Genspect

Brief Guidance for Pediatricians & Primacy Care Providers

QUALITY AND SAFETY IN CLINICAL PRACTICE

This quick reference guide has been developed in consultation with a number of senior clinicians directly involved in the care of gender-questioning people. It is aimed at pediatricians and primary care providers who work with adolescents and young people from puberty to the age of 25 years old. It aims to counteract the low-grade evidence-base that currently underlies many guidance documents for gender-related mental health support and seeks to help clinicians to alleviate the patient's gender-related distress.

We believe that there is a new phenomenon of large numbers of young people questioning their gender, which is best described as 'Rapid Onset Gender Dysphoria'. This description, coined in 2018 by American public health researcher Lisa Littman, provides what we believe is the best account of the new cohort of gender-questioning adolescents. While it is not a diagnosis, this description factors in the strong role of social influence among these children, as well as the significant levels of comorbidities. While the term is not universally accepted, the research upon which it is based has stood the test of substantial academic scrutiny.

DIFFERENT APPROACHES TO GENDER DISTRESS

Theoretically, there are three ways to approach difficulties in relation to gender:

- The individual's sense of gender can become aligned to their biological body;
- The individual's body can be altered to align with their sense of gender;
- The individual's distress can be helped with a range of different approaches.

Given the heavy medical burden associated with medical transition, we believe that the least-invasive-first approach is most beneficial for the individual. This guide makes the case for a psychotherapeutic approach that seeks to support the individual to accept their biological sex as the most appropriate first line treatment for young people with gender-related distress.

WPATH acknowledges the difficulties in identifying the most appropriate approach to gender-related challenges, stating that the 'current evidence base is insufficient' (p.17). Although the gender identity affirmative approach is now widely employed, there is little evidence to support this approach.

The presumption that only gender specialists can work with gender dysphoria is not based on any evidence, and is creating an obstacle to the provision of therapeutic support for gender dysphoria. A trauma-informed approach — rooted in generic skills of engagement that clinicians already commonly use — is appropriate for this condition.

GENDER AND EXPLORATION

Gender-related distress occurs in a context. It is not an encapsulated condition that occurs on its own, and we recognize that gender-questioning young people can often be impacted by complex pre-existing family, social, psychological and/or psychiatric conditions. Exploration of these factors is an essential step in effective support for gender-related distress.

The research related to conversion therapy for sexual orientation shows that this is a damaging and inappropriate process and should not be carried out on anyone. We are concerned that a narrow understanding of conversion therapy simplifies a life-long evolving process of identity formation and body acceptance. Clinicians need to be mindful that they do not inadvertently carry out conversion therapy on individuals who are distressed by their sexual orientation, such as supporting a lesbian who is experiencing internalized homophobia to become a "straight" trans man.

It is important to delineate clearly between childhood-onset gender dysphoria and adolescent-onset gender dysphoria when working with gender-questioning young people. It remains the case that the large majority of pre-pubertal children with gender dysphoria reconcile with their biological sex by puberty.

A sizable portion of gender non-conforming children later develop a homosexual orientation. Adolescent-onset gender dysphoria is a new cohort that is under-researched; however, the preliminary data suggest that co-morbidities are a significant risk factor with this population and social contagion can play a role.

WORKING WITH GENDER-QUESTIONING YOUNG PEOPLE

The following clinical considerations and challenges are provided to assist clinicians in their work. Gender-questioning children should be allowed to engage in gender non-conforming behavior as much as is practical. It's best to encourage a wide variety of interests which involve both sexes.

It is valuable to find a sensible, middle-of-the-road approach between an accepting and supportive attitude towards the child's gender dysphoria and protecting the child from the negative reactions of others. Help the child to be realistic about the actual situation.

Full social transition of young children is not recommended, as it can concretize what otherwise could have been a temporary identity.

Encourage appropriate limit setting. Limits are important for all children, but especially for gender dysphoric children who, even if they receive hormones and surgery later in life, cannot completely fulfill their deepest desire to have been born in the body of the other sex.

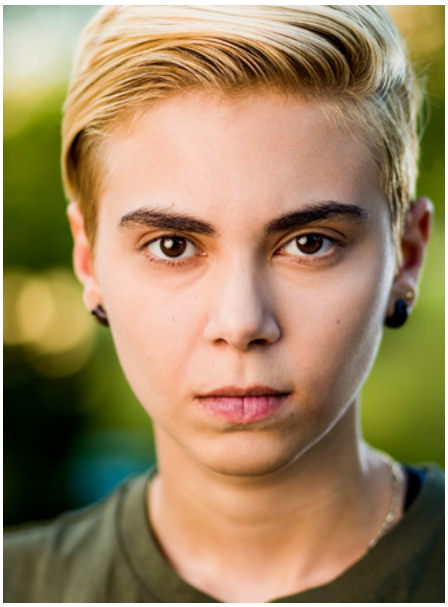
Gender-questioning young people might be better helped if they are viewed in the same way as anyone else presenting to a service with symptoms of distress and psychological difficulties. It is not helpful to treat gender identity issues in total isolation from other aspects of the patient's life. As noted in the Interim Report on the Tavistock's gender identity services by Dr. Hilary Cass, former President of the UK's Royal College of Paediatrics and Child Health, a significant issue raised was diagnostic overshadowing — young people presenting with gender dysphoria have complex needs,

but once they are identified as having gender-related distress, other important healthcare issues can be overlooked.

Co-morbidities are common with gender dysphoria, especially ASD, ADHD, social anxiety, depression, suicidality and eating disorders. A holistic approach includes a comprehensive exploration of how these conditions impact the young person.

The clinical management of the gender-questioning young person should acknowledge that identity formation is an important psychosocial stage of development for youths between 12 and 25 years old, and this can present as an identity crisis.

A change in gender identity can sometimes manifest as a concrete physical solution to a psychic trauma that leads to a belief that parts of the self can be discarded or left behind.



THE LEAST-INVASIVE-FIRST METHOD

A cautious, least-invasive-first approach is mirrored in general clinical best practice. Psychotherapy should be a first-line treatment for gender-questioning young people before medical interventions such as puberty-blockers, cross-sex hormones and/or sex reassignment surgery.

Although the gender identity affirmative model approach has recently been suggested as the best way to treat gender identity, there is actually no substantial long-term evidence base to support this approach. It is certainly important to affirm and to support patients to express themselves in an open-minded setting, but it is seldom helpful to concretize every idea and belief a patient might have.

We have serious concerns about affirmation-only therapy, which we believe forecloses other options for the therapeutic client. While it is important to affirm the depth of the young person's feelings, affirmation can stray into confirmation unless the therapist retains the ability to explore the whole picture. Affirmative-only therapists use a model which prevents them from taking a depth-perspective of the young person's feelings. This risks glossing over other factors which may be causing them to question their gender identity. We strongly believe that therapists' hands should not be tied in this way.

SEX AND SEXUALITY

Some young and vulnerable people believe that they can fully change sex. This serves to emphasize how important it is to discuss the reality of biology and sex in an age appropriate way. It might be helpful to address issues of gender role stereotypes to liberate the individual from society's gendered expectations.

Sexual orientation and gender identity development are not the same thing, and both need to be addressed and explored. Internalized homophobia may lead young people to question their identity, and adolescent-onset gender dysphoria can sometimes be a way for teenagers to avoid their anxieties regarding their sexuality.

LANGUAGE AND SENSITIVITY

The language and terminology involved in gender-related issues is constantly changing, and this may lead clinicians to the mistaken belief that they do not understand the issues at hand. It is helpful to take some time to learn the language, terminology and acronyms, so these do not become superficial obstacles to the provision of mental health assessment and support.

SUICIDE AND SUICIDALITY

When assessing for suicide risk, gender-questioning children are often perceived to be at higher risk. In fact, suicide risk is similar in this cohort to the general suicide rate in those experiencing mental health issues.

Clinicians need to be aware that suicide remains a risk after affirmation and/or medical transition, and that suicidality is sometimes linked to the wish of trying to get rid of aspects of the self.

MEDICALIZATION

Although there are self-reported improvements from receiving hormones and surgeries, there is as yet no consensus that medical treatments lead to better future psychosocial adjustment. Psychological difficulties typically remain after transition. The lack of evidence for the safety and efficacy of puberty blockers and cross sex hormones has led Sweden, Finland, and the UK to essentially cease these treatments for minors.

There are growing numbers of people detransitioning. However, there is still no research that yields an estimate of the rate and timing of desistance from a trans identity among older teens and adults. A recent study demonstrates that the causes of gender distress may only become clear with the benefit of hindsight: factors such as trauma and unmetabolized grief may have profound effects on young minds.

As children experiencing gender dysphoria mature and progress through puberty and into adulthood, the majority of them will be able to accept and live with their biological sex, adult body and sexual orientation. This well-documented phenomenon creates an ethical dilemma for those who recommend gender role change for these children. This is why we advocate for a cautious, non-physical interventionist approach for children.