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CPS Position Statement on An Affirming Approach to Caring for Transgender and Gender-diverse Youth: Part 1

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Introduction:

Hi! I'm Annaliese Beck-McKenzie and I use pronouns she/her. I am a fourth-year medical student at the University of British Columbia. Today on PedsCases we will be discussing the 2023 CPS Position Statement on an affirming approach to caring for transgender and gender-diverse youth (1). Thanks to Dr. Ashley Vandermorris, Staff Physician in the Division of Adolescent Medicine at the University of Toronto SickKids hospital and lead author of the CPS statement, for her guidance in creating this podcast. This podcast will be divided into two parts; the first will focus on important terminology, gender identity development, assessment of gender diverse youth, and diagnosis of gender dysphoria. Stay tuned for the second part of this podcast where we will discuss gender affirming treatment options. This subject is topical given the abundance of misinformation surrounding gender affirming care and the restriction of access to this care in some provinces; we won't delve into this, but we hope this podcast series will help to educate care providers on evidence-based care to improve gender affirming care for Canadian youth.

The objectives for today are as follows:

1. Define common terminology care providers should know in serving gender-diverse populations.
2. Briefly describe the stages of gender identity development in children and youth.
3. Define gender dysphoria; gender incongruence and outline the diagnostic criteria.
4. Describe the approach to the adolescent interview, with a focus on the HEEADSSS assessment as it relates to gender diversity.
5. Apply this knowledge to a clinical case!

Case:

Let's get started with a clinical case: meet Avery, a 13-year-old who was assigned male at birth who started using the pronouns she/her two years ago. Avery presents to your general pediatrics office with her father and mother, Fred and Anne. Avery tells you that for the past few years she has felt as if she doesn't fit in with her peers. As a child, Avery did not care for stereotypical masculine activities and preferred to play dress up, play with dolls, and do arts and crafts. Avery enjoyed dressing as a girl as this made Avery feel more like herself. When Avery's extended family would call her a "good boy" Avery would express frustration and say

that she did “not feel like a boy”! At bathtime, Avery expressed a strong dislike for her genitals and said she would rather have “what the girls have”. Avery experienced bullying at school and found it challenging making friends. Avery did make a couple of close friends over the years who were both girls. The internal distress Avery felt about being different than the other kids affected her mood and ability to concentrate on schoolwork. Avery’s parents did not fully understand Avery’s distress but tried their best to support her and help her to discuss her feelings around gender. Now, at the age of 13, Avery is starting to experience some pubertal changes including scrotal enlargement. Avery is finding this distressing as she does not feel like a boy and hates the way these changes make her look and feel. Avery wishes she would develop breasts and be treated like a girl by others. She feels her feelings and reactions are more in keeping with girls, and wishes she was a girl. She is experiencing ongoing distress as well as bullying which has led her to take sick days to avoid her peers. Avery is wondering what these feelings mean, and if there are any options to help make her appear more feminine. Before we answer these questions for Avery and her parents, let’s discuss some relevant background information.

Important terms:

Objective 1. Let’s start by outlining some terms care providers should know when caring for gender diverse youth. Gender identity, also known as “experienced” or “affirmed” gender, is defined as an individual’s internal sense of their gender. This may differ from their assigned sex at birth, which is based on visible sex characteristics such as genitalia; in this podcast we will use the terms assigned female at birth (AFAB) and assigned male at birth (AMAB). When gender identity aligns with one’s assigned sex at birth, we use the term cisgender, and when it differs, we use the term transgender. Gender diverse is a broad term which can encompass those who identify as non-binary, transgender, two-spirit, etc. A more comprehensive list of relevant definitions can be found in the CPS statement linked in this script.

Stages of gender identity development:

Let’s move onto Objective 2: Describe the stages of gender identity development in children and youth. Gender identity development begins early in life. By the age of 2, children can identify the difference between sexes. By age three, most children can label their own gender. Throughout preschool, they begin to understand the idea of gender stability throughout life. Preschoolers tend to conceptualize gender based on external appearances, gender roles and behaviours; thus, they often prefer toys and activities that are stereotypically associated with their gender. By 2 or 3 years old, some kids are able to identify discordance between their assigned sex at birth and their gender identity.

By the age of 6 or 7, children begin to understand gender as independent of external features. As they grow, their understanding of gender becomes more sophisticated and less stereotyped. This also applies to transgender children, many of whom have a strong sense of their gender identity by school age. For others, this understanding may occur after puberty and beyond.

Gender diversity is common in children and youth – studies have found between 1 and 4% of adolescents identify as transgender. This is particularly salient for health care providers working with children and youth, as transgender youth are at increased risk of adverse health outcomes including suicide, self-harm, eating disorders, anxiety, and depression due to factors

such as stigmatization, violence, and harassment. Access to gender affirming care can be crucial in mitigating risk.

You may be thinking that the term gender diversity is nonspecific. In this podcast we'll narrow in on the **definition and diagnostic criteria of gender dysphoria**, given that a many Canadian jurisdictions require a formal diagnosis in order to access gender affirming medical treatment. **This brings us to objective 3!**

Diagnosing gender dysphoria in children and youth:

Gender dysphoria describes the distress that can occur when one's gender identity does not align with their assigned sex at birth. The inclusion of gender dysphoria in the DSM-5-TR is contentious given that this may pathologize gender diversity and perpetuate stigma. On the other hand, some advocates argue that including the term in the DSM-5 allows greater access to care. The World Professional Association for Transgender Health Standards of Care 8 (WPATH SOC-8) advocates for the ICD-11 definition of "gender incongruence" when a diagnosis is required for access to services, given that this term has less pathologic connotations. Prior to puberty, the nuances of diagnosis are less important since medical intervention is not recommended for pre-pubertal children. In adolescents, however, timely diagnostic assessment and access to psychosocial support is crucial given that presentation at a younger age and earlier pubertal stage are associated with decreased adverse mental health outcomes.

Let's explore the DSM-5 diagnostic criteria for gender dysphoria in adolescents and adults. Gender dysphoria is defined as:

A. An incongruence between one's experienced/expressed gender (gender identity) and their assigned gender, lasting at least **six months, with at least two of** the following:
    1) **Incongruence** between one's gender identity and their primary or secondary **sex characteristics** (or in young adolescents, the anticipated secondary sex characteristics).
    2) A strong desire to be **rid** of one's primary and/or secondary sex characteristics because of this incongruence
    3) A strong desire to have the primary and /or secondary sex characteristics of the **other** gender.
    4) A strong desire to **be** of the other gender (or some alternative gender different from one's assigned gender).
    5) A strong desire to be **treated** as the other gender (or some alternative gender).
    6) A strong conviction that one has the typical **feelings and reactions** of the other gender (or some alternative gender).

Patients must also meet criterion B, where this incongruence contributes to clinically significant distress or impairment in functioning in social, occupational, or other domains.

In pre-pubertal children, the diagnostic criteria rely more on external expressions of gender through clothing, play, roles, and gendered objects. We won't get into the fine details in this podcast, but more information can be found in the CPS statement.

Now that we know the diagnostic criteria, you might be wondering how one goes about assessing gender diverse youth in the first place. By now, you've probably heard of the

HEEADSSS assessment. **In objective 4, we'll review the approach to interviewing gender diverse adolescents using the HEEADSSS assessment**. Before conducting a HEEADSSS assessment, be sure to review confidentiality and its limits, and then to ask these questions without the parents/guardians present.

HEEADSSS Assessment in gender diverse youth:

First, inquire about their **home** life. Particularly, ask if those at home are supportive of the patient's gender identity and if they use their pronouns. Also ask if they feel safe expressing their gender identity at home.

Next, ask about **education and employment**. Examples include safety expressing their gender at school as well as access to preferred washrooms.

The additional E stands for **eating**: be sure to ask whether they restrict or increase what they are eating in attempt to alter their body to match their gender identity.

A stands for **activities**: inquire about supportive peers/friends as well as safety expressing their gender identity during activities outside of school.

Next, ask about **drugs**. If substance use is present, ask if this is ever related to one's feelings about gender.

The three S's stand for **sexuality, suicide, and safety**. Is the patient attracted to particular genders? Are they sexually active? If they have a partner, ask if this partner knows about and supports their gender identity.

Note whether **depressive symptoms or suicidality** are present alongside gender dysphoria. You can start by asking how they feel about identifying with a gender that differs from their assigned sex at birth.

Finally, ask about their **safety,** and whether or not there are places or people who make them feel unsafe expressing their gender identity.

Case recap:

Let's go back to our case. Avery asks you, now that I know more about gender dysphoria, do you think I might be experiencing this?

Thinking back to Avery's presentation, you explain that she does meet the criteria for gender dysphoria: she expresses a strong dislike for her developing male genitalia, a preference for female sex characteristics, a desire to be a girl and be treated like one. She also feels her emotions and reactions are more in keeping with those of girls. These feelings have been longstanding and there is associated functional impairment as she is experiencing ongoing bullying and is missing school as a consequence. Avery and her parents agree that she fits the diagnosis of someone with gender dysphoria. They ask you, now that we know this, what's next?

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You briefly summarize options for gender affirming care, re-iterating that each individual may have different experiences and goals and these may change over time. You explain that Avery could continue pursuing a social transition through gender-affirming pronouns, names, clothes, etc. to help herself feel like her most genuine self. You explain that some people choose to pursue gender affirming medical treatment, such as hormone blocking therapy, gender affirming hormones, and gender affirming surgery. Avery tells you that she feels she has already made many gender-affirming changes in her life, but is still quite distressed about her gender incongruence, especially these physical changes happening to her body. She would like to explore her options for medical interventions. You book her for a follow-up appointment in 3 weeks to begin to discuss these options and give her and her family some time to reflect. They thank you again for taking the time to assess Avery and are encouraged that there are options for Avery to feel like her most genuine, happy self.

Conclusion:

That's it for part one of this two-part podcast on the CPS statement on gender affirming care. Let's briefly summarize: Gender diversity is common in children and youth and timely access to gender affirming care can promote positive mental health. Care providers should familiarize themselves with terminology around gender diversity to promote safe and open interactions with patients. Development of gender identity begins as early as 2 years old and becomes more sophisticated throughout childhood and adolescence. Discordance between one's experienced gender and their assigned sex at birth often presents during childhood and adolescence; this is described as gender dysphoria or gender incongruence. Care providers should know the definition and diagnostic criteria of gender dysphoria, as a formal diagnosis is currently required for access to gender affirming medical intervention in most Canadian jurisdictions. The HEEADSSS assessment can be used in holistically assessing gender-diverse adolescents, and can help identify important medical, psychological, psychosocial, and safety strengths and concerns.

Thanks for listening to this PedsCases Podcast! Stay tuned for Part 2 where we'll dive into gender affirming treatment options, including puberty blockers, gender affirming hormones, and gender affirming surgery.

References:

1. Vandermorris A, Metzger DL. An affirming approach to caring for transgender and gender-diverse youth. Paediatr Child Heal. 2023;28(7):437–48.

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