# THE TRANSGENDER CHILD AND ADOLESCENT: WORKING WITH FAMILIES

Suzanne Zinck, MD, FRCPC
Department of Psychiatry
IWK Health Centre

Jeff McCrossin, MSW
IWK Mental Health & Addictions

Dalhousie Department of Psychiatry
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## Acknowledgment

Dr. Arati Mokashi
IWK Health Centre
Department of Endocrinology

*for* slide content on medical transition

## Objectives

1. You will learn the terminology of gender expression
2. You will be able to describe criteria and psychosocial assessement involved in making a diagnosis of gender dysphoria
3. You will understand the time course of gender variance and dysphoria
4. You will understand the evidence for treating transgender youth
5. You will become familiar with gender affirming treatments and outcomes
5. You will learn about working with families of gender questioning and transgender youth.

## Video

- For Adobe Connect users, click video link to play.

## Terminology

- Cis-gender,Transgender or 'Transexual'
  - **FTM: (natal female parts) transmale/transman**
  - **MTF: (natal male parts) transfemale/transwoman**
  - Intersex: varying syndromes
- Gender fluidity: expression and internal include all
- Gender variance: behaviour, pronouns & others' views
- Varying terms: use the one the child uses
- Charting: use preferred name, pronouns and state assigned birth gender (just once!)

Halifax Sexual Health Centre 'Sexuality: Useful Terms to Understand'
http://www.hshc.ca/?q=content/sexuality-useful-terms-understand

## "Discomfort" and dysphoria

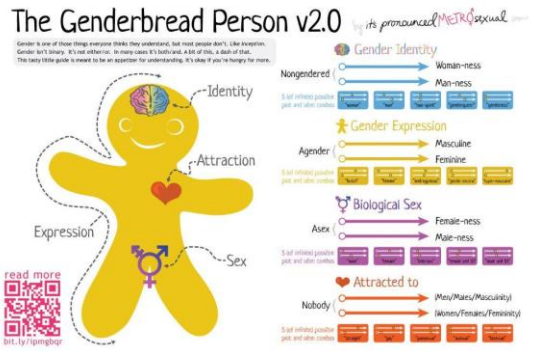
Gender dysphoria

Exists on a spectrum from discomfort, questioning to cross-gender identification to transition.

Common body concerns of adolescence are still present and at times most prominent.

Dysphoria is not just a 'transgender' issue

We can all experience discomfort with an assumed or assigned gender role or with our bodies




## 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 important areas of functioning.
- *Specify* if: **With a disorder of sex development** (e.g., a congenital adrenogenital disorder such as 255.2 [E25.0] congenital adrenal hyperplasia or 259.50 [E34.50] androgen insensitivity syndrome).
- **Coding note:** Code the disorder of sex development as well as gender dysphoria.

DSM-5, APA 2013

## Gender Dysphoria in Adolescents and Adults

- 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 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).
  - 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, occupational, or other important areas of functioning.
- *Specify* if: **With a disorder of sex development** (e.g., a congenital adrenogenital disorder such as 255.2 [E25.0] congenital adrenal hyperplasia or 259.50 [E34.50] androgen insensitivity syndrome).
- **Coding note:** Code the disorder of sex development as well as gender dysphoria.
- *Specify* if: **Posttransition:** The individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one cross-sex medical procedure or treatment regimen—namely, regular cross-sex hormone treatment or gender reassignment surgery confirming the desired gender (e.g., penectomy, vaginoplasty in a natal male; mastectomy or phalloplasty in a natal female).

DSM-5, 2013

## Prevalence

- It is difficult to accurately estimate the number of transgender people, mostly because there are no population studies that accurately and completely account for the range of gender identity and gender expression (APA 2015).
- Acceptance and awareness are increasing

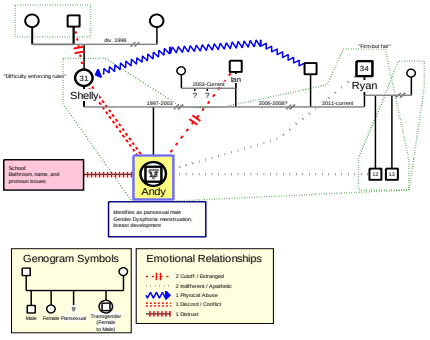
## A Word about Etiology

UNKNOWN

## Case example Andy

- 13 year old, assigned female at birth. Preferred name: Andy
- Referred to CMHC by mom due to family conflict, risky behaviour, suicidal ideation. Central Referral decided going to Transgender Health team appropriate.
- Gender journey: identified as "ultra-femme" in grade 5/6. Came out to mom as lesbian, then as pansexual and male. Mom felt this was a phase, but found it to persist.
- Blended family. Biological father made first contact in Fall 2015.
- Mom and step-dad struggled with preferred name & pronoun use. Contrast in parenting styles. Maternal grandparents undermined parental authority.
- Mom a survivor of domestic abuse. Andy exposed to verbal conflict from age 3-4.
  - Attachment rupture: Andy put in care of maternal grandparents while mom sought refuge out of province.
- Invited mom, step-dad, and Andy to family sessions.
- Assessment and informed consent → Referred to endocrinology for puberty suppressing treatment.

## Case example: Andy | Referral




## 'Natural History': a Quick Summary

- Natal males are referred more than females
- Most gender dysphoric children do not grow up to have GD: 80% have the dysphoria resolve.
- Greater number of GD symptoms or diagnosis at early age predicts persistence of transgender identity.
- Desistence tends to occur at onset of puberty or by age 12-13 if it will occur
- Greater numbers of desisters are homosexual compared to the general population. More GD children grow up to identify as gay or bisexual. (Selection bias may be high!)
- Note: this sample may include some who are only gender variant due to how GD is identified

KJ Zucker, JAACAP 2008 47:12; 1362-1363

## Gender Transition outcomes

- Majority of persisters *in prospective (teen to adulthood) clinical samples* seek gender reassignment either through hormones, surgery or both (75-100%)*

*JM Wallein and P Cohen-Kettenis, JAACAP, 2008

## Suicide Risk

- Canadian Trans Youth Health Survey
  - >66% Canadian youth (14-25y) reported poor or only fair mental health
  - >33% had attempted suicide in the prior 12 months
- Protective factors: Suicide risk was significantly reduced
  - Social support
  - Parental support for gender identity
  - Having personal identification documents changed to appropriate sex designation
  - Absence of transphobia (physical violence/sexual assault)
  - Completion of medical transition including hormones/surgery

**Bauer et al. *BMC Public Health*. 2015; 15: 525**
**Public Health Agency of Canada website**

## Three potential approaches to treatment of children with GD

- Work with children and parents to lessen gender dysphoria "with aim to increase desistence" (make them comfortable with their natal sex).
- ***Watchful waiting with support until age 13 or later, with or without use of GnRH analogues***.
- Encourage children to fully transition immediately and monitor for persistence.

KJ Zucker, JAACAP 2008 47 (12): 1362-1363.

## Five Elements of Clinical Work

WPATH SOC version 6:

- Comprehensive assessment
- Psychotherapy ("highly recommended" in version 7)
- Gender expression
- Hormone therapy
- Surgical therapy

- Assessment begins the treatment: the validation of 'diagnosis' can be therapeutic and may allow further exploration and expression of gender and facilitate or enhance a family's acceptance and understanding.

## Primary Assessment & Follow-Up Format

- All youth receive 90 minutes to 3 hours of basic assessment using DSM 5 and WPATH as guides.
- Comprehensive assessment of gender, sexual and mental health histories in **context of development and family**.
- Follow-up of minimum 6 months to provide support if no previous follow-up
- Explore attitudes if rigidity of gender roles is present.

- For GnRH analogues, extreme distress with natal puberty and/or gender dysphoria and social expression of other gender since childhood (approximately 6-12 months follow-up if time without active puberty).

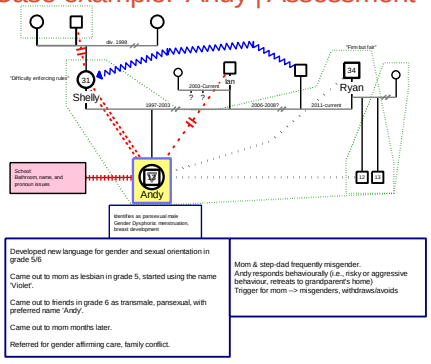
- For feminising or masculinising hormone referral:

6 months of expression "18/7" preferably "24/7" to meet WPATH/CPATH SOC guidelines for pre-referral services of assessment of eligibility and readiness and to assist in adjustment during coming out and social transition (meeting readiness criteria).

## Questions from Families about Diagnoses of Gender Dysphoria or Gender Variance

- Is this "real"? How do you know?
- Will they change their mind?
- If they do, what should we do?
- Why is my child/sibling like this? Is it my fault?
- Will they commit suicide?
- Will they be a victim of intimidation or violence?
- What will my friends/in-laws/parents think?
- What do I tell the school?
- How can I help my child?
- Will they be happy?
- Will they find love?

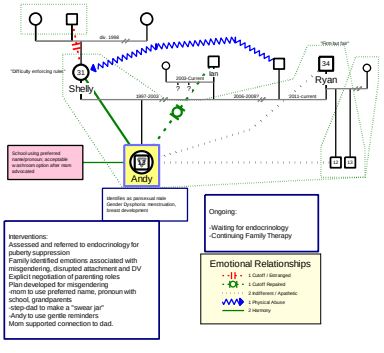
## Case example: Andy | Assessment




## Work within Families

- All three are ideal:
  - Acceptance
  - Support
  - Understanding
- What's in a name?
- "I miss my daughter/son/brother/sister"
- Anxieties for well-being
- Telling sibs and extended family
- Family adaptation to new role has a process and grieving can occur
- For those who face extreme rejection, families can be made as well as born

## Case example: Andy | Tx Plan




## Transforming : Social Transition

- Dressing as felt gender ( neutrally *or* mixed is A-OK!)
- Hiding obvious sexual characteristics that can lead to misgendering:
  - Binding of breasts (FTM)
  - Tucking of penis and testicles (MTF)
- Vocal training (self or professional)
- Gesture (natural or practiced)

## Unique assessment content

- Sexual History for teens only
  - Relationship to body is only what needs to be understood
  - Behaviours: "Some hormones affect sexual function or sensation. To ensure you are making an informed decision, may I ask which parts do you use in sexual practice? Or, may I tell you how they might affect these, in general terms?" Relevant ONLY if contemplating medical/surgical changes

- Goal setting
  - Exploration? Expression?
  - Social transition: dress, pronouns. Families are transitioning too.
  - Hormone or surgical referral?

## Eligibility and Readiness

- Eligibility
  - Gender dysphoria
  - Age
  - Social transition/presentation; no set duration
  - Therapy follow-up

- Readiness
  - Further consolidation of the evolving gender identity
  - Improving mental health and/or self-esteem with transition socially
  - Improved functioning in the new or confirmed gender role
  - Clinician & therapist's and patient's judgment of the above

  (e.g. if any mental health or substance abuse problems, these need to be stable enough for treatment to proceed).

WPATH SOC , version 7 2011

# MEDICAL TRANSITION

## Questions from Parents about Pubertal Suppression and Gender Affirming Hormones

- Why is this important?
- Why now? (Why not at 18? Or, When they move out?)

- What are the side effects?
- Is it reversible? What if they change their mind?
- Will they still be able to conceive a child?

- How much does it cost? Is it covered?

WPATH *Standards of Care*, 7th version, 2011

## Reasons for medical transition early

- Suicidality increases in those wanting to medically transition, who are waiting for access to care
- Body dysphoria worsens with puberty
- "inability to pass" in ones felt gender
- Transphobia (TransPulse Survey – N=433 16-25y)
  - 20% physically or sexually assaulted
  - 97% avoided public spaces including bathrooms and schools
- Families need to know this, especially if they are fearful or opposed.

**"I just want to be "Andy" the guy. Not Andy the trans guy"**

Olson et al. *Arch Pediatr Adolesc Med.* 2011; 165(2): 171-176
Spack N et. al. *Pediatrics.* 2012; 129(3): 418-425. 97 patients (1998-2010)
Bauer and Scheim. Transgender People in Ontario, Canada

## Withholding Treatment

NOT a NEUTRAL Option!

## Evidence

- Published transgender-specific level 1 evidence is non-existent
- Long-term studies –
  - Longest transgender adult follow up study 30 years
  - Longest pediatric study follow up study 10 years
    - small numbers

Annelou LC et. al. *Pediatrics*. 2014; 134(4): 1-8
Gooren LJ et. al. *J Clin Endocrinol Metab*. 2008; 93(1): 19-25

## The Dutch Protocol

- Cross sex hormone therapy for adolescents
  - First started treatment in adolescents 1998 in Amsterdam
  - Age of majority 16 years
- Pubertal suppression
  - Under Dutch law: Ages 12-16 years can make treatment decisions with parental consent
  - Minimum age for pubertal suppression 12 years

## Young Adult Outcomes after Puberty Suppression

- N=55 adults
- Hormone therapy during adolescence
- Assessed 3 times: questionnaires GD, BD, psychosocial functioning
  - T0: Before start of puberty suppression (mean age 13.6y)
  - T1: When cross-sex hormones introduced (mean age 16.7y)
  - T2: At least 1 year after gender affirming surgery (mean age 20.7y)

Annelou LC et. al. *Pediatrics*. 2014; 134(4): 1-8

## Results

- GD remitted after GAS (but not with pubertal suppression alone)
- Psychological functioning – improved over time with 30% in the clinical range dropping from to 7% (similar to general population)*
- No regret during puberty suppression, CSH or after GRS surgery
- High satisfaction with appearance in identified gender

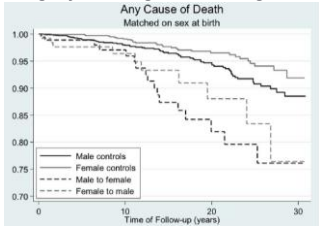
## Physical Outcomes

- Some research suggests that post-operative psychopathology is associated with factors that make it difficult to pass in the new gender
  - Looking like a man when living as a woman
- MTF adults who had received puberty suppression or androgen blockers
  - Voices tend to sound less male and had only sparse beard growth

Ross & Need. 1989.
Cohen-Kettenis PT and van Goozen SHM. *J Am Acad Child Adolesc Psych. 1997; 36(2): 263-271*

## Medical/Surgical Transition Not Perfect

Death from any cause after sex reassignment surgery among 324 transgender persons




- Controls: population matched 10 controls per trans adult by birth year
- Majority of excess deaths related to suicide (2.7 vs 0.1 per 1000 person years)

Dhejne C et. al. *PLoS ONE. 2011; 6(2): e16885*

## Puberty Suppression: When?

- Normal timing onset of Tanner 2
  - As early as 8 years in natal females
  - As early as 9 years in natal males
- Many children will arrive at these Tanner stages quite early
  - Some natal females are menstruating and have completed puberty by age 12y
- To determine whose GD will persist, need to experience some puberty (also important for MTF surgical outcome)
  - **Guidelines use pubertal staging rather than a specific age cut-off**

## Case: ANDY part 2

- 13 y.o. natal female who identifies as male
- Prefers male pronouns
- MALE------O----------I----------FEMALE
- He was very distressed by puberty.
  - Double layers to cover chest
  - Loved to swim but now cannot wear a bathing suit
  - Started breast development at age 9y and menses at 11y6m
  - Devastated when period began - Could not go to school for 2-3 days during periods
  - Benefits and Risks of Lupron discussed – very interested

## Case: ANDY

- 5 months later in transhealth endo follow up:
  - Andy has independently discussed wish for Lupron with parents and Dr. Zinck
  - Prefers female pronouns, wears her hair long
  - Identifies as mostly male
  - Remains distressed by menses
  - Doesn't allow physical exam to assess puberty
- A GnRH stimulation test confirms central puberty
  - Start lupron
  - Will return with 4th or 5th dose of lupron for a repeat GnRH stimulation test to confirm pubertal suppression

## Criteria for Hormone Therapy

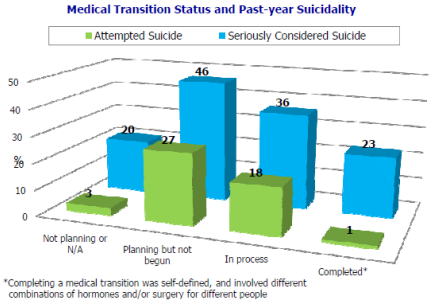
- No clear criteria for adolescents
- Eligibility criteria for adults:
  1. Persistent, well-documented GD
  2. Capacity to make a fully informed decision and to consent to treatment
  3. Age of majority in a given country
  4. If significant medical or mental health concerns are present, they must be reasonably well-controlled
- No age of consent regarding medical decision making in most provinces (Except NB/QC) –"mature minor doctrine"
  - Assessment of individual's capacity to provide informed consent
  - By age 14 years the average adolescent has switched from concrete to formal operational thinking – think about consequences of therapy vs no therapy

WPATH *Standards of Care, 7th version,* 2011
www.royalcollege.ca/portal/page/portal/rc/common/documents/bioethics/section1

## Family work at this stage

- Family work does not change:
  - Wide range of expressed emotion
  - Facilitate opinions shared
  - Identifying maladaptive patterns
    e.g., are pronouns & name still used? If not, why not?
- Similar reactions: a new level of adjustment
- Parents often see child is happier and more "comfortable in their own skin."
- Worries do not disappear for parents, often just change.
- School interventions may change

## Mental Health Support




http://transpulseproject.ca/wp-content/uploads/2012/08/Trans-Health-Advocacy-Summit-2012-Results-vFINAL.pdf

# QUESTIONS?

Sue Zinck
suzanne.zinck@dal.ca
Jeff McCrossin
jeff.mccrossin@iwk.nshealth.ca

# FREQUENTLY ASKED QUESTIONS

## Identification Documents

- Access Nova Scotia office
- Gender Marker Change
  - As of Oct 1, 2015 – no SRS needed
  - Parental consent if 15y or younger (as with name change)
  - $24.95 (cf name change $165.70)
  - Plus birth certificate ($33.00 – $39.00)
  - Professional statement letter
  - Not an insignificant cost for some families

## Sex Reassignment Surgery (SRS)

- SRS is also known as Gender Reassignment Surgery (GRS) or Gender Affirming Surgery (GAS)
  - 18 years and above (can refer at 17y)
- Covered by MSI:
  - For transmen hysterectomy and bilateral salpingo-oophorectomy, mastectomy/chest contouring, phalloplasty and meitoidoplasty
  - For transwomen, vaginoplasty (incl penectomy/ orchiectomy)
- Not covered:
  - tracheal shaving, jaw reshaping, vocal cord surgery, breast augmentation

## Clinical Practice Guidelines

- **International (WPATH)**
  Standards of Care for the Health of Transsexual,Transgender, and Gender Nonconforming People, version 7, 2011.
- **AACAP Official Action Practice Parameter for GLBTQI youth** Available via Dal Libraries e-journals:
  Journal of the American Academy of Child and Adolescent Psychiatry Sept 2012 51(9): 957-974
- **Canadian Trans Youth Health Survey (2015)**
  - http://www.dal.ca/content/dam/dalhousie/pdf/Diff/gahps/SARAVYC_Trans%20Youth%20Health%20Report_EN_Final_Web.pdf
  - Summary of findings available on www.cpath.org

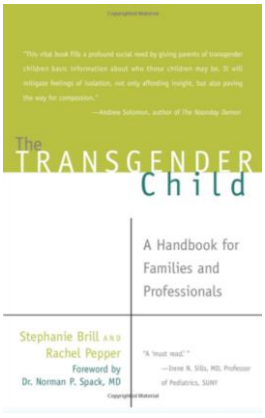
## Community Resources

PFLAG Canada: Halifax since 1994
- For parents and friends of LGBT youth
- No parent group specific to Trans issues

- http://www.pflagcanada.ca

## HRM Community Resources

- Youth Project:
  - Transformers groups
  - Social opportunities
  - Trans-safe summer camps
  - Support from peers & staff
  - Referral info for primary and specialist care clinicians
  - www.youthproject.ns.ca
  - Facebook group (closed) Transgender families




## Quality Web PDF resources for Families

- Families in Transition
  www.ctys.org/about_CTYS/documents/FamiliesInTRANSition-CTYS-080608.pdf
- Parenting a Child with Gender Variant Behaviours
  www.childrensnational.org
- Family Acceptance Project
- https://familyproject.sfsu.edu/
- Dalhousie file share for resources for families
- Centre of Excellence for Transgender Health
  - http://transhealth.ucsf.edu/

## Embrace Diversity

… move beyond tolerance, or the "putting up with difference", we must engage our ethical, moral, and professional responsibilities in order to embrace and to learn from diversity and difference. We must see this as a critical opportunity for self and social improvement. This deep engagement ought to include a sustained conversation … on issues related to human sexuality, gender equality, and nondiscrimination on the basis of sexual orientation, gender identity, and gender expression. The stark reality is that there is still much work for us to do if we are to move beyond shallow notions of tolerance and envision the day in which we will build truly genuine … cultures based on respect and dignity that not only support, but also affirm and celebrate the full range of human potential and diversity.

**Canadian Teachers Confederation. Supporting Transgender and Transsexual Students in K-12 Schools.**

## Keep questioning

Are we welcoming and "safe"?

- Attitudes/biases
- Language & pronouns
- Facilities: bathrooms, change rooms, triage set-up
- Front desk staff
- Information posters/pamphlets/Ally Program
- Knowledge base
- Ask if you do not know

Challenge our own assumptions