



Most psychologists haven't been trained to work with transgender and gender-nonconforming kids, but the growing number of individuals disclosing their transgender identities underscores the need for competent care for this population.

CE

CONTINUING EDUCATION EMBRACING A GENDER- AFFIRMATIVE MODEL FOR TRANSGENDER YOUTH

BY REBECCA A. CLAY

When Brenda Smith's 14-year-old daughter Samantha* announced that she hated her body, Brenda thought she was just having a rough time with puberty. But then the middle-schooler fell into a deep depression. She started wearing "binders," which flattened her breasts but made it difficult to breathe. She stopped eating in hopes of slimming her hips. When Samantha told her pediatrician she wanted a mastectomy, the practice urged the family to consult a gender specialist.

After one meeting, the psychologist concluded that Samantha was transgender and should proceed to transition. Brenda and her husband, Jim, weren't so sure, especially since Samantha had recently been diagnosed with high-functioning autism spectrum disorder. "We

thought, 'She's just stuck on this and will get unstuck and move on to another topic,'" Brenda remembers. That didn't happen. Instead, the family sought help from a psychologist specializing in both gender dysphoria and autism—conditions they soon learned often co-occur—and moved ahead slowly. "It was a process of saying goodbye to a daughter and welcoming a son," says Brenda. Although she and Jim had hoped to spare their child the challenges of being transgender in an often unwelcoming world, they knew they had done the right thing when they saw the joy and relief that testosterone treatment and a double mastectomy brought. While Sam still struggles with autism and still counts every calorie, he is now enjoying college and getting good grades.

The Smiths' story echoes many of the themes found in the rapidly evolving literature on gender dysphoria—distress caused by an incongruence between one's gender identity and gender assigned at birth—in children and adolescents. Controversies abound, say pediatric psychologist Diane Chen, PhD, of the Ann & Robert H. Lurie Children's Hospital of Chicago, and colleagues (*Clinical Practice in Pediatric Psychology*, Vol. 6, No. 1, 2018). How many kids maintain a transgender identity into adulthood? Can adolescents make well-informed decisions about hormonal and surgical interventions? Are the high rates of depression

and anxiety common among transgender youth the result of societal discrimination and other external factors, or something within themselves?

Even the terminology is rapidly changing as clinicians' growing awareness, the ever-increasing research literature, and advocacy by transgender and gender-nonconforming individuals themselves reshape terms (see box). In 2013, the Diagnostic and Statistical Manual of Mental Disorders (Fifth Edition) replaced "gender identity disorder" with "gender dysphoria." And the World Health Organization is changing "gender identity disorders" to "gender incongruence" and moving these categories out of the chapter on mental disorders to a new section on sexual health in the forthcoming edition of the International Classification of Diseases. There is still active discussion about whether to include a diagnosis at all for children who are exploring their gender identities.

But with the evidence base in flux, clinicians and researchers are already producing guidance to help children, youth and families who need help now. That guidance includes APA's "Guidelines for Psychological Practice With Transgender and Gender Nonconforming People" (*American Psychologist*, Vol. 70, No. 9, 2015) and the World Professional Association for Transgender Health's "Standards of Care for the Health of Transsexual,

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Learning objectives: After reading this article, CE candidates will be able to:

1. Discuss research on the mental health benefits of affirming children's gender identities.
2. Describe what the affirmative model looks like in psychology practice.
3. Discuss key considerations in helping children make decisions about their ultimate gender.

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Transgender, and Gender Non-conforming People.” These and other guidance reflect a growing consensus that psychologists should help children explore their gender identities and help families support their children and be on the lookout for commonly co-occurring concerns, such as eating disorders and autism.

Although most psychologists haven’t been trained to work with transgender and gender-nonconforming kids, the growing number of individuals disclosing their transgender identities as barriers come down and media role models proliferate makes the need for culturally competent care for this population increasingly urgent, says Anneliese A. Singh, PhD, of the University of Georgia. Singh co-chaired the task force that developed APA’s guidelines along with lore m. dickey, PhD, of Northern Arizona University. Recent data from the California Health Interview Survey, for example, found that 27 percent of California’s 12- to 17-year-olds report being gender-nonconforming to some degree (UCLA Center for Health Policy Research, 2017).

“We need psychologists in everyday practice to have a strong grasp of trans-affirming knowledge in working with their clients,” says Singh, associate dean for diversity, equity and inclusion and a professor of counseling and human development services. Even if they’re not working with transgender people and those who reject the discrete male and female binary notion of gender, says Singh, “they certainly will be working with people who have those relationships in their lives.”

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Practitioners can’t just send such clients to a colleague who specializes in gender diversity, adds Sarah Burgamy, PsyD, a private practitioner in Denver who describes herself as living “along the gender spectrum as a gender-nonconforming self-identified woman/androgynous individual.”

“Human diversity is not a specialty,” says Burgamy, part of a multidisciplinary team at Children’s Hospital Colorado’s TRUE Center for Gender Diversity and a member of APA’s Committee on Sexual Orientation and Gender Diversity. “It’s incumbent upon us all to really seek ongoing competency.”

Getting past the idea of a binary model of gender is key, says Burgamy, who provides trainings on gender diversity. “People are going to walk through the door and may already possess an identity that’s not a cisgender identity, that’s something like transgender or nonbinary, agender or any of the numerous ways people think about themselves,” she says.

Psychologists must also overcome any feelings that gender diversity is a fad, she says. “There’s evidence across cultures, across the world that gender diversity exists.”

AFFIRMATIVE PRACTICE

The research in this area is burgeoning, says Diane Ehrensaft, PhD, director of mental health at the Child and Adolescent Gender Center at the University of California, San Francisco. And it increasingly suggests the value of gender-affirming practice that respects and supports the gender identities and experiences of children and adolescents, says Ehrensaft, who has reviewed

the literature along with Jack Turban, MD, of Massachusetts General Hospital (*Journal of Child Psychology and Psychiatry*, online first publication, 2017).

The new research has a simple message: When transgender children get support affirming their gender identities, their mental health difficulties go down; when they don’t get support, they go up. “That’s where the radical shift is,” says Ehrensaft, noting that past research focused on what was wrong with transgender kids. “It looks like the pathology lies in the culture, not inside the child.” The Trump administration’s plans to undo a rule protecting transgender individuals from discrimination by insurers and health-care providers is just one example of the threats transgender individuals face from the world around them, says Ehrensaft.

What does the affirmative model look like in everyday practice? It begins with culturally competent intake interviews, say David T. Solomon, PhD, an assistant professor of psychology at Western Carolina University in Cullowhee, North Carolina, and colleagues (*Psychology of Sexual Orientation and Gender Diversity*, Vol. 4, No. 4, 2017).

Even before seeing a transgender client, psychologists should familiarize themselves with the research and culture. “Therapists practicing for a while may not be familiar with trends,” says Solomon. Reflecting the trend of viewing gender identity as fluid and occurring along a spectrum, he says, many young people are moving from a more binary view of gender to a more nonbinary view, for example.



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Psychologists should also avoid making assumptions, whether about the client’s current gender or desire to transition to a different one. The psychologist’s job, says Solomon, is to create an inclusive, welcoming environment for their clients to safely explore their gender identities. Confronting your own biases is key, says Solomon. Even well-meaning psychologists may struggle to accept a nonbinary view of gender or believe that new views of gender are just a passing fad. Solomon cites as an example a former colleague who insisted that a young client choose a gender instead of being “genderqueer”—a term used by some whose gender doesn’t align with the binary understanding of gender.

How therapy should proceed depends on the client’s age. There is still some controversy about “social gender transition”—behaviors such as changing

names, pronouns and clothing—before puberty, says Ehrensaft. However, a review of the literature she and colleagues conducted suggests that socially transitioned prepubertal children are typically well-adjusted (*International Journal of Transgenderism*, online first publication, 2018).

The controversy is rooted in older, methodologically flawed research that gave rise to the notion of transgender “persisters” and “desisters,” says Ehrensaft. As APA’s guidelines point out, past research has suggested that most individuals diagnosed with gender dysphoria as children no longer identify as a different gender by the time they hit adolescence or early adulthood. But that research may inflate the number of young people whose transgender or gender-nonconforming identities don’t last, the guidelines note, since some of the research classified young people as desisters

Research shows that when transgender children get support affirming their gender identities, their mental health difficulties go down. When they don’t get support, they go up.

if they didn’t return to clinics for medical interventions after their initial assessments—even though their later gender identities were unknown.

Plus, as Ehrensaft and her co-authors point out, the early research didn’t necessarily distinguish between gender identity (the internal sense of being male, female or something else) and gender expression (clothing and other external presentations and behaviors that can express gender roles). A boy who wears dresses, for example, might still be comfortable with being a boy. The small, readily identifiable subset of children who focus strongly on identity rather than expression typically persist in their transgender identities, says Ehrensaft.

Even in the absence of definitive research about the best way to help their children, parents are increasingly supporting their children’s explorations of their gender, says Ehrensaft.

And that kind of support reduces the distress traditionally associated with gender dysphoria in youth, according to the TransYouth Project, a national, longitudinal study of socially transitioned children. Principal investigator Kristina R. Olson, PhD, an associate professor of psychology at the University of Washington, and colleagues, for instance, have found that children ages 3 to 12 who had socially transitioned were no more depressed than non-transgender siblings and other children (*Pediatrics*, Vol. 137, No. 3, 2016). Their anxiety levels were only marginally higher.

In addition to helping parents support their children, psychologists should help parents work

through their own grief, worry and other concerns separately to avoid adding to their children’s stress, suggest Sabra Katz-Wise, PhD, of Boston Children’s Hospital and Harvard Medical School, and colleagues (*Journal of Counseling Psychology*, Vol. 64, No. 1, 2017).

MEDICAL INTERVENTIONS

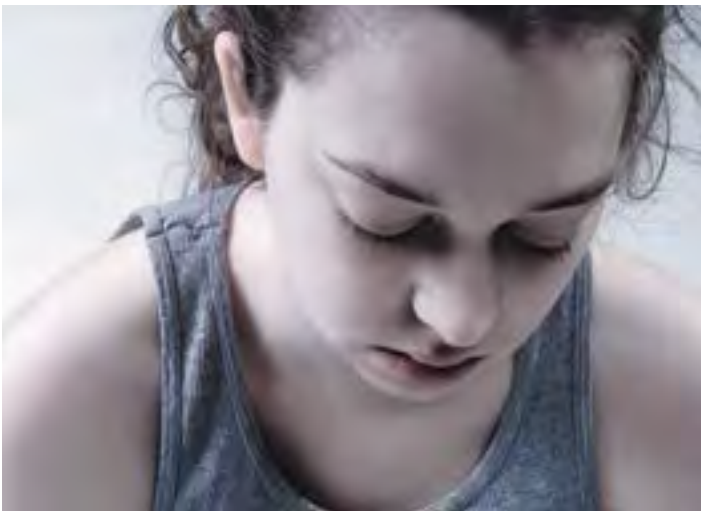
As puberty and the irreversible change it brings approach, transgender and gender-nonconforming youth may not be ready to make a decision about their ultimate gender. Puberty-blockers can temporarily suppress the development of secondary sex characteristics and

thus buy younger children time to explore their gender identities.

Once they make a decision, less-reversible gender-affirming medical interventions, such as surgery and the use of hormones to masculinize or feminize the body, can help adolescents make their outsides match their insides. These interventions also appear to reduce psychological distress, according to a literature review conducted by Cecilia Dhejne, PhD, of Stockholm’s Karolinska Institute and University Hospital, and colleagues (*International Review of Psychiatry*, Vol. 28, No. 1, 2016).

But deciding when a teen is ready to make less-reversible changes is still a matter of debate,

says Laura Edwards-Leeper, PhD, an associate professor of clinical psychology at Pacific University in Forest Grove, Oregon, and the founding psychologist of the nation’s first pediatric interdisciplinary clinic serving transgender adolescents, located at Boston Children’s Hospital. Pediatric gender clinics are shifting toward earlier medical interventions, she says. And that’s generally a good thing, she and colleagues say. In a chart review of transgender youth evaluated for possible hormone treatment at Boston Children’s, for example, they found that while most of the 56 young people had healthy psychological profiles, older teens were more likely



As puberty approaches, transgender and gender-nonconforming youth may not be ready to make a decision about their ultimate gender.

to be anxious and report lower happiness and satisfaction than younger patients (*Psychology of Sexual Orientation and Gender Diversity*, Vol. 4, No. 3, 2017).

The field is also moving away from the idea of psychologists and other clinicians as strict “gatekeepers” who once forced transgender individuals to “jump through a bunch of hoops” before signing off on less-reversible medical interventions, says Edwards-Leeper, citing as examples requirements to undergo a certain amount of therapy and to socially transition, including living full-time as one’s affirmed gender for a certain period of time. That shift toward less paternalism and greater autonomy in decision-making is fine for adults, but adolescents need a developmentally appropriate informed consent process, she and colleagues argue (*Psychology of Sexual Orientation and Gender Diversity*, Vol. 3, No. 2, 2016).

“The stakes are higher with adolescents when you’re talking

about irreversible medical interventions,” says Edwards-Leeper, adding that mental health concerns often mean there’s a lot of pressure on physicians to act quickly. “It’s harder for adolescents to think about long-term implications for the decisions they make during this developmental stage. And they’re more impulsive.” To ensure truly informed consent, Edwards-Leeper suggests that psychologists conduct a comprehensive, collaborative assessment, meeting with adolescents and family members separately to gather information about their gender-identity trajectory and set realistic expectations.

One key issue to discuss is fertility preservation, says Chen, an assistant professor of psychiatry and behavioral sciences at Northwestern University’s Feinberg School of Medicine.

Yet less than 14 percent of transgender and gender-nonconforming adolescents have discussed with health-care providers the issue of how

gender-affirming hormones affect fertility, Chen and colleagues have found (*Journal of Adolescent Health*, in press).

In addition to inadequate provider training in this area, lack of insurance coverage for fertility preservation procedures, and confusion about whose role it is to discuss fertility implications, adolescents themselves may not be eager to discuss potential parenthood, says Chen. For one, it’s not developmentally normative for adolescents to be thinking about parenthood. Plus, fertility counseling often occurs during the informed consent process for hormones. “At that point, youth often just want to move forward with their transition, live authentically and access treatment,” says Chen. “Pursuing fertility preservation procedures may slow down that process.”

To prevent rushed decisions, Chen’s team brings up fertility early in an individual’s care, sometimes even during the first visit, and both the primary medical provider and mental health provider have ongoing discussions about fertility with the patient and family. They also discuss the need for contraception to prevent unwanted pregnancy and alternative ways of becoming a parent, including adoption.

SPECIAL ISSUES

Psychologists should also be aware of conditions that frequently accompany gender dysphoria, such as eating disorders. “Someone who’s biologically female but identifies as a male may desire weight loss so they’ll have slimmer hips and look more masculine,” says Claire Peterson,

A GLOSSARY

DEFINING TRANSGENDER TERMS

The language used to describe the experience of transgender and gender-nonconforming individuals is evolving rapidly—and there continues to be disagreement about it. Still, with that caveat, here are key concepts as defined by the task force that developed APA’s “Guidelines for Psychological Practice With Transgender and Gender Nonconforming People.”

- **Cisgender:** Used to describe an individual whose gender identity and gender expression align with the sex assigned at birth.
- **Gender binary:** The classification of gender into two discrete categories of male and female.
- **Gender dysphoria:** Discomfort or distress related to an incongruence

between an individual’s gender identity and the gender assigned at birth.

- **Gender expression:** Clothing, physical appearance and other external presentations and behaviors that express aspects of gender identity or role.
- **Gender identity:** An internal sense of being male, female or something else, which may or may not correspond to an individual’s sex assigned at birth or sex characteristics.
- **Gender nonconforming:** Describes an individual whose gender identity or gender expression differs from the gender norms associated with the sex they were assigned at birth.
- **Genderqueer:** Describes an individual whose gender identity doesn’t align with a binary under-

standing of gender, including those who think of themselves as both male and female, neither, moving between genders, a third gender or outside of gender altogether.

- **Trans-affirmative:** Being aware of, respectful and supportive of the needs of transgender and gender-nonconforming individuals.
- **Transgender:** An umbrella term encompassing those whose gender identities or gender roles differ from those typically associated with the sex they were assigned at birth.
- **Transition:** The process of shifting toward a gender role different from that assigned at birth, which can include social transition, such as new names, pronouns and clothing, and medical transition, such as hormone therapy or surgery.

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PhD, an assistant professor of behavioral medicine and clinical psychology at Cincinnati Children's Hospital Medical Center. "They sometimes use eating disorder behavior to achieve weight and shape goals."

That bodily dissatisfaction can turn deadly, Peterson and colleagues have found (*Suicide and Life-Threatening Behavior*, Vol. 47, No. 4, 2017). In a clinical sample of almost 100 transgender adolescents and emerging adults, 30 percent had attempted suicide at least once, while almost 42 percent reported self-injury. "Kids who had a strong desire for weight change were disproportionately more likely to have a history of suicide attempts," says Peterson, also an assistant professor of pediatrics at the University of Cincinnati College of Medicine. For this population, she says, an interest in weight loss may be a marker of more severe distress and high-risk behaviors. Psychologists working with young people with gender dysphoria should ask about eating behaviors, she urges.

Autism spectrum disorder is another common co-occurring condition, says John Strang, PsyD, who directs the Gender and Autism Program at Children's National Health System in Washington, D.C.

To guide practitioners in the absence of longitudinal data, Strang led a study that pulled together clinicians and researchers with expertise in the co-occurrence of the

two conditions, who worked together to achieve clinical consensus—what Strang calls the "very best practice that's possible at this time." The resulting "Initial Clinical Guidelines for Co-occurring Autism Spectrum Disorder and Gender Dysphoria or Incongruence in Adolescents" (*Journal of Clinical Child and Adolescent Psychology*, Vol. 47, No. 1, 2018) have two key messages, he says. First, young people with autism may need extra support and extra time as they explore their gender and consider different paths before having surgery or starting hormone treatment to masculinize or feminize their bodies. At the same time, psychologists and others should recognize that some youth with autism spectrum disorder truly are transgender. Having autism "should not be a reason for them to be excluded from gender-related supports," says Strang.

The guidelines also call on psychologists and other providers to collaborate in the care of this complex subset of patients. "If you're a gender [specialist], make friends with the autism provider across the hall," suggests Strang. "Ideally, we'd like to see that people in both specialties become expert in the other field so that gender-care providers are more likely to recognize autism and know how to work well with kids on the autism spectrum and vice versa." ■

*Pseudonyms used to protect the family's privacy.



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