Gender Identity Issues in Primary Care

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Evolving ideas of gender

• 0.17 – 1.3 % of youth identify as transgender (Connolly et al. 2016)
• The majority of 18-34 year olds see gender as a spectrum (Fusion Millennial poll, 2015)
• 12% of millennials identify as transgender or gender non-conforming (Harris Poll, 2017)
• 56% of 13-20 year olds know someone who uses gender neutral pronouns (J. Walter Thompson Marketing Research)
The language of Gender

- Bigender
- Intersex
- Trans
- Aromatic
- FTM
- Ally
- Transexual
- Femme
- Passing
- Cissimilation
- Transition
- Dysphoria
- Transgender
- Two-spirit
- Sexual
- Genderqueer
- Heteronormative
- Boi
- Non-conforming
- Genderexpression
- Nonbinary
- GenderIdentity
- Transmisogyny
- Gay
- Top-surgery
- Monosexual
- Queer
- Cisgender
- Bi-gendered
- Orientation
- Binary
- Transsexual
- Pansexual
- MTF
- Lesbian
- Agender
- Stealth
- Equity
- Fluid
The language of Gender

- Cis, trans
- Agender – does not have a gender; gender neutral
- Trans-girl/female
- Trans-boy/male
- Gender variance/non-conforming – gender identity or expression varies from cultural norms prescribed for a particular sex
- Gender fluid – not static; evolving
- Genderqueer – anyone who does not identify with conventional gender identities, roles, expression and/or expectations
- Mis-gender – verb; to get it wrong
- Transsexual – outdated; considered offensive by many in trans community
Development of Gender Identity

• Age 2-3 – gender identity starts to emerge

• Age 4 – most children have stable sense of their gender identity

• Age 5-7 – gender constancy is achieved
Dimensions of Gender

• Body/biology
  • our experience of our own body; how an individual physically perceive himself/herself/theirself
  • how society “genders” bodies – assigns certain characteristics at “male” or “female”
  • how others’ treat us based on appearance

• Identity – sense of oneself as masculine, feminine, blended or neither

• Expression – how an individual’s gender is presented to the world and how this shapes interactions with others
Daily challenges for gender non-conforming (GN) youth and families

- Timing of transition - Who gets told and how much?
- How and where is it safe/comfortable to start to express GN socially and physically
- What bathroom is appropriate?
- Anticipating and managing reactions of family - immediate and extended may be different)
- Impact on parents (experience of loss)
- Anticipating and managing reactions of friends, neighbors, religious community
- Social stigma of not clearly “fitting in” – bullying, teasing and abuse
- Dealing with systems that may not be deft at accommodating GN/GV—medical, DMV, school
- Accessing appropriate medical and mental health support
Challenges at school

- Telling—not telling
- Who to tell and when
- Transferring to a new school – “going stealth”
- Gym class, bathrooms
- Pronoun use by teachers and peers
- Bullying, harassment—peers and adults
Mental Health Risks

- Social isolation and rejection
- Feelings of being misunderstood
- Low self-esteem/self-worth
- Bullying/trauma
- Increased risk of
  - Depression and anxiety
  - Self-harming behaviors
  - Suicidality
  - Eating Disorders
- Extreme rejection can lead to homelessness, substance use and sex work
Gender Dysphoria (GD) - definitions

- Discomfort with one’s biological sex and/or gender role assigned to it
- Results when there is distress due to dimensions of gender not being in alignment
- “incongruence, with or without distress, related to a discrepancy between an individual’s assigned gender at birth and their experienced gender.” (APA, 2013)
- DSM-5 diagnosis
Gender Dysphoria

• NOT experienced by the majority of gender non-conforming (GN) individuals
• Can be temporary in context of questioning or exploring gender identity
• Can resolve at any point in process but also may not resolve (in the case of unresolved psychological, family or cultural issues)
• Gender Affirming Care can help resolve GD
• Increases risk of mental health issues
• Can gender conforming individuals have gender dysphoria?
Marked incongruence ≥ 6 mos between experienced/expressed & assigned gender including strong desire/preference for 6 of following:

1. Strong desire to be or insistence one is the other gender (or some alternative) different from assigned one (mandatory characteristic).
2. Strong preference for **cross-dressing** in or simulating female attire (assigned boys); or only masculine clothing/resistance wearing feminine clothing (assigned girls).
3. Strong preference for **cross-gender roles** in make-believe/fantasy play
4. Strong preference for **toys, games, or activities** stereotypically used/played by other gender.
5. Strong preference for playmates of the other gender
6. Strong rejection of typically masculine toys/games/activities & strong avoidance of rough-and-tumble play (assigned boys); or strong rejection of typically feminine toys, games, and activities (assigned girls)
7. Strong dislike of one’s sexual anatomy
8. Strong desire for the primary and/or secondary sex characteristics that match one’s experienced gender

- Also: **distress or impairment** in social, school, or other important areas
DSM-5 Gender Dysphoria in Adolescents

- **Marked incongruence** ≥ 6 mos between experienced/expressed & assigned gender including 2 of following:
  1. Marked incongruence between experienced/expressed gender and primary and/or secondary sex characteristics (or anticipated ones in young adolescents).
  2. Strong desire to be rid of primary and/or secondary sex characteristics because of marked incongruence with experienced/expressed gender (or desire to prevent development anticipated secondary sex characteristics in young adolescents).
  3. Strong desire for primary and/or secondary sex characteristics of other gender.
  4. Strong desire to be of the other gender (or an alternative one from assigned one).
  5. Strong desire to be treated as the other gender (or an alternative one from assigned one).
  6. Strong conviction that one has typical feelings & reactions of the other gender (or an alternative one from assigned one).
- Also: distress or impairment in social, school, or other important areas
What is Gender Affirming Care?

- Supporting social transition
- Pubertal Blockers (GnRH agonists) – Tanner 2
- Cross-sex Hormones or Gender-affirming hormone treatment – 16 yrs/13.5-14 is some cases
- Surgery (vaginoplasties, breast surgery) – 18 yrs
- Providing mental health treatment – co-occurring conditions or related stress
- Formal consultation to schools and medical providers
Why is Gender Affirming Care Important?

- Moral imperative - “First do no harm”
- Improves mental health – reduces depression, and anxiety to levels on par with cisgender peers (Olson et al. Pediatrics. 2016)
- Safety – reduces self-harm and suicide attempts
Developmentally-Informed Care

- Comprehensive - more important than expediency
- Individualized approach that identifies, acknowledges and addresses unique needs
- Includes parents/caregivers – demonstrated benefit for them and adolescent
- Substantial mental health component – broad MH assessment, “readiness” eval and support along the way
- Evidenced based and recommended by WPATH, AACAP, Endocrine Society and APA
Why is this approach necessary?

- Adolescents are not yet adults and this care is not exempt (like substance use treatment, e.g.)
- Brain are still developing – unique influences of biology and psychology
- By definition, identity at this age is fluid – they are susceptible to influence of all kinds – peer/parent, positive/negative
- Lack power and can feel trapped
- Fertility issues and medical treatments in particular need collaborative approach
- Comprehensive approach determines success more than early medical intervention
Controversies in Gender Affirming Care
(Kimberly et al. Pediatrics. 2018)

- Lack of data on long-term outcomes
  - Impact of early social transitions that “don’t stick”
  - Cardiovascular and metabolic side effects of estrogen/testosterone therapy
  - Impact on the developing brain
- Issues of consent – “developmentally informed”
- Decisions have to be made without full information
- Delaying puberty may add psycho-social stress – not “advancing” with peers
- Transitioning may cause child to feel “trapped” in their decision
“Transitioning” = “Pursuing congruence measures”

- Typically refers to MtF or FtM transition
- Commonly used to refer to the steps a transgender, agender, or non-binary person takes in order to find congruence in their gender
- Can include social, physical and surgical changes – “alignment in one or more dimensions of the individual’s gender as they seek congruence across those dimensions.” (Genderspecturm.org)
- “Transition” refers to what others see and how others see the individual not necessarily change in individual’s identity
GD/GN and ASD

- Overlap is controversial area/active debate
- Treatment Guidelines for ASD + GD (Strang et al. 2018) are based on data indicating a high-rate of co-occurrence
- Several studies suggest higher rates of ASD in individual receiving support for GD compared to general population (GP) (Glidden et al. 2016; Paterski et al. 2014)
- Prevalence of GID in ASD (8%) appears to be higher than GP (1%) (DeVries et al. 2010)
- Children and teens with ASD 7X more likely to express gender variance (Strang et al. 2015)
Theories to Explain Correlation

- GD and ASD may be truly co-occurring disorders
- Gender variance may be related to unique social behavior and unusual characteristics associated with ASD – difficulty navigating many developmental challenges
- Gender dysphoria may be manifestation of rigidity - may be “unable to let [gender aspect of identity] go.”
- May be “content” or manifestation of OCD
- Gender Dysphoria may mimic some (HF) ASD traits/characteristics – social awkwardness, anxiety
- ASD individual may seek an accepting group and presume GNC explains their challenges
Addressing Gender Non-conformity (GN) in ASD

- Consult specialists in both areas
- Move slowly and cautiously – “start low and go slow”
- Address co-occurring MH issues/problem behaviors
- Think of gender care the same as any other care with regards to strategies and level of support to child and family
- Support in making decisions to the best of their ability – informed consent may look different
- Keep in mind, expressions of GN and transitions may look different
- Consider (but don’t estimate) unique peer affiliative tendencies
- ASD is not a contra-indication for GAC including medical intervention
Who does well....

- Supportive family
- Supportive culturally-sensitive school
- Supportive peer network – online or in-person
- Gender-affirming/gender-congruent care – supported social transition in childhood; may include medical intervention if appropriate circumstances
- Comprehensive evaluation and treatment approach
- Appropriate mental health support – around TG and other issues; individual/group therapy
Suggestions for managing GD/NC in your clinic

• Confirm name and preferred pronouns – chart this!
• Be open, honest and affirming
• Apologize in advance – you WILL make mistakes
• Now how and when to refer to specialists - gender clinic, psychiatric, autism
• Educate yourself. If appropriate, ask the youth to educate you.
• Ask if they feel safe - 75% feel unsafe at school; 25% physically harassed; 12% report assault (Kosciw et al. 2012)
• Consider ASD evaluation if GD/NC diagnosis
• Consider GD/NC screening if ASD diagnosis
Resources

- [www.GenderSpectrum.org](http://www.GenderSpectrum.org)
- World Professional Association for Transgender Health ([www.wpath.org/](http://www.wpath.org/))
- Seattle Children’s Gender Clinic
  Contact: Lara Hayden, MSW, LCSW
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