.gov)

Mental Health Screening Assessment Tools

Example: Child Behavior Checklist

The Child Behavior Checklist (CBCL) is a component of the Achenbach System of Empirically Based Assessment (ASEBA). The ASEBA is used to detect behavioral and emotional problems in children and adolescents. The CBCL is completed by parents. The other two components are the Teacher's Report Form (TRF) (completed by teachers), and the Youth Self-Report (YSR) (completed by the child or adolescent himself or herself).

The 2001 revision of the CBCL, the CBCL/6-18 (used with children 6 to 18), is made up of eight syndrome scales (internalized and externalized):
• anxious/depressed • depressed • somatic complaints • social problems
• thought problems • attention problems • rule-breaking behavior
• aggressive behavior

schoolagecbcl.pdf (livelight.org)

Assessments around gender identity and stressors related to identity development and transitioning

Gender Exploration & Assessment Questions for Children, Youth, and Families (Compiled by Antonia Barba, LCSW)

- Family assessment in some stages also inform process
- Different questions based on age of child/youth and for parents/caregivers

Assessment Topics:

- Name
- Pronoun(s)
- Asking and talking about gender identity
- History of gender identity
- Experiences in their body
- Goals related to gender expression

Assessments around gender identity and stressors related to identity development and transitioning

TGD Child Patient in Primary Care: Practical Advice for a 10-minute Consultation

History of gender identity concerns

Social History

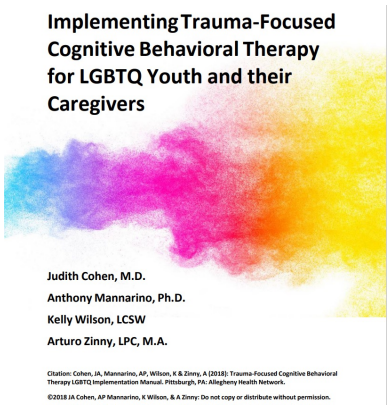
Screen for Depression and Self-Harming or Suicidal Thoughts

Is the school supportive?

Any symptoms and signs of puberty?

From Assessment to Treatment
Therapeutic Approaches

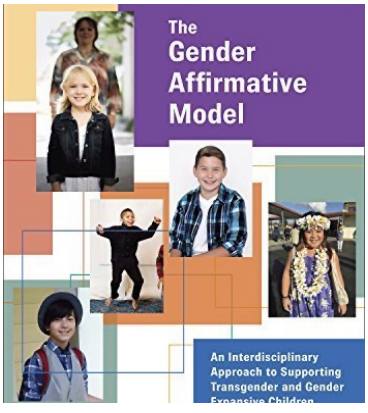
- **CBT**
- **EMDR**
- **DBT**
- **Liberation-Based Therapy**
- **Family Functional Therapy**



The Gender Affirmative Model

Individual treatment for the child is indicated for one of five reasons:

1. Assess a child's gender status;
2. Afford the child a "room of their own" to explore their gender;
3. Identify and attend to any co-occurring psychological issues;
4. Address and ameliorate a child's gender stress or distress;
5. Provide sustenance in the face of a nonaccepting or rejecting social milieu, which might include family, school, religious institution, or community.



The Gender Affirmative Model

Therapeutic goals in the gender affirmative model include:

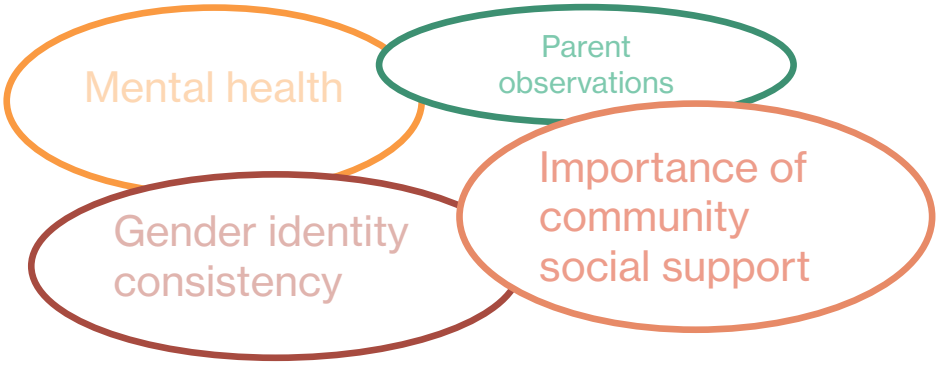
- Facilitating an authentic gender self
- Alleviating gender stress or distress
- Building gender resilience
- Securing social supports

"In this model, gender health is defined as a child's opportunity to live in the gender that feels most real or comfortable to that child and to express that gender with freedom from restriction, aspersion, or rejection. Children not allowed these freedoms by agents within their developmental systems (e.g., family, peers, school) are at later risk for developing a downward cascade of psychosocial adversities including depressive symptoms, low life satisfaction, self-harm, isolation, homelessness, incarceration, posttraumatic stress, and suicide ideation and attempts"

D'Augelli, Grossman, & Starks, 2006; Garofalo, Deleon, Osmer, Doll, & Harper, 2006; Roberts, Rosario, Corliss, Koenen, & Bryn Austin, 2012; Skidmore, Linsenmeier, & Bailey, 2006; Toomey, Ryan, Díaz, Card, & Russell, 2010; Travers et al., 2012

Studies prove positive outcomes for youth with support

TransYouth Project
(Kristine Olson, Princeton)



https://www.hrc.org/resources/2018-lgbtq-youth-report

Summary

- ✓ Understand how society, culture, and family impact mental health outcomes of TGNB and gender diverse youth.
- ✓ Obtain mental health and gender identity assessment tools, and therapeutic models.

Remember to listen to youth! They are the experts of their own lives!

References

- The child transgender patient in primary care: practical advice for a 10-minute consultation (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6181097/)
- Identifying the Intersection of Trauma and Sexual Orientation and Gender Identity: Part 2: Key Considerations, NCTSN (https://www.nctsn.org/resources/identifying-the-intersection-of-trauma-and-sexual-orientation-and-gender-identity-the-screener)
- Affirming gender: Caring for gender-atypical children and adolescents (https://gender-spectrum.cdn.prismic.io/gender-spectrum/1ff82f5f-d2a6-4711-ba14-1d3c0ef759ea_Gender+Affirmative+Medical+Care+Packet-compressed.pdf)
- Establishing Trust with Youth Seeking Gender Affirmative Medical Care (https://genderspectrum.org/articles/medical-establishing-trust)
- Darlene Tando, LCSW Gender Worksheet (https://darlenetandogenderblog.files.wordpress.com/2017/08/newworksheet2019.pdf
- Family Acceptance Project Youth and Family Questionnaires, Appendix 3 in Cohen, JA, Mannarino, AP, Wilson, K & Zinny, A (2018): Trauma-Focused Cognitive Behavioral Therapy LGBTQ Implementation Manual. Pittsburgh, PA: Allegheny Health Network.

Transgend Health. February 2022; 7(1): 7–29.

Published online 2022 Feb 14. doi: 10.1089/trgh.2020.0165

Family-Based Interventions with Transgender and Gender Expansive Youth: Systematic Review and Best Practice Recommendations

Jean Malpas, [1,2,*] Michael J. Pellicane, [1,3] and Elizabeth Glaeser [1,4]

Gender-Affirming-Care-January-2020.pdf (thetrevorproject.org) The Trevor Project Research Brief: Gender-Affirming Care for Youth January 2020

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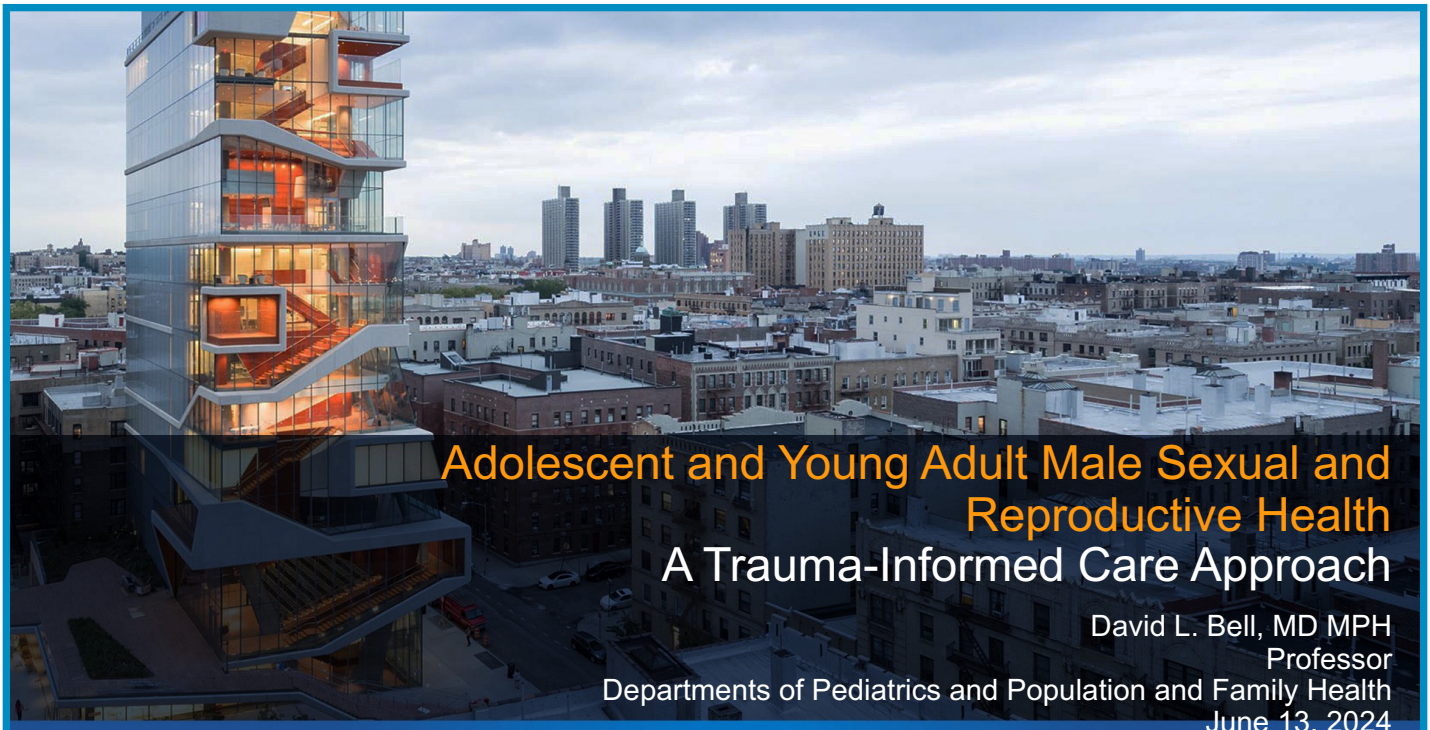

Adolescent and Young Adult Male Sexual and Reproductive Health

A Trauma-Informed Care Approach

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Professor
Departments of Pediatrics and Population and Family Health
June 13, 2024

COLUMBIA | NewYork-Presbyterian

Objectives

Participants will be able to

- List at least three unique risk factors associated with AYA males in the context of sexual and reproductive health.
- Understand and Implement the CUES Model (Confidentiality, Universal education, Empowerment, and Support)
- Discuss cases in reference to Principles of Trauma-Informed Care

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AYA Males and SRH: Unique Risk factors

- Limited Access to Information
- Societal and Peer Pressure
- Mental Health Stigma and Communication Barriers

The CUES Model

C - Confidentiality

U - Universal Education

E - Empowerment

S - Support.

Six Principles of Trauma-Informed Care

1. Safety
2. Trustworthiness and Transparency
3. Peer Support
4. Collaboration and Mutuality
5. Empowerment, Voice, and Choice.
6. Cultural, Historical, and Gender Issues

Reflection

- Reflect on your clinical and educational environment. Does it consistently adhere to the principles of Trauma-Informed Care?

- Have you had opportunities to apply Trauma-Informed Care practices with adolescent and young adult males?"

Six Principles of Trauma-Informed Care

1. **Safety**
2. Trustworthiness and Transparency
3. Peer Support
4. Collaboration and Mutuality
5. Empowerment, Voice, and Choice.
6. Cultural, Historical, and Gender Issues

Case 1

19-year-old male had a rectal complaint. Patient was interviewed. During the physical exam with four observers – residents and students, the senior clinician asked the patient to turn around and bend over so that all could visually "examine" him.

Reflection

Safety: Ensuring both physical and emotional safety for patients. This involves creating a care environment that makes patients feel secure, respected, and comfortable. For sexual and reproductive health, this means privacy during examinations and sensitive, non-judgmental communication.

Turn to your neighbor and discuss briefly:

Did this scenario support or negate the Safety Principle? Please explain.

Case 2

A second opinion was asked for a 17-year-old male who had a testicular exam finding. The senior clinician asked permission from the patient to be in the room with the consultant and a student. The patient agreed. The senior clinician leaned across the exam table with their chin resting on their hand observing the exam.

Reflection

Safety: Ensuring both physical and emotional safety for patients. This involves creating a care environment that makes patients feel secure, respected, and comfortable. For sexual and reproductive health, this means privacy during examinations and sensitive, non-judgmental communication.

Turn to your neighbor and discuss briefly:

Did this scenario support or negate the Safety Principle? Please explain.

Six Principles of Trauma-Informed Care

1. Safety
2. **Trustworthiness and Transparency**
3. Peer Support
4. Collaboration and Mutuality
5. Empowerment, Voice, and Choice.
6. Cultural, Historical, and Gender Issues

Case 3

An 18-year-old male is refusing to have a genital exam.

Reflection:

What has been your approach in the past?

White Board Activity:

Reflection:

What are the possible concerns he might have?

White Board Activity:

A Suggested Approach

- Ask his concerns, if he can verbalize them.
  - Don't assume that he feels comfortable telling you any or all of his concerns.
- Explain what are the components of the exam.
  - Explain what you will do and why?
  - How long it will take?
  - Acknowledge that many guys feel awkward at first about the exam.
  - Ask him is there anything that would make him a bit more comfortable?

Six Principles of Trauma-Informed Care

1. Safety
2. Trustworthiness and Transparency
3. **Peer Support**
4. Collaboration and Mutuality
5. Empowerment, Voice, and Choice.
6. Cultural, Historical, and Gender Issues

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Case 4

17-year-old male, at an initial medical visit, is visibly anxious about being in the office. He discloses that he fears he has an STI?

Reflection:

- From the patient's perspective what might be making him anxious?
- What are assumptions that come up for you?
- Reflect on how you or a colleague might handle this concern.
- How would you start that communication with this patient?

My perspective

Getting STIs or using condoms is not a moral issue, it is a public health issue.

Persons with penises are a part of the equation.

Our public health has accepted guidelines for routine STI testing, but it is only focused on females and MSMs.

As a system, we fail communities by not trying to eradicate curable STIs which should include more robust guidelines for testing all persons with penises without judgement.

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5. **Empowerment, Voice, and Choice.**
6. **Cultural, Historical, and Gender Issues**

Case 5

21-year-old male who has been in and out of the justice system presents for a genital exam. Your institution has a 'no-opt out' policy for chaperones.

Body autonomy

- Self-determination
- Informed Consent
- Privacy
- Respect for Bodily Integrity
- Freedom from Discrimination
- Agency and Voice

Reflection:

- How does a “no-opt-out” policy potentially add to this person’s trauma?
- If this was a Black male, what additional components of historical trauma might surface?

Closing Thoughts

- **Unique Risks for SRH for AYA males**
- **The CUES Model**
  (Confidentiality, Universal education, Empowerment, and Support)
- **Trauma-Informed Care**
  (Safety; Trustworthiness and Transparency; Peer Support; Collaboration and Mutuality; Empowerment, Voice, and Choice; Cultural, Historical, and Gender Issues)

References

1. Adolescent health: boys matter too. Lancet. 2015;386(10010):2227. doi:10.1016/S0140-6736(15)01160-5

2. Miller E. Trauma-Informed Approaches to Adolescent Relationship Abuse and Sexual Violence Prevention. Pediatr Ann. 2019;48(7):274-279. doi:https://doi.org/10.3928/19382359-20190617-01

3. Mengjia Liang, Sandile Simelane, Guillem Fortuny Fillo, Satvika Chalasani, Katherine Weny, Pablo Salazar Canelos, Lorna Jenkins, Ann-Beth Moller, Venkatraman Chandra-Mouli, Lale Say, Kristien Michielsen, Danielle Marie Claire Engel, Rachel Snow, The State of Adolescent Sexual and Reproductive Health, Journal of Adolescent Health, Volume 65, Issue 6, Supplement,
2019, Pages S3-S15,

References

4.Frydman, Ruth. "6 key principles of a trauma-informed approach." *Cent Integr Heal Solut Trauma* (2020)

5. The ABC's of Bodily Autonomy, June 2023 by the Youth Coalition for Sexual and Reproductive Rights; https://www.unfpa.org/sites/default/files/resource-pdf/ABCofBodilyAutonomyPwDs.pdf; accessed May 24, 2024

Question 1

Compared to adolescent girls, adolescent boys have less risk or different risks related to SRH?

A.) Less Risk related to SRH
B.) Different Risks related to SRH
C.) The same risks
D.) No risks

Question 2

Establishing your office /clinic space as 'safe space' supports and encourage disclosure which is one of our clinical goals. (T/F)

Question 3

Which chaperone policies afford the best patient autonomy regarding their SRH choices and the body autonomy?

A.) No opt-out policies
B.) Opt-out policies
C.) Opt-in policies