Induction of Lactation in Trans and Nonbinary Clients

Bryna Hayden, IBCLC. | USLCA 2022: New Horizons in Lactation

FIRST THINGS FIRST:

Being Trans, gender non-conforming, or non-binary is <u>not a choice</u>. It is a central and inalienable part of our humanity. Refusal to recognize trans or gender nonconforming people and their identities is considered gender-based violence.

TAKEAWAYS FROM THE TALK :

Medical Transition Types
(*every experience is unique, none are "required" to be Trans*)

Hormonal
Referred to as "gender affirming therapy" (GAT), "hormone replacement therapy" (HRT), or "gender affirming hormone therapy" (GAHT).

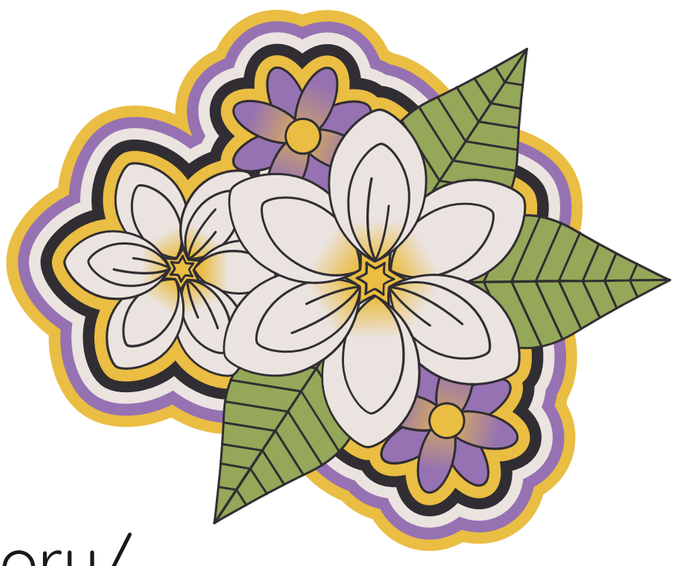
Surgical
Commonly refered to as "top surgery" and "bottom surgery".

Social Transition
This involves changing appearance, name used with friends or loved ones, name used socially, and pronouns used.

Legal Transition
This involves legally changing identifying documents like birth certificate, ID, and legal name.

Parenting
Trans parents are just like any other parents. They have the same hopes, wants, and dreams for their kids as cis parents. Trans parents love their children joyfully, and immensely. Trans parents also face more barriers and challenges than cis parents. They don't have the same access to resources, available evidence-based information, or the acceptance of society.

RESOURCES & LINKS:



Trans Lifeline (US based)
877-565-8860

Cultural Betrayal Trauma Theory Information
https://jmgomez.org/cultural-betrayal-trauma-theory/

PFLAG
https://www.pflag.org/

Gender Census Worldwide
https://gendercensus.com/results/2021-worldwide/

Transfem Science (a free hormone dosing and blood level estimator):
https://transfemscience.org/

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Success conversations look different for every person:

- What are their primary goals?
- What level of milk supply are they hoping to achieve?
- What is the approach in the event of dysphoria?
- What is their hormonal profile, and what needs to change for successful induction of lactation?

Dysphoria

The data we have available suggests that dysphoria is experienced in 60-80% of trans folks. Dysphoria co-occurs with neurodivergence, depression, and anxiety at a rate upwards of 56%. Depression is diagnosed in upwards of 80% of trans people. These do not always occur together, but it isn't a surprising finding- given the abusive social environment and direct abuse many people experience.

One of the main treatments for gender dysphoria is gender-affirming medical care, also called medical transition, hormone-replacement-therapy (HRT), or gender affirmation therapy. This can be either medication-based or surgical, or both. It is not something used by all trans people. It can be used to transition from one binary to another, or for a nonbinary transition.

PMADS

Most postpartum depression surveys are based on cisgender women. Men who give birth are excluded from the data, as well as women partners who identify as mom, but who did not give birth.

Trauma-Informed Care

Due to provider bias and negative experiences, Trans & Nonbinary populations' participation in care is lower. Because perinatal care is largely centered on cisgender women, much of the information is not targeted or adaptable, either. Trans & Nonbinary clients are often under-informed and are frequently labeled as "noncompliant" by providers who misinterpret reluctant participation in care as a lack of interest or desire.

Cultural Betrayal Trauma Theory & Intersectionality

Cultural Betrayal Trauma Theory stems from Freyd et al. (2008) and Gomez et al. (2018)'s work, defined as when one's own culture or family betrays them in a primary way, which can cause a lasting traumatic impact which continues through to their children and loved ones. Layered with the intersections of oppression, the experience of parenting after being disowned by one's own parents for being Trans or Nonbinary can be highly impactful. Be mindful of your client's background and trauma history when supporting them, and ensure they have support where applicable.

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Hormones

The hormones encountered in induction of lactation (IOL) are the same, it just depends on whether they're exogenous (administered) or endogenous (produced without medication).

ESTROGEN (ESTRADIOL)
PROGESTERONE
TESTOSTERONE (YES, REALLY)
CORTISOL
THYROID HORMONES
PROLACTIN

Labwork & Baseline Values

Your client's physiology & health history will determine their baseline hormonal profile. This needs to match a baseline profile when beginning the protocol. Dosing, method of hormone administration and medications used differ widely. It may take time to achieve this baseline. Labs should be drawn at the beginning to establish a baseline for your client, as well as weekly to ascertain peak & trough level timing, dosing amounts, and methods of medication administration (IM, oral, etc.).

Cardiovascular health, iron status, liver health, thyroid status, and A1C status should be established, as well as monitored throughout the protocol, to ensure client's physical health is maintained. STI status should be normal for them or negative. If they have a chronic condition, know the interactions that progesterone can have with anti-retroviral therapy.

Lactogenesis I

Estradiol should be titrated up to the level goals. Progesterone is also introduced and titrated up to level goals. They should be cycled together for the duration of the protocol (12-24 weeks, depending on previous tissue growth and tissue growth and proliferation experienced during the protocol). Estradiol should then be titrated down to baseline levels while progesterone is maintained at level goals until Lactogenesis II begins. It is then stopped without titration, to simulate the delivery of the placenta, which predicates Lactogenesis II. Prolactin agonists should be introduced up to 1 week before titrated reduction of estradiol begins (if a prolactin agonist is indicated, check prolactin levels by labwork to see if it's being endogenously produced by pituitary first).

CBC/IRON STATUS: WNL
PROGESTERONE: 100-200 NG/ML
ESTRADIOL: 2500-6000 PG/ML
TESTOSTERONE: BELOW 18NG/DL
PROLACTIN: ABOVE 100-200 NG/DL
TSH, FT3, FT4, TPO: WNL
A1C: <6.5%
STI PANEL: NORMAL/NEGATIVE
LIVER ENZYMES: WNL

Prolactin labs should be done fasting and should include one draw before stimulation (pumping, bodyfeeding) and again 30 min after stimulation. Levels should be doubling from baseline. If client is on a high dose of prolactin agonist medication, levels may not change, but they should be within recommended range for lactation.

Lactogenesis II

Preparation for Lactogenesis II should include manual chest/breast exam to evaluate glandular tissue proliferation, response to protocol, as well as standard anticipatory guidance in preparation for lactation consult: discussion of expectant management of engorgement, as well as a pumping or nursing plan. The preparation should include teaching around hand expression, pumping, latching, and self care and support during the hormone shift. Stimulation should be frequent in the first 2-4 weeks, and should include pumping or nursing q2hrly with one longer stretch (4h) every 24h. Labs should continue to monitor levels and dysphoria should be managed appropriately. Mental health screens and support should take place before, during, and after initiation of Lactogenesis II.

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Hand Expression for Trans Parents

AFTER TOP SURGERY, HAND EXPRESSION IS A LITTLE DIFFERENT

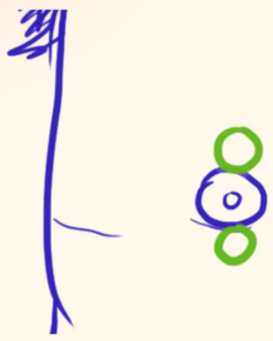
#1

Start by washing your hands with soap & warm water.

#2

Massage your chest/pec area. Stroke with two fingers toward your areola.

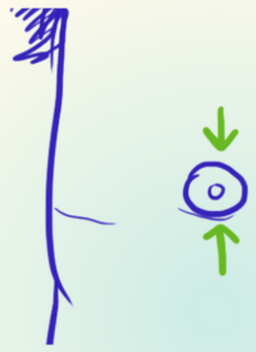
#3



Place your thumb and forefinger on your areola and press gently toward your chest wall. If you hit scar tissue, move closer to the nipple.

#4

Squeeze your fingers together, gently. Roll your fingers a bit to massage your ducts.



#5

Pull gently toward the nipple, away from your chest wall. Repeat in a rhythm. Change up pressure until you see beads of colostrum or milk.

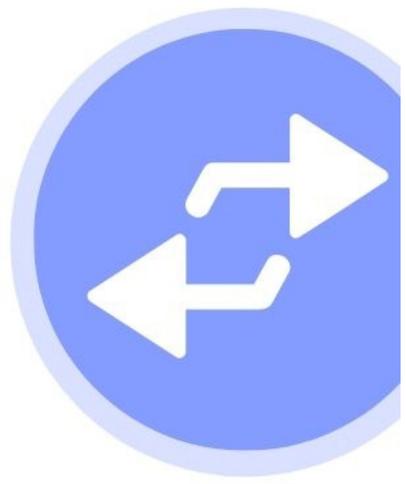
@DOULAMYSOUL

INCLUSIVITY IS ACTIVE AND ONGOING

UNDERSTAND TRAUMA

Having a working knowledge about how trauma works in the brain and in emotional & social health is critical for welcoming a diverse clientele to your business or practice. It's essential that you know the common pitfalls on this journey.

MAKE ROOM FOR COGNITIVE DISSONANCE



The things you might have been taught aren't always true for everyone. This seems like a simple concept, but it's the root of most cognitive dissonance. That is to say, when something is true or real that you didn't previously understand or know to be true. There are many situations in inclusivity work where this arises. Sit with the discomfort, and on your own time, examine why you feel the way you do. It doesn't mean you are wrong or bad, it just offers an opportunity to expand your own horizons.

PLACE YOUR CLIENT'S EXPERIENCES FIRST

Your client's experience takes priority over whatever you may have learned about the group or culture to which they belong or are a member. Everyone is an individual!

THE ANSWER IS IN THE COMMUNITY

Whenever you are in doubt about the best way you can serve a particular client, reach out to them and ask. Do the work beforehand to find out what their community resources are. Is there someone who can serve this client better than you can? How can you support them? This is important when prioritizing social justice in your work.