Gender Diversity: Supporting Transgender & Gender-nonconforming Children and Adolescents

Marco A. Hidalgo, PhD
Lisa Simons, MD
Division of Adolescent Medicine
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Objectives

• Distinguish between various aspects of gender phenomenology

• Describe gender identity development and the trajectories of gender dysphoria in early childhood

• Identify common presentations of gender nonconformity in childhood and adolescence

• Learn about approaches to assessment and care of gender-nonconforming and transgender youth
Disclosures

• No financial conflicts of interest to disclose

• Treatment recommendations are based on best available evidence

• All medical treatments discussed in this presentation are off-label for use
Terminology
Terminology

**SEX**
- Attributes that characterize biological maleness and femaleness:
  - Sex-determining genes
  - Chromosomes
  - Hormones
  - Anatomy

**GENDER**
- Attitudes, feelings, and behaviors that a given culture associates with a person’s biological sex (APA, 2011):
  - Gender expression
  - Gender roles/behaviors
  - Gender identity
  - Varies by place, time period

*Biological construct*  *Social construct*
Terminology

**Gender Identity**
- An individual’s personal sense of self as male, female, or an alternate gender

**Gender Role**
- Behaviors, attitudes, and personality traits that a society in a given historical period designates as “masculine” or “feminine”
  - e.g., men: aggressive, strong, dominant, emotionally reserved; women: nurturing, dependent, passive

**Gender Expression**
- How gender identity is communicated to others
  - e.g., one’s name, gender pronoun, style of dress, interests, etc.
Key Terminology (continued)

- **Gender Nonconformity** (or **Gender Variance**)
  - Gender expressions, identity and behaviors that fall outside the norm for one’s natal gender
  - Long-standing occurrence – not a fleeting curiosity or interest
Terminology

Transgender

1. Individuals with an affirmed gender identity different than their biological sex (birth-assigned gender)
2. Transgender (like gender nonconformity) can be used as an umbrella term describing gender identity, expression, or behaviors which fall outside of culturally-defined norms
3. Incorrect and Correct Uses
   a. Incorrect as noun: “She’s a transgender.”
   b. Incorrect as verb: “That person is transgendered.”
   c. Incorrect: “A transgendered person.” (akin to “whitened”)
   d. Correct: “A transgender person/male/female”

The term “Trans*” reflects ...
“There is no one way to be trans*”
Key Terminology (continued)

• **Transgender female (MtF):**
  – Natal male sex with an affirmed female gender identity

• **Transgender male (FtM):**
  – Natal female sex with an affirmed male gender identity

• **Gender queer/Non-binary/Demi-**
  – Terms that reflect gender identities outside of the (male/female) gender binary

• **Cisgender** (*cis* - “on this side of”)
  – Describe people whose gender identity is congruent with biological sex

“My preferred gender pronoun is __. What is yours?”
Terminology

Gender dysphoria
- Internal distress experienced due to the discordance between gender identity versus gender socialization to date and/or sexual anatomy

Gender transition
- Process by which an individual begins living in their affirmed gender role
- This may involve social, medical and/or surgical transition
- No one way to be Trans*; therefore, no one way to transition.
Other Terminology

**Sexual orientation**
- The tendency to be romantically/physically attracted to persons of the same sex*, opposite sex, both sexes, or neither sex.

*Can also refer to attraction based on gender (and not anatomy)

Examples of sexual orientation identity labels:
- Straight, gay, lesbian, bisexual, pansexual, asexual
Gender Development
Gender Development

• By 18-24 mo, children develop the ability to label gender

• Between 2-4 years, most children recognize gender differences, use gendered pronouns

• By age 5 to 6 years, most children declare a gender identity of male or female

• For most children, this identity is consistent with their birth-assigned sex ("natal sex") and remains constant across the lifespan

Gender Development

• Many children experiment with gender expression and roles
  – Cross-gender play (toys, games)
  – Cross-gender dress

• Exploring gender is a very normal part of development
Gender Nonconformity in Childhood

- Some children exhibit **persistent, insistent** nonconforming behaviors and expression

- Behaviors/expression vs. identity?
Gender-nonconforming Youth

- Increasing numbers of gender-nonconforming youth are being referred for care
- Presenting for care younger
- Referred by therapists, PCPs, parents, schools...
Clinical Presentation Patterns

- In children, aged 4-11, boys 3-6x more likely to be referred for gender-related evaluation/tx despite:
  - Birth-assigned girls exhibiting > gender variant behavior
  - Verbally expressed binary transgender desires (e.g., mtf, ftm) being low and comparable between girls and boys

  van Beijsterveldt et al., 2006

- Suggests less social tolerance for gender variance in boys than girls

- In adolescents, referral rates are nearly equal (1.75:1, NM to NF) Zucker & Lawrence, 2009
Diagnostic Vignette

HPI: 16 year-old birth-assigned female who identifies as female. “Came out” as lesbian to parents 6 mos ago. Prior to this no psychiatric hx.

-Experiencing depressive symptoms since “coming out”
-Describes family as not “believing” she is lesbian

What are possible preliminary diagnoses?

A. Adjustment Disorder with Depressed Mood
B. Homosexuality
C. Persistent Depressive D/O (Dysthmic D/O)
D. Both A & C
E. None of the above
Shifting Perspectives

**Gender Identity Disorder (GID)**
- Psychiatric diagnosis in the DSM-IV-TR
- Principle criteria: Persistent cross-gender identification resulting in clinically significant distress

**Gender Dysphoria (GD)**
- Replaced GID in the DSM-V
- Principle criteria: Clinically significant distress resulting from incongruence between one’s assigned and asserted gender

Identity is NOT Pathology
2013 Removal of GID from DSM

• Identity is not a pathology, and can be asserted without a diagnosis
  – Not all experience dysphoria related to their identity

• “Disordered identity” can contribute to social marginalization

• “Binary-based” – not inclusive of gender-fluid people

• Precedent: Homosexuality, removed from DSM in 1973
  – From reparative tx to helping *some* individuals manage psychosocial adjustment/conflict related to sexual orientation
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 six of the following (one of which must be Criterion A1):

• 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).

• In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.

• A strong preference for cross-gender roles in make-believe play or fantasy play.

• A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.

• A strong preference for playmates of the other gender.

• In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.

• A strong dislike of one’s sexual anatomy.

• A strong desire for the primary and/or secondary sex characteristics that match one’s experienced gender.

• The condition is associated with clinically significant distress or impairment in social, school, or other areas of functioning.
Gender Dysphoria

Gender Dysphoria in Adolescents

A marked incongruence between one’s experienced/expressed gender and assigned gender, of at least 6 months’ duration, as manifested by at least two of the following:

• 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).

• A strong desire to be rid of one’s primary and/or secondary sex characteristics because of an incongruence between one’s experienced/expressed gender (or in young adolescents, a desire to prevent the development of anticipated secondary sex characteristics).

• A strong desire for the primary and/or secondary sex characteristics of the other gender.

• A strong desire to be of the other gender (or some alternative gender different from one’s assigned gender).

• A strong desire to be treated as the other gender (or some alternative gender different from one’s assigned gender).

• 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).

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

Natural History of Gender Dysphoria

• For the majority of pre-pubertal children, GD does not “persist” into adolescence
  – In a minority, GD does “persist”

• In contrast to GD in childhood, GD that persists into adolescence is unlikely to subside
  – For many children, GD intensifies with pubertal changes

• Most adolescents and adults with GD recall childhood gender-nonconforming behavior and questioning gender identity
  – Not all trans* teens, adults or their parents report these experiences

Drescher & Byne. Gender dysphoric/gender variant (GD/GV) children and adolescents: Summarizing what we know and what we have yet to learn. *Journal of Homosexuality*, 2012
Gender Dysphoria

Predictors of Persistence of GD

Study examining factors associated with persistence of childhood GD in a clinic-referred sample of youth in the Netherlands (n=127) suggests that the likelihood of transgender identity in adolescence/adulthood may be predicted by:

1) High intensity of childhood GD
2) Tendency to assert their gender cognitively versus affectively: * “I am a boy” versus “I feel like a boy”

Possible Contributing Factors?

- **Psychological Influences**
  - Parenting factors
    - Over- and under-involvement in childhood (without notable nor consistent results)
    - Parentally-enforced childhood gender nonconformity (largely anecdotal studies without causal links)
  - Dissociative coping resulting from extreme childhood trauma (while rates of recalled abuse are greater in adult transgender populations, no causality can be determined from these studies)
    (see Sánchez & Vilain, 2013)

- **Biological Influences**
  - Inconsequential influences of sex hormones and androgen-stimulating genes on gender variance
  - MRI studies suggest similarities in the brains of adult male-to-female transsexuals compared to non-transsexual natal females
    (Luders et al., 2009; Rametti et al., 2011)
Psychiatric Conditions in Children with GD

- High comorbid anxiety in children with GD (per DISC) (Wallien et al., 2007)
  - 52% with 1+ comorbid diagnosis - 31% with anxiety disorder (most commonly SpPh and SepAnx)

- Higher internalizing than externalizing disorders in both natal genders (ibid; Skagerberg et al, 2013)
  - NM > internalizing bxs than NF; no differences in externalizing bxs

- Per CBCL PR, > gender variance in children with ND disorders compared non-referred groups (Strang et al., 2014)
  - ASD: 7.59 times more likely to express gender nonconformity
  - ADHD: 6.64 times more likely to express gender nonconformity
Psychosocial Risk

- Anxiety
- Depression
- Low self-esteem
- Family rejection
- Social isolation
- Self-injury
- Suicidal ideation, attempts
- Physical, sexual and verbal harassment and assault
- Unemployment
- Homelessness
- Drug use/abuse
- Incarceration
Psychosocial Risk

In a survey of transgender and gender-nonconforming adults, **41%** had ever attempted suicide.

*The national average is **4.6%***

Herman et al. Suicide Attempts among Transgender and Gender Non-Conforming Adults: Findings of the National Transgender Discrimination Survey, January 2014
Approaches to Care
Corrective Approach

- **Tenets:** (1) To prevent transgenderism is to prevent psychosocial adversity, (2) Identity as pathology/disorder (GID), (3) internal gender identity in childhood is malleable through behavioral techniques and change efforts, (4) Gender identity and expression should align with natal gender

- **Strategies:**
  - Discourage gender nonconformity, Encourage gender-normative play and preferences
  - Reversible (e.g., social transition), Partially reversible (e.g., HRT) and Irreversible treatments (e.g., surgery) for “persisters” aged 16 and up
A Federal Stance Against Conversion Approaches

- Variations in SO and GI within spectrum of human diversity
- SO / GI change efforts are coercive, harmful, and should not be part of therapy
Two Supportive Approaches

• “Wait and See” approach
• Affirmative approach

Shared tenets:

1. Gender variations are not disorders,
2. Gender may be fluid (not always binary)
3. Follow international guidelines/recommendations regarding the appropriate use of hormonal interventions
“Wait and See” Approach

Tenets:

1. Transgender identity cannot be determined before the onset of puberty

2. Attempts to ↓ GD should discourage gender transition until after the onset of puberty (i.e., “wait and see” if GD persists)
Affirmative Approach

– Tenets:

1. Decision to ↓ GD through gender transition belongs to family

2. Clinical input from medical & MH providers help inform family’s decision of how to support a child of any age (Hidalgo, et al., 2013)

– Goal: Help child and family decipher subjective gender experience as related to both identity and expression
Evidence Base for Affirmative/Supportive Approaches

- Children rejected and not supported are at increased risk of the following during adolescence:
  - Depressive symptoms, low life satisfaction, self-harm, isolation, posttraumatic stress, incarceration, homelessness, and suicidality

- Family acceptance and support during adolescence tied to the following in young adults:
  - Positive self-esteem, high social support, positive mental health, less depressive symptoms, greater self-esteem, greater life satisfaction (compared with youth whose families were non-supportive)

Lurie’s GSDP: An Affirmative Model
Gender and Sex Development Program

**Gender Development**
Director: Rob Garofalo, MD, MPH

- Children/adolescents who are:
  - Gender nonconforming
  - Transgender
  - Gender questioning
  - Gender-fluid

**Sex Development**
Director: Earl Cheng, MD

- Infants/children/adolescents with Disorders of Sex Development:
  - Conditions marked by abnormal chromosomal, gonadal or anatomic development
Our Multidisciplinary Clinical Team

- **Program Manager**
  - Jennifer Leininger, MEd

- **Pediatrics/Adol Med**
  - Rob Garofalo, MD, MPH
  - Lisa Simons, MD

- **Endocrinology**
  - Courtney Finlayson, MD

- **Social Work**
  - Sarah Cohen, LCSW

- **Surgery**
  - Julia Corcoran, MD

- **Psychology**
  - Diane Chen, PhD
  - Marco Hidalgo, PhD

- **Psychiatry**
  - Scott Leibowitz, MD

- **Nursing**
  - Ginny Scheffler, RN

- **Ethics**
  - Joel Frader, MD

- **Research**
  - Jennifer Jensen, APN
Lurie Children’s

Services

- Multidisc Care
- Longitudinal Research
- Community Consultation & Training
- Therapist Consultation
- Voice Therapy Group
- Parent Support Groups
- Youth Groups (Child & Teen)
“Is My Child Transgender??”

- Gender nonconformity is a normative variation of human diversity
- Provide education on gender development
- Tease apart gender – expression versus identity
- Transgender does not equal Gender Dysphoria

Beyond the Binary: Gender Spectrum

The Gender Unicorn

Gender Identity
- Female/Woman/Girl
- Male/Man/Boy
- Other Gender(s)

Gender Expression/Presentation
- Feminine
- Masculine
- Other

Sex Assigned at Birth
- Female
- Male
- Other/Intersex

Sexually Attracted To
- Women
- Men
- Other Gender(s)

Romantically/Emotionally Attracted To
- Women
- Men
- Other Gender(s)
Gender Transitioning

– Process by which an individual begins living in their affirmed gender role
– No one way to be Trans*; therefore, no one way to transition.

• Reversible
  – Social transitioning
  – Hormone blockers (GnRH agonists)

• Partially reversible
  – Gender affirming hormones

• Irreversible
  – Gender affirmation surgeries
Vignette 1
“Andrew” 6 year old natal male

- From his earliest years preferred dresses, make-up and dolls
- At 3 asked his parents to buy him feminine clothing, a wig
- At 4 he told his mother “I can’t wait to get to heaven to be a girl” – (which she interpreted as his perception of heaven being a place where all wishes come true)
- On a number of occasions, he’s told his parents “I’m a girl”
- Visited their pediatrician – told “it’s just a phase”
- A year ago, parents allowed him to wear dresses/skirts inside the home (they note that he’s so much happier during these times)
- Mom, tearfully explains “He’s so insistent - it’s beginning to feel oppressive...not allowing him to be who he is”
Pre-pubertal Children

• Presentation varies widely, often depending on environment

• Without pressure to conform, children may not be dysphoric

• May become angry, upset, sad, or withdrawn when parents or others attempt to redirect their behavior
Reversible: Social Transitioning

• The way a person presents themselves to the world:
  • Physical appearance
  • Names
  • Gender-related Pronouns
  • Other changes in social role or living situation: Bathrooms, dorms

• Social transitioning for pre-pubertal children remains controversial
  • Comparable rates of dep & anx found in socially transitioned children, compared with their siblings and same-aged peers (Olson et al., 2016)
Vignette 2
“Jack” 9.5 yo natal male

- Preference for stereotypically masculine clothing, toys and play since his earliest years
- Reports knowing he was “really a boy” since age 5, when he remembers insisting on typical-male clothing and cutting his hair short
- Socially transitioned at age 5
- Had been doing well until recently – parents concerned about Jack’s increasing anxiety – seems more withdrawn, often avoiding school
- Recently Jack is expressing concern he will grow breasts and develop pubic hair: “I don’t want this to happen because I’m a boy...and boys don’t have those”
- Exam: Breasts SMR 2, Pubic hair SMR 1
Puberty

I BRING YOU SOCIAL ANXIETY! AND HAIR!

Nobody likes The Puberty Fairy.
Puberty

- **Female puberty**
  - Breast development
  - Growth spurt
  - Change in body shape
  - Increase fat deposition in hips, thighs, buttocks
  - Body hair growth
  - Menarche

- **Male puberty**
  - Increase in testicular volume
  - Enlargement of penis
  - Increase muscle mass
  - Deepening of voice
  - Adam’s apple
  - Body and facial hair growth
  - Body shape (broadening of shoulders)
  - Skull and bone structure
  - Increased secretions of oil/sweat glands
  - Growth spurt
Medical Care
Peri-pubertal Children

- For gender non-conforming adolescents, these physical changes can be **unbearable**

- Gender dysphoria often **intensifies** or emerges around puberty

- Early intervention with GnRH agonists may **alleviate** psychological harm

- GnRH agonists (leuprolide, histrelin) effectively suppress the production of sex hormones at the pituitary level
GnRH Agonists (aka Puberty Blockers, Puberty Suppression)

1) Initial agonist flare (release of LH/FSH already produced)

2) Down-regulation of receptors...desensitizing the pituitary...blocking secretion of testosterone or estrogen
GnRH Agonists

• POTENTIAL BENEFITS
  – Completely reversible
  – “Buys time”
  – Allows exploration while distress is alleviated
  – Prevents the physical changes of an undesired puberty, some irreversible
  – May prevent future medical interventions/surgeries
  – Safe
Potential Risks

Limited long-term studies of GnRH agonists used to suppress puberty in gender nonconforming children:

1. Bone density
   - Delemarre-van de Waal, 2006
   - 21 patients treated with GnRH agonists for 2 years or longer
   - During treatment, bone density remained the same range (lower than age-matched peers) – caught up with addition of sex hormone

2. Height
   - Decreased growth velocity

3. Impact on brain development ??

Practice Guidelines

- The Endocrine Society, 2009

- Recommend that adolescents who fulfill eligibility and readiness criteria undergo treatment to suppress pubertal development

- Suppression of puberty should start after the first signs of puberty, no earlier than Tanner 2-3

GnRH Agonists: Follow-up

- de Vries et al.
  - n=70
  - Psychological assessment upon entry (T0), before the start of cross sex hormones (T1):
    - Behavioral and emotional problems decreased
    - Depressive symptoms decreased
    - General functioning increased
    - Gender dysphoria did not decrease
  - None opted to discontinue pubertal suppression and all 70 patients continued on to start gender-affirming hormone treatment

Vignette 3
“Jon” 15 yo natal female, affirmed male

– As a toddler Jon would only play with trains, cars, action figures
– Recalls feeling happy when male peers accepted him
– At 4 yo asked for “boys clothes only” and requested a haircut “like a boy’s”
– At age 6, Jon told his mother “God made a mistake”
– In elementary school, Jon was always considered a “tomboy”
– In 3rd grade, he tried “to be feminine and fit in”... but this felt miserable
– In 5th grade, puberty started and Jon became increasingly distressed - began wearing a bra to cover slight breast development. By 6th grade he routinely wore 2-3 bras to conceal his chest
– Jon disclosed to his parents in 7th grade – Mom tearfully explains she initially told him “it will go away”
– They didn’t discuss it again until this year, when Mom noticed Jon’s increasing discomfort with his body
Partially Reversible: Gender Affirming Hormones

- Indicated for adolescents with **consistent, persistent** and **insistent** gender identity

- **Goals**
  1. Reduce endogenous, undesired sex hormones
  2. Replace endogenous hormones with those of one’s asserted gender, thereby inducing secondary sexual characteristics of one’s asserted gender
Partially Reversible Gender Affirming Hormones

- The Endocrine Society, 2009
  - For those who meet eligibility and readiness criteria, start cross-sex hormones no earlier than 16 years old

- Lurie Children’s
  - Individualized management needed for each adolescent – initiating prior to 16 yo may have psychosocial benefit

Masculinizing therapy: Testosterone

- Amenorrhea
- Redistribution of body fat
- Increase in muscle mass
- Increase in body/facial hair growth
- Voice deepening
- Acne
- Increase libido
# Timeline of Changes

<table>
<thead>
<tr>
<th>EFFECT</th>
<th>ONSET (months)</th>
<th>MAX (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acne</td>
<td>1-6</td>
<td>1-2</td>
</tr>
<tr>
<td>Facial/body hair growth</td>
<td>6-12</td>
<td>4-5</td>
</tr>
<tr>
<td>Scalp hair loss</td>
<td>6-12</td>
<td></td>
</tr>
<tr>
<td>Increased muscle mass</td>
<td>6-12</td>
<td>2-5</td>
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<tr>
<td>Fat redistribution</td>
<td>1-6</td>
<td>2-5</td>
</tr>
<tr>
<td>Cessation of menses</td>
<td>2-6</td>
<td></td>
</tr>
<tr>
<td>Clitoral enlargement</td>
<td>3-6</td>
<td>1-2</td>
</tr>
<tr>
<td>Vaginal atrophy</td>
<td>3-6</td>
<td>1-2</td>
</tr>
<tr>
<td>Deepening of voice</td>
<td>6-12</td>
<td>1-2</td>
</tr>
</tbody>
</table>
Risks/Side Effects

- Weight gain
- Acne
- Mood changes
- Male-pattern baldness
- Liver injury
- Increased risk for heart disease
  - Lipids, blood pressure
  - Increased with family history of heart disease, smoking, obesity
- Increased risk for diabetes
- Increased red blood cells (polycythemia)
- Fertility?
Set Clear Expectations

- Everyone responds to hormones differently!
- It may take years to see the full effects of hormones
- Talk about what it does NOT affect (breasts, ? height etc.)
- The right dose for one person is not necessarily the right dose for the next
Feminizing therapy: Estrogen

- Breast development
- Redistribution of body fat
- Decrease in muscle mass
- Reduction in body/facial hair growth
- Reduction in erections
- Reduction in testicular volume
- Decreased libido
## Timeline of Changes

<table>
<thead>
<tr>
<th>EFFECT</th>
<th>ONSET (months)</th>
<th>MAX</th>
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</thead>
<tbody>
<tr>
<td>Breast growth</td>
<td>3-6</td>
<td>2-3 years</td>
</tr>
<tr>
<td>Redistribution of body fat</td>
<td>3-6</td>
<td>2-3 years</td>
</tr>
<tr>
<td>Decrease in muscle mass</td>
<td>3-6</td>
<td>1-2 years</td>
</tr>
<tr>
<td>Skin softening</td>
<td>3-6</td>
<td>Unknown</td>
</tr>
<tr>
<td>Decreased libido</td>
<td>1-3</td>
<td>3-6 months</td>
</tr>
<tr>
<td>Decreased erections</td>
<td>1-3</td>
<td>3-6 months</td>
</tr>
<tr>
<td>Decreased testicular volume</td>
<td>3-6</td>
<td>2-3 years</td>
</tr>
<tr>
<td>Decreased sperm production</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>Decreased hair growth</td>
<td>6-12</td>
<td>&gt;3</td>
</tr>
</tbody>
</table>
Risks/Side Effects

- Risk of blood clots (*ask about smoking)
- Headaches
- Nausea
- Mood changes
- Loss of libido
- Weight gain
- Liver injury
- Increased risk for heart disease
  - Increased with family history, smoking, obesity
- Increased risk for diabetes
- Gallstones
- Fertility?
Set Clear Expectations

- Everyone responds to hormones differently!
- It may take years to see the full effects of hormones
- Talk about what it does NOT affect (voice, facial structure, etc)
- The right dose for one person is not necessarily the right dose for the next
Follow-up

• de Vries et al.
  – n=55 transgender adults who had received puberty suppression during adolescence evaluated 3 times:
    • Before start of puberty suppression (T0)
    • Cross-sex hormones were introduced (T1)
    • 1 year after gender reassignment surgery (T2)
  – GD was alleviated
  – Psychological functioning improved
  – Well-being similar to age-matched sample

* Great need for more long-term studies
Fertility Preservation

- Gender affirming hormone therapies have unknown effects on fertility

- Important to discuss one’s fertility desires and the potential impact of hormones on fertility during consent process

- Fertility preservation consultation/treatment in collaboration with Northwestern University
Who is a Candidate for Hormones?

• No cookie cutter approach

• Any medical intervention requires:
  – Patient informed consent
  – For minors, patient assent and permission from guardians
  – Readiness assessment/letter
  – Baseline labs/exam
Irreversible Gender-affirming Surgery

• Difficult to find surgeons willing to perform gender-affirming procedures in minors

• Anecdotally, masculinizing “top surgery” has been performed in trans adolescents who consent along with their parents/legal guardians

• Lack of data examining impact of surgery on gender dysphoria in adolescence
Barriers to Care

- Cost
- Lack of insurance coverage
- Lack of medical/surgical providers with expertise
- Lack of mental health clinicians with expertise
- Negative past experience with health care
Psychological Gender Health Assessment & Affirming Therapy
Responsibilities of the Affirming Psychotherapist

- Form an alliance
Responsibilities of the Affirming Psychotherapist (cont.)

• Seeking Ongoing Consultation and Interdisciplinary Training
  – Keeping up with research and new medical treatment approaches
  – Guidelines on care
  – Managing internal bias (e.g., countertransference)

• Receive Ongoing Consultation and Psychoeducation
  – Mental health providers
  – Teachers

• Community Advocacy
  – Agency- or clinic-wide
  – School-based, or Community-wide
  – Managed care/Insurance providers
Responsibilities of the Affirming Psychotherapist (cont.)

• Conduct comprehensive, initial assessment
  – 2-3 hours involving child, parents, siblings, and teacher reports

• If indicated, assess readiness for hormonal therapies

• Individual, family, and/or group therapy
  – Peer-based support groups for all family members

• Ongoing consultation with medical providers

• Be CONSISTENT with employing these methods across sessions or lengths of stay
  – Brief colleagues with whom you share cases
Common Challenges Parents/Caregivers Face

- Confusion about their child’s gender development
- Fear for child’s safety and well-being
- Sense of guilt regarding child’s gender identity or expression
- Fear of condemnation from people in one’s community
  - “What will people say seeing my little boy wearing pink?”
  - Being ostracized by a spiritual leaders/community
  - Fear of being reported by others for child abuse
  - “Safe Folder” (see www.imatyfa.org)
Common Challenges Parents/Caregivers Face

• Doubting the veracity of their child’s gender identity, particularly teens without h/o gender nonconformity

• Limit-setting with their children, particularly around aspects of early social transition - (e.g., when to wear gender-nonconforming clothing, accessories)

• Feelings and adjustment
  – Unconditional love
  – Grief/sense of loss
  – Regret and shame
  – Self-doubt (e.g., “Am I doing the right thing?”)
Common Challenges Siblings Face

- Feeling overshadowed by sibling
- Stress – signs can be acting out, behavioral problems, sadness, irritability
- Teasing of the sibling
- Grief regarding the loss of sibling’s gender
- Negotiating when to disclose to others about their trans* sibling
Psychological Gender Health Assessment

Format:
• Multi-informant (self, parent, siblings, school personnel)
• Multi-modal (family, 1:1, observation, questionnaires)

Domains:
• History of Gender Variance (including assessment of Gender Dysphoria)

• Co-morbid Psychopathology, and R/O Differential Diagnoses including:
  – Poorly managed psychotic disorder
  – Restricted, repetitive patterns associated with Autism Spectrum Disorder
  – Maladaptive coping related to adjustment or traumatic stress disorder (Ehrensaft, 2011)
Psychological Gender Health Assessment

Domains (cont.):
• Parent/Caregiver Factors
  – Stress – *Parenting Stress Index, Short Form*
  – Support of Gender Variance – *Parent Support of Gender Variance* (Forbes, 2012)

• Appropriateness/Readiness for Gender Transition
  – Example: Social transition or (if Tanner 2+) hormonal intervention
  – Child and Social Agents (parents/caregivers, siblings, extended family, school)
    (Coolhart et al., 2012)

• Experiences of transphobia, non-affirmation, internalized transphobia, pride, peer/community connection
  – Gender Minority Stress and Resilience questionnaire (Testa et al., 2014)
Psychological Gender Health Assessment

- Assessment of Gender History
  - Longstanding history of presenting in stated gender (i.e., persistence)
  - Gender identification across situations and time (i.e., consistency)
  - Emphatic assertion of core gender identity (i.e., insistence)

- Developmental factors to keep in mind:
  - Gender development factors previously mentioned
  - Stages of operational thinking (e.g., Concrete vs. Formal Operational)

- Words
  - Insistent and persistent verbal expression of gender mismatch
  - Conviction versus desire
    - “I am a girl” versus “I wish I were a girl”
    - Conviction observed in prepubertal children (Cohen-Kettenis et al., 2012)
Psychological Gender Health Assessment

• Assessment of Gender History (continued)
  – Actions in prepubertal children (Noted by Spack in Brill & Pepper, 2011)
    • Bathroom behavior (e.g., Girls urinating while standing)
    • Aversion to swimsuits of natal gender
    • Undergarments of opposite natal gender
    • Toys typically marketed to opposite natal gender

  – Intensity of childhood Gender Dysphoria (current/past)
    • Keeping in mind: not all trans *adolescents/adults exhibit GD in childhood

(Brill & Pepper, 2011; Cohen-Kettenis, 2012)
Affirming Therapy

• Individual time with client, parents/caregivers, and siblings
  – Process challenges, provide psychoeducation, facilitate support

• Role-playing with clients and families on
  – Interactions with peers
  – Interactions with other parents
  – Negotiating disclosure in interpersonal situations (e.g., dating)

• Evidence-based care when psychopathology present
  – ADHD
  – Mood and Anxiety Disorders
  – Traumatic stress conditions
Affirming Therapy: Parent/Caregiver Consultation

• Encourage parents to educate themselves on gender development and how health professionals can help their child
  • Recommend books, Connect to specialists, Send responsible programming (e.g., PBS, NPR broadcasts)
  • Teach that “identity does not equal disorder”

• Help parents identify their parenting philosophy
  – Role of affirmation, love, support, empathy, and role modeling

(Brill & Pepper, 2011)
Affirming Therapy: School Consultation

- Encourage school to create a supportive classroom AND organizational culture
  - Adopt zero tolerance policy for discrimination – market this policy throughout the school, and with parents, do staff trainings on gender development, educate students, and educate parents
  - Educate students, staff, and parents on gender variance during back-to-school night
  - Update forms that limit gender options, update transcripts to reflect legal name changes
Affirming Therapy: School Consultation (cont)

• Encouraging supportive school environment (cont)
  – Honor preferred names and pronouns, and honor gender diversity in curricula
  – Develop school guidelines for transgender students

  – Addressing safety: Bathrooms, athletic teams, locker rooms, etc.

• In less responsive school environments, assist parents of trans* children in qualifying for 504 Plan with strategies to minimize exposure to peer discrimination

• Document harassment of gender-variant students, and relay this to school personnel
Hormonal Treatment of Trans* Youth with GD

- Requires psychosocial support
- Require parental consent
- Baseline lab assessment
- Letter of readiness from a mental health provider documenting:
  - Psychosocial assessment - evaluating support, identifying anything that may make transitioning difficult
  - Understanding (and reasonable expectations) of medications
  - Exclusion of any condition that may confound the diagnosis of GD
Assessing Readiness for Hormone Therapy
Readiness Assessment for Hormone Therapy in Youth

• Presence and Intensity of Gender Dysphoria
  – Keeping in mind: not all adolescents exhibit GD in childhood
    (Brill & Pepper, 2011; Cohen-Kettenis, 2012)

• Readiness for Gender Transition
  – Self:
    • Degree of social transition to date
    • Serious condition or other significant issue calling into question youth’s motivation, or gender identity
      – Cognitive dysfunction
      – Poorly managed psychotic disorder
      – Restricted, repetitive patterns associated with Autism Spectrum Disorder
      – Maladaptive coping related to trauma history (Ehrensaft, 2011)

  (Coolhart et al., 2012)
Readiness Assessment for Hormone Therapy in Youth

• Readiness for Gender Transition
  – Self (cont):
    • Comprehension of effects of hormone therapy
    • Expectations for physical, mood, social changes
    • Impact on fertility, interest in fertility preservation options

  – Social Agents (parents/guardians, caregivers, siblings, extended family, school)
    • Degree of gender affirmation
    • Comprehension of effects of hormone therapy
    • Expectations, potential reactions: physical, mood, social changes

• Youth Assent/Parental Consent
  • Capability of minor to assent to care (or provide informed consent if 18+)
    (Coolhart et al., 2012)
When to Refer?

• If personal biases prevent the delivery of competent care

• Youth expressing interest in gender-specific medical or mental healthcare

• Youth or family member struggling with youth’s gender variance

• Youth or family member seeking more education about gender development
When to Seek Consultation

Seeking information...

• Behalf of youth expressing interest in gender-specific medical or mental healthcare

• Up-to-date info on trans*-competent care

• Behalf of youth or family member struggling with youth’s gender variance

• Behalf of youth or family member seeking more education about gender development
The Role You Can Play
What Youth Want Providers to Know

“I don’t consider myself to be any kind of sick because I’m transgender and only wish to be treated with the same casual, natural respect you give any person. Basically, I dislike it, as a transgender person, when my gender makes people uncomfortable or awkward. I’m just another person.”

- 18 yo transgender patient at GDC
Thank You!