Gender Diversity in Children and Adolescent

The truth is an unruly beast (Machiavelli)

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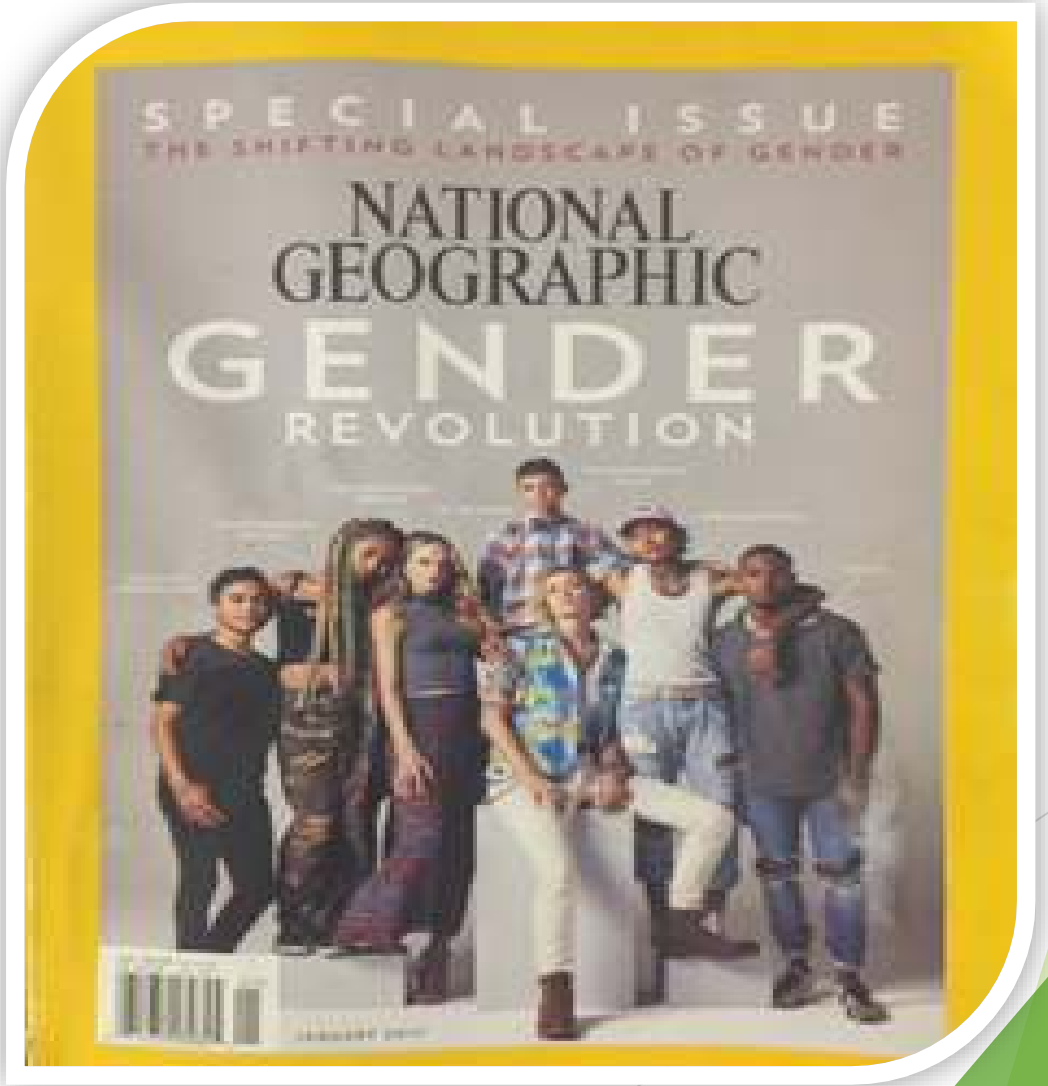


Questions

What does it mean to be male or female?

What were your first memories of being male of female?

Can you think of any generalisation that can be applied to *all* members of one gender, and *only* members of that gender?

Definitions

Gender identity
Person's *subjective* sense of identification with either the male or female gender as manifested in appearance, behaviour and other aspects of a person's life.

Gender expression/orientation
The external, *objective* presentation of one's gender, as expressed through one's name, clothing, behaviour, hairstyle or voice, and which may or may not conform to socially deemed behaviours and characteristics typically associated with being either masculine or feminine.

Cisgender
A term for someone whose gender identity aligns with their sex assigned at birth.

Gender diverse/expansive
A term used to describe people who do not conform to their society or culture's expectations for males and females. Not all gender diverse people are transgender.

Trans* or transgender
A term for someone whose gender identity is not congruent with their sex assigned at birth. The term transgender may be used when a person experiences incongruence between one's experienced or expressed gender and one's assigned gender.

Non-binary
A term to describe someone who doesn't identify exclusively as male or female.

Gender fluid
A person whose gender identity varies over time.

Agender
A term to describe someone who does not identify with any gender.

Brotherboy and Sistergirl
Aboriginal and Torres Strait Islander people may use these terms in a number of different contexts, however they can be used to refer to trans and gender diverse people. Brotherboy typically refers to masculine spirited people who were assigned female at birth. Sistergirl typically refers to feminine spirited people who were assigned male at birth.

Social transition
The process by which a person changes their gender expression to better match their gender identity.

Medical transition
The process by which a person changes their physical sex characteristics via hormonal intervention and/or surgery to more closely align with their gender identity.

Sex and Sexuality

Sex is related to your biology and/or anatomy

Your **sexuality** is about who you're attracted to sexually and romantically. People who are attracted to others of a different sex are known as 'heterosexual' or 'straight'. People who are attracted to others of the same sex are known as '**homosexual**'; 'gay' or 'lesbian'.

Sexuality is more complicated than just being gay or straight.

Some people are **bisexual** and are attracted to both men and women. Others see sexual attraction and gender as fluid and find labels like 'straight', 'gay' or 'bi' too rigid and fixed. These people may prefer to self-identify as '**queer**'.

The term **pansexual** refers to an attraction to another that is not based on physical or sexual attraction.

"I identify as a cis-gendered, heterosexual AngloAustralian male"

Gender Dysphoria

DSM-V (2013) - Gender dysphoria replaced 'Gender Identity Disorder'. Focus on dysphoria as the clinical problem and not identity per se.

Emphasises that *gender non-conformity* is not a mental disorder

For a person to be diagnosed with gender dysphoria, there must be *strong and persistent* cross-gender identification that causes *clinically significant distress or impairment* in social, occupational, or other important areas of functioning.

In children, the desire to be of the other gender must be present and verbalised.

It is important to note that not all gender non-conforming people are dysphoric

Being transgender does not equate to having a mental illness. However, a diagnosis of Gender Dysphoria is given when someone who is transgender experiences significant distress relating to their gender

DSM-5 Criteria: Gender Dysphoria in Children

A. 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 he or she 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 typically masculine toys, games, and activities and **a strong avoidance** of rough-and-tumble play; in girls (assigned gender), a **strong rejection** of typically 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, occupational, or other important areas of functioning.

DSM-5 Criteria: Gender Dysphoria in Adolescent & 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 two 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

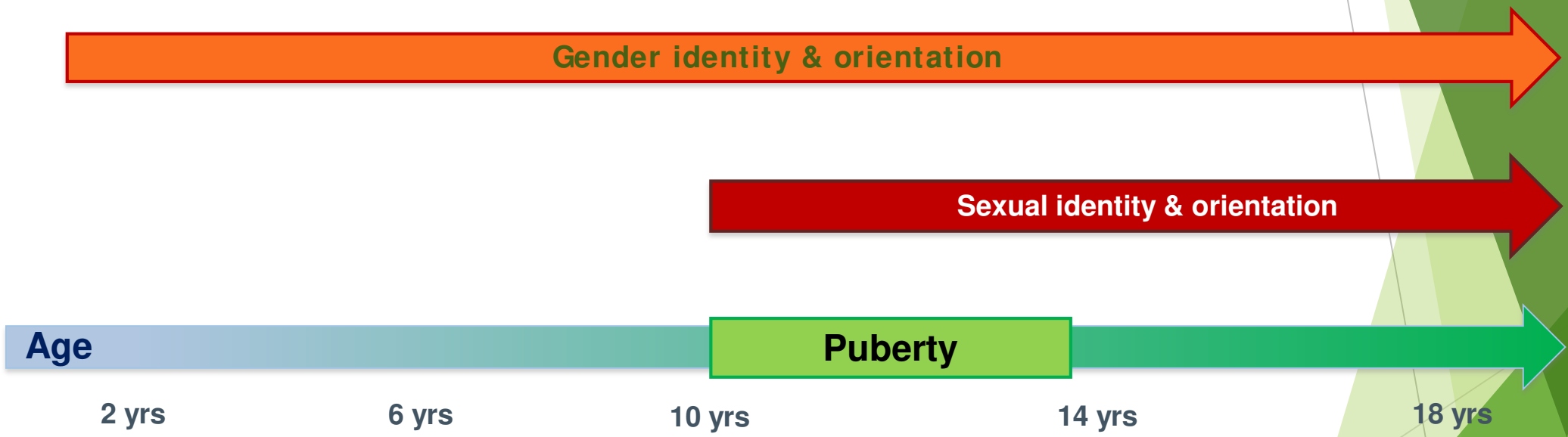
4. A **strong desire** to be of the other gender (or some alternative gender different from one's assigned gender)

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, occupational, or other important areas of functioning.

Gender & Sexual Identity/Orientation Development



Aetiology. No Satisfactory Explanation
Bio-psycho-social approach; Primary or Secondary

***Genetic*. Additive genetic component accounts for ~62% of variance**

***Biological*. There is emerging evidence in Intersex/Disorders of Sex Development (*Male Brain;* no, this is not an oxymoron!)**

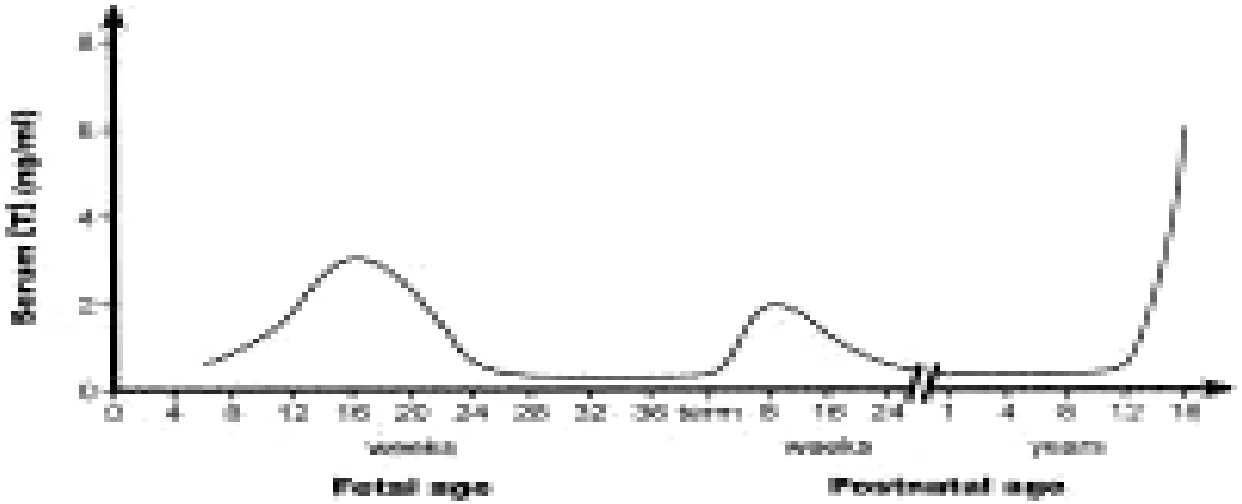
- **Females XX; Males XY**
- **X Chromosome 1,500 genes; Y Chromosome 100 genes including important SRY Gene**
- **Structural differences**
- **Biochemical differences**
- **Intersex research: Is there a '*sensitive' period*' when there is plasticity in gender development??**

***Psychological*. Cause or effect. Assumption that individual or family psychopathology or distress 'causes' or supports gender dysphoria**

***Social*. Not as simplistic as Social Learning theorists may suggest**

Sexual Differentiation & Androgen Imprinting

- **Mean serum testosterone in male foetus and child**
- **Large amounts of androgen particularly during:**
  - Weeks 8-20 gestation
  - 6-12 months
  - ~Puberty



The Journal of Urology; 2002 168:2145

Prevalence – Gender Diversity

No systematic epidemiological studies. Vary depending on when and where performed.

<u>Child Cohorts</u>: Cross-gender behaviour from CBCL (0,1,2)

- Item 5 "Behaves like opposite sex"
  - **3.8% boys; 8.3% girls >= 1 (aged 4-11)**
- Item 110 "Wishes to be of opposite sex"
  - **1.0% of boys; 2.5% of girls**

<u>Not all such children will fulfil DSM criteria for Gender Dysphoria</u>

Prevalence in adolescent cohort studies
Not known, estimates vary depending on methodology:

Population based study of 2168 adolescents in Minnesota

- 2.7% trans / gender non conforming *Eisenberg ME et al – J Adol Health*

New Zealand Adolescent Health Survey (Youth 2012) A national, cross sectional, population based survey 8,166 secondary school students. *T.C Clark et al Journal of Adolescent Health (2014)*

- 1.2% reported being transgender (?gender diverse or questioning)
- 2.5% reported not being sure about their gender
- 1.7% did not understand the question

Referral Rates

- **Girls seem to exhibit more cross gender behaviour than boys**
- **Boys more likely to be referred for assessment**
  - Cultural 'norms': Well established that parents, teachers and peers less tolerant of cross-gender behaviour in boys; girls need to display a higher threshold for referral
- **Canadian Data**
  - ~5.8:1 in children ↓ to 1.3:1 in adolescents
- **Netherlands**
  - ~2.9:1 in children ↓ to 1.2:1 in adolescents

Persistence of gender diversity into adolescence and beyond: Can we predict?

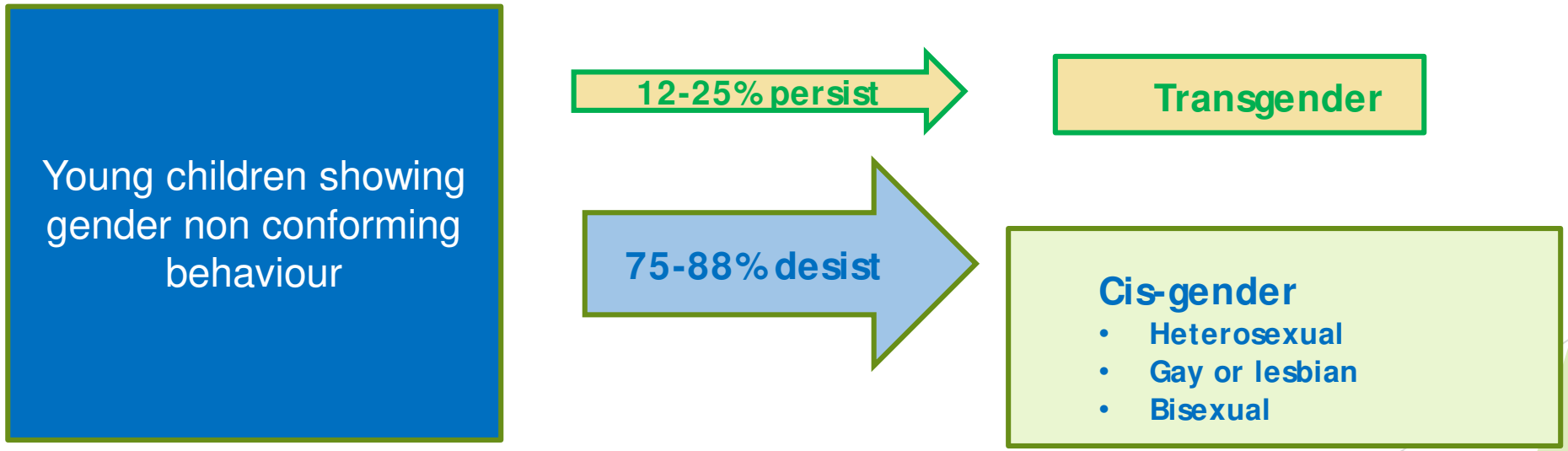
Some Clues

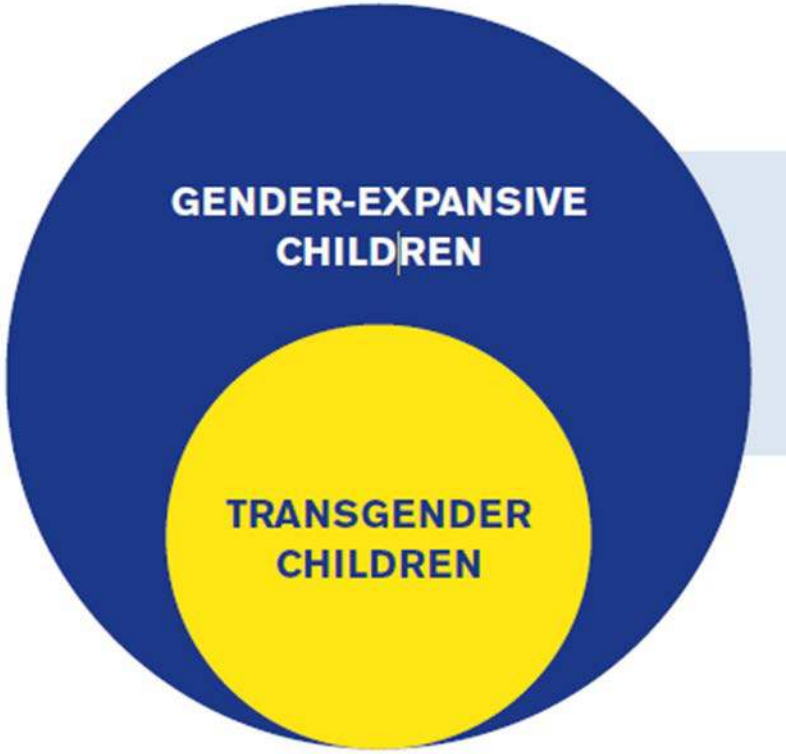
Persisters more likely to meet FULL DSM-IV (and now DSM-5) criteria

Persisters more likely to have extreme scores on measures of gender dysphoria and cross-gender behaviour *(Gender Identity Questionnaires)* - So called "Dosage effect"

Persisters more likely to present early; ?? Present to Gender Clinics

Persisters have higher levels of body dissatisfaction





GENDER-EXPANSIVE CHILDREN

- Behavior, preferences or other traits are not gender-typical
- Not necessarily distressed –except because of bullying or stigma

TRANSGENDER CHILDREN

- Distressed about assigned sex and/or expected gender identity
- May call for gender transition

Psychiatric Co-morbidity

- **High levels of behavioural problems and mental health issues that increase with age**
  - Depression > Anxiety
  - CBCL Clinical range
    - 47%children
    - 85%adolescents
- **Not surprising, given social ostracism & peer rejection which becomes more pronounced with time**

Mental Health Statistics

Mental health issues

- 4 out of 5 trans young people have ever self-harmed (**79.7%**)
  - This is compared to **10.9%** of adolescents (12-17 years) in the Australian general population
- Almost 1 in 2 trans young people have ever attempted suicide (**48.1%**)
  - This is 20 times higher than adolescents (12-17 years) in the Australian general population
  - This is 14.6 times higher than adults (aged 16-85 years) in the Australian general population
- 3 in 4 trans young people have ever been diagnosed with depression (**74.6%**)
  - This is 10 times higher than adolescents (12-17 years) in the Australian general population
- **72.2%** of trans young people have ever been diagnosed with anxiety
  - This is 10 times higher than adolescents (12-17 years) in the Australian general population
- **22.7%** of trans young people had been diagnosed with an eating disorder
- **25.1%** of trans young people had been diagnosed with post-traumatic stress disorder

Risks for poor mental health

- **89%** had experienced peer rejection and **74%** had experienced bullying
- **78.9%** had experienced issues with school, university or TAFE
- **68.9%** had experienced discrimination
- **65.8%** had experienced lack of family support
- **22%** had experienced accommodation issues or homelessness.

2017 Australian study

859 young people

194 Parents of gender diverse

Online survey

Strauss, P., Cook, A., Winter, S., Watson, V., Wright Toussaint, D., Lin, A. (2017). Trans Pathways: the mental health experiences and care pathways of trans young people. Summary of results. Telethon Kids Institute, Perth, Australia.

Mental Health Statistics:2017 online Australian study

- *859 young people*
- *194 Parents of gender diverse*

Why the increased interest?

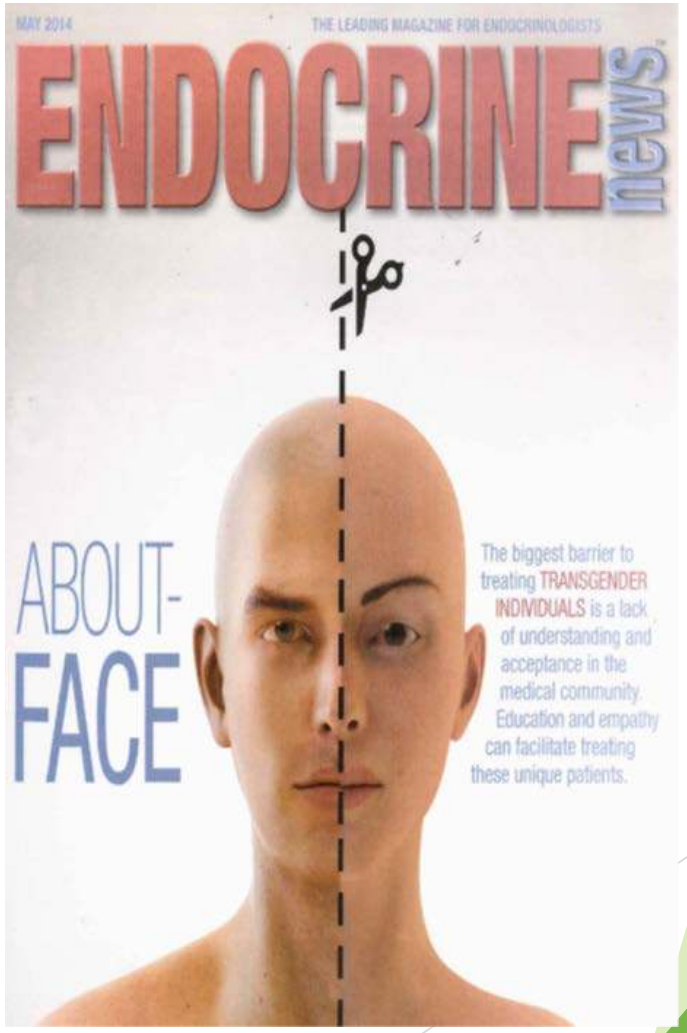
1. Less resistance and increased interest in the diagnosis; 'tipping point'
2. Increasing online information
3. Refined diagnostic criteria
4. Medical treatment and legal position now defined by law
5. Accepted international treatment guidelines
6. Increasing number of support groups (patients and families); 'out of the closet'
7. Consequence. Increased acceptance = increased confusion
   - Gender identity vs. sexual confusion
   - Sexual abuse
   - ASD
   - Adolescent development – pushing boundaries

ASSESSMENT AND TREATMENT

Hembree, W.C. et al. Endocrine Treatment of Gender-Dysphoric/ Gender incongruent persons: An Endocrine Society Clinical Practice Guideline. *The Journal of Clinical Endocrinology & Metabolism* 2017 102:11 pp. 3869–3903 https://doi.org/10.1210/jc.2017-01658

Australian Standards of Care (SOC) and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents (2017)

Colema, E. et al. Standards of Care for the health of Transexual, Transgender, and Gender Nonconforming People, V. 7. *World Professional Association for Transgender Health* (WPATH) (2011)



Recommended Treatment Process Based on Best Practice Guidelines

3 - 11 yr

Multidisciplinary Assessment

Mental Health Ax
Medical Ax
Fertility Preservation
Family support
School assistance

Mental Health work within the Gender Clinic

1. **Assess level of gender diversity/dysphoria (DSM-5, WPATH Standards of Care).**
   - Comprehensive assessment of child and family
   - Provide information on diversity of gender identities and expressions, medical treatment options, counselling referrals, family therapy etc. Goal is to find a comfortable gender expression and inform regarding all options including medical intervention

2. **Assess and treat mental health comorbidities in collaboration with CYMHS or other community mental health providers.**
   - High mental health comorbidities

3. **Assess, prepare and refer for medical treatment if applicable.**
   - Readiness and eligibility standards WPATH Standards of Care, Australian Endocrine Guidelines

Rationale for treatment post puberty: It is uncommon for GD to desist when present as a child and continues into puberty

PsychoEducation for Young Person and Family

- Gender vs Sexuality
- Gender variance
- Gender identity
  - Meaning
  - Management
- Sexual Health & General Health
- Mental Health
- Who to tell; when to tell
- Parents & siblings & extended family
- School, clubs, churches, sports groups etc
- Loss and grief (parents/ siblings/ family)
  - *Don't forget the siblings*
- Time frames & Best Practice Guidelines
- Waiting is ok
- Pubertal suppression
- Hormones & replacement; reversible vs. irreversible
- Storage of eggs or sperm
- Family Court (less important now)
- Sex reassignment
- Legal issues & rights
- Support groups
- Books, questionnaires and research
- Contraindications

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3 - 11 yr

Multidisciplinary Assessment

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School assistance

Gender Dysphoria persists post onset of puberty

~12 – ~16 yr

Stage 1 treatment

Fully reversible

"Puberty Blockers"

Commencement at ~ Tanner stage 2

eg Lucrin

Family Court approval not required

Medical Assessment in Gender Dysphoria

Determine:

- **Chromosomes are normal and consistent with the natal gender**
- **Internal and external genitalia are consistent with the chromosomes and natal gender**
- **No hormonal disorder causing gender dysphoria**
- **Growth and pubertal status**
- **Personal or family medical history which would potentially increase the risks of**
  - **Phase 1 treatment: pubertal suppression**
  - **Phase 2 treatment: cross hormone treatment**

Hormonal Treatment in Gender Dysphoria

Goals of pubertal suppression & cross hormone (gender affirming) treatment

Suppress **the hormones and the secondary sex characteristics of the natal sex**

- *Phase 1* – pubertal suppression (M ~12 yrs, F ~ 8-10+yrs)

Induce **the development of the secondary sex characteristics of preferred gendered**

- *Phase 2* – cross hormone treatment (from ~16 years)

Criteria for adolescents to commence pubertal suppression (Phase 1): *Australian SOC 2017*

- Tanner Stage 2 pubertal status has been achieved (child has entered puberty)
- A diagnosis of Gender Dysphoria in Adolescence made by a psychiatrist or a clinical psychologist with expertise in child and adolescent development and mental health
- Do not suffer from psychiatric co-morbidity that interferes with the diagnostic work –up or treatment
- Medical assessment including fertility preservation counselling has been completed +/- referral to a gynaecologist and/or andrologist when required and referral for fertility preservation intervention when requested (sperm cryopreservation, testicular biopsy)
- Have adequate psychological + social support during treatment
- "Real life experience" – *minimum* of 3-6 months living as preferred gender

Detailed Informed Consent documents for Phase 1: Both parents/guardians and young person give consent

Benefits of Pubertal Suppression

- Aids in the diagnosis and therapeutic phase similar to ‘real life’ experience
- Management of gender dysphoria usually improves
- Pubertal suppression is fully reversible
- Physical outcome after cross hormone therapy is improved (eg voice in MTF not broken)
- Maintains end organ sensitivity to sex steroids, allowing satisfactory cross – gender body changes with low doses of hormones

Recommended Treatment Process Based on Best Practice Guidelines

3 - 11 yr

Multidisciplinary Assessment

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Gender Dysphoria persists post onset of puberty

~12 – ~16 yr

Stage 1 treatment
Fully reversible

"Puberty Blockers"

Commencement at ~ Tanner stage 2
eg Lucrin

Family Court approval not required

16 - 18 yr

Stage 2 treatment
Partially reversible

"Cross Hormone Treatment"

Commencement at ~ 16
eg oestrogen or testosterone

Family Court approval not required since 30 Nov 2017 – Determination of Competency

Criteria for adolescents to commence gender affirming hormone therapy (Phase 2): *Australian SOC 2017*

- **Commences when:**
  - A diagnosis of Gender Dysphoria in Adolescence
  - Fulfil the criteria for Phase 1
  - Are ~16 years or older
- **Ongoing discussions with child and family**
- **Multidisciplinary review**
  - The treating team should agree that commencement of oestrogen or testosterone is in the best interest of the adolescent and informed consent from the adolescent has been obtained.
  - Consider second opinion if there are differing professional opinions, familial conflict re treatment, or the case is atypical
- **Medical assessment including fertility preservation counselling has been completed**

Recommended Treatment Process Based on Best Practice Guidelines

3 - 11 yr

Multidisciplinary Assessment

Mental Health Ax
Medical Ax
Fertility Preservation
Family support
School assistance

Gender Dysphoria persists post onset of puberty

~12 – ~16 yr

Stage 1 treatment

Fully reversible

"Puberty Blockers"

Commencement at ~ Tanner stage 2
eg Lucrin

Family Court approval not required

16 - 18 yr

Stage 2 treatment

Partially reversible

"Cross Hormone Treatment"

Commencement at ~ 16
eg oestrogen or testosterone

Family Court approval not required since 30 Nov 2017 – Determination of Competency

18+ yr

Adult Services

Irreversible

Surgery if desired
and/ or
ongoing hormone treatment

Generally not performed in Australia < 18

ETHICAL AND LEGAL CONSIDERATIONS

Ethical Considerations

- **Do no harm (non-maleficence)**
  - There are long term physical risks
  - Reversibility and risk of regret
  - Impacts on fertility

- **BUT ALSO NEED TO CONSIDER RISKS OF NOT OFFERING TREATMENT**
  - Irreversible physical changes of delayed treatment including poor physical and mental health outcomes
- **Beneficence:** Improving outcomes for young gender diverse people
- **Respect for autonomy**
  - Respect for a young person (and their parent's) wishes
  - Age of competency: Capacity of young people to consent to long term treatment; where is the 'cut off'??
- **Justice**
  - Issues of poor access to treatment - waiting lists, few services

Legal: Can a school cancel/refuse a student's enrolment?

- The *Anti-Discrimination Act 1991* (Qld) makes it unlawful to discriminate against another person on the basis of a person's gender identity
- Direct discrimination will occur if the school treats a student less favourably because of gender identity
- If the school refuses to enrol based on gender identity, it would face exposure to the risk of a discrimination complaint

Logistical Issues

- **Name on school records**
  - Queensland State Schools are required to record the name of a student as it appears on his/her birth certificate
    - **On official documents (i.e. report cards)**
    - **Can go by an alias**
    - **NAPLAN**
  - That obligation does not apply to independent schools, though refusal to change a student's name may be discriminatory

Logistical Issues (cont)

- **Toilets, change rooms, uniforms, school photos …**
  - Imposition of conditions on attendance may be discriminatory
  - Negotiate reasonable response with parents & school
  - Manage interests of other students and interests of relevant student … and parents …. and siblings.
- **Camps**
- **Relationships *between* students**

Births, Deaths and Marriages Act (Qld)

- **Change of <u>name</u> on Birth Certificate:**
  - A child's parents may apply to register a change of the child's name
  - The application will not be approved for a child who is 12 years or more unless the child consents or is unable to understand meaning/ implications of changing name

Births, Deaths and Marriages Act (Qld)

Change of gender on Birth Certificate*:

- Can be registered (even for a child) provided that the person has undergone *sexual reassignment surgery*
- Sexual reassignment surgery means a surgical procedure involving the alteration of a person's reproductive organs carried out:
  - To help the person to be considered to be a member of the opposite sex; or
  - To correct or eliminate ambiguities about the sex of a person.

**Currently under review*

Other Forms of Identification

Hospital records - varies

- Change name and gender at parent's request
- No change on birth certificate required

Medicare

- Change name – bring in new birth certificate (gender not an issue with medicare)

Passport

- Can apply to be recognised under preferred name and gender
- DFAT form letter

Drivers Licence (Qld)

- New regulations (from September 2016) – Gender (and height & eye colour) phased out.

Finally ….
These patients will continue to keep me awake at night.

- Numerous Ethical and Practical Conundrums
- Sudden presentation: Adolescent with no childhood history
- Adolescent with childhood history and significant psychopathology
- Disengaged or hostile parent
- ASD and GD
- Children of parents with GD

Be a support person

Apply your current professional skills and knowledge in working with marginalised children and adolescents

Builds resiliency through strengthening family and social supports

Advocate and educate to reduce discrimination, and demonstrate your respect in words and actions

Seek first to understand

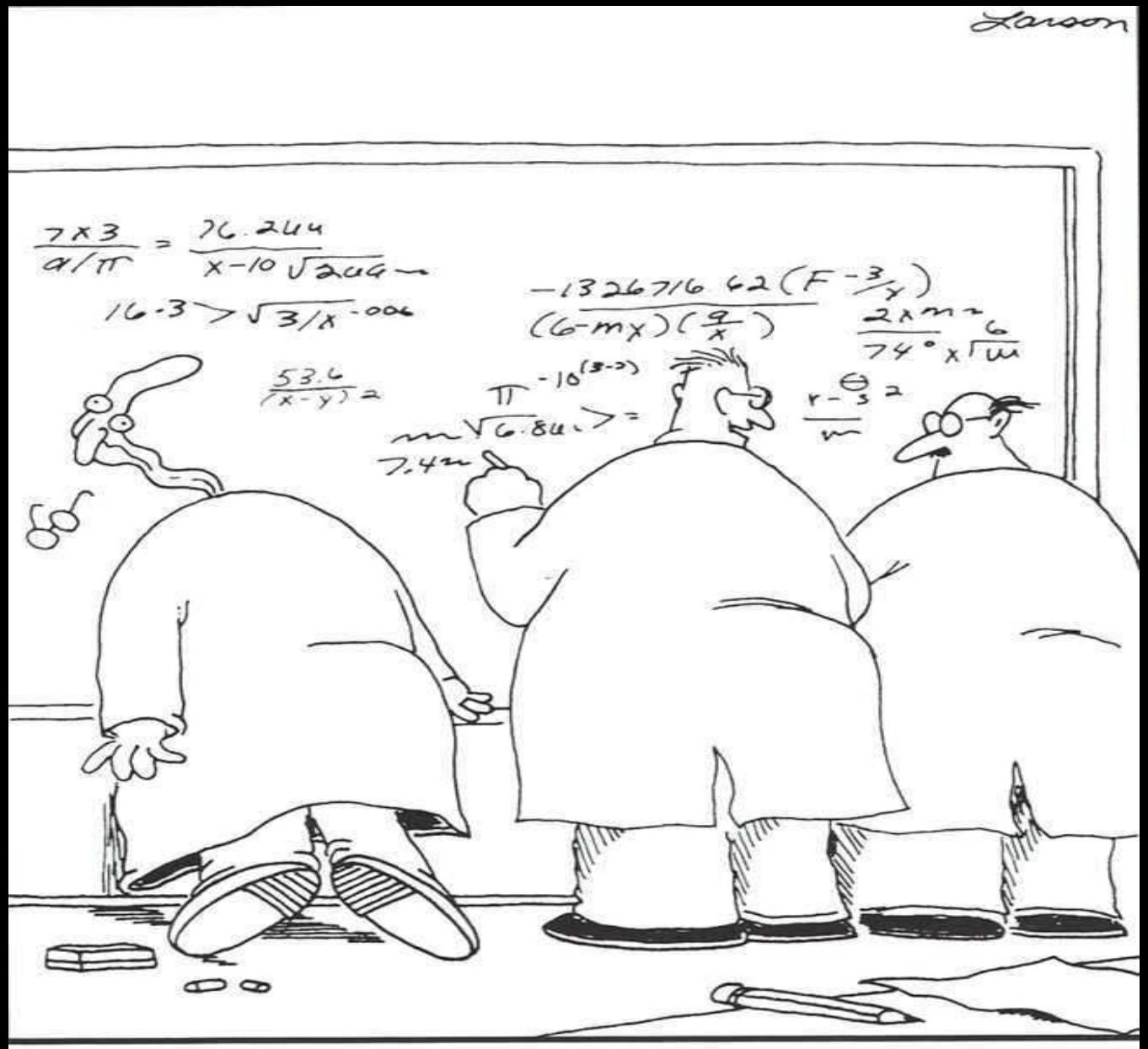
Final Quote ….

“Gender non conformity is not pathological, yet gender dysphoria is a specific distress that can be alleviated through medically necessary treatment.

Untreated or undertreated gender dysphoria leads to increased morbidity and mortality. We are negligent if we do not treat these cases.

It is not an experiment but a valid and well researched treatment option, medically necessary for many people”

Eli Coleman, University of Minnesota 2013



"Ha! Webster's blown his cerebral cortex."