Holistic Psychiatric Care of Gender Dysphoric Children and Adolescents

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Reflecting contemporary knowledge and a changing social landscape, the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) has taken the historic steps of renaming Gender Identity Disorder to Gender Dysphoria, removing the diagnosis from the category of Sexual Dysfunctions, and placing it in a class by itself (APA, 2013). These important changes pave the way for clinicians to offer care to gender nonconforming and gender dysphoric individuals without the need for the stigmatizing labels that have been used by psychiatry in the past. Indeed, both the American Psychological Association and the American Psychiatric Association have reported recent increases in demand for clinicians educated in the care of children and adolescents with gender identity concerns (Cousino, Davis, Ng, & Stancin, 2014). Advanced Practice Psychiatric Nurses (APPNs) are uniquely positioned to provide comprehensive mental health care for these individuals. To facilitate this knowledge, a review of the literature on psychiatric assessment and treatment of gender dysphoria was conducted using relevant databases (Cochrane, CINAHL, PubMED, PsychInfo, PsychiatryOnline) focusing on results from 2010 to present. A search of prominent governmental health agencies and accredited gender-specific health agencies in Europe and North America for current guidelines pertaining to the care of gender dysphoria in children and adolescents was also undertaken. This paper provides a synthesis of the literature including essential information regarding a holistic standard of care that APPNs should provide for youth experiencing gender dysphoria, including cultural and psychiatric aspects of assessment and psychosocial and pharmacological treatment options.
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Social attitudes and societal norms in the United States and around the world have become more progressive and accepting of gender fluidity over the past decades, and this shift has led to the destigmatization of gender questioning persons by the American Psychiatric Association (APA). Gender dysphoria, no longer known as gender identity disorder and no longer considered a sexual dysfunction, is defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) as a significantly distressing and functionally impairing desire to be a gender other than the one assigned (American Psychiatric Association, 2013). Evidence shows that gender questioning thoughts and behaviors disturbing enough to qualify as clinically significant do frequently manifest in young children and adolescents, and many persist into adulthood (Olson, Schrager, Belzer, Simons, & Clark, 2015).

Despite more progressive social attitudes, children and adolescents experiencing gender dysphoria continue to face overwhelmingly negative attitudes from society at large. Adolescents with gender dysphoria are more likely to report familial rejection, social stigmatization and feelings of being marginalized, are more likely to be victims of violence or to use illegal drugs, and are also at much higher risk of psychiatric co-morbidities such as major depression, anxiety, and self-harm behaviors (Dettore et al., 2015; Olson et al., 2015). Fuss, Auer, and Briken (2015) suggest that the additional mental health burden on young people with gender dysphoria is consistently high enough to be considered a critical aspect of treatment of the condition.

The epidemiology of gender dysphoria has not yet been extensively studied, and estimates of its prevalence vary widely between sources. The DSM-5 states that the prevalence is very low at 0.005 to 0.016 percent among adult natal males and 0.002 to 0.003 percent among adult natal females (American Psychiatric Association, 2013). However, recent nationally representative
studies among children in New Zealand and the United Kingdom found that 1.2 percent of middle school age children indicated they identified as transgender and 2.5 percent stated they were not sure about their gender (Fuss, Auer, & Briken, 2015). Gender variable response rates as high as 4.57 percent have been found in studies on children under the age of ten in Italy, however it is important to note that approximately seventy five to eighty five percent of young children do not persist past puberty with feelings of variable gender (Dettore et al., 2015). The increasing medical and social acceptance of gender fluidity has led to a greater number of individuals and families feeling comfortable seeking care for gender dysphoria and higher demand for providers educated on gender related care. In light of the very serious mental and physical health consequences of gender dysphoria, Advanced Practice Psychiatric Nurses (APPNs) should be well versed in the holistic care of this population.

**Purpose**

The new DSM-5 diagnosis of gender dysphoria has legitimized the condition in the eyes of both the public and of medical and mental health providers, and has helped pave the way for an increase in research into the best possible treatments for the condition. While the study of effective treatment for gender dysphoric children and adolescents is in its infancy, it is imperative that APPNs have knowledge of socially and culturally sensitive assessment of these patients as well as of available evidence-based pharmacologic and psychotherapeutic treatments. As gender nonconforming youth are a vulnerable population due to the lasting stigma attached to the condition, it is also important for APPNs to have a body of knowledge related to psychiatric comorbidities and the availability of resources in the community.

The purpose of this research paper is to increase the working knowledge of APPNs surrounding gender dysphoria in children and adolescents, in turn increasing the quality of care
available for this population. This paper will identify key terms and definitions related to gender nonconforming individuals, define current methodology in sociocultural and psychiatric assessment, synthesize current evidence based best practices in psychosocial and pharmacological treatment, and address interdisciplinary care. Armed with the most current knowledge surrounding gender dysphoria in children and adolescents, APPNs can be prepared to provide holistic care for this emerging population.

**Significance**

Though the available data suggest that the incidence of gender dysphoria in children and adolescence is low, there has been a definite increase in the number of individuals in this population seeking care over the past two decades. This rise in demand for care, coupled with the drop in number of practicing psychiatric providers, suggests that APPNs will be asked to provide care for gender dysphoric children or adolescents at some time in the course of a career. In addition, evidence shows that the incidence of serious psychiatric co-morbidity is high among gender dysphoric youth, indicating that these patients may initially present for care of another mental health issue (Fuss et al., 2015). It is essential that every APPN have the ability to provide assessment, treatment, and appropriate referrals for this vulnerable population.

Gender dysphoric youth face many challenges navigating life, and are in dire need of mental health professionals that have the knowledge and ability to provide care according to the most up to date standards. Drescher and Byne (2012) state that while this population may be a focus of positive attention in popular culture, individuals continue to face myriad negative social issues such as bullying, harassment, and isolation, sometimes even from their own families. As it has been empirically shown that negative social experiences positively predict future psychopathology, it is easy to see that gender dysphoric youth are at a much higher risk for, and
indeed do exhibit, more comorbid mental illness than their cisgender peers (Drescher & Byne, 2012). However, it has recently been shown that gender dysphoric children who are treated early and supported by family and peers in their choice of gender identity do not exhibit abnormal levels of depression and anxiety, indicating that the development of psychopathology in gender dysphoric youth is not unavoidable (Olson, Durwood, DeMeules, & McLaughlin, 2016).

Psychiatric nurses have long provided care to the most marginalized populations, accepting widely variable cultures and treating those who may have been rejected by society with dignity and respect. The Code of Ethics for Nurses provides specific guidance on this point, stating that the nurse should always practice with “compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems” (American Nurses Association, 2014, p. 38). APPNs clearly must embody this tradition, and provide and advocate for care of gender dysphoric youth that is culturally sensitive, empathic, and promotes the dignity and physical and mental health of individuals in this population.

**Theoretical Framework**

Madeleine Leininger’s Theory of Culture Care Diversity and Universality provides an excellent framework from which to view the holistic care of gender dysphoric youth. Leininger describes the purpose of her theory as the description of the various cultural factors influencing health, emotional well-being, illness, and death as seen through the lens of divergent cultures (Leininger, 1997). A culture is defined within the theory as a set of learned and shared values, beliefs, and norms that shape and guide individuals decisions on how to live, and care is defined as actions that are taken to assist individuals to improve health or well being, or to face illness or death (Leininger, 1997). One of the main tenets of the theory is culturally congruent care, the
importance of upholding the culture of the patient while providing care and placing importance on restructuring care to fit the cultural desires of the patient (Leininger, 1997). In order to accomplish this level of culturally appropriate care, Leininger (1997) states that the nurse must have a thorough understanding of her own culture and be especially cognizant of any biases she may hold.

Individuals who are gender questioning or gender fluid, and also youth who are diagnosed with gender dysphoria can be considered to have their own unique culture, termed transgender culture (http://www.glaad.org/transgender/transfaq). Though a thorough exploration of transgender culture is beyond the scope of this paper, it is important to realize that there is a clear distinction between sexual orientation and gender identity; the two are not related. This is one basic fact APPNs providing care for gender dysphoric youth must recognize in order to provide culturally congruent care. Other areas to consider include the individual’s preferred choice of pronoun and name, level of comfort when discussing transition status, and the handling of health information with extreme sensitivity to the individual’s right to confidentiality. Evidence suggests that individuals in this already marginalized population may be less likely to return to care with a practitioner who does not provide culturally competent care, and may even avoid returning to care at all after having discriminatory or disrespectful encounters with healthcare providers (McManus, 2008). It is the responsibility of APPNs to remain educated on evolving issues in the transgender community and to treat gender dysphoric youth with respect and dignity in order to promote the best health outcomes in a culturally competent manner.

Definitions

**Sex** - the biological and chromosomal makeup of the body, visibly manifested in the outward genitalia and secondary sex characteristics; traditionally a choice is made between male and
female at the time of birth

**Gender**- the state of being male or female, with respect to the social and cultural differences between male and female as well as consideration of personal definitions of male or female

**Gender identity**- one’s personal conception of being male, female, somewhere between the two, or neither

**Gender nonconformity**- variation in gender role from conventionally held norms; includes gender questioning, gender fluid, gender nonconforming, genderqueer, and other affirming terms

**Gender dysphoria**- diagnosable psychiatric illness defined by significant disturbance in mood, affects, and functioning due to feelings of incongruence between an individual’s gender identity and biological or assigned sex: not experienced by all gender nonconforming individuals

**Transgender**- individuals whose gender identity is not congruent with their biological or assigned sex; transfeminine or MTF (male to female) individuals have transitioned from natal male sex; transmasculine or FTM (female to male) individuals have transitioned from natal female sex

**Cisgender**- individuals whose gender identity is congruent with their biological or assigned sex

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**Literature Review**

**Characteristics of Gender Dysphoria and Relationship to Mental Health**

Holt, Skagerberg, and Dunsford (2016) recently conducted a retrospective cross-sectional study of the demographics and associated mental health symptoms and social difficulties of children and adolescents referred to the Gender Identity Development Service (GIDS) in London, UK. The study examined fifteen variables related to the demographics of the individual, family structure, and characteristics of gender dysphoria, and ten variables related to mental health symptomatology. Data was collected for all new referrals for gender dysphoria between
the ages of 0 to 18 years over a period of one year, and the total number of participants was two hundred and eighteen.

Demographic results showed that this sample of gender dysphoric youth presented from 88.7 percent Caucasian backgrounds, with 67.9 percent living with both parents or with mother, and are 62.8 percent natal females and 37.2 percent natal males (Holt et al., 2016). The authors did not provide a comparison of the individual and family demographics to the population at large, removing the ability to generalize the results. Age of first gender dysphoric feelings was found to be between 0 and 6 years for 42.7 percent, between 7 and 12 years for 34.9 percent, and between 13 and 18 years for 17.9 percent, suggesting that gender dysphoria more often develops before the onset of adolescence (Holt et al., 2016). Data also showed that a significantly higher percentage of natal females then natal males both preferred to be called by a non-given name and were living full or part time as their preferred gender (Holt et al., 2016).

Holt et al. (2016) found that the most common social difficulty encountered by gender dysphoric youth was bullying, experienced by 47 percent of participants, and the most common mental health issues were depression at 42 percent and self-harming behaviors at 39 percent of participants. The authors also found dramatic increases in the incidence of self-harm, suicidal ideation and attempts, depression, anxiety, bullying, and abuse between the 5 to 11 year old age group and the 12 to 18 year old age group, indicating that the onset of puberty may be a key time in the treatment of gender dysphoria. This study does highlight the need to ensure that all youth presenting for treatment of gender dysphoria are assessed for depression, suicidal thoughts, self-harming behaviors, and victimization. However, it is limited by the lack of inclusion or exclusion criteria, the small sample size, and the fact the assessments from which the data was collected were not standardized in any way and therefore are subject to bias, error, or omission on the part
Another study seeking to outline the demographics and mental health challenges facing gender dysphoric youth was structured in a prospective observational style using a standardized patient survey (Olson et al., 2015). New referrals to the Center for Transyouth Health and Development at Children’s Hospital in Los Angeles were screened for inclusion over a twenty-two month period. Inclusion criteria included age between 12 and 24 years, diagnosis or presence of gender dysphoria, desire to transition genders, and lack of previous or current hormonal treatment, and fluency in English (Olson et al., 2015). A total of ninety-six computer assisted surveys and physical assessments were evaluated via descriptive statistics for basic demographics, gender measures, baseline physiology, psychosocial variables, and risk behaviors. Gender measures were quantified using the Utrecht Gender Dysphoria Scale Adolescent Version, depression was measured using the Beck Depression Inventory II, and risk behaviors were assessed with the Alcohol, Smoking, and Substance Involvement Screening Test (Olson et al., 2015).

Olson et al. (2015) found that the demographics of the participants were ethnically heterogeneous, with 51 percent Caucasian and 49 percent from African American, Latino, Asian, and other ethnicities. When compared with cisgender youth, physiologic parameters were largely unremarkable, including baseline testosterone levels in natal females and estradiol and prolactin levels in natal males (Olson et al., 2015). However, the authors stress that the Body Mass Index (BMI) scores of the cohort are significantly higher than that of cisgender youth (Olson et al., 2015). Transfeminine youth were much less likely (57%) than transmasculine youth (94%) to be living in their preferred gender role, and also showed higher rates of gender dysphoria on the Utrecht scale (Olson et al., 2015). Sexual orientation data was collected in this study of
adolescents, and the findings indicate that both transmasculine and transfeminine youth vary widely in this area. While 57 percent of the participants identify as heterosexual members of their preferred gender, the remainder claim a wide variety of orientations including lesbian, gay, bisexual, asexual, and other, leading the authors to conclude that it is possible that neither natal sex nor preferred gender are the overriding factor in determining sexual orientation (Olson et al., 2015).

The Beck Depression Inventory results showed that 32 percent of the participants had mild, moderate, or severe depressive symptoms, and 49 percent reported having had thought about suicide while 29 percent had a history of a suicide attempt (Olson et al., 2015). Astonishingly high numbers of participants reported use of alcohol (75.5 percent), tobacco (58 percent), cannabis (61.5 percent), and other illegal drugs (43 percent), highlighting the need for appropriate assessment of substance use as well as for preventative and treatment services for mental health and substance abuse specific to this population (Olson et al., 2015). While this study is far better standardized and controlled than the Holt et al. (2016) examination of the characteristics of gender dysphoric children and adolescents, it is still limited by the small sample size and inability to generalize results to gender dysphoric youth who are outside the urban population.

To further elucidate consistent findings of increased incidence of mental illness among gender dysphoric youth, Aitken, VanderLaan, Wasserman, Stojanovski, and Zucker (2016) undertook a comparative retrospective study of rates of self-harm and suicidality in children referred for gender services versus siblings, children referred for other mental illness, and non-referred children. The authors examined responses to the Child Behavior Checklist (CBCL) of a sample of 572 gender referred children, 425 siblings, 911 referred children, and 911 non-referred
children over a period of forty years (Aitken et al., 2016). The authors used specific items on the CBCL to create indices of gender dysphoria, self-harm, suicidality, and poor peer relations. It should be noted that a caregiver, not the child, rates the CBCL and that it is impossible to determine if all responses to the examined surveys were given by primary caregivers, thus weakening this study somewhat. In addition, the extended time period over which the CBCL surveys were given may skew results due to cultural variation in responses over time.

Results showed that overall peer relations are poorer among children referred for any type of mental illness, but not significantly higher among those referred for gender dysphoria; however, natal males with gender dysphoria had significantly poorer peer relationships (Aitken et al., 2016). Similar results were returned for rates of both suicidal thoughts and deliberate self-harm, with the highest rates present among the referred group, and the gender dysphoric group having a significantly higher rate than either the siblings or the non-referred children (Aitken et al., 2016). Interestingly, a breakdown in the rates by age group shows a clear rise in suicidal thoughts, self-harm behaviors, and suicide attempts at the ages of nine to twelve years, mirroring the findings of Holt et al. (2016) (Aitken et al., 2016). The authors suggest that assessment of children with gender dysphoria should always include questions regarding suicidality and self-harm behaviors. Also of note in all three of the studies examined is the finding that natal males suffering from gender dysphoria seem to carry a higher burden of comorbid mental health issues and social stigma.

Not until very recently has research surrounding gender dysphoric youth who have transitioned to live as their preferred sex been undertaken. Olson, Durwood, DeMeules, and McLaughlin (2016) have attempted to begin to close this gap with a cohort study of transgender children who have been supported in their chosen gender identities. A sample of 73 transgender
Holistic Psychiatric Care of Gender Dysphoric children ages 3 to 12 was compared with two control groups consisting of 49 siblings of the transgender children and 73 normally developing children with respect to levels of anxiety and depression (Olson et al., 2016). Inclusion criteria for the study were that the child identify as the gender opposite their natal sex, be living as the preferred gender in all contexts of everyday life, use the pronoun of the preferred gender, and be prepubescent (Olson et al., 2016). Anxiety and depression levels were measured using parental report on the National Institutes of Health Patient Reported Outcomes Measurement Information System short forms, providing comparison with national norms as well (Olson et al., 2016).

Significant differences were not found between the transgender children and the control groups or the national average in terms of levels of depression, and anxiety levels were found to be very slightly elevated among transgender children, but did not reach clinical or even preclinical levels (Olson et al., 2016). The authors suggest that these results show the positive effects of a variety of variables, especially supportive family and social surroundings, yet point out that the families of children who have transitioned at young ages may be much better motivated and equipped to deal with such a life change than a typical family (Olson et al., 2016). This study, while groundbreaking, does have a small sample size and is constrained by the fact that the results cannot be generalized to all young children with gender dysphoria, as there is no way to determine the level of family and social support any particular individual would receive when transitioning to a preferred gender. However, the results do reinforce that family and social relationships are critical to enhancing mental health and well being of gender dysphoric youth and therefore should be assessed and supported.

One of the concerns surrounding supporting younger gender dysphoric children to transition to a preferred gender is the fact that many children will not persist past adolescence
with gender identity concerns. A longitudinal study done by Steensma, McGuire, Kreukels, Beekman, and Cohen-Kettenis (2013) examined the rates of persistence into adolescence and possible factors associated with persistence into adolescence of children diagnosed with gender dysphoria at a large gender clinic in the Netherlands between 2000 and 2008. 127 adolescent subjects were followed for four years, and 37 percent were identified as persisting with gender dysphoria due to returning to the clinic for further treatment (Steensma et al., 2013). The authors investigated intensity of gender dysphoric feelings, psychological functioning, and peer relations in childhood, and gender identity, gender dysphoria, body image, and sexual orientation in adolescence (Steensma et al., 2013). Retrospective chart reviews of the CBCL, Teacher’s Report Form (TRF), the Gender Identity Interview for Children (GIIC), and the Gender Identity Questionnaire (GIQ), along with concurrent monitoring of the adolescents results on the Gender Identity Interview for Adults and Adolescents (GIAA), the Utrecht Gender Dysphoria Scale (UGDS), the Body Image Scale (BIS), and a sexual orientation questionnaire were used as measurement methods (Steensma et al., 2013).

Results showed that among the many variables, older age at start of treatment and natal female sex were highly significant positive predictors of persistence of gender dysphoria into adolescence (Steensma et al., 2013). Other statistically significant predictors present in childhood included high intensity of gender dysphoria as indicated by responses to the GIIC and having socially transitioned to the preferred gender (Steensma et al., 2013). As could be expected, the adolescents who persisted showed much higher levels of gender dysphoria on the GIAA and the UGDS than the desisters, as well as higher levels of body image dissatisfaction on the BIS (Steensma et al., 2013). With regards to sexual orientation, persisting adolescents of both sexes were much more likely to be attracted to those of their natal sex than desisting adolescents.
(Steensma et al., 2103). The authors conclude that treatment for gender dysphoric youth should be structured keeping in mind that natal females, those with higher levels of gender dysphoric feelings, and those who socially transition to the preferred gender are more likely to persist, and therefore treatment must be carefully tailored to each individual (Steensma et al., 2103).

**Current Treatment Methodology**

The treatment of gender dysphoric youth has only recently begun to be supported by the medical and psychiatric communities, leading to the creation of specialized gender identity clinics that provide services specific to this population. The first gender identity clinic to serve children and adolescents, the Center of Expertise on Gender Dysphoria, is located in the Netherlands and over the past thirty years has developed a widely accepted treatment protocol termed the Dutch approach. Cohen-Kettenis, Steensma, and DeVries (2011) outline the steps taken in the diagnosis and treatment of gender dysphoric children and adolescents beginning with establishing rapport with both the patient and the family, maintaining a neutral yet supportive attitude during the assessment process. As puberty-suppressing hormone therapy and gender reassignment services (GR) are offered as part of treatment, is it essential that clinicians gather enough information over an appropriate amount of time. Parents are asked to complete the CBCL and a development questionnaire prior to the first session, and patients are asked to complete the CBCL Self-Report and a number of other assessment tools such as the BIS and GIQ (Cohen-Kettenis et al., 2011). A complete psychodiagnostic assessment is performed, as well as a family session to determine how the family interacts with one another, and the patient is then seen alone to explore issues surrounding the gender dysphoria (Cohen-Kettenis et al., 2011). Information is given to the family on possible treatment options, benefits, and risks of puberty suppression and GR including infertility and the broader social implications of changing gender
If it is determined after the initial intake that the patient does have clinical gender dysphoria, referrals are made for a medical assessment and a psychiatric evaluation (Cohen-Kettenis et al., 2011). Patients with significant psychiatric co-morbidity or psychological or family problems must receive adequate treatment before taking hormones or undergoing GR, and this treatment is offered through the clinic in the form of individual, family, and group psychotherapies and psychiatry (Cohen-Kettenis et al., 2011). It is extremely important to determine if the gender dysphoria is related to gender confusion, aversion to sex or genitalia, or autism spectrum disorder, as these conditions must be resolved before medical treatment is initiated (Cohen-Kettenis et al., 2011). Psychological interventions are offered on a long-term basis to all patients, and include therapy aimed at clarifying gender identity, increasing self-esteem, addressing feelings of guilt and shame, and coping with social stigma (Cohen-Kettenis et al., 2011). Supportive family therapy, sexual education, and information therapy regarding what to expect in the course of gender dysphoria treatment are also offered (Cohen-Kettenis et al., 2011).

Though endocrine treatment of gender dysphoria is outside the scope of APPNs, it is necessary to have a working knowledge of the eligibility criteria for this treatment so that referrals can be made when necessary. To receive puberty suppressing hormones, the Dutch approach requires a history of gender dysphoria in childhood, intensification of gender dysphoric feelings as puberty nears or throughout puberty, lack of serious psychosocial problems, support of family or caregivers, comprehension of the results of the treatment, Tanner staging of at least stage 2 or 3, and age of at least 12 years (Cohen-Kettenis et al., 2011). It is the prevailing opinion of most gender dysphoria experts that when these criteria are met it will have become clear to the
individual whether or not the gender dysphoria is going to persist into adolescence and adulthood, and also at this time most young people are able to understand the implications of going ahead with hormonal treatment.

DeVries and Cohen-Kettenis (2012) have further expanded on the Dutch approach, especially as regards the particulars of how the management of assessment and treatment of children and adolescents differ. The differing approaches in management are based on the possible developmental trajectories of gender dysphoria; some children presenting with gender dysphoric feelings will lose these at the time of onset of puberty, while others will persist with gender dysphoria into adolescence and then adulthood. Therefore, the management of prepubertal children consists of a ‘watchful waiting’ approach, during which the child is continually assessed to determine if the gender dysphoria is continuing to be clinically significant and diagnosable (DeVries & Cohen-Kettenis, 2012). Assessment is focused not only on the degree of gender dysphoria, but also on possible environmental influencing factors, family stressors and response, and cognitive and psychosocial functioning and development (DeVries & Cohen-Kettenis, 2012). Treatment during childhood is not aimed at the gender dysphoria, but at any comorbid psychiatric, psychosocial, emotional or behavioral problems that the child or family may be experiencing (DeVries & Cohen-Kettenis, 2012). Parents are extensively counseled on strategies that allow them to be supportive to the child, yet not encourage extensive social transitioning to the preferred gender before the onset of puberty (DeVries & Cohen-Kettenis, 2012). In contrast to gender dysphoric children, nearly all adolescents presenting for treatment have persisted with gender dysphoria and request some form of GR. Once diagnosis and eligibility has been determined (see Cohen-Kettenis et al., 2011) the Dutch protocol calls for intense individual and family psychotherapy with a nonjudgmental and open approach to provide
support during GR treatment and transitioning to the preferred gender (DeVries & Cohen-Kettenis, 2012).

Zucker, Wood, Singh, and Bradley (2012) have outlined the model of care used for young gender dysphoric children at the Gender Identity Service located in Toronto, Canada. The clinic was established in the 1970s and has adhered to a therapeutic, biopsychosocial model of treatment that focuses on assessing the clinical course of gender dysphoria and providing supportive psychotherapeutic treatments for prepubescent children and families. Initial intake assessment consists of a telephone interview with parents or caregiver concerning background, socioemotional and gender development, any mental health treatment or concerns, physical health, family mental health history, and a question and answer period for the parents (Zucker et al., 2012). Emphasis is on developing therapeutic rapport with caregivers during this period of information gathering, and information regarding length of assessment and typical treatment are provided while enough information is gathered to determine if the child likely meets DSM criteria for gender dysphoria (Zucker et al., 2012). A family interview, interview with the child, extensive psychological testing of the child, and a feedback session are then conducted to determine if treatment is necessary (Zucker et al., 2012). Each case is formulated based on biological factors, psychosocial factors including parental response to gender dysphoric behaviors, social cognitive level of the child especially with regards to the constancy of gender, any associated psychopathology, and psychodynamic mechanisms that may have been transferred from parent to child (Zucker et al., 2012). Treatment is grounded in psychotherapy and consists of individual play therapy for the child, parent counseling and therapy, parent and caregiver interventions in the home and social environment, and psychotropic medications to treat any comorbid psychiatric conditions (Zucker et al., 2012). The center in Toronto differs
significantly from the Dutch approach in that the goal of treatment is to encourage the desistance of gender dysphoria before adolescence with the use of therapeutic and supportive techniques.

In contrast to the Gender Identity Service in Toronto, the Gender Management Service (GeMS) clinic located at Children’s Hospital in Boston cares exclusively for gender dysphoric youth who are post-pubertal and therefore may be eligible for GR services (Edwards-Leeper & Spack, 2012). The methodology used by at GeMS very closely follows the Dutch approach with the notable exception that no mental health services are provided on site, leaving it up to the patients and families to find and continue with the required mental health interventions (Edwards-Leeper & Spack, 2012). This can be seen as a weakness of the program, however consistent follow up with a staff psychiatrist and proof of ongoing therapy are required in order to continue treatment. GeMS is unique in its position as the first treatment center for gender dysphoric youth in the United States, and has much to add regarding the principles behind responsible treatment of this population. Edwards-Leeper and Stack (2012) state that it is imperative that care provided to gender dysphoric youth “respects and trusts every patient’s self-affirmed gender identity… adheres to standards of care that are empirically supported… abides by ethical principles which support interventions that do no harm to the patient” (p. 324).

In addition to an expansion of the fundamentals behind care of gender dysphoric youth, recently there has been a call by prominent gender dysphoria researchers to institute a standardized protocol for assessment (Dettore et al., 2015). While the purpose of this protocol is to enable more expedient and useful research, an examination of the proposed assessment tools can be very useful for clinical practice with gender dysphoric youth. Dettore et al. (2015) suggest a comprehensive assessment of overall functioning consisting of the Child Behavior Checklist (CBCL), Youth Self Report (YSR), Teacher’s Report Form (TRF), and the Children’s Global
Assessment Scale (CGAS). When given together, these tests provide a picture of any actual or potential emotional or behavioral issues as reported by the child, parents, and teachers, and can be standardized into syndrome scales which are DSM diagnostically oriented (Dettore et al., 2015). Specific to the assessment of gender dysphoria, the Gender Interview for Adolescents and Adults (GIAA), the Utrecht Gender Dysphoria Scale (UGDS), the Recalled Childhood Gender Identity Scale, and the Body Image Scale (BIS) are suggested to evaluate past and current intensity of gender dysphoric feelings (Dettore et al., 2015).

Another area that APPNs should have knowledge specific to regarding gender dysphoric clients is the use of psychotherapy techniques. Fraser (2009) has provided an overview of the therapeutic modalities currently in use and most helpful with this population. The use of established models of psychotherapy in ways that can benefit gender dysphoric individuals and help therapists understand the transgender experience is cited as the major area of focus (Fraser, 2009). Narrative psychotherapy is positioned as a way for the therapist to allow the client to tell an individual story of the birth of a true self, while psychodynamic therapy can be used to show the client that the authentic gender that has never been acknowledged may be at the root of unhealthy ego development (Fraser, 2009). Other therapeutic techniques that can be beneficial include the identity emergence model, which supports the development of a new self through five established stages, and the hypothesis of minority stress and resilience, which addresses the stressors inherent in facing the stigma of belonging to the transgender culture (Fraser, 2009). APPNs who intend to practice psychotherapy with this population should seek further education on these therapeutic modalities.

Best Practice Guidelines

The World Professional Association for Transgender Health (WPATH) has long provided
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the gold standard of guidelines for care of transgender persons, and version 7 of the Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People includes a section specific to the care of gender dysphoric youth. Coleman et al. (2012) state that mental health professionals working with gender dysphoric youth should have minimal credentials including but not limited to training in child and adolescent developmental psychopathology and competency in the diagnosis and treatment of normal childhood problems. These professionals should also expect to perform multiple roles including involvement in assessment, diagnosis, family and individual psychotherapy, interdisciplinary referral, and education and advocacy with families, schools, and the community at large (Coleman et al., 2012).

Guidelines presented by WPATH concerning the psychological assessment of gender dysphoric youth are as follows: conduct a thorough assessment of the gender concerns and any concurrent mental health issues of the youth and family while maintaining a positive and accepting attitude; assessment should ascertain the nature of the youth’s gender identity and be psychodiagnostic, to include emotional development, peer and family relationships, and intellectual functioning; in adolescents the assessment should be used to provide education on the benefits and limitations of GR treatment, as the reactions to this information may indicate degree of gender dysphoria as well as level of family support (Coleman et al., 2012). As concerns psychological and social interventions, mental health professionals are expected to: facilitate an attitude of acceptance and support for the gender dysphoric youth from families and communities; support families in expressing anxiety and fear about outcomes and management; not impose a binary view of gender but allow for open self-expression on the part of the gender dysphoric youth; support the youth and families through making difficult decisions about treatment, expressing new gender roles, and social transitions; educate and advocate with
families, schools, and communities to help generate support for gender dysphoric youth clients; use psychotherapy to reduce distress related to gender dysphoria, related family and social difficulties, or to support clients through medical treatment and social transitioning (Coleman et al., 2012). Coleman et al. (2012) stress that mental health professionals should never attempt any treatment aimed at trying to make a gender dysphoric person become more congruent with his or her natal sex, but should support the affirmed gender identity.

As regards making a social transition to a chosen gender identity in early childhood, Coleman et al. (2012) state that they are unable to make a practice recommendation at this time due to lack of evidence and conflicting professional opinions, but that mental health professionals should support children and families psychotherapeutically through whatever decision they choose. Finally, though medical interventions have not been discussed at length in this paper, it is important to note that the WPATH guidelines state the importance of referring pubertal gender dysphoric youth for medical treatment at a gender identity clinic or with a pediatrician or endocrinologist, due to the fact that withholding treatment has been shown to increase the level of gender dysphoria and resultant psychological distress (Coleman et al., 2012).

Lawrence (2014) provides succinct recommendations for the assessment and treatment of gender dysphoric children and adolescents based on the DSM-5 criteria and taking into consideration areas of disagreement and consensus. In prepubertal individuals, the goals of treatment are agreed to be to promote general psychological well being and identify and treat any present psychopathology; there are still some arguments as to whether to attempt to promote the desistance of gender dysphoric feelings with the goal to prevent the need for future GR (Lawrence, 2014). It is recommended that parents be educated on all possible developmental
HOLISTIC PSYCHIATRIC CARE OF GENDER DYSPHORIC

Trajectories in gender dysphoric children and the likelihood of persistence versus desistence, as well as the higher probability that the child will present as homosexual or bisexual as an adult and the possibility of the need for GR if the child persists with gender dysphoria (Lawrence, 2014). In pubertal and post pubertal adolescents, there is consensus that after gender dysphoria has been confirmed by extensive assessment treatment in the form of psychotherapy, real life experiences in the affirmed gender, and hormone therapy should be offered after any comorbid psychopathology has been adequately addressed (Lawrence, 2014). Psychotherapy should include education on what to expect from GR services and be supportive of social transitioning activities such as changing style of dress, name, and use of gendered pronouns; all interactions should encourage the patient to explore options for how they would like to live in the world (Lawrence, 2014).

The American Academy of Child and Adolescent Psychiatry has recently updated its practice guidelines regarding the treatment of sexual minority and gender nonconforming youth. These parameters are less specific to gender dysphoria, but rather provide guidance for mental health professionals in the most appropriate diagnostic and also ethical and respectful treatment of this vulnerable population. Adelson (2012) states that psychiatric evaluation should include age-appropriate evaluation of psychosocial development, family dynamics surrounding gender identity and nonconformity, and the cultural values of the family and youth. Confidentiality should be of the utmost concern during assessment and treatment, considering the prior social rejection and hostility these patients may have experienced (Adelson, 2012). Along the same lines, assessment should include questions about circumstances that confer increased psychosocial risk for gender dysphoric youth such as bullying, substance abuse, suicidality, and high-risk behaviors (Adelson, 2012). Mental health providers should be educated on the current
evidence regarding the course of gender identity development, should plan treatment with the knowledge that there is no evidence that gender identity or sexual orientation can be changed with treatment or therapy, and should be aware that attempts to so do can be harmful (Adelson, 2012). Finally, Adelson (2012) states that all clinicians should be prepared to act as liaisons with the community, schools, and other health professionals to advocate for the needs of gender nonconforming youth and should be aware of resources available in the community for this population. These principles provide a foundation on which APPNs can base practice with gender dysphoric youth and family clientele.

Methods

An online search using the Harley E. French Library of the Health Sciences through the University of North Dakota was conducted to investigate the state of current knowledge regarding gender dysphoria in children and adolescents. Five databases were searched for articles specific to the search term ‘gender dysphoria’; the Cochrane Library, CINAHL, PubMed, PsychINFO, and Psychiatry Online. Search results were limited to articles published between the years 2010 to 2016 in peer-reviewed journals concerning children and adolescents. The Cochrane Library search returned no results for systematic reviews, and four results concerning treatment of gender dysphoria specific to endocrinology. Psychiatry Online returned 37 results, with two systematic reviews including treatment parameters for gender dysphoria.

CINAHL initially returned 52 results; 14 articles were specific to endocrine treatment, 26 articles were commentary or related to non-psychiatric care, and 4 articles were specific to minority populations within gender dysphoria, leaving 8 reviewable articles. PubMed results were further limited to systematic reviews and returned 24 results initially; 12 of these were related non-psychiatric care, leaving 12 reviewable articles. PsychINFO returned 126 results; 7
articles were specific to endocrine treatment, 28 articles were commentary or related to non-
psychiatric care, 38 articles were specific to minority populations within gender dysphoria, there
was significant crossover between the returned articles within PsychINFO and other databases,
leaving 20 reviewable articles. In addition to the database literature search, a manual search of
the references in the reviewed articles was undertaken with the same search criteria, resulting in
12 more articles reviewed.

In order to increase the current level of knowledge surrounding the holistic treatment of
gender dysphoric youth, the key results of this paper will be synthesized into an educational
PowerPoint presentation (see Appendix). The author will disseminate the presentation online to
faculty and peers in the Psychiatric and Mental Health Nurse Practitioner program at the
University of North Dakota. The presentation will also be given to clinical staff at Natalis
Counseling and Psychology Solutions, a large urban outpatient mental health center, and in an
abbreviated form to the members of the Gender Sexuality Alliance, a teacher-facilitated group of
high school students that meet to discuss and advocate for LGBT+ issues in the Minneapolis
area. Reaching out to current and future APPNs can directly influence the level of care gender
dysphoric youth are able to receive, and educating community youth activists on the care that
APPNs provide increases the likelihood that gender dysphoric youth will feel comfortable
seeking treatment from APPNs as mental health providers.

Results

The described online literature search highlighted a depth of research concerning the
treatment of youth gender dysphoria via medical intervention, as well as controversy surrounding
the diagnosis and recent focus on examination of the causes of gender dysphoria and comorbid
medical conditions. Due to the psychiatric assessment and treatment focus of this paper, these
The fifteen studies included in this review consist of six quantitative studies, five descriptive studies, one meta-analysis, two standard of care documents, and one practice parameter. The quantitative studies consist of a mix of cross-sectional and cohort retrospective reviews, with one ongoing longitudinal cohort review. The quantitative studies were chosen for inclusion based on subject matter relevant to characteristic of gender dysphoria in children and relation to mental health and treatment outcomes. The descriptive studies were chosen for inclusion to illustrate treatment methodology of this emerging disease. Finally, national and international standard of care documents and practice parameters were chosen to provide an overview of holistic treatment guidelines for APPN practice.

**Discussion**

Despite concerns related to the need for continued research into the psychiatric assessment and treatment of gender dysphoric youth, recommendations for appropriate holistic care can be made. It is above all most important that APPNs practice with this population and their families with respect to the unique cultural aspects of the gender dysphoric population. As evidenced throughout the literature review, these children and adolescents often feel marginalized by society and are ostracized by peers and even family due to gender nonconforming behaviors or expressing feelings that may be seen as sexually nonconforming; this can then lead to damaged self esteem and self worth and feed into the development of comorbid psychiatric diagnoses such as depression and anxiety, and even substance use and abuse. In order to provide holistic care for gender dysphoric youth, it is important for APPNs to suspend any personal biases and convey respect for the individual at hand throughout psychiatric assessment and treatment. When considering the role of families in assessment and treatment, it is important not to overlook the
role of guidance that the provider can take. Modeling accepting behaviors with family members and providing education on the course of illness in gender dysphoria may help to alleviate some of the negative outcomes evidenced in the literature review such as adolescent homelessness and substance use and abuse.

APPNs should be aware that the quantitative evidence surrounding gender dysphoria in youth is not conclusive at this time, owing in part to the fact that this is an emerging area of study and also to the fact that it is extremely difficult to perform randomized controlled trials on a small population of child subjects. The current evidence suggests that gender dysphoric youth present with gender nonconforming feelings well before puberty, come from a wide variety of backgrounds, and vary in sexual orientation at puberty. In addition, it is accepted that the majority (around 65-75%) of children presenting with gender dysphoric feelings will lose these feelings at the onset of puberty. Therefore, it is important to use caution when recommending a course of treatment for young children with gender dysphoric feelings. Those children that do continue to have gender dysphoric feelings after puberty are termed ‘persisters’ and will generally remain gender dysphoric into adulthood; after this time it is prudent to consider a more aggressive treatment course. In childhood, the rates of gender dysphoria between the sexes are nearly the same, though at puberty natal females had a higher rate of transitioning socially to the preferred sex than natal males and experienced less social stigma and marginally less comorbid psychiatric pathology. It is also important for clinicians to note that higher levels of or more intense feelings of gender dysphoria in children have been found to correlate with persistence of gender dysphoria into adolescence and adulthood.

Multiple studies included in this review show marked increases in rates of depression, suicidal thoughts, self-harming behaviors, and alcohol and drug use and abuse among gender
dysphoric youth. Significantly, the rates of these increased dramatically with the onset of puberty, suggesting that changes in the body making the unwanted sex more apparent worsen the course of gender dysphoria. Reports of bullying, victimization, peer discord, and family strife also increase at onset of and during puberty and adolescence. This makes the onset of puberty an important time for assessment and treatment of both gender dysphoric feelings and comorbid psychiatric and social issues. Recently it has been shown that gender dysphoric youth that are living as the preferred gender in a supportive environment have drastically lower rates of comorbid psychiatric illness and no higher level of persistence past puberty, suggesting that social support can alleviate much of the depression, anxiety, and self-harm evident in this population.

Bearing in mind the characteristics of gender dysphoria, it is important for APPNs to have a basis for comprehensive assessment of affected youth and families. In addition to the usual psychiatric intake, it is recommended by all gender identity clinics to obtain a standard battery of tests specific to gender dysphoria. These are to be completed by the child and the parents and or caregivers, and include at minimum the Child Behavior Checklist (CBCL), Youth Self Report (YSR), Children’s Global Assessment Scale (CGAS), Gender Interview for Adolescents and Adults (GIAA), and Utrecht Gender Dysphoria Scale (UGDS). The CBCL, YSR, and CGAS assist the clinician in determining if there are developmental or behavioral problems or comorbid psychiatric conditions that must be addressed. The GIAA and UGDS help to determine the level and extent of the gender dysphoria. In addition, the Recalled Gender Identity Scale (RCGIS) and Body Image Scale (BIS) are helpful in diagnosis and treatment planning by expanding knowledge of how the patient historically felt and currently feels about gender and physical self.

Included in all assessments should be questions pertaining to levels of depression and
anxiety, suicidality, self-harming behaviors, social stigmatization, bullying, substance use and abuse, and family dynamics. The patient and family should be assured that confidentiality will be strictly maintained, and the APPN must adopt an attitude of acceptance while assessing psychosocial development, family dynamics, peer relations, and the overall reaction of the youth and family to the gender dysphoria. It is especially important to note any prior or current psychiatric or medical diagnoses that may be contributory or comorbid with the gender dysphoria, as well as the family reaction and support or lack thereof of the child and the diagnosis, as these will affect the course of treatment.

Psychiatric care of gender dysphoric youth is complex and consists of pharmacological management of pre-existing or comorbid conditions, psychotherapy with the individual and family, and appropriate medical referrals. Gender dysphoria, though considered a psychiatric diagnosis by the APA, is not treated pharmacologically and can be seen as a temporary condition in which the individual is struggling to obtain the true gender identity. Therefore, treatment with psychiatric medications is limited to any disease process that is comorbid with the gender dysphoria. Many gender dysphoric individuals will face circumstances in life that place them at much higher risk for psychiatric illness; therefore APPNs should be prepared to assess and treat them pharmacologically for these conditions.

Psychotherapeutic methods in gender dysphoric children vary at this point in time. It is widely accepted that the best course of action with prepubertal children is watchful waiting; that is, to provide a supportive environment in the home and through play therapy. Psychoeducation and family therapy are suggested for parents and caregivers to engender an understanding of gender dysphoria, the clinical course, possible outcomes, and above all to gain support for the child no matter what the outcome may be. Some experts support social transitioning to the
preferred gender before puberty, but others suggest that this may result in social stigma and further psychiatric problems if the gender dysphoria does not persist. Overall, the area of psychotherapy in gender dysphoric children needs further investigation.

In pubertal adolescents who have persisted with gender dysphoric feelings, it is imperative for the APPN who is providing primary care of gender dysphoria to provide a referral to an endocrinologist or gender identity clinic that can manage the medical needs pertaining to pubertal suppression or hormonal treatment when the gender dysphoric feelings are at a level that is affecting daily life. Treatment guidelines, practice parameters, and multiple studies agree that endocrine treatments are beneficial for psychiatrically stable gender dysphoric youth at, during, and post puberty. Psychotherapeutically, it is important to provide psychoeducation to families and caregivers about what to expect during the course of these endocrine treatments, and during transition to the preferred gender. For the patient, it is recommended that individual therapy continue throughout the course of treatment and address social transitioning, body image, and societal stigma. While treating gender dysphoric youth, APPNs should expect to continue to learn about gender dysphoria, to expand knowledge of this condition in the healthcare community, and to advocate for these patients and this population.

**Conclusion**

Clearly, as a new addition to the DSM-5, gender dysphoria in children in adolescents is an area that is new to research. Nursing and medicine have much to learn about how this condition came about, how we can appropriately assess these patients, and how we can treat the underlying causes and the very common psychiatric comorbidities. More research is needed into the best practices in psychotherapy for gender dysphoric children, as well as into how to best provide therapy for families who are unsure about the diagnosis of gender dysphoria. Much more
research is called for in the areas of how best to serve adolescents with comorbid psychiatric disorders and co-occurring substance use and abuse disorders. As this area is so new, the years ahead will provide ample opportunity for this research to be conducted.

As western society has evolved, gender nonconformity has come to be more accepted. However, it is plain that gender nonconforming and therefore gender dysphoric individuals still face major obstacles in society, even from a very young age. In addition to upholding our responsibilities for basic assessment and treatment of gender dysphoric youth, APPNs must provide an example for health professionals and society as a whole with our treatment of the gender dysphoric population. Social policy is changing to provide civil liberties to all individuals, and health policy needs to follow suit. APPNs can lead this change by advocating for resources for LGBT+ and gender nonconforming individuals in the form of funding for the needed research, expansion of coverage for psychiatric and endocrine treatments, and new gender identity clinics that will provide better access to services. The purpose of this paper has been to widen the education of APPNs on the care of the gender dysphoric population and expand the understanding of and empathy for this marginalized population. The times when we have the opportunity to learn the most are those times when we need to question what we have been taught to blindly accept. In the case of gender dysphoric children and adolescents, this questioning is happening at the dawn of life. As health care providers, we can learn greatly from the courage and honesty displayed by these patients, and utilize our skills and the power of advocacy to enable them to live full and healthy lives.
Introduction: What is gender dysphoria?

- **NEWLY PLACED INTO ITS OWN CLASS IN DSM-5**
  - No longer considered a sexual dysfunction, or termed gender identity disorder

- **DEFINITION: A SIGNIFICANTLY DISTRESSING AND FUNCTIONALLY IMPAIRING DESIRE TO BE A GENDER OTHER THAN THE ONE ASSIGNED** (APA, 2013)

- **FREQUENTLY MANIFESTS IN EARLY CHILDHOOD AND ADOLESCENCE**
  - Prevalence low, but more cases reported now than ever before
- **SOCIETAL STIGMA REMAINS HIGH**
  - High rate of comorbid psychiatric and substance use diagnoses
  (APA, 2013)
Purpose

- Increase working knowledge of APPNs on gender dysphoria in youth
  - Increase level of care available for this population
- Identify key terms and definitions
- Define current psychiatric treatment methodology
  - Sociocultural and psychiatric
- Outline evidence based practices for assessment and treatment
  - Psychosocial and pharmacological
- Address interdisciplinary care needs
Significance

- Rise in demand for care of gender dysphoria and high levels of psychiatric co-morbidity = likely that APPNs will care for gender dysphoric youth

- Negative social consequences predictive of future mental health issues
  - Gender dysphoric youth who are supported show few to no psychiatric comorbidities (Olson et al., 2016)

- Code of Ethics for Nurses
  - The nurse should always practice with “compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems” (ANA, 2014, p.38)
  - Uphold the tradition of psychiatric nurses providing care for the most marginalized populations
Theoretical Framework:
Leininger’s Theory of Culture Care
Diversity and Universality

• **PURPOSE OF THE THEORY**
  - description of the various cultural factors influencing health, emotional well-being, illness, and death as seen through the lens of divergent cultures

• **DEFINITION OF CULTURE**
  - defined within the theory as a set of learned and shared values, beliefs, and norms that shape and guide individuals’ decisions on how to live; care is defined as actions that are taken to assist individuals to improve health or well-being, or to face illness or death

• **CULTURALLY CONGRUENT CARE**
  - the importance of upholding the culture of the patient while providing care and placing importance on restructuring care to fit the cultural desires of the patient

(LEININGER, 1997)
Culturally Congruent Care and Gender Dysphoria

- **Hurdles to culturally appropriate care**
  - APPN must have a thorough understanding of her own culture and be especially cognizant of any biases she may hold
  - Gender nonconforming individuals less likely to return to care or seek future care after experiencing caregiver bias (McManus, 2008)

- **Transgender culture**
  - http://www.glaad.org/transgender/transfaq

- **Basic facts to remember**
  - there is a clear distinction between sexual orientation and gender identity
  - individual’s preferred choice of pronoun and name
  - level of comfort when discussing transition status
  - handling of health information with extreme sensitivity to the individual’s right to confidentiality
Definitions

- **Sex**: the biological and chromosomal makeup of the body, visibly manifested in the outward genitalia and secondary sex characteristics; traditionally a choice is made between male and female at the time of birth.

- **Gender**: the state of being male or female, with respect to the social and cultural differences between male and female as well as consideration of personal definitions of male or female.

- **Gender identity**: one’s personal conception of being male, female, somewhere between the two, or neither.

- **Gender nonconformity**: variation in gender role from conventionally held norms; includes gender questioning, gender fluid, gender nonconforming, genderqueer, and other affirming terms.
Definitions

- **Gender dysphoria**: diagnosable psychiatric illness defined by significant disturbance in mood, affect, and functioning due to feelings of incongruence between an individual’s gender identity and biological or assigned sex: not experienced by all gender nonconforming individuals

- **Transgender**: individuals whose gender identity is not congruent with their biological or assigned sex; transfeminine or MTF (male to female) individuals have transitioned from natal male sex; transmasculine or FTM (female to male) individuals have transitioned from natal female sex

- **Cisgender**: individuals whose gender identity is congruent with their biological or assigned sex
Methods

- Harley E. French Library of Health Sciences, University of North Dakota
  - Databases: Cochrane Library, CINAHL, PubMed, PsychINFO, and Psychiatry Online
- Search term ‘gender dysphoria’
  - Limiters: 2010-2016, ages 0-18, peer-reviewed
  - Articles concerning endocrine treatment, non-psychiatric care, specific populations, commentary excluded
- Total articles appropriate for review: 52.

- Manual search of references in reviewed articles also performed

- Standards of Care and Practice Parameters
  - World Professional Association for Transgender Health (WPATH)
  - American Academy of Child and Adolescent Psychiatry (AACAP)
Results

- **Depth of research on non-psychiatric care of gender dysphoria**
  - Surgical and endocrine interventions, comorbid medical issues
  - Social commentary
- **Very few RCTs, systematic reviews, meta-analyses**
  - Difficulty in performing research with small population of children
- **Emerging evidence through quantitative studies at gender clinics**
- **15 studies included in review**
  - Six quantitative studies, five descriptive studies, one meta-analysis, two standard of care documents, one practice parameter
Literature Review

- CHARACTERISTICS OF GENDER DYSPHORIA AND RELATIONSHIP TO MENTAL HEALTH
- CURRENT TREATMENT METHODOLOGY
- BEST PRACTICE GUIDELINES
Characteristics of Gender Dysphoric Youth

- **Demographics**
  - Ethnically heterogenous, vary widely in sexual orientation
  - Varying family structures
  - No physiological differences found between gender dysphoric and cisgender youth
  - BMI scores higher in gender dysphoric adolescents, suggesting body dysmorphia

- **Age of first gender dysphoric feelings usually before puberty**
  - 42.7% between 0-6 years, 34.9% between 7 and 12 years, 17.9% between 13 and 18 years (Holt et al., 2016)

- **Natal males vs natal females**
  - Natal females more likely to seek care, socially transition to preferred gender
  - Natal males exposed to more societal stigma in the form of bullying and nonacceptance from family
  - Natal males have higher levels of gender dysphoria on the Utrecht Gender Dysphoria Scale (UGDS)

(Aitken et al., 2016; Holt et al., 2016; Olsen et al., 2015)
Relationship to Mental Health

- **Comorbid psychiatric pathology**
  - Most common are depression, self-harm, suicidality, anxiety
  - Gender dysphoric youth at much higher risk for these pathologies than cisgender youth
    - 32% have depressive symptoms, 49% have thought about suicide, 29% report a suicide attempt (Olsen et al., 2015)
  - Rates of depression, suicidal ideation, and self harm drastically increase at onset of puberty
  - Recent studies show that socially transitioned and supported youth do not show the same increased levels of pathology

- **Social issues**
  - Most common are victimization, bullying, and being rejected by family
  - Peer relation scores are significantly lower for natal males

- **Substance abuse**
  - Use of alcohol, tobacco, cannabis, and other drugs has been found to be markedly increased among gender dysphoric adolescents; over 75% of adolescent respondents reported alcohol use in a recent study (Olsen et al., 2015)

Persistence vs. Desistence of Gender Dysphoria

- Not all children with gender dysphoric feelings will continue to have these feelings after puberty - termed desisters
  - 60-75% of children will be desisters

- Factors r/t persistence
  - Historical feelings of gender dysphoria
  - Peer relations in childhood
  - Social transitioning

- Positive predictors of persistence
  - High levels of gender dysphoria on UGDS
  - High intensity of gender dysphoric feelings
  - Having transitioned socially to the preferred gender
  - Higher levels of body dissatisfaction on the Body Image Scale
  - Natal female sex
  - Sexual attraction to the natal sex
  - Older age at start of treatment

(STEENSMAS ET AL. 2013)
Current Treatment Methodology: The Dutch Approach

- **Most influential gender clinic**
- **Assessment and diagnosis**
  - Standard psychological testing (see Suggested Psychological Testing)
  - Complete psychodiagnostic assessment of individual and family
  - Psychoeducation on possible treatment options, benefits, and risks of puberty suppression and GR including infertility and the broader social implications of changing gender
- **Referrals outside of clinic**
  - Medical assessment and psychiatric evaluation
    - Significant psychiatric co-morbidity or psychological or family problems must receive adequate treatment before taking hormones or undergoing GR
    - Extremely important to determine if the gender dysphoria is related to gender confusion, aversion to sex or genitalia, or autism spectrum disorder
- **Gender reassignment (GR) services**
  - Endocrine and surgical services offered to pubertal youth meeting criteria (see Endocrine Treatments)
  - Prepubertal individuals treated with watchful waiting approach to determine persistence vs. desistence
- **Psychological services**
  - Treatment during childhood is not aimed at the gender dysphoria, but at any comorbid psychiatric, psychosocial, emotional or behavioral problems that the child or family may be experiencing
  - In persisting adolescents undergoing GR, intense individual and family psychotherapy with a nonjudgmental and open approach to provide support during GR treatment and transitioning to the preferred gender

(COHEN—KETTENIS ET AL., 2011; DEVRIES & COHEN-KETTENIS, 2012)
The Toronto Approach

- First established gender clinic
- Assessment and diagnosis
  - Telephone interview with parents or caregiver concerning background, socioemotional and gender development, any mental health treatment or concerns, physical health, family mental health history, and a question and answer period
  - Family interview, interview with the child, extensive psychological testing of the child, and a feedback session are then conducted to determine if treatment is necessary
  - Biopsychosocial case formulation based on parental response to gender dysphoric behaviors, social cognitive level of the child especially with regards to the constancy of gender, any associated psychopathology, and psychodynamic mechanisms that may have been transferred from parent to child
- Psychological services
  - Individual play therapy for the child
  - Parent counseling and therapy
  - Parent and caregiver interventions in the home and social environment
  - Psychotropic medications to treat any comorbid psychiatric conditions
- No gender reassignment services are offered
  - Goal of treatment is to encourage the natural desistance of gender dysphoria before adolescence with the use of therapeutic and supportive techniques

(Zucker et al., 2012)
Treatment methodologies continued

- **Endocrine treatments**
  - Outside scope of APPN treatment
  - Determine eligibility for referral
    - lack of serious psychosocial problems, support of family or caregivers, comprehension of the results of the treatment
    - history of gender dysphoria in childhood, intensification of gender dysphoric feelings as puberty nears or throughout puberty
    - Tanner staging of at least stage 2 or 3, and age of at least 12 years (Cohen-Kettenis et al., 2011)

- **Psychotherapies**
  - Supportive of child, family, and preferred gender identity
  - Play therapy for children and psychoeducation for caregivers (DeVries & Cohen-Kettenis, 2012; Zucker et al., 2012)
  - Narrative and identity emergence models for adolescents (Fraser, 2009)
## Suggested Psychological Testing

- **Standardized protocol for assessment suggested by gender dysphoria researchers (Dettore et al, 2015)**
  - Assessment of overall functioning
    - Child Behavior Checklist (CBCL)
    - Youth Self Report (YSR)
    - Teacher’s Report Form (TRF)
    - Children’s Global Assessment Scale (CGAS)
- **Specific to gender dysphoria**
  - Gender Interview for Adolescents and Adults (GIAA)
  - Utrecht Gender Dysphoria Scale (UGDS)
  - Recalled Childhood Gender Identity Scale
- **Specific to body image**
  - Body Image Scale (BIS)
Best Practice Guidelines

- World Professional Association for Transgender Health (WPATH) Standards of Care Version 7, 2012
  - thorough assessment of the gender concerns and any concurrent mental health issues of the youth and family
    - Psychodiagnostic re gender identity
    - emotional development, peer and family relationships, and intellectual functioning
    - education on the benefits and limitations of treatment
  - facilitate an attitude of acceptance and support for the gender dysphoric youth
    - maintain a positive and accepting attitude
    - support families in expressing anxiety and fear about outcomes and management
    - support the youth and families through making difficult decisions about treatment, expressing new gender roles, and social transitions
    - educate and advocate with families, schools, and communities
  - never attempt any treatment aimed at trying to make a gender dysphoric person become more congruent with his or her natal sex
    - Refer pubertal youth for endocrine and transition services
    - use psychotherapy to reduce distress related to gender dysphoria, related family and social difficulties, or to support clients through medical treatment and social transitioning

(Coleman et al., 2012)
Best Practice continued

- American Academy of Child and Adolescent Psychiatry (AACAP) Practice Parameter, 2012
  - Psychiatric assessment and evaluation of youth and family
    - age-appropriate evaluation of psychosocial development, family dynamics surrounding gender identity and nonconformity, and the cultural values of the family and youth
    - questions about circumstances that confer increased psychosocial risk for gender dysphoric youth such as bullying, substance abuse, suicidality, and high-risk behaviors
    - Confidentiality should be of the utmost concern during assessment and treatment
  - Maintain education on current treatments
    - plan treatment with the knowledge that there is no evidence that gender identity or sexual orientation can be changed with treatment or therapy, and be aware that attempts to so do can be harmful
  - Act as liaison with the community, schools, and other health professionals
    - advocate for the needs of gender nonconforming youth
    - be aware of resources available in the community

(Adelson, 2012)
Discussion and Recommendations

- Culturally Appropriate, Holistic Care
- Assessment
- Treatment
- Future Research and Advocacy
Holistic Psychiatric Care

- Practice with respect for unique cultural aspects of gender dysphoric population
- Maintain sensitivity to societal stigma
  - Gender nonconforming feelings and behaviors have been shown to lead to ostracization by peers and family, bullying
  - Can then lead to damaged self esteem and self worth and feed into the development of comorbid psychiatric diagnoses
- Suspend personal biases and convey respect for individuals and families
- Provide modeling of respectful behaviors and guidance for families and caregivers
  - May help to alleviate some negative outcomes such as adolescent homelessness and substance use and abuse
Assessment

- Comprehensive psychiatric assessment
- Additional psychological testing to determine extent of gender dysphoria
  - CBCL, YSR, CGAS, GIAA, UGDS, RCGIS, BIS
- Included in all assessments: questions pertaining to depression, self-harm, suicidal thoughts and attempts, substance use and abuse, victimization, bullying
  - At onset of and during puberty, incidence of the above are likely to rise
- Medical assessment of any diagnoses that may contribute to the gender dysphoria
- Family assessment to include family dynamics, reaction to gender dysphoria, support or lack thereof for individual
- Maintain strict confidentiality and attitude of acceptance
Treatment

- Gender dysphoria, though considered a psychiatric diagnosis by the APA, is not treated pharmacologically and can be seen as a temporary condition in which the individual is struggling to obtain the true gender identity
- Pharmacological and psychotherapeutic management of comorbid psychiatric conditions
- Psychotherapy
  - Prepubertal children: watchful waiting. Provide a supportive environment in the home and through play therapy
  - No consensus on social transitioning to preferred gender before puberty
  - Pubertal youth: individual therapy throughout the course of treatment. Address social transitioning, body image, and societal stigma
- Family treatment
  - Psychoeducation and family therapy at all ages and stages
    - engender an understanding of gender dysphoria, the clinical course, possible outcomes, and above all to gain support for the child no matter what the outcome may be
  - For families of transitioning youth, what to expect during the course of these endocrine treatments, and during transition to the preferred gender
- Referral for gender reassignment/endocrine treatment
  - Should be given for pubertal or post pubertal youth in whom gender dysphoric feelings are affecting daily life
  - Endocrine and OR treatments are beneficial and indicated for these individuals
Recommendations

- **Research: vast opportunities to learn about gender dysphoria as an emerging disorder**
  - Etiology and true prevalence of the disorder
  - Best practices in psychotherapy for gender dysphoric children
  - How to best provide therapy for families who are unsure about the diagnosis of gender dysphoria
  - How best to serve adolescents with comorbid psychiatric disorders and co-occurring substance use and abuse disorders

- **Education**
  - APPNs and other psychiatric providers have a knowledge deficit regarding assessment and treatment of gender dysphoria, especially in children and adolescents
  - Rising numbers of cases show that more education on the condition is called for in order to adequately provide for this population

- **Advocacy**
  - APPNs must provide an example for health professionals and society as a whole with our treatment of the gender dysphoric population
  - Advocate with families, schools, community groups, and legislators for the dignity and rights of gender nonconforming individuals
References

References

References


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