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Working with Caregivers of Gender Diverse Youth

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Objectives

- Provide a brief overview of gender terminology and relevant research
- Discuss a framework for assessing caregiver readiness and barriers
- Offer strategies/techniques to use in therapy
- Case examples

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Disclosures

I'm privileged (white, cis, educated, resourced, able bodied, etc.)

It's a privilege to work with gender diverse patients and I do so with humility

I practice through an affirmative care, trauma informed model

Working with this population is not for everyone

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About Our Clinic

- Established in 2016 we are a multidisciplinary team consisting of Endo, Adol Med, NPs, RNs, SW, and Psych
- Referrals can be made within our system to various specialties including GYN, Urology, Plastics, Dermatology and Speech Pathology
- Families can self-refer or be referred by outside providers via the website
- We have served over 700 families
- About 20% are AAPI

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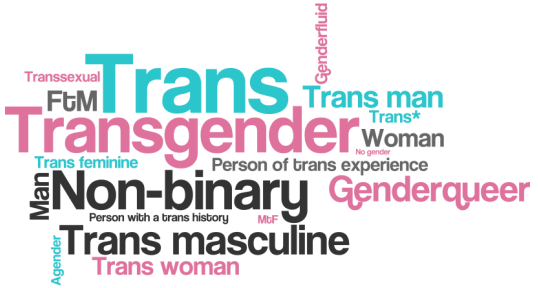
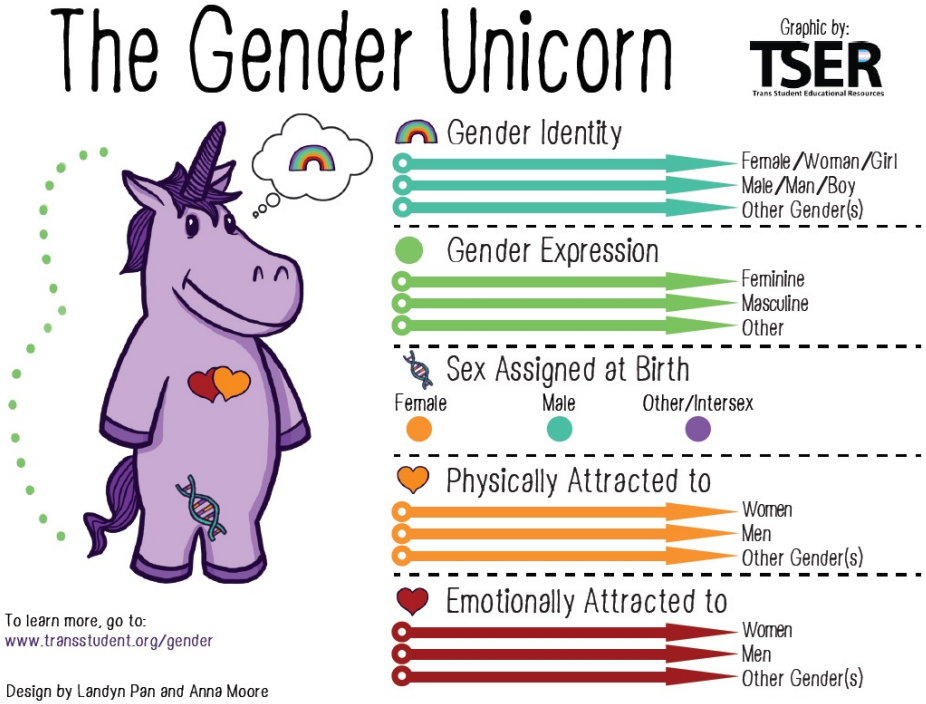
Gender Terminology





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Identify the caregiver type

- The Worrier – focuses on future either regret or negative mental health outcomes
- The Misinformed – has absorbed incorrect information and taken those as fact
- The Wanderer – has very little knowledge and information and needs direction
- The Unsupportive – has strong views that are inconsistent with supporting youth
- The Scientist – need for data and statistics

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Identify stage of readiness

PRECONTEMPLATION
Build awareness for my need to change

CONTEMPLATION
Increase my pros for change and decrease my cons

PREPARATION
Commit and plan

ACTION
Implement and revise my plan

MAINTENANCE
Integrate change into my lifestyle

Caregivers in denial regarding identity

Caregivers understand child identifies a certain way but don't feel they need to support

Caregivers are trying to support child but have reservations regarding intervention

Caregivers are actively seeking treatment and engaged in process

Caregivers easily use name and pronouns and are comfortable with interventions and advocate for child

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Caregivers in denial regarding identity

- “It seems like this is just trendy right now”
- “They only identify that way because of a YouTube video they saw”
- “Isn’t this just social contagion?”
- “This wasn’t around when I was their age”
- “Why are the numbers increasing so rapidly?”

- Provide historical context
- Reason for rate increase
- Assure caregivers that this is not due to social media

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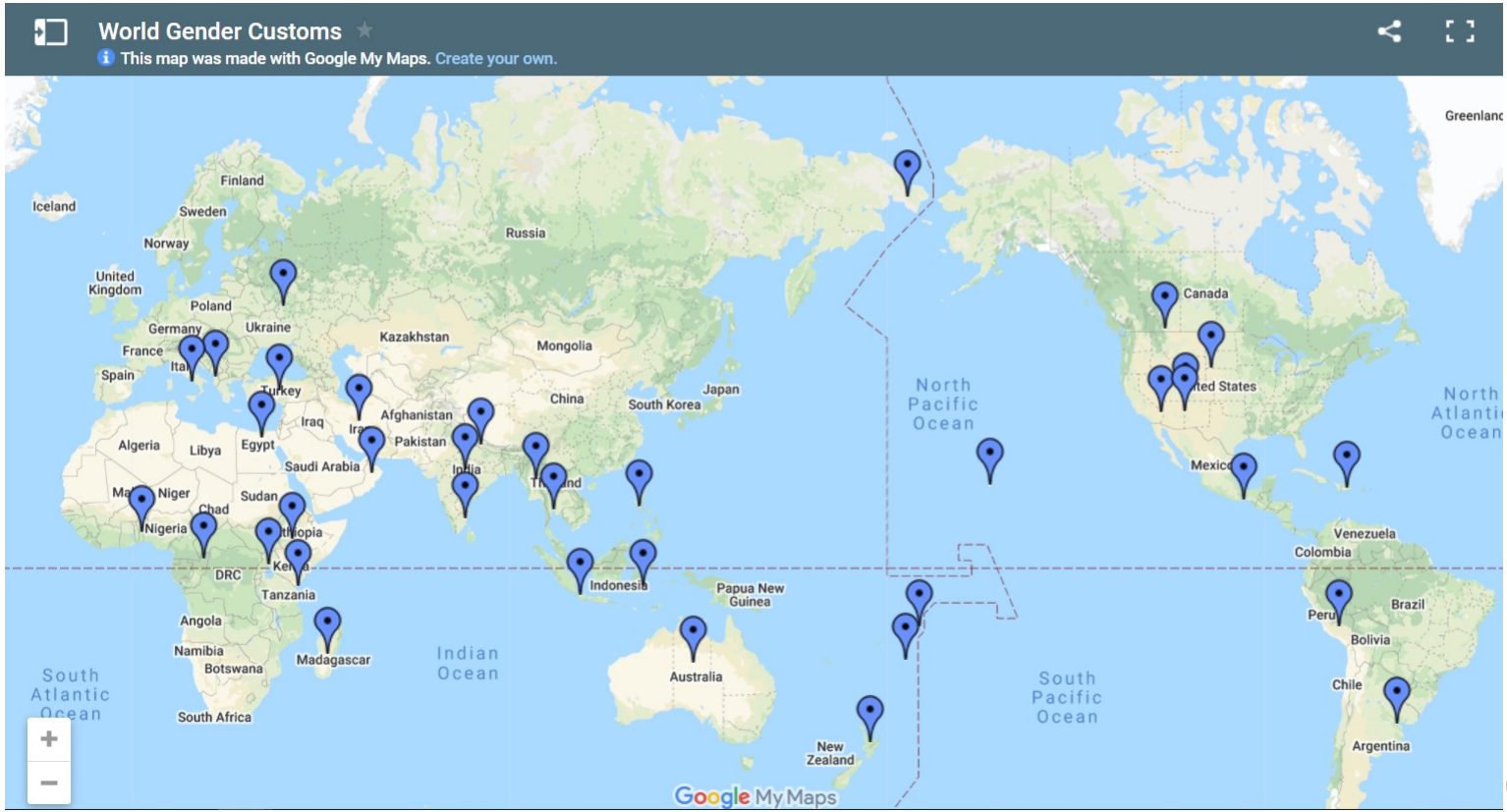
A cross cultural view



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A historical perspective

1755 – Charlotte Clark publishes autobiography, first documented open transgender male

1910 – Magnus Hirschfield coins the term “transvestite” and creates the first clinic to serve transgender people (Berlin)

1917 – Dr. Alan Hart first documented male to transition (hysterectomy and gonadectomy) in the US

1930 – Lili Elbe a Danish painter becomes first known recipient of gender affirmation surgery

1948 – Harry Benjamin becomes first endocrinologist to use hormone therapy

1966 – Johns Hopkins opens first Gender Clinic

1972 – Sweden allows citizens to legally change their sex

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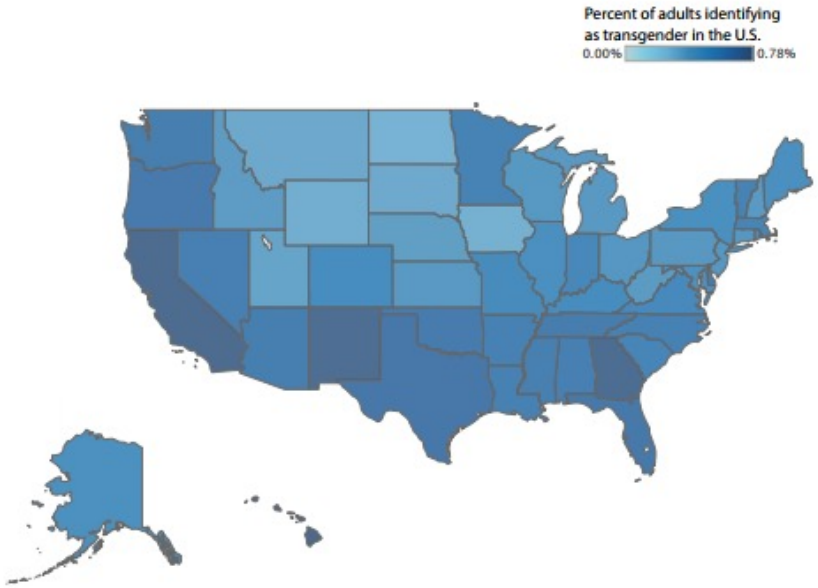
Rates

- 2016 Williams Institute survey 1.4 million (0.68%) double the number of 10 years ago



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Maybe it's how you ask the question

- Williams Institute – 150,000 youth (0.7%)
  - "Do you consider yourself to be transgender?"
- Recent study from Minnesota surveyed 80,929 high school students (9^{th}-11^{th} grade)
  - "Do you consider yourself transgender, genderqueer, genderfluid, or unsure about your gender identity?"
  - 2.9%
- Outside the US
  - New Zealand (2013) – 8.166 adolescents surveyed 1.2% identified as transgender, 2.5% reported being unsure, 1.7% did not understand the question

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Caregivers understand child identifies a certain way but don't feel they need to support

- "My child doesn't seem bothered by pronouns"
- "They say it's okay for me to use their birth name"
- "I've never heard them correct anyone"
- "They haven't asked me to use a different name or pronoun"
- "Nothing has changed since they came out"

- Emphasize importance of caregiver support as an intervention
- Highlight the differences in journeys and how hard it is to advocate in the beginning
- Identity and expression don't always align
- Breakdown gender stereotypes

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Name and pronouns matter

- Russell, Pollitt, Li & Grossman (2018)
  - Name used in more settings resulted in lower depression scores, suicidal ideation, and suicidal behavior
  - Even when controlling for social support
  - Increasing by one context = 5 point reduction (60 point scale), 29% decrease in SI, and 56% decrease in suicidal behavior
- Just because it doesn't appear to matter, doesn't mean it isn't causing dysphoria
- Youth shouldn't be expected to advocate for themselves right away (anxiety, safety)

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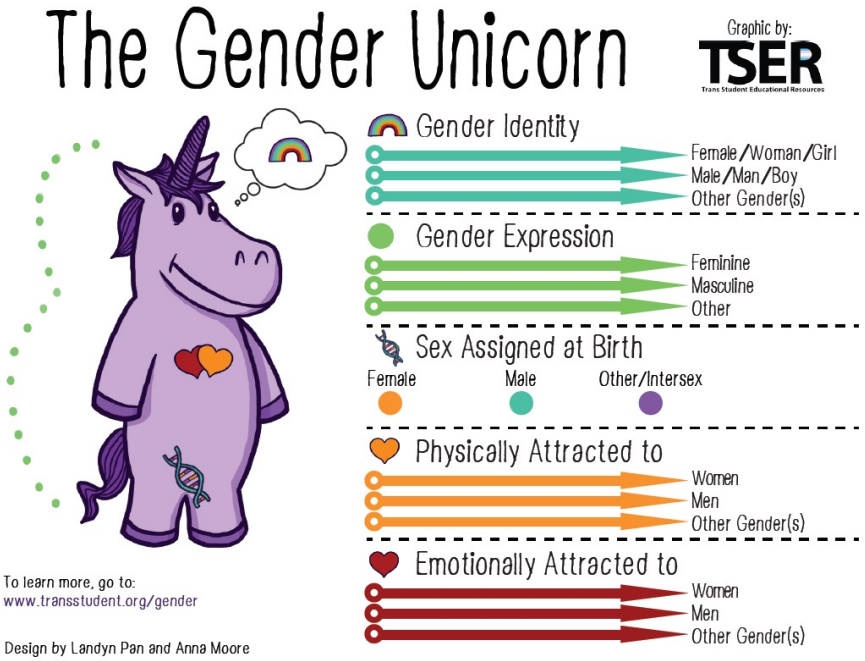
Identity and Expression are different things



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Caregivers are trying to support child but have reservations regarding intervention

- "Why can't they just be (female/male) without changing their body?"
- "They're too young to know what they want"
- "We don't know enough about the medical risks"

- Help youth describe their experience with dysphoria and how interventions will improve quality of life (physical and psychological)
- Provide education regarding develop of gender
- Encourage families to speak with a medical professional to discuss the risks and rates of negative outcomes

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Kohlberg 1966

Basic Gender Identity (2-3yo)	Ability to differentiate girl from boy (based on body parts and expression)
Gender Stability (4-5yo)	Understands gender is stable over time (boy today, boy tomorrow; girl become women)
Gender Consistency (6-7yo)	Understands gender is consistent regardless of wearing different clothes or engaging in different activities

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Medical Risks

Risk Level	Feminizing hormones	Masculinizing hormones
Likely increased risk	Venous thromboembolic disease[A] Gallstones Elevated liver enzymes Weight gain Hypertriglyceridemia	Polycythemia Weight gain Acne Androgenic alopecia (balding) Sleep apnea
Likely increased risk with presence of additional risk factors[B]	Cardiovascular disease	
Possible increased risk	Hypertension Hyperprolactinemia or prolactinoma	Elevated liver enzymes Hyperlipidemia
Possible increased risk with presence of additional risk factors[B]	Type 2 diabetes[A]	Destabilization of certain psychiatric disorders[C] Cardiovascular disease Hypertension Type 2 diabetes
No increased risk or inconclusive	Breast cancer	Loss of bone density Breast cancer Cervical cancer Ovarian cancer Uterine cancer

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Youth who transition have better mental health outcomes

Longitudinal impact of gender-affirming endocrine intervention on the mental health and well-being of transgender youths: preliminary results

Christal Achille[1], Tenille Taggart[2], Nicholas R. Eaton[2], Jennifer Osipoff[1], Kimberly Tafuri[1], Andrew Lane[1] and Thomas A. Wilson[1*]

Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment

WHAT'S KNOWN ON THIS SUBJECT: Puberty suppression has rapidly become part of the standard clinical management protocols for transgender adolescents. To date, there is only limited evidence for the long-term effectiveness of this approach

AUTHORS: Annelou L.C. de Vries, MD, PhD,[a] Jenifer K. McGuire, PhD, MPH,[b] Thomas D. Steensma, PhD,[a] Eva C.F. Wagenaar, MD,[a] Theo A.H. Doreleijers, MD, PhD,[a] and Peggy T. Cohen-Kettenis, PhD[a]

Well-Being and Suicidality Among Transgender Youth After Gender-Affirming Hormones

Luke R. Allen and Laurel B. Watson
University of Missouri, Kansas City

Anna M. Egan and Christine N. Moser
Children's Mercy Hospital, Kansas City, Missouri

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Overall

- Meet caregivers where they are and approach in a collaborative manner
- Express understanding that they care about their child and wants what is best for them
- Build rapport before challenging
- Refer to parent groups or mentors
- Be patient!
- You won't always win ☹

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Case 1: Unsupportive

- 13 year old designate female, male identifying bi-racial (caucasian/latinx) youth presents to clinic following a referral from PCP. Came out to family about a year ago, is interested in menstrual suppression and hormone therapy. Initially, mother is using name and sometimes pronouns, father is using neither.

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Case 2: Legal Issues

- 16 year old designated male, female identifying Caucasian youth comes to clinic following inpatient hospitalization for suicidal ideation. Caregivers are not together and only father comes to the visit. You are told that mother lives out of state, has no contact with patient, and is unsupportive of identity and transition.

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Case 3: Pronouns

- A 15 year old designated female, male identifying Chinese youth presents to clinic after being referred by PCP. Only mother is attending the appointment and you note that she is using the name but not the pronouns. You are told that father is using neither.

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