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Blue Cross and Blue Shield of Kansas *Provider Workshop*

Today's Presenters *a little about us*



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Part I

Caring for Transgender Youth: A Mental Health Perspective

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Overview

Today's *conversation*

AGENDA

Review terminology related to gender affirming care, current prevalence and demographic trends

Identify common comorbid mental health conditions and understand the SDOH impacting transgender youth

Enhance understanding of current clinical guidelines for the assessment & treatment of transgender youth

Examine the ethical considerations surrounding medical interventions for transgender youth

Increase awareness of recent federal guidance and state-level restrictions impacting access to GAC

WHAT WE'LL DISCUSS

GAC: transgender youth



Key definitions

Sex assigned at birth

- ◆ Based on genitalia observed at birth
- ◆ Recorded as M or F on birth certificate

Gender identity

- ◆ A person's inner sense of self: of being a male or female
- ◆ Can be binary or nonbinary

Gender expression

- ◆ How a person externally communicates their gender through clothing, mannerisms and behavior
- ◆ Distinct from gender identity
- ◆ Influenced by society and cultural norms

Sexual orientation

- ◆ Describes emotional, romantic, or sexual attraction to other
- ◆ Includes identities such as heterosexual, gay, lesbian, bisexual, queer

Understanding Gender Identity: Clinical Terminology

Transgender (trans)	Gender dysphoria DSM-5-TR	Gender incongruence ICD-11	Gender affirming care WHO
A person whose sex assigned at birth does not align with their gender identity (how they see themselves)	A marked and persistence incongruence, between an individual's experienced gender and the assigned sex Emphasis on related distress and impaired functioning	A marked and persistence incongruence, between an individual's experienced gender and the assigned sex Uses terms such as strong dislike or discomfort instead of distress	GAC includes medical, surgical as well as psychosocial and behavioral interventions designed to support and affirm an individual's gender identity

Diagnosis of gender dysphoria/gender incongruence is required to provide GAC medical interventions to transgender youth

DSM 5-TR criteria

(F64.2) Gender Dysphoria in Children

- ◆ A marked incongruence between one's experienced/expressed gender and assigned gender, of at least **6 months duration**, as manifested by **at least 6** of the following (one of which must be **criterion A1**):
 - ◆ 1. **A strong desire to be of the other gender or an insistence that one is the other gender** (or some alternative gender different from one's assigned gender)
 - ◆ 2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing
 - ◆ 3. A strong preference for cross-gender roles in make-believe or fantasy play
 - ◆ 4. A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender
 - ◆ 5. A strong preference for playmates of the other gender
 - ◆ 6. In boys (assigned gender), a strong rejection of typical masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typical feminine toys, games and activities
 - ◆ 7. A strong dislike of one's sexual anatomy
 - ◆ 8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender
- ◆ B. The condition is associated with **clinically significant distress or impairment in social, school or other important areas of functioning**.
- ◆ Specify if: with a disorder /difference of sex development

DSM 5-TR criteria

(F64.0) Gender Dysphoria in Adolescents and Adults

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

Prevalence, mental health and SDOH in trans youth

<https://www.cdc.gov/mmwr/volumes/73/su/pdfs/su7304a6-H.pdf>

Prevalence

- ◆ 3.3% identify as transgender (trans); 2.2% questioning (Q) gender identity
- ◆ **Rate increase** from 1.4% in 2022

Mental health

- ◆ **Depression:** 70% (vs 50% cis females & 26% cis males)
- ◆ **Suicide attempts:** 25% (vs 11% cis females & 5% cis males)
- ◆ **Serious suicide attempts** requiring medical treatment: 10% (vs 2.6% cis females & 1% cis males)
- ◆ **School bullying:** 40% (vs 15% cis males & 20% cis females)
- ◆ **Missed school** due to feeling unsafe (past 30 days): 25% (vs. 8.5% cis males & 15% cis females)

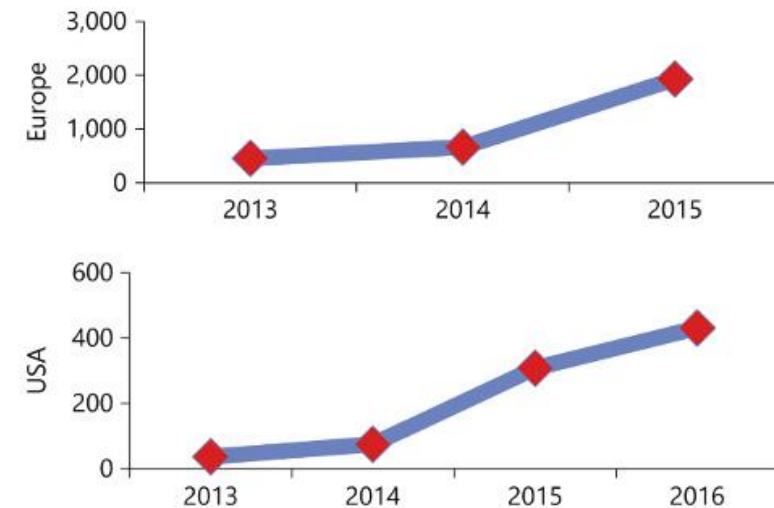
SDOH

- ◆ **School connectedness:** 36% (vs 62% cis males & 50% cis females)
- ◆ **Housing instability:** 1:10 trans students, 5x more likely than cis
- ◆ **Stigma and discrimination:** leads to poor mental health, especially for those who lack family or social support
- ◆ **Family stressors:** includes adverse childhood experiences and parental rejection

Cass review: demographics and comorbidity

- ◆ Independent review commissioned by **NHS** to ensure high standard of care for transgender children and youth
- ◆ **Increase in numbers and change in case mix:** more birth-registered adolescent females, previously birth-registered males presenting in childhood
- ◆ Increase due to greater acceptance of trans identities among younger generation and increased awareness through **media coverage**
- ◆ **Generational differences:** 5.6% of Generation Z young adults identified as trans or non-binary vs 2.4% Millennials and 1.5% Generation X
- ◆ Complexity of presentations with **co-occurring mental health issues** and high prevalence of **adverse childhood experiences**
- ◆ Higher rates of depression, anxiety, eating disorders, suicidality, self harm, ASD and ADHD
- ◆ Formal diagnosis of **gender dysphoria** reported to range from 29% to 100%
- ◆ Association with mental health disorders is complex and bidirectional
- ◆ **Non-binary** identity seen in up to 19%, highest in the **16–24 year age group**, important to recognize and deliver appropriate support to this group

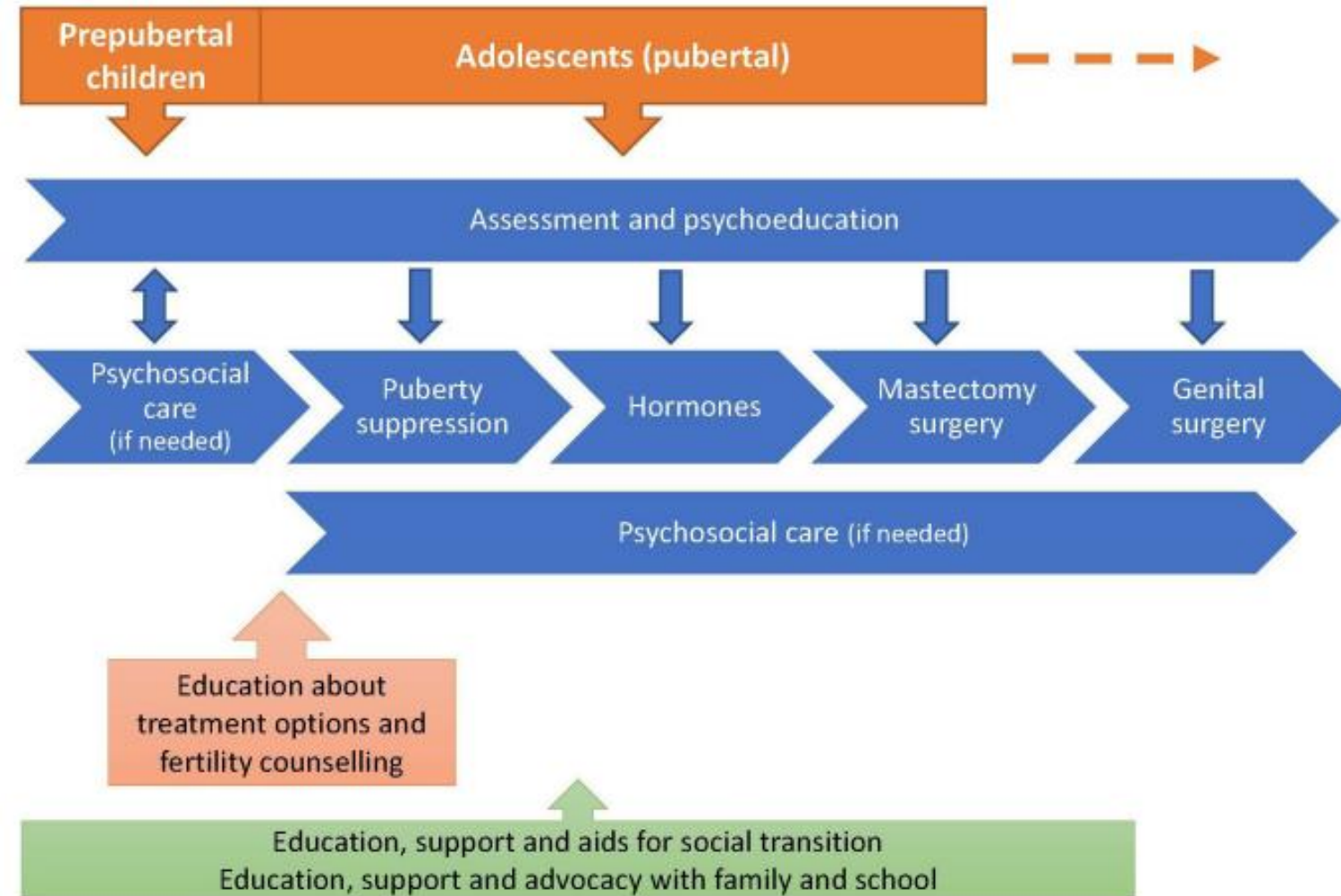
Referrals to gender clinics in USA and Europe



Phased pathway of assessment & care across guidelines

Social transition is usually first step in gender transition

WPATH (2022) standards of care (SOC version 8) removed age thresholds for cross-sex hormones and surgeries



Guidelines: assessment recommendations

- ◆ **Multidisciplinary Team Involvement:** Care should be provided by specialists including mental health professionals, endocrinologists, and experts in gender and child development
- ◆ **Types of assessment:** (1) comprehensive psychosocial assessment, (2) medical or 'readiness' assessment for adolescents seeking hormonal treatments and (3) diagnostic assessment for gender dysphoria/incongruence
- ◆ Only the Swedish and WPATH guidelines contain detail on assessment process
- ◆ The UK Royal College of Psychiatrist (RCPsych) guideline recommends mental health services assess for gender dysphoria and co-occurring mental health difficulties
- ◆ Finnish, Norwegian and Swedish guidelines recommend that local mental health services provide assessment and psychosocial interventions
- ◆ Five guidelines recommend assessing for neurodevelopment conditions including **ASD**
- ◆ **WPATH** recommends assessment of co-occurring MH/developmental concerns, family dynamics/support and decision-making capacity. Involvement of caregivers is essential. Extended assessments are recommended for complex cases (e.g., comorbid mental health disorders, co-occurring ASD, or absence of childhood gender incongruence)
- ◆ **Care planning:** a holistic, individualized care plan should be developed with input from the full multidisciplinary team

Guidelines: treatment recommendations:

Social transition

- ✦ Refers to **social changes to live as a different gender** such as name change, pronoun use, altering appearance, bathroom access, participation in gender segregated activities, changes to legal documents
- ✦ Ranges from **limited changes** in appearance to **full social transition** from an early age, may live in stealth
- ✦ A **key distinction between children and adolescents** is the influence of parental attitudes and beliefs, which significantly shape a child's ability to socially transition
- ✦ There are **diverse perspectives** on early social transition
 - Some evidence that it **may improve mental health** in children experiencing gender-related distress
 - Others caution that early transition **may alter the natural trajectory of gender identity development**, potentially increasing likelihood of pursuing medical interventions.
- ✦ **Trends:** It is now common for children and adolescents presenting to gender clinics to have already undergone partial or full social transition
- ✦ **Clinicians should support parents in decision making**, helping them understand:
 - Normal developmental variation in gender role behavior and expression
 - Avoiding premature decisions in young children, including considering partial transitions to keep future options open

Guidelines: treatment recommendations

Psychological interventions

- ◆ **Historical Context:** care for children/adolescents with gender incongruence was in the past primarily psychosocial, puberty blockers introduced more recently as an early medical intervention
- ◆ **Current guidelines:**
 - Finnish and Swedish guidelines recommend **psychosocial care as first-line treatment**. However, there is divergence
 - Five guidelines suggest that not all youth require psychosocial care
 - All guidelines except one, promote a gender-affirmative approach
- ◆ The **goal of psychological intervention** is not to alter gender identity, but to:
 - Explore concerns and experiences
 - Alleviate distress
 - Support youth regardless of their chosen care pathway
- ◆ **For youth pursuing medical interventions:** essential to address co-occurring mental health and psychosocial challenges, such as family conflict, barriers to school and social participation, bullying and minority stress
- ◆ Use **standard, evidence-based psychological and psychopharmacological approaches** to manage distress and co-occurring conditions. Include support for parents/caregivers and siblings
- ◆ Navigating life as a transgender person can be challenging, important to help the youth to function and thrive, and provide with tools to build **resilience**

Medications: Leuprolide, Histrelin, Goserelin, Triptorelin, Nafarelin (GnRH analogs)

Puberty blockers: Gonadotropin releasing hormone analogs

- ✦ Suppress sex hormone production to halt pubertal development
- ✦ Used **off label** for transgender youth with **gender dysphoria** to suppress puberty
- ✦ Treatment is initiated **Tanner stage 2** (early puberty)
- ✦ Promoted as a **temporary pause to allow child time to explore gender identity** without distress from developing unwanted secondary sex characteristics
- ✦ Puberty blockers first used in Dutch clinic in mid-1990's in "juvenile transsexuals" (**Dutch protocol**)
- ✦ Became **standard practice** in transgender medicine by the mid-2010s
- ✦ **Intended benefits:** improve gender dysphoria, overall mental health and reduce suicidal ideas
- ✦ **Evidence summary:**
- ✦ **Dutch protocol study data** (Biggs, 2023): longitudinal data on 70 adolescents reported improvements in behavioral/emotional problems and depressive symptoms, and general functioning
 - Eligibility: early childhood onset of gender dysphoria, worsening at puberty onset, age ≥ 12 , Tanner stage 2, psychological stability, no major mental health issues, and strong family support
 - Limitations: No comparison group; participants received regular psychological support
- ✦ **Tavistock Clinic (UK) study** (Carmichael et al, 2021): No significant changes in gender dysphoria or mental health outcomes (44 patients)
- ✦ **Recent meta-analysis** (Miroshnychenko et al, 2025): Found very low certainty of evidence regarding improvements in global functioning, depression, and gender dysphoria

Puberty blockers: Key Questions for Clinical Consideration

◆ Question: Is puberty suppression truly time limited and reversible?

- When discontinued, puberty typically resumes but **long-term use** is frequently seen in practice
- Earlier onset of puberty seen globally
- Increasingly early social transitions may lead to earlier initiation of puberty blockers to support youth living in stealth
- Long term use seen in nonbinary youth who wish to maintain a sex-ambiguous appearance
- For some youth, indecision about pursuing masculinizing or feminizing hormones may result in longer use

◆ Question: Does arresting puberty lock in gender dysphoria that may have resolved in puberty?

- Prior to the widespread use of gender-affirming care, studies indicated that approximately 67% of childhood gender dysphoria resolved by or during puberty

◆ For many children cascading effect seen, this is the first step to hormone treatment and surgery

- **UK study:** Carmichael (2021) found that 43/44 children on puberty blocker proceeded to take cross-sex hormones
- **Dutch protocol study:** de Vries (2011) results from the Dutch study sample of 70 adolescents showed that no adolescent stopped puberty blocker and all started cross-sex hormone treatment

Long term side effects of puberty blockers and hormones

- ♦ **Bone health:** Prolonged use of Puberty blockers may reduce bone density, which could increase the risk of fractures later in life
- ♦ **Impact on fertility:** While puberty blockers are not sterilizing, delaying puberty followed by hormone treatment may impact fertility. Children/adolescents should be offered **fertility counseling and preservation** prior to going on to a medical pathway
- ♦ **Impact on brain development:** more research is needed on neurocognitive effects of puberty suppression, impacts brain regions associated with executive function, emotion regulation, and social cognition
- ♦ **Emotional and psychological effects:** Impact on psychosocial development of youth with suppressed puberty while their peers develop normally has not been studied
- ♦ **Height and growth:** puberty blockers pause growth spurt, potentially affecting final adult height
- ♦ **Cardiovascular and metabolic risks:** elevated risk of heart attack and strokes in females taking testosterone
- ♦ **Sexual function:** Concerns about potential impact on sexual pleasure and orgasm
- ♦ **Monitoring & Follow-Up:** Regular assessments by a multidisciplinary team to monitor bone health (DEXA scans), track growth, mental health and overall wellbeing
- ♦ **Research Gaps:** Insufficient data on long-term physical and psychological outcomes, more research is urgently needed

WPATH Guidelines SOC 8 – Key Updates (2022)

- ◆ World Professional Association for Transgender health (WPATH) released updated standards of care in 2022 in which **age thresholds for cross-sex hormones and surgeries were removed**
- ◆ Previously hormone therapy was started around age 16 followed by surgeries at age 18 or older, except for chest mastectomy at age 16
- ◆ **The international clinic survey** (Hall et al) found most gender clinics require **stable mental health** before prescribing hormones. Some clinics have no minimum **age**; others range from 14-16 years. The required **duration of gender dysphoria** varies, ranging from childhood onset to stable over 2 years
- ◆ WPATH recommends **12 months of hormone therapy prior to surgery** to achieve the desired surgical result unless hormone therapy is either not desired or is medically contraindicated
- ◆ **Trends:** Data indicate rates of gender-affirming surgeries have increased since 2000, and more transgender youth seeking vaginoplasty
- ◆ A 2017 study (Milrod) found over half (55%) of 20 WPATH-affiliated US surgeons had performed **vaginoplasty in minors**
- ◆ Due to complexity and high complication rates, **phalloplasty is not recommended for youth under 18**

Evidence and Controversy:

Gender-Affirming Care and Suicide Prevention

- ♦ **Clinician and Parent Concerns:** widespread worry that delaying gender-affirming medical treatment may increase the suicide risk in transgender youth. Gender-affirming care is often viewed as life-saving
- ♦ **Supporting Evidence:**
 - **Turban et al. (2020):** Adolescents who accessed pubertal suppression had lower lifetime suicidality compared to those who wanted it but didn't receive it
 - **Tordoff et al (2022):** medical interventions (Puberty blockers or hormones) were associated with reduced depression and suicidality over a 12-month period
- ♦ **Critiques:** include observational nature of studies (cannot prove causation) and outcomes affected by confounding factors such as family support, access to mental health care and socioeconomic status
- ♦ **Gender-Affirming Care Model:** While high suicide risk in youth with gender dysphoria is cited to support puberty blocker and hormone use, comorbid conditions (psychiatric, neurodevelopmental, ACEs) are often overlooked
- ♦ **Major medical organizations** including the American Academy of Pediatrics and American Medical Association continue to **support GAC**, citing its role in reducing depression and suicidality

Reevaluating GAC: Global Policy Shifts

♦ **European Health Authorities (2021-2022):**

- Recommend restricting puberty blockers to formal research protocols or exceptional cases
- Prioritize psychological support and treatment of coexisting psychiatric and neurodevelopmental conditions
- Systematic reviews found existing studies to be of low quality, with high risk of bias and insufficient evidence

♦ **French Académie Nationale de Médecine (2022):**

- Urges great caution in using medical interventions in youth
- Highlights risks including impact on growth and bone fragility, infertility, emotional and intellectual consequences and menopausal symptoms in girls

♦ **NHS (UK): based on Cass review (April 2024)**

- Puberty blockers now offered only under research protocols
- Recommended extreme caution for prescribing hormones before age 18 (previously age 16)
- Emphasized mental health assessments and family support as central to care

♦ **US Department of Health and Human Services report (HHS, 2025) <https://opa.hhs.gov/gender-dysphoria-report>**

- Raised concern about medical interventions citing weak evidence of benefit and significant risks
- Recommends a shift toward psychotherapy
- Critics of the HHS report argue it misrepresents the medical consensus and risks promoting conversion therapy-like practices under the guise of "exploratory therapy"

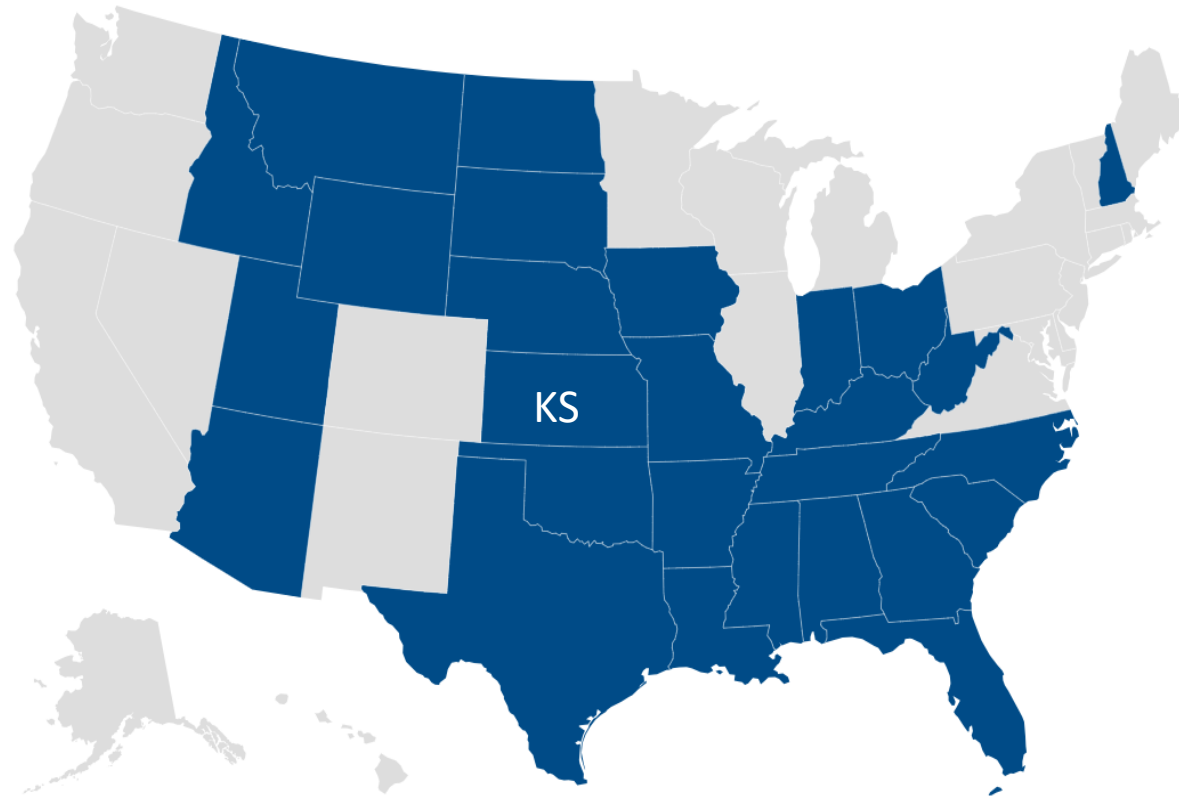
♦ **Providers should engage in multidisciplinary care, evidence-based practices that prioritize patient safety**

Ethical Considerations in Pediatric GAC

- ◆ **Autonomy vs. Competence:** Should respect for child's autonomy override concerns about decision making competence? Clinicians & parents question whether a child can truly understand long-term consequences of puberty suppression
- ◆ **Assent/consent** requires ability to
 - Comprehend the nature and purpose of the treatment
 - Discuss risks and benefits of available treatment options
 - Appreciate long-term consequences of the decision
 - Communicate a clear and informed choice
- ◆ **Best Interest Principle:** Treatment decisions should involve input from the child, parents, and healthcare/welfare professionals
- ◆ **Adolescent Decision-Making:** Emotional, cognitive, and psychosocial maturity must be evaluated; impulsivity and peer influence may impair judgment
- ◆ **Open Future Principle:** Choices should preserve future autonomy, protecting rights children will exercise as adults
- ◆ **Beneficence:** early intervention for best cosmetic results vs waiting for cognitive maturity
- ◆ **Treatment Management:** Assess ability to adhere to treatment, manage medications, and attend follow-ups. Youth should be well informed about expected outcomes and typical timelines for changes and any implications of stopping the treatment

Legal Landscape of Youth Gender Affirming Care

<https://www.kff.org/other/dashboard/gender-affirming-care-policy-tracker/>



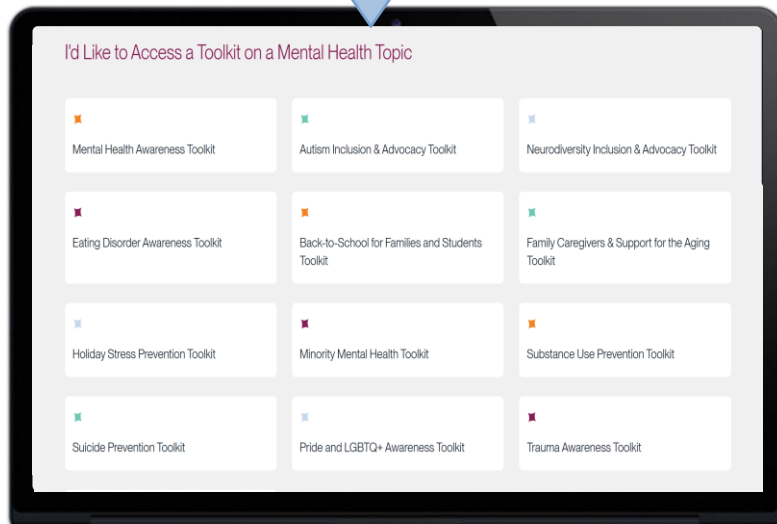
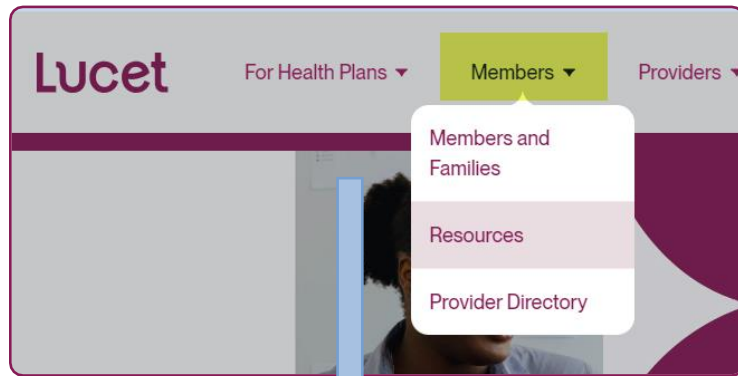
- ◆ **27 states** (includes **KS**) have enacted laws/policies limiting youth access to GAC
- ◆ **40% of trans youth** (ages 13-17) live in a state with laws limiting access to GAC
- ◆ **17 states** are facing lawsuits challenging their laws/policies limiting youth access to GAC
- ◆ **24 states** impose professional or legal penalties on healthcare practitioners providing minors with GAC
- ◆ **Trump executive order** (January 2025) **restricted federal funding** to facilities that provide GAC to minors
- ◆ **US Supreme Court upheld the Tennessee ban** (June 2025) effectively clearing the way for other states to ban GAC (United States v. Skrmetti)
- ◆ Many **GAC clinic closures** due to state restrictions (Borah et al. 2023)

Conclusions: clinical takeaways

- ♦ The session addressed the **increasing prevalence** of youth identifying as transgender, highlighting the **impact of comorbid mental health conditions** and social determinants of health (**SDOH**) that disproportionately affect this population
- ♦ **Holistic assessment** is essential, including comprehensive mental health evaluation and an individualized care plan that is **trauma-informed and culturally competent**
- ♦ **Evidence-based psychological and psychopharmacological interventions** should be employed to manage distress related to gender incongruence and co-occurring mental health conditions. Support should extend to parents, caregivers, and siblings
- ♦ Services should implement a **distinct care pathway for pre-pubertal children**, focusing on:
 - **Parental guidance** and support
 - Clinical assistance with decisions regarding **social transition**
- ♦ **Ethical considerations** surrounding medical interventions must be addressed to ensure **informed consent** and **shared decision-making**
- ♦ The session aimed to **enhance clinical understanding** and promote compassionate, informed care for transgender youth

Pride & LGBTQ+ Support Toolkit

Free Resources: LucetHealth.com



◆ **Articles:** Parenting an LGBTQ+ child

◆ **Tips:** Support for coming out

◆ LGBTQ+ Dictionary

◆ Infographics

◆ **Links to more resources:**

LGBT National Hotline: 888-843-4564

The Trevor Project

<https://www.thetrevorproject.org/>

PFLAG:

<https://pflag.org/>

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