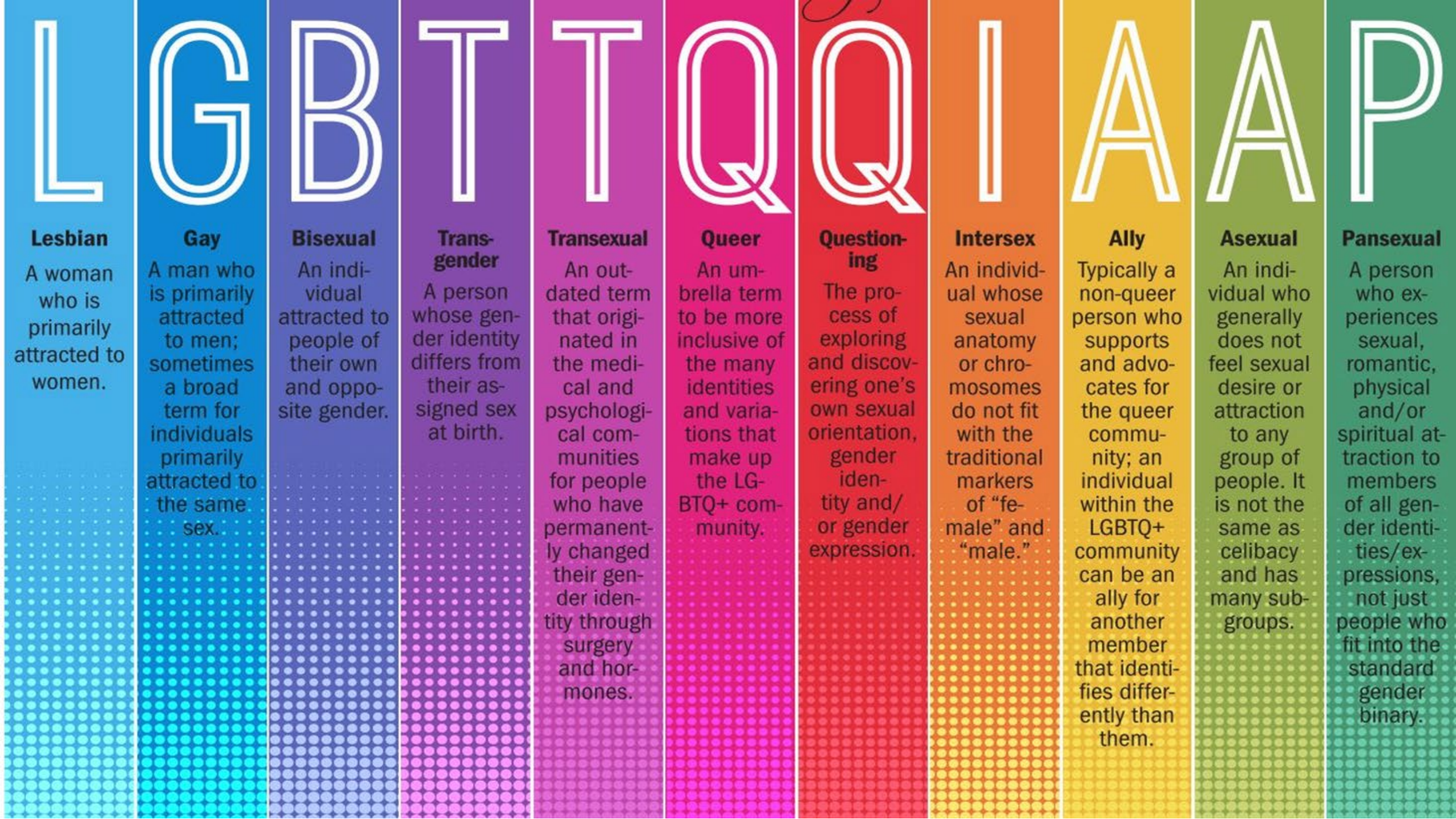
Assessment of gender diverse young people

Dr Yolandie Goodyear

Child and Adolescent Psychiatrist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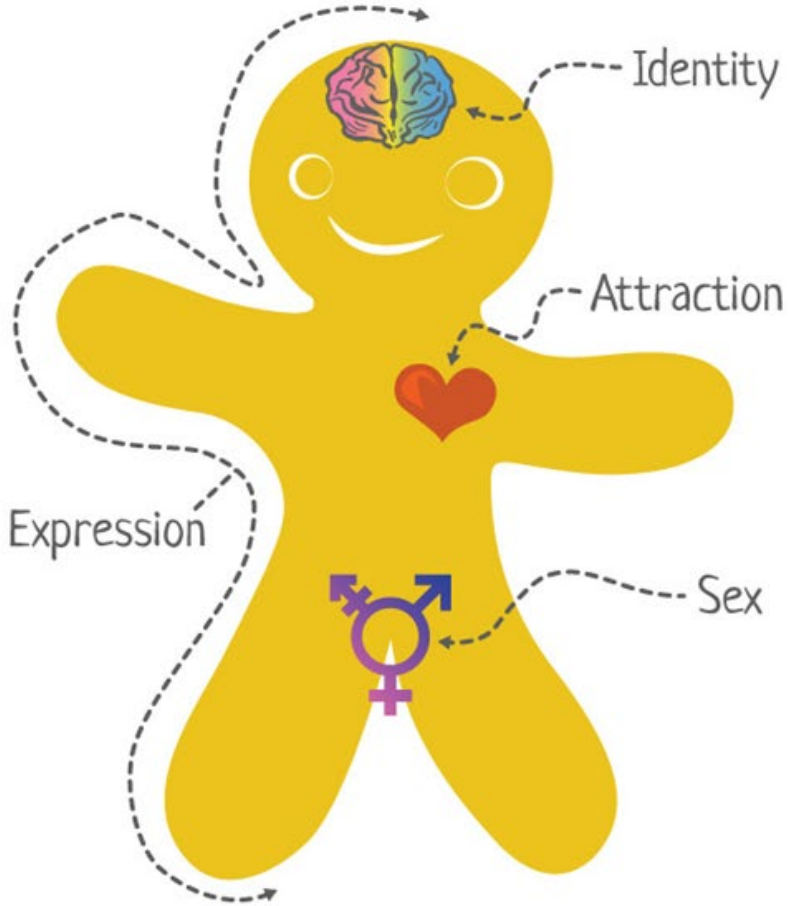
Lesbian
A woman who is primarily attracted to women.
Gay
A man who is primarily attracted to men; sometimes a broad term for individuals primarily attracted to the same sex.
Bisexual
An individual attracted to people of their own and opposite gender.
Transgender
A person whose gender identity differs from their assigned sex at birth.
Transexual
An outdated term that originated in the medical and psychological communities for people who have permanently changed their gender identity through surgery and hormones.
Queer
An umbrella term to be more inclusive of the many identities and variations that make up the LGBTQ+ community.
Questioning
The process of exploring and discovering one's own sexual orientation, gender identity and/or gender expression.
Intersex
An individual whose sexual anatomy or chromosomes do not fit with the traditional markers of "female" and "male."
Ally
Typically a non-queer person who supports and advocates for the queer community; an individual within the LGBTQ+ community can be an ally for another member that identifies differently than them.
Asexual
An individual who generally does not feel sexual desire or attraction to any group of people. It is not the same as celibacy and has many subgroups.
Pansexual
A person who experiences sexual, romantic, physical and/or spiritual attraction to members of all gender identities/expressions, not just people who fit into the standard gender binary.

The Genderbread Person v3.3

by it's pronounced METROsexual .com



Gender Identity

- Woman-ness
- Man-ness

Gender Expression

- Feminine
- Masculine

Biological Sex

- Female-ness
- Male-ness

Sexually Attracted to

- (Women/Females/Femininity)
- (Men/Males/Masculinity)

Romantically Attracted to

- (Women/Females/Femininity)
- (Men/Males/Masculinity)

Assessment - terminology

- **AMAB/AFAB:** assigned male/female at birth – assumption made about gender based on visualisation of genitals
- **Transgender:** someone whose gender identity is not congruent with sex assigned at birth
- **Cisgender:** someone whose gender identity is congruent with sex assigned at birth

Assessment

What is gender dysphoria?

- Gender dysphoria refers to the feeling of unease between one's gender identity and genetic sex.
- Incongruence sex assigned at birth and gender identity

- *Can you remember the age/time when you realised you were not just a child, but a child with a gender?*

Assessment

Stages of gender development (Kohlberg):

- Gender identity (age 2) : ability to label self as a boy/girl
- Gender stability (age 4): gender stays constant over time (“I was born a boy and I will grow up to be a boy”)
- Gender consistency (usually age 6 – 7): gender is invariant despite outward changes (“ that woman has short hair and is wearing shorts but is still a woman”) (1)

1) https://www.mentalhelp.net/articles/early-childhood-gender-identity-and-sexuality/ Accessed 11 June 2016

Gender Dysphoria in Children (DSM V):

Marked Incongruence > 6 months between experienced/expressed and assigned gender, including preference/desire (6):

- Desire/insistence one is the other/alternative gender – different from assigned at birth gender
- Preference for cross-dressing: male clothing (assigned girls) or female clothing (assigned boys)
- Preference for cross-gender role in fantasy games
- Preference for toys/games/activities stereotypically played by the other gender
- Preference for playmates of the other gender
- Strong rejection of typically gendered toys (either gender)
- Strong dislike of one's sexual anatomy
- Strong desire for the primary/secondary sex characteristics that match one's own experienced gender

Plus distress or impairment in social/school/other important areas

Gender Dysphoria in Adolescents/Adults

Marked Incongruence > 6 months between experienced/expressed and assigned gender including preference/desire (at least 2):

- Marked incongruence between experienced/expressed gender and primary/secondary sex characteristics (or anticipated)
- Strong desire to be rid of primary/secondary sex characteristics because of marked incongruence with experienced/expressed gender (or desire to prevent development anticipatory characteristics)
- Strong desire for primary/secondary sex characteristics of other gender
- Strong desire to be of the other gender (or an alternative form of the gender assigned)
- Strong desire to be treated as the other gender (or an alternative form of the gender assigned)
- Strong conviction that one has typical feelings/reactions of the other gender (or an alternative form of the gender assigned)

Plus distress or impairment in social/school/other important areas

A single trait/two is not enough – must be strong an enduring (not due to a different condition affecting identity)

- Gender ID may unfold/be revealed in time; can be experienced as binary (male vs female) or continuous (spectrum) (2)

2) Lgbthealtheducation.org, (2015). Fenway Health | National LGBT Health Education Centre. [online] Available at: http://www.lgbthealtheducation.org [Accessed 1 Apr. 2015].

Assessment

Why does this matter?

- The prevalence of GD in childhood and adolescence: 0.7% of children/adolescents <18, and approx. 1.8% high school students (3)
- 2% to 4% of boys and 5% to 10% of girls behaved as the opposite sex from time to time (4)

Only in Western culture?

- Brotherboys and Sistergirls
- Fa'afafine are a third-gender people of Samoa
- Native American

3) Dubin S., Lane M., Morrison S., *et al. J Med Ethics* 2020: 46: 296 - 299
4) Bonifacio, H. and Rosenthal, S. (2017). Gender Variance and Dysphoria in Children and Adolescents. Pediatr Clin N Am 62 (2015) 1001–1016

Assessment

What causes gender dysphoria?

- Theories around causality of gender dysphoria/nonconformity:

  complex interaction of biological, genetic, family, social, and cultural factors

(AusPATH: Public Statement on Gender Affirming Healthcare, including for Trans Youth)

Assessment

Differential diagnoses:

- Nonconformity to stereotypical sex role behaviours
- Psychosis
- Body Dysmorphic Disorder
- DID – which alter?
- Complex PTSD
- Co-occurrence with ASD

Comorbid conditions

The First Australian National Trans Mental Health Study – 2014:

- 43.7% depressive symptoms; 18.3% for a panic syndrome; 16.9% for another anxiety syndrome
- One in 5 participants reported thoughts of suicidal ideation or self-harm
- LGBT-specific suicide risk factors, including gender nonconformity, age of first same-sex attraction, and LGBT victimization
- Psychiatric illness may increase health risk behaviour

Hyde Z, Doherty M, Tilley PJM, McCaul KA, Rooney R, Jancey J (2014) The First Australian National Trans Mental Health Study: Summary of Results. School of Public Health, Curtin University, Perth, Australia.

Risk factors

- Trans men, and especially trans women – depressive symptoms
- Non-binary individuals - anxiety disorder

- Also: lower educational attainment; being unemployed or unable to work; low income; poor self-rated health; wanting to take hormone therapy; wanting to undergo surgery; difficulty changing identifying documents; not feeling comfortable telling doctors about being trans; and a recent experience of discrimination.

Eating behaviour/body image

- Lifetime prevalence for anorexia nervosa (1.7%), bulimia nervosa (1.3%), and binge-eating disorder (2.2%) diagnoses are higher among sexual minority adults
- Perpetuated by minority stress, discrimination, body dissatisfaction, traditional expectations of bodies, menses
- Gender dysphoria treatment has been shown to increase body satisfaction.
- A particular clinical challenge in caring for transgender youth with eating disorders is the standard use of growth charts based on sex.

Curr Opin Psychiatry. Author manuscript;
available in PMC 2021 November 01.

ASD

- Increased prevalence of autism spectrum disorders (ASDs), varying from ~6% to over 20%
- Estimated prevalence of 0.6%–0.7% in the general population.
- In comparison, among children and early adolescents with ASDs, gender variance is >7-fold more common than among non-referred controls
- Why?

Assessment

- What if they change their mind?

Assessment

Does gender dysphoria persist?

- Variable according to studies (ranging from 1.5% to 37%) (5, 6)
- Rates more persistent for GD diagnosed in adolescence (7)
- If diagnosed in adolescence: more than 80% persistence (8)
- Controversy (9)

5) Möller, B., Schreier, H., Li, A. and Romer, G. (2009). Gender Identity Disorder in Children and Adolescents. Current Problems in Pediatric and Adolescent Health Care, 39(5), pp.117-143.
6) Wallien, M. and Cohen-Kettenis, P. (2008). Psychosexual Outcome of Gender-Dysphoric Children. Journal of the American Academy of Child & Adolescent Psychiatry, 47(12), pp.1413-1423.
7) de Vries, A., Noens, I., Cohen-Kettenis, P., van Berckelaer-Onnes, I. and Doreleijers, T. (2010). Autism Spectrum Disorders in Gender Dysphoric Children and Adolescents. J Autism Dev Disord, 40(8), pp.930-936.
8) Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P. and DeCuypere, G. et. al. (2012). Standards of Care for the Health of Transsexual,Transgender, and Gender-Nonconforming People. 7th ed. World Professional Association for Transgender Health (WPATH), pp.24 - 33.
9) Discussion of the “Bell versus Tavistock decision” Dr Julia K. Moore, Consultant Child and Adolescent Psychiatrist
MBBS (Hons), FRANZCP, Cert Child Adol Psychiatry

Assessment

Predictors of persistence:

- Intensity of dysphoria and meeting criteria for formal diagnosis (4)
- Cognitive cross-identification (I “am” a boy/girl/other)
- Greater rates of persistence for natal girls (10)

4) Lgbthealtheducation.org, (2015). Fenway Health | National LGBT Health Education Centre. [online] Available at: http://www.lgbthealtheducation.org [Accessed 1 Apr. 2015].
10) Steensma, T., McGuire, J., Kreukels, B., Beekman, A. and Cohen-Kettenis, P. (2013). Factors Associated With Desistence and Persistence of Childhood Gender Dysphoria: A Quantitative Follow-Up Study. Journal of the American Academy of Child & Adolescent Psychiatry, 52(6), pp.582-590.

Assessment

- Referral
- Meet with young person and family: together and then separately
- Set the scene and agenda
- Ask family, then young person

  What would you like to talk about in the interview today?

  How can I help?

- Ask preferred name and pronouns – watch the room

Assessment

Education with everyone in the room:

- Roles of providers
- Assessment process
- Psychoeducation
- Young person’s capacity to give informed consent, parental consent
- Liaison with other providers

- Questions they may have

Assessment

Psychosocial history:

- Family tree (3 generation genogram), pets
- Family h/o mental ill health
- School: level, attendance, subjects
- Any issues at school?
- Friends, romance, interests/hobbies

Get to know the person

Assessment

- Developmental history
- Physical and mental health
- Risk issues – trauma, problematic substance use, risk-taking behaviour, sex work?

- Young children - draw a picture of themselves: (1) as they currently are (2) how they would like to look in future.

Assessment

MAKE NO ASSUMPTIONS – need to ask

Assess gender dysphoria:

- How did you figure it out?
- How long have you felt this way?
- What would you like to look like (every journey is individual)?
- Who have you told and how did it go?

Assessment

Trigger Warning

- How do you feel about your body?
- Which parts of your body do you struggle with?
- Shower/getting dressed
- Do you bind/tuck?
- Periods?

Assessment

- How do you cope?

(This is to assess resilience or less safe coping strategies)

- Do they feel supported by family/ school/peers?

Assessment

- What do they know about the next steps in transition process?
- Where do they get most of the information from?
- What interventions would you like?

Do not assume everybody wants “all the things”

Assessment

Questions for young people, and then also for parents around early years:

- Temperament
- Preference – toys, friends, clothes
- Trauma

Assessment

Parent assessment

- How do they feel?
- Support groups?
- What do they know about the next steps?
- Questions/Comments

Acknowledge and validate what they are feeling

Assessment

- **Consent and competency:** Assessment of patient's capacity to make an informed decision and consent to treatment of their own free will

- Re Kelvin (2017) - all young people and their parents/carers to Court for gender affirming hormones prior to age 18.
- Re Imogen (2020) - treatment for people under 18 with no dispute between parents/carers if:

    - The Gillick competent
    - A diagnosis of gender dysphoria
    - Proposed treatment for gender dysphoria

- Any dispute: FLC

Assessment

- At clinics offering a gender-affirmative model of gender health care - properly considering and weighing up their decisions to commence, or not commence, treatment.
- A four-quadrant method
- Under each of the following four headings, points specific to the young person's situation and care needs

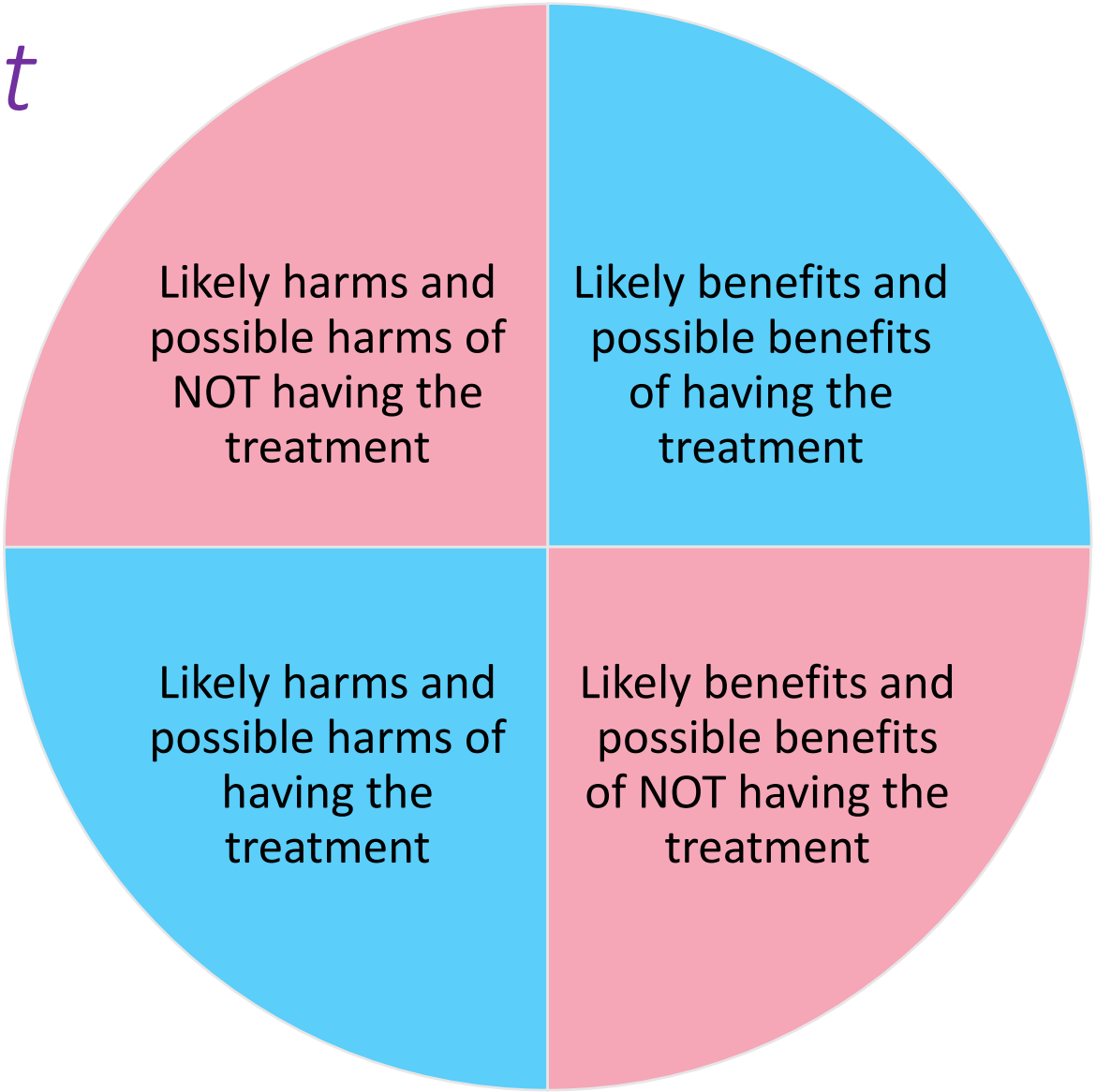
Likely benefits and possible benefits of having the treatment

Likely benefits and possible benefits of NOT having the treatment

Likely harms and possible harms of having the treatment

Likely harms and possible harms of NOT having the treatment

Assessment


Likely harms and possible harms of NOT having the treatment
Likely benefits and possible benefits of having the treatment
Likely harms and possible harms of having the treatment
Likely benefits and possible benefits of NOT having the treatment

Assessment

1. Provide treatment advice
2. Offer family support
3. Offer supportive counselling for exploring gender identity, alleviating distress, and navigating other psychosocial difficulties.
4. Coexisting mental health concerns
5. Educate and advocate
6. Liaison – other providers, school, Medicare

Assessment

Check in with yourself/reflect before treatment:

- YOUR discomfort/ transference/ psychological defences
- YOUR knowledge (or lack thereof)
- YOUR own barriers to implementation

Assessment

- Thank you to Matt and Elizabeth and Dani!