Welcome to UVM/AHEC
ECHO:
Children’s Mental Health

February 18, 2021

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• RECORDING OF SESSION TO BEGIN
Gender Identity in Children & Adolescents
Addressing Mental Health Concerns
Agenda

• Introductions
• Objectives
• Didactic Presentation (15-20 min)
• Case presentation
  • Clarifying questions
  • Participants – then faculty panel
• Discussion
• Recommendations
• Summary
• Closing Announcements
  • Submission of new cases
  • Completion of evaluations
CME Disclosures

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Series Objectives

• By the end of this series, the learners should be able to:

  • Feel more comfort and confidence in identifying, treating, and referring a variety of complex children's mental health presentations.
Let’s Start With Some Questions
You are scheduled to see a patient for the first time. The front desk staff call you and say Adam is waiting for his appointment. When you go into the waiting area, the only person you see is a young woman with long hair, wearing an ankle-length dress and make-up and carrying a handbag. You say, “Adam?” The patient replies, “I go by “Lexi, actually.” What is the most appropriate response?

1. “Oh, I’m so sorry! You’re the first transgender patient I’ve worked with. The front desk said your name is Adam. I’ve made a horrible mistake.”

2. Ignore her remark and direct her to your office.

3. Say, “I’m sorry about that’; thank you for correcting me.”

4. Take her to the front desk staff and tell them the mistake they made. Explain to Lexi in front of the office staff that it is their fault.
How many hours of LGBTQ mental health training does the typical clinician receive?

1. None
2. 1-2
3. 5
4. 10

https://www.lgbtqiahealtheducation.org/resources/

What should you call a person who is assigned female at birth and identifies as female?

1. Trans woman
2. Cis female
3. Gender binary
4. Co-gender
Tim is a fifteen year-old adolescent boy of trans experience who has been seeing you in an outpatient clinic for treatment of panic disorder. He sees you for weekly psychotherapy and has recently started to talk about his sexual orientation. He asks you if it is normal for a trans man to be attracted to gay men and wants to know how he should identify regarding his sexual orientation. What’s your response?

1. If he identifies as male and is attracted to men, he must be a gay man.
2. If he was assigned female at birth and is attracted to men, he is straight.
3. You don’t know at this point, and you’d have to ask more questions about his behavior to give an appropriate response.
4. Sexual orientation and gender identity are separate. What is important is how he identifies himself and you can help him to explore this topic in your sessions.
The estimated population of TGNC people in the US is approximately 0.6%. Why does it seem that there are more TGNC people today than ever before?

1. Research is better able to identify TGNC because researchers have a better understanding of what questions to ask.
2. Gender diverse people feel safer identifying as TGNC because society has become more aware of the gender spectrum.
3. Growing awareness of gender diversity may help isolated people better explain their gender diverse feelings, whereas before, these feelings were suppressed.
4. All of the above
Which of the following children is most likely to continue to meet criteria for gender dysphoria in adulthood?

1. 4-year-old natal female with two-year history of preferences for playing sports, dressing in “male” clothes, and who has recently chosen a preferred male name

2. 6-year-old natal male with three-year history of preferring to have long hair, seeking to wear his mother’s make-up, and expressing a consistent preference for playing with girls in his class

3. 10-year-old natal male who has recently indicated to his therapist that he has feelings for male peers

4. 14-year-old natal female, who for the past year, has experimented with dressing up as a male and is now requesting to be called by a male name

5. 15-year-old natal male who three months ago became aware that he feels attracted to only men and questions whether he should have been born with female anatomy?
People who feel they don’t fit into traditional gender stereotypes and exist outside of the realm of what most people would say is male and female may identify as:

1. Gender non-conforming
2. Pansexual
3. Cisgender
4. LGBT

Gender variance, or gender nonconformity, is behavior or gender expression by an individual that does not match masculine or feminine gender norms.

Transgender: An umbrella term for people whose gender identity and/or gender expression differs from what is typically associated with the sex they were assigned at birth.

Some people might see themselves as either male or female. Others may exist both as male and female. Others may express they belong to neither male nor female genders.
According to studies, what percentage of transgender people report being out to their medical providers?

- One-third (33%) of respondents reported having at least one negative experience with a health care provider in the past year related to being transgender, such as verbal harassment, refusal of treatment, or having to teach the health care provider about transgender people to receive appropriate care.

- In the past year, 23% of respondents did not see a doctor when they needed to because of fear of being mistreated as a transgender person, and 33% did not see a doctor because of cost.

Tristan is a 19 year-old man of trans experience. He has been receiving treatment for post-traumatic stress disorder. Lately, in the setting of his parents refusing to speak to him as he transitions, he has been getting more depressed. He has become more suicidal with a plan and he agrees to be admitted to a psychiatric inpatient setting. Upon admission, Tristan’s psychiatrist calls you to consult on the case. He says that the patient’s mood problems are due to Testosterone, so this will be stopped and an anti-depressant started. What should be your response?
Corey is a 16-year-old trans man. He has been engaged in therapy for the past six-months for treatment of anxiety and depression. He isn’t ready to start testosterone and is not sure it’s the right decision for his body. He said he probably doesn’t need testosterone anyway because his periods just stopped about two-months ago. He was so happy this happened without having to do anything. How should you proceed?
Jacob is a 15 year-old teenage boy. He has been having symptoms of gender dysphoria for several years, but has had to keep his gender identity hidden from his parents and most of his friends at school. He lives in an area where multiple trans-identified people have been assaulted and his parents would likely disown him if he outing himself to them. Jacob’s been engaged in therapy, which his parents understand to be focused around depression. Symptoms of depression are noted but he has also been confiding in you his gender identity. He has read online about binders and had a spandex one delivered to a friend’s home. He was excited about wearing it and the relief it brings him and would like to keep it on all the time. What would you advise?
Take Home Points

- Gender variation is not a disorder
- If there is pathology, it more often stems from cultural reactions (e.g., transphobia, homophobia, sexism) rather than from within the youth
  - Youth are an underserved and poorly researched population
- Specific medical and mental health needs
- High risk for significant morbidity and mortality
- Youth and families need information about realistic outcomes, options, risks & benefits for informed consent
Gender refers to our internal thoughts about who we are...it’s the first major factor other than the color of our skin that will touch and shape our entire lives. Generally, the sex we are assigned at birth and gender we come to identify with are congruent.
An Introduction

• Youth across development are presenting with gender identity concerns to mental health professionals with increasing prevalence
  ○ Variety of chief complaints
  ○ Many families and their children are struggling for answers and direction

• Wide variation in-terms of how patients present their gender, what types of interventions they seek, what families think about gender, and whether they do or don’t have a co-occurring psychiatric issue

Our job: to make diagnostic, formulation, and treatment decisions in concert with youth and their families

Is it clinically appropriate to move forward with sought after interventions that may or may not lead to irreversible changes on the youth’s body?
Our Role as Mental Health Professionals

1. Diagnosing gender dysphoria (GD)
2. Assessment of Mental Health Profile of Youth and Family
   a. Provide counseling and support
   b. Treat co-occurring mental health concerns
   c. Referrals
3. Educate and Refer for additional physical interventions to alleviate GD
4. Educate and advocate
5. Provide information and referral for peer support

Priorities: Prevent Self-Harm & Suicide
Family/Parent Acceptance
Considerations for a referral to a mental health provider:

1. Evidence of gender dysphoria; co-existing anxiety, depression, suicidality, interpersonal conflict with peers or parents.

2. Youth wanting additional support and resources to explore TG and/or non-binary gender identities

3. Not gender dysphoric, but seeking additional support and planning for affirmation

4. Parents who are uncomfortable or rejecting of child’s identity and behaviors
Social and Psychological Interventions

1. Help families to have an accepting and nurturing response to the concerns of their child.
2. Reduce distress and ameliorate other psychosocial difficulties; support before, during, and after interventions
3. Support families in managing uncertainty and anxiety about psychosexual outcomes; help youth develop positive self-concept
4. Give ample room for patients to explore different options for gender expression
5. Support decision-making regarding extent to which patients are allowed to express a gender role consistent with identity
6. Support families and youth as educators and advocates
7. Strive to maintain a therapeutic relationship with youth and their families throughout social changes and physical interventions
Framing the Assessment

1. Clarifying the aims
   a. Diagnostic clarity
   b. Appropriateness of specific gender-affirming medical intervention
   c. Determine the potential impact of interventions on independent mental health concerns

2. The assessment process may reveal other concerns (it’s dynamic)

Your meeting with a family and a twelve year-old who are expecting to begin treatment for underlying anxiety, yet they may be shortly starting gender affirming hormone treatment. Starting two interventions in close proximity may pose challenges in assessing treatment response.

- What do you do?

Determine the underlying cause of presenting complaint.
Work with family and referring providers to understand risks and benefits of each decision.
You are tasked with doing an assessment for ‘hormone readiness’ in an adolescent who another provider has determined meets criteria for Gender Dysphoria.

You initiate an assessment and it becomes unclear whether the teen meets criteria for GD.

What would be the next steps?

- Think about the concept of an **affirmative gender-informed assessment**
  - Work collaboratively with family and youth, and other providers to provide support and care, allowing room for young person to explore their identity in a non-pathologizing way and supporting interventions to maximize wellness and functioning
  - No initial agenda other than to be open-ended in the exploration of diagnostic and treatment possibilities

Helpful to avoid terms like **readiness assessment**, **gender assessment**, or **psychopharmacological assessment**
Guidelines for Clinical Assessment

https://www.wpath.org/publications/soc

J Clin Endocrinol Metab, November 2017, 102(11):3869–3903
Gender-Informed Assessment

Principle 1. A comprehensive psychiatric evaluation should take into consideration psychosexual development in a way that is appropriate to developmental level and the clinical situation. Questions about sexual feelings, experiences, and identity or about gender role behavior and gender identity can help clarify any areas of concern related to sexual identity. Sexual and gender minority adolescents very frequently face unique developmental challenges, as described above. If an initial screen indicates that issues of sexual orientation, gender nonconformity, or gender identity are of clinical significance, these challenges can be explored in greater depth. (e.g., asking “is this greater depth.
life?” rather than “do you have a boyfriend, girlfriend?”) until the adolescent reveals a particular sexual orientation.
Guidelines further stipulate that the presence of the diagnostic criteria for GD is necessary before initiating:

- Pubertal suppression
- Gender-affirming hormones
- Potential surgical interventions (irreversible)
Seeking Treatment - Readiness?

With available information:

- Decides whether individual fulfills criteria for treatment for GD/gender incongruence

- Informs the individual about possibilities and limitations of various kinds of treatment. Provides correct information to prevent unrealistically high expectations

- Assess whether medical interventions may result in unfavorable psychological and social outcomes

Helps to ensure that all dimensions of a patient’s health have been assessed and optimized - including mental health, coping skills, support post-intervention
1. The client’s general identifying characteristics;

2. Results of the client’s psychosocial assessment, including any diagnoses;

3. The duration of the referring health professional’s relationship with the client, including the type of evaluation and therapy or counseling to date;

4. An explanation that the criteria for hormone therapy have been met, and a brief description of the clinical rationale for supporting the client’s request for hormone therapy;

5. A statement that informed consent has been obtained from the patient;

6. A statement that the referring health professional is available for coordination of care and welcomes a phone call to establish this.
In cases in which severe psychopathology, circumstances, or both seriously interfere with diagnostic work or make satisfactory treatment unlikely, clinicians should **assist the adolescent in managing other issues**

For adolescents, the diagnostic procedure usually includes a complete psychodiagnostic assessment (57) and an assessment of the decision-making capability of the youth. An evaluation to assess the family’s ability to endure stress, give support, and deal with the complexities of the adolescent’s situation should be part of the diagnostic phase (58).
Gender Dysphoria

- Keep in mind: not all children or teens that may identify as something other than cisgender will experience distress or dysfunction as a result of their identity (transgender but not meeting criteria for GD)

- What’s the nature and characteristics of a youth’s gender identity?

- Meeting criteria may seem straightforward...or not

- Biopsychosocial assessment provides additional clarity to the overarching psychological profile of the youth and family
  - Co-occurring psychopathology
  - Family functioning - strengths and weaknesses
  - Family conflict - influence youth’s assertion
  - Temperament, psychological factors
  - Cognitive aspects - conflate gender phenomena
Incongruence between experienced/expressed gender and natal gender

Clinical levels of DISTRESS resulting from incongruence

Gender Dysphoria

A sense of alienation to some or all of the physical characteristics or social roles of one's assigned gender
Table 1.2 DSM-5 criteria for gender dysphoria in children

A. A marked incongruence between one’s experience/expressed gender and natal gender of at least 6 months in duration, as manifested by at least six of the following eight indicators, at least one of which must be criterion A1:

1. 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)
2. 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 wearing of typical feminine clothing
3. A strong preference for cross-gender roles in make-believe play or fantasy play
4. A strong preference for toys, games, or activities stereotypically used or engaged in by the other gender
5. A strong preference for the 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; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities
7. A strong dislike of one’s 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, school, or other important areas of functioning

*APA 2013 [1]
Table 1.3  DSM-5 criteria for gender dysphoria in adolescents and adults²

<table>
<thead>
<tr>
<th>A.</th>
<th>A marked incongruence between one’s experience/expressed gender and natal gender of at least 6 months in duration, as manifested by at least two of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>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)</td>
</tr>
<tr>
<td>2.</td>
<td>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)</td>
</tr>
<tr>
<td>3.</td>
<td>A strong desire for the primary and/or secondary sex characteristics of the other gender</td>
</tr>
<tr>
<td>4.</td>
<td>A strong desire to be of the other gender (or some alternative gender different from one’s designated gender)</td>
</tr>
<tr>
<td>5.</td>
<td>A strong desire to be treated as the other gender (or some alternative gender different from one’s designated gender)</td>
</tr>
<tr>
<td>6.</td>
<td>A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one’s designated gender)</td>
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</tbody>
</table>

| B. | The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning |

Specify if:

1. The condition exists with a disorder of sex development
2. The condition is posttransitional, in that 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 sex-related medical procedure or treatment regimen – namely, regular sex hormone treatment or gender reassignment surgery confirming the desired gender (e.g., penectomy, vaginoplasty in natal males; mastectomy or phalloplasty in natal females)

²APA 2013 [1]
Can Non-Binary Individuals Meet Criteria for GD?

- A person does not have to identify with either the male or female gender to experience dysphoria.

- However, the DSM-5 also focuses heavily on gender dysphoria as the desire to be the “opposite” gender. Because gender nonbinary people do not wish to be the “opposite” gender, they may not feel included in traditional diagnostic criteria.

- It is important to assist adolescents in establishing their identity by actively exploring identity-related choices and encouraging identity development in their affirmed identity in a safe and supportive environment.

A non-binary person has a gender identity that does not match the sex they were assigned at birth; they do not identify solely as a man or a woman. They may identify as both, neither, or as a gender somewhere in between.

Mental health professionals should not impose a binary view of gender. They should give ample room for clients to explore different options for gender expression. Hormonal or surgical interventions are appropriate for some adolescents, but not for others.
Appropriateness for Hormonal and/or Surgical Interventions?

- Interventions only apply to those who are psychologically mature (?) and at Tanner stage 2 and beyond
- Take into account the power imbalance that exists between teen and provider
  - Appointment viewed as ‘means to an end’ which can impact what’s disclosed and not
  - Minimization of psychiatric symptoms
  - Falsely describing a binary gender identity
- Establishing trust with teen and family is of paramount importance
- Frame assessment as a collaborative process with shared goals of promoting healthy adolescent development (may or may not include medical interventions)
- Timing important: withholding treatment not a neutral act
## What Might Impair Readiness?

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute, unstable psychiatric condition</td>
<td>Acute, unstable psychiatric condition</td>
</tr>
<tr>
<td>Challenging family dynamics (lack of consent)</td>
<td>Challenging family dynamics (lack of consent)</td>
</tr>
<tr>
<td>Fertility issues not yet addressed</td>
<td>Fertility issues not yet addressed</td>
</tr>
<tr>
<td>Not understanding benefits, risks, effects, timelines</td>
<td>Not understanding benefits, risks, effects, timelines</td>
</tr>
<tr>
<td>False expectations</td>
<td>False expectations</td>
</tr>
<tr>
<td>Psychosocial stressors affecting compliance and ability to follow-up</td>
<td>Psychosocial stressors affecting compliance and ability to follow-up</td>
</tr>
<tr>
<td>Insurance issues</td>
<td>Insurance issues</td>
</tr>
<tr>
<td>Is social transition required?</td>
<td>Is social transition required?</td>
</tr>
</tbody>
</table>

A staged process is recommended to keep options open through the first two stages. Moving from one stage to another should not occur until there has been adequate time for adolescents and their parents to assimilate fully the effects of earlier interventions.
Pronouns

- An effective way to build an alliance
- Introduce yourself with preferred name and pronoun
- Ask everyone to introduce themselves with a chosen name and set of pronouns
- What if parent is highly averse to gender diversity?

When people refer to me, I feel most comfortable with male pronouns

- Observing affect in the room is important
- Don’t want to isolate one member of the family
- Myriad situations in which use of pronouns and name can change depending on circumstances and time

<table>
<thead>
<tr>
<th>Subjective</th>
<th>Objective</th>
<th>Possessive</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>He</td>
<td>Him</td>
<td>His</td>
<td>He is in the waiting room. The doctor is ready to see him. That chart is his.</td>
</tr>
<tr>
<td>She</td>
<td>Her</td>
<td>Hers</td>
<td>She is in the waiting room. The doctor is ready to see her. That chart is hers.</td>
</tr>
<tr>
<td>They</td>
<td>Them</td>
<td>Theirs</td>
<td>They are in the waiting room. The doctor is ready to see them. That chart is theirs.</td>
</tr>
<tr>
<td>Ze</td>
<td>Hir</td>
<td>Hirs</td>
<td>Ze is in the waiting room. The doctor is ready to see him. That chart is his.</td>
</tr>
</tbody>
</table>
No Consistent Developmental Trajectory

Don’t mislabel as “just a phase”

- Think about **Consistency, Insistence, Persistence**
- Some gender non-conforming children may go on to adopt identity that is different from assigned gender (10-30%)
- Gender-typed behavior is noticeable and stable between 3 and 5 years-old (especially with individuals with high and low gender typical behavior)

With current knowledge, we cannot predict the psychosexual outcome for any specific child. Prospective follow-up studies show that childhood GD/gender incongruence does not invariably persist into adolescence and adulthood (so-called “desisters”). Combining all outcome studies to date, the GD/gender incongruence of a minority of prepubertal children appears to persist in adolescence (20, 40). In adolescence, a significant number of these desisters identify as homosexual or bisexual. It may be that children who only showed some
Recognize gender differences, use gendered pronouns. Gender Stability usually reached by ____ years

Label gender primarily based on visible anatomy ____ months

By age ___, most children declare a gender identity as male or female (Gender Constancy)
Understanding of Concepts

- Developmentally appropriate understanding of the difference between
  - Gender identity
  - Gender expression
  - Sexual orientation
- How do individuals see themselves as sexual beings?
  - May help them recognize aspects about their gender that they might not have thought about
- Possible that notions can be conflated by youth and/or family

A 12-year-old assigned male at birth presents in clinical practice living in a rural area where homosexuality is widely considered a “negative lifestyle.” He presents as very effeminate and enjoys experimenting with makeup, which has elicited punishment from his parents who believe that this type of behavior is a sin. He opens up to his provider revealing that he has attractions to other boys and does not feel anything for girls other than wanting to be friends with them. He says, “I think this means I might be a girl since it just is not allowed for boys to like boys in that way.”

A 14-year-old depressed assigned female at birth with autism spectrum disorder presents in clinical practice seeking testosterone therapy. The patient has been binding his chest and is using male pronouns. You ask him how he felt about being perceived as female and he responds with, “Every time I would wear a dress or makeup, people would stare at me and it would make me uncomfortable. Guys don’t have to deal with that. I think being a guy is easier.”

A parent of a 16-year-old transgender female seeking estrogen treatment asks to speak with the clinician privately. The parent, who has been making strides in accepting her new daughter (previously a son) appears distressed. She tells the clinician “I just caught him, I mean her, with pictures on her phone kissing another girl. If she is interested in girls, then I don’t understand why she cannot simply just go back to be a boy? Maybe she’s just a boy and not transgender after all. Help!”
Identity: internal sense of self

Gender diverse: term used to describe people with gender behaviors, appearances, or identities that are incongruent with those culturally assigned to their birth sex
- Genderqueer, Nonbinary, Transgender, gender fluid, gender creative, etc.
- Some find that gender nonconforming has a negative and exclusionary connotation

Transgender: a subset of gender diverse youth whose gender identity doesn’t match assigned sex and remains consistent, persistent, and insistent over time.
Mental Health Issues
MENTAL HEALTH IS
Transgender and gender diverse children and teenagers are a vulnerable population, but there are clearly individuals that function well and show few mental health difficulties.

It’s important to be aware of mental health vulnerabilities that exist in gender diverse youth but also understand factors related to psychological difficulties to help build resilience.
What We Know...

• Experiencing “wrong puberty”:
  o Triggering for symptoms of depression, anxiety, maladaptive coping, and suicidality

• Social discrimination
  o Economic marginalization
  o Social isolation
  o Abuse, victimization
  o Inadequate health care
  o Rejection

• Stress from being in a minority group
  o Chronically high stress experienced by members of stigmatized minority group
  o Create or exacerbate emotional/behavioral problems
  o Many youth experience shame; internalized transphobia
Minority Stress and the Impact of Acceptance

Stressors dictated by social forces

- Higher rates of bullying, harassment, and peer victimization mediate higher odds of substance use, psychological distress, low life satisfaction, depression, suicidality, and self-harm
- Pressure to conform to gender norms → more internalizing problems
- Poor peer relations: strongest predictor of emotional/behavioral problems
- LGBT teens with parents who try to change their orientation → more depression, suicidality, and less educational attainment in young adulthood

Psychopathology

- Fearfulness of being singled out
- Social avoidance
- Withdrawal
- Hopelessness

Secondary to stigma and discrimination

Resultant from Gender Dysphoria

Independent of gender concerns but can influence how gender is experienced and expressed

Gender-related concerns know no social class, geography, race, or other grouping
Crisis calls touch on...

- Suicidal ideation: 59%
- Covid-19: 42%
- Lack of trans community: 24%
- Family rejection: 22%
- Verbal/emotional abuse: 21%
- Medical transition: 18%
- PTSD: 15%
- Body dysphoria: 14%
- Misgendering/deadnaming: 14%
- Coming out to family: 13%

Medical treatments to bring one’s body more in line with one’s gender

Note: Percent of crisis calls associated with each topic between March 9 and Aug. 2. A call can be associated with multiple topics.

https://www.washing...
Overall, 1.8% of youth identified as transgender. The almost 2% prevalence rate is more than double the previously available estimate of 0.7%. The prior estimate was based on the patterns of transgender identity among adults (Herman et al., 2017). However, it was noted that the 0.7% estimation would be inaccurate if younger cohorts identify as transgender at a sharply higher rate than 18–24 year-olds. This YRBS data reveals that younger youth are indeed identifying as transgender at an increased rate.

LGBT students are nearly 2.5 times as likely at heterosexual/cisgender students to feel so sad or hopeless during the past year that they stopped doing some activities.

LGBT students are nearly four times as likely as heterosexual/cisgender students to have hurt themselves on purpose during the past year.

LGBT students are four times as likely as heterosexual/cisgender students to have made a suicide plan during the past year.

LGBT students are five times as likely as heterosexual/cisgender students to have attempted suicide during the past year.
1 in 3 trans youth attempted suicide in the past year (Veale et al., 2015).

Trans people are 2x more likely to think about and attempt suicide than LGB people (Irwin et al., 2014).

67% of transitioning people thought more about suicide before transitioning whereas only 3% thought about suicide more after their transition (Bailey et al., 2014).
Prevalence of Mental Health Difficulties

- Historically, data comes from specialized gender clinics
- With increase in visibility and recognition of gender diversity in youth
  - Increase in publications in other populations: high school and community samples

  **Depression and Anxiety Disorders**
  are two most common co-existing diagnoses in TG and GD teens
  (rates 5 x higher than cis peers)

  **Higher risk of eating disorders, substance use disorders**

  **Socially transitioned prepubertal TG children and young TG adolescents**
  who are supported in their identity have developmentally normative levels of depression and only minimal elevations in anxiety

- Evidence also suggests an *increased prevalence of ASD* among TGNC youth
Suicide & Self-Harm: A Significant Concern

• Studies indicate that self-harm and suicidality are more common in TGD youth in comparison to cisgender peers
  • Prevalence is twice as high as non-TG peers
  • Depressive symptoms and school-based victimization associated with higher risk
• 9% of TG children attempt suicide by 15
• >30% by age 19
• >40% of TG adults have attempted suicide

**WHAT’S KNOWN ON THIS SUBJECT:** Although initial evidence indicates transgender adolescents (TGAs) have high rates of suicidality, previous studies have been limited by insufficient measurement of gender identity. TGAs assigned female at birth could have higher rates of suicidality than TGAs assigned male at birth.

**WHAT THIS STUDY ADDS:** Using comprehensive measures of gender assigned at birth and current gender identity to examine TGA suicidality, we indicate transgender males and transgender females have higher odds of suicidal ideation and attempt than their cisgender peers.

PEDIATRICS Volume 144, number 5, November 2019
What can reduce risk?

- Supportive and strong relationships with family and friends
- Completed medical transition (if medical transition is desired)
- Self-awareness and acceptance
- Access to gender affirming health care
- Not having access to lethal means such as guns or potentially deadly medications
- Having one's name and pronouns accepted (Bailey et al., 2014; Bauer et al., 2015a; Haas et al., 2011; SPROC, 2008).
In one study, the suicide attempt rate among teens who identified as trans:

- among those with strongly supportive parents
- among those whose parents were not supportive

http://transpulseproject.ca
https://www.lgbtmap.org/file/Advancing%20Acceptance%20Infographic%20FINAL.pdf
Mental Health and Timing of Gender-Affirming Care

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- Puberty is a vulnerable time
- GAMC (hormone blockers and/or gender-affirming hormones) → decrease in emotional and behavioral problems and improvement in overall psychological functioning.
- 300 adolescents

WHAT THIS STUDY ADDS: Gender-incongruent youth who present to gender-affirming care later in life have higher rates of psychoactive medication use and mental health problems. We use our findings to suggest that this group is particularly vulnerable and highlight the need for appropriate care.

Among 300 teens seeking gender-affirming care, a significantly higher proportion of adolescents older than 15 reported experiencing mental health problems compared with children under 15, including the following (all P<0.05):

- Depression (46% vs 30%)
- Self-harm (40% vs 28%)
- Suicidal consideration (52% vs 40%)
- Attempted suicide (17% vs 9%)
CONCLUSIONS: This is the first study in which associations between access to pubertal suppression and suicidality are examined. There is a significant inverse association between treatment with pubertal suppression during adolescence and lifetime suicidal ideation among transgender adults who ever wanted this treatment. These results align with past literature, suggesting that pubertal suppression for transgender adolescents who want this treatment is associated with favorable mental health outcomes.
Acceptance and Understanding of Gender Diversity

Decrease Stigmatization Around Gender Diversity
Minority Stress

**Fig. 5.1** Minority stress and resilience factors in TGD individuals. Dashed lines reflect inverse relationships. (Reprinted with author permission [3])

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M. Forcier et al. (eds.), *Pediatric Gender Identity,*
Engaging Parents

Learn that gender presentations are varied and gender expression can unfold over time. Kids need space for exploration.

Increased confidence and self-acceptance

Higher Self-Esteem and Positive Health Outcomes

Model appropriate responses to teasing and harassment

Address worry parents may have about future of their child.
Victimization
Future Relationships
Acceptance
Medical Interventions

Guide parents from ‘all or none’ viewpoints toward practicing more ‘both/and’ thinking (affirm identity and recognize difficulties)

How to advocate and promote safety

Space to discuss perceived loss. How can family system include child’s identity?
I am worried about how often my son plays with his sister’s dolls. What do you think? Do you think my son may be gay?

Playing with dolls is not typical of boys. He may be gay. Maybe I should refer you to a psychiatrist.

Tell me more about what sort of play and activities your child enjoys? How do you and the family support and encourage the range of his play? All children experiment with and explore toys and play that are more stereotypical of the opposite gender. What is most important is for you to help your child explore their interests.

My school-age daughter refuses to wear a dress. She is always playing with the neighborhood boys. I think she may be a lesbian. I am worried.

Lots of girls hate dresses. But you as the parent can make her wear what you think is appropriate. You need to set better limits on her clothing choices.

Tell me more about the conversations you and your child have had around wearing dresses and other types of clothes. Why does your child refuse to wear a dress? Has your child talked about other aspects of being a girl or gender? What would your child wear if it was all up to them?
We found out that my daughter thinks she is a boy trapped in a girl’s body from a Facebook post. Can we help her not be a lesbian?

Being gay is not so bad anymore. Being gay is more accepted and cool for kids. Let’s talk some more about and try to understand about your child’s identity and feelings about their birth-assigned gender versus their feelings, attractions, and possible sexual orientation. Gender and sexual orientation get confusing but they are very different aspects of each person.

My son is driving his father crazy with the feminine clothes he wears, his long hair, etc. My son and his father fight all the time. I am so worried. What should I do?

You should tell your son to get a haircut and wear normal clothing. Being effeminate is only going to get him beat up at school.

Why do you think this upsets your child’s dad? Does it upset you? Have you talked to your child about their preference for feminine clothes? Have you asked your child how they feel about their dad’s reactions and the fighting?
“Just Getting Out of Bed Is a Revolutionary Act”: The Resilience of Transgender People of Color Who Have Survived Traumatic Life Events

Consider how to encourage these factors and build upon them over time and across contexts.
Medical and mental health providers play a role in helping youth and families feel supported and affirmed, as well as making individuals feel invalidated, stigmatized, and discriminated against.
Ten Things Transgender and Gender Nonconforming Youth Want Their Doctors to Know

Jack Turban, BA, Tony Ferraiolo, CRC, Andrés Martin, MD, MPH, Christy Olezeski, PhD

1. “Sexuality and gender are two different things. TOTALLY separate.”
2. “Talking to strangers about these things is uncomfortable.”
3. “Nonbinary people exist.”
4. “Names, pronouns, and gender markers are important.”
5. “Don’t ask about my genitals unless medically necessary.”

6. “Genital and breast exams are uncomfortable for most people, and they can be particularly uncomfortable for me.”
7. “Puberty blockers and cross-sex hormones can save my life.”
8. “Please train your staff as well. Many of us have had visits starting with the wrong tone, starting with check-in. This can make me shut down.”
9. “If I am depressed or anxious, it’s likely not because I have issues with my gender identity, but because everyone else does.”
10. “Let me know that you are on my team.”
Many of us have had to put up with bullying and misunderstanding in school and in our communities. Some of us have even been refused medical treatment by our doctors and been told that being transgender is wrong. More than anything, we want to know that our doctors are on our side and will not judge us. I know that you will probably make mistakes with pronouns or other things. Explaining that you are on my team and want to learn can make all the difference.
• RECORDING TO BE STOPPED FOR CASE PRESENTATION
Cases/HIPAA

• Names
• Address
• DOB
• Phone/Fax #
• Email address
• Social Security #
• Medical Record #

The discussion and materials included in this conference are confidential and privileged pursuant to 26VSA Section 1441-1443. This material is intended for use in improving patient care. It is privileged and strictly confidential and is to be used only for the evaluation and improvement of patient care.
Case
Questions and Concerns/Discussion
Conclusion

• Volunteers to present cases (this is key to the Project ECHO model)
  • Please submit cases to Michael.Hoffnung@uvmhealth.org

• Please complete evaluation survey after each session

• Claim your CME at www.highmarksce.com/uvmmmed

• Please contact us with any questions, concerns, or suggestions
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