Gender Dysphoria and Nonconformity

Pediatric Mental Health ECHO
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DULCAN'S TEXTBOOK OF Child and Adolescent PSYCHIATRY

SECOND EDITION

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Key Concepts

• *Gender identity* = an individual’s personal sense of self as male or female, which is not assigned, but psychologically rooted;
Key Concepts

• Per cognitive theories of gender development, majority of children have a sense of gender identity by age 3yrs;

• Most establish a lifelong male or female gender identity consistent with their natal sex by age 5 or 6yrs;
Key Concepts

• *Gender expression* = method of communicating gender identity within a given culture;
  – Varies by culture;
  – Varies over time;
Key Concepts

• Gender nonconformity = sometimes used synonymously with gender variance, gender role behavior that does not conform to culturally defined norms;

• Gender discordance = incongruence between anatomical sex and gender identity;
Key Concepts

• *Gender dysphoria* = affective disturbance that individuals with gender discordance may experience;
Key Concepts

• *Transsexual* = individuals with gender discordance and gender dysphoria who identify as the “opposite” gender and who may pursue some form of social, medical, and/or surgical gender reassignment to decrease their gender discordance and dysphoria;
Key Concepts

• Transgender = has evolved to become an all-inclusive term for individuals who exhibit any combination of gender nonconformity, gender discordance, and/or gender dysphoria, including those formerly described as transsexual;
Key Concepts

• *Sexual orientation* = the sex of a person to whom an individual is erotically attracted and comprises several components including sexual fantasy, patterns of physiological arousal, sexual behavior, sexual identity, and social role;
Key Concepts

- *Cisgender* = person in whom affirmed gender matches natal sex;
- *Genderqueer* = person who defies all categories of culturally defined gender and prefer to self-identify as gender-free, gender-neutral, or completely outside gender;
Key Concepts

• *Pansexual* = a colloquial term used by youth who are attracted to individuals along all lines of the gender spectrum, not necessarily within the male-female gender binary;
Key Concepts

• *Disorder / difference of sex development* = congenital medical condition that results in discordance between a person’s genetic sex and the appearance of the external or internal reproductive structures;
  – DSDs may include congenital adrenal hyperplasia, 46 XY DSD, or hypospadias;
DSM-5 = Gender Dysphoria (Adolescents and Adults)

• Marked incongruence between expressed or experienced gender and assigned gender, lasting at least 6mos and manifested by at least 2 of the following:
  – Mismatch between expressed / experienced gender and primary and/or secondary sex characteristics (in young adolescents, the anticipated secondary sex characteristics);
DSM-5 = Gender Dysphoria (Adolescents and Adults)

- Strong desire to be rid of primary and/or secondary sex characteristics because of the mismatch described above;
- Strong desire for the primary and/or secondary sex characteristics of the other gender;
- Strong desire to be of the other gender (or some alternative gender different from one’s own assigned gender);
DSM-5 = Gender Dysphoria (Adolescents and Adults)

– Strong desire to be treated as the other gender (or some alternative gender different from one’s assigned gender);
– Strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one’s assigned gender);
DSM-5 = Gender Dysphoria (Adolescents and Adults)

• Condition results in clinically significant distress or impairment in social, occupational, or other important areas of functioning;

• Specifiers:
  – With a disorder of sex development;
  – Posttransition;
Key Concepts

• *Gender variance in children* = those who act and / or dress in ways typically associated with the other gender;

• *Gender variance in adolescents* = gender dysphoria may be triggered or exacerbated by phenotypic changes of puberty;
Epidemiology

- Homosexuality emerging in adolescence doesn’t appear to exceed 10% across cultures;
- No US population-based studies of gender-variant identity or behavior phenomena in children, adolescents, or adults;
Epidemiology

- Parent report studies in Canada and Netherlands for children 4-11yrs:
  - Natal girls vs. natal boys (8.3% vs. 3.8%) rated as having behavior “like the opposite sex”;
Mental Health Vulnerabilities

• Higher exposure to rejection, discrimination, victimization and bias;
• Higher risk for bullying, peer nonacceptance, and family rejection;
• LGB youth from “rejecting families”:
  – Up to 9x greater risk for suicidal behavior, higher risk for illegal drug use, unprotected sex, depression vs. LGB youth controls;
Mental Health Vulnerabilities

• Due to psychosocial challenges, higher rates of anxiety, depression, self-harming;
• 8x greater prevalence of ASD in gender-variant children presenting to specialized gender clinic vs. general population;
• Higher than expected rate of gender variance among children presenting to specialty clinic for ASD treatment;
Overview of Gender and Sexuality Development

• Per prospective research on trajectories of childhood gender variance:
  – Gender dysphoria tends to abate during early adolescence in majority of youth;
  – As adults, more likely to express gender consistent with natal sex, and more likely to ID as gay, lesbian, or bisexual vs. heterosexual;
Overview of Gender and Sexuality Development

– If gender dysphoria does not resolve around puberty, then likely to persist into adulthood;
– Predictors of transgenderism per Dutch study:
  • High degree of GD that persists into adolescence and more cognitive vs. affective statements regarding gender (“I am a girl/boy” vs. “I wish I were a girl/boy”);
Assessment

• Clinical interview with the child or adolescent and parents, both together and separately;
  – Evaluate for GD and co-morbidities;
  – Affirm current gender expression and identity, while lacking assumptions about future identities;
Assessment

• If meet criteria for GD, then assess the following variables:
  – Persistence = how long?
  – Consistency = when and where?
  – Insistence = how emphatic?
  – Cognitive vs. affective assertions?

• These have been implicated in predicting who accepts natal gender;
Assessment

• Growing research supporting the predictive validity of the Gender Identity Interview for Children (GIIC);
Four Issues to Consider

1. Shift in treatment of transgender adults from gatekeeper model to informed consent model (ie. no required MH exam);

2. Previously controversial interventions have gained in acceptance (eg. prepubertal social gender transition, pubertal suppression in young adoles.);
Four Issues to Consider

3. Increased focus on affirming approaches that support emotional adjustment;

4. Must create a welcoming clinical experience for treatment of gender variant youth.
Treating GD in Adolescents

• Focus on improving self-esteem, coping strategies, open-ended ID exploration, and considering external factors (ie. working with school and family);

• No evidence that encouraging suppression or change of internal aspects of self (eg. sexual orientation or gender ID) through behavioral modification is effective;
Treating GD in Adolescents

• “Corrective” approaches have been deemed harmful by the AACAP;
• Family members struggling to accept gender-nonconforming adolescent may benefit from therapy;
• Consider combining supportive individual, family, and parent guidance techniques;
Treating GD in Adolescents

• Consider connecting adolescents to groups of other gender-nonconforming youth;
  – Get to know community resources for LGBT youth;

• Get to know the various therapeutic options to treat GD;
Social Gender Transition

- Using name and pronouns of the adolescent’s affirmed gender;
  - Supportive approach;
  - Help adolescent who is exploring and/or ambivalent;

- Simulating physical appearance of the affirmed gender (e.g. breast binders or breast pads);
Pubertal Suppression Therapy

- GRH-agonist to suppress development of distressing secondary sexual characteristics of the youth’s natal sex;
- Developed in Netherlands;
- Transgendered adolescents who have matured to at least Tanner stage 2 can “buy time” to explore gender ID before moving to less reversible options;
Pubertal Suppression Therapy

• Associated with positive MH outcomes;
• May prevent need for more invasive procedures (eg. mastectomy) while promoting more typical appearance in the affirmed gender later on;
  – This, combined with psychological support, is associated with better MH outcomes;
Pubertal Suppression Therapy

- Ability to appear as one’s affirmed gender is associated with better psychiatric outcomes for transgender adults;
Cross-Sex Hormone Therapy

• Partially irreversible interventions that promote the development of secondary sex characteristics of the desired gender;
  – Used for adolescents aged 16yrs and older;

• World Professional Association of Transgender Health Standards of Care
  – Lists indications, risks, and benefits of CSHT;
Cross-Sex Hormone Therapy

• Some clinics moving to do CSHT at younger ages;
  – Waiting until late adolescence to start CSHT among those getting pubertal suppression can delay important effects of sex hormones;
    • eg. bone development, effects on brain development
  – Waiting can also ignore importance of going through puberty with peers;
Cross-Sex Hormone Therapy

- Optimally, adolescent referred to CSHT would happen after comprehensive psychiatric assessment to ensure that adolescent meets criteria for GD, has psychosocial supports in place, and any co-morbid psychiatric conditions are being treated;
Surgical Interventions

• Irreversible surgical procedures are sometimes beneficial for transgender adults when transitioning to the sex consistent with their gender identity;
  – eg. metoidoplasty, phalloplasty, vaginoplasty;
• Don’t assume that all adolescents with gender dysphoria desire to pursue such interventions;
Discussion