SANDYFORD
caring about sexual, reproductive and emotional health

NHS
Greater Glasgow and Clyde

Just a phase? - Gender Identity Disorder in Children and Young People

Dr Gordon Wilkinson

Consultant Child & Adolescent Psychiatrist

Young People's Gender Clinic, Sandyford Services, Glasgow

SANDYFORD
caring about sexual, reproductive and emotional health

NHS
Greater Glasgow and Clyde

Overview

- Scotland’s Young People's Gender Service
- GID/Gender dysphoria
- Assessment, management & clinical considerations
- Mental health & Sexual health issues
- Implications

SANDYFORD
caring about sexual, reproductive and emotional health

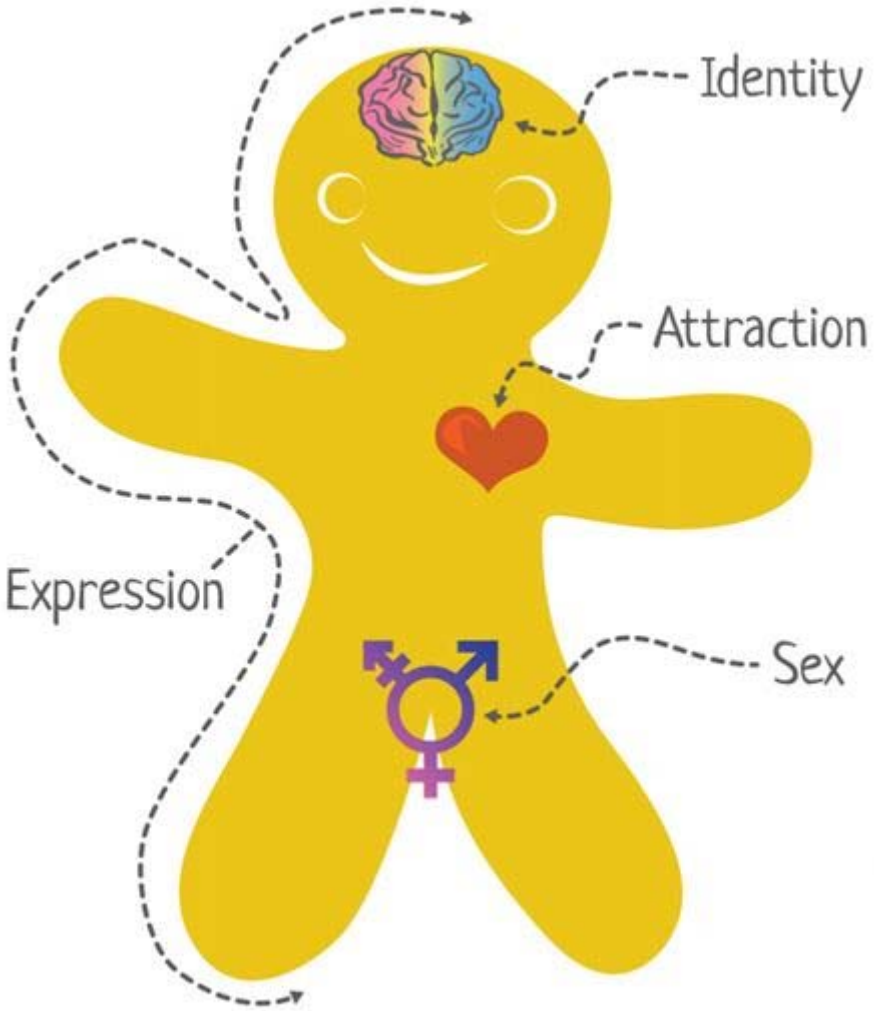
NHS
Greater Glasgow and Clyde

Young People's Gender Service

- National service, developing since 2013
- Housed within Sandyford
- Referrals for YP <17 years
- Accept referrals from multiple agencies, including self referrals
- Staffing
  - Psychiatry 1.5 days/week
  - Clinical psychology 5.5 days week (since Nov 16)
  - Occupational Therapist (1 day/week)
  - Young people's counsellor

SANDYFORD
caring about sexual, reproductive and emotional health

NHS
Greater Glasgow and Clyde

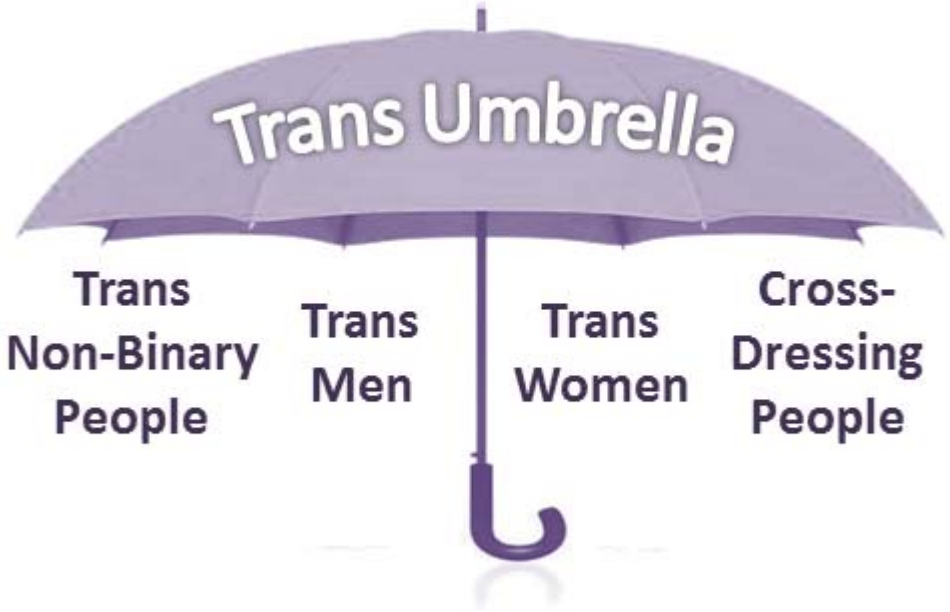


SANDYFORD
caring about sexual, reproductive and emotional health

NHS
Greater Glasgow and Clyde

Gender identity is a SPECTRUM

- Cisgender
- Transgender
- Non-Binary Gender



- Trans* is an all encompassing term to denote the above diagram

SANDYFORD
caring about sexual, reproductive and emotional health

NHS
Greater Glasgow and Clyde

ICD-10 Diagnostic criteria for GID

Transsexualism (F64.0) [GID in adults/adolescents] has 3 criteria:

1. A desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment

2. The transsexual identity has been present persistently for at least 2 years

3. The disorder is not a symptom of another mental disorder or a genetic, intersex or chromosomal abnormality

NB – binary model of gender

'Gender Incongruence' in revised DSM V and forthcoming ICD11

Separate chapter of its own (currently sits in Disorders of Adult personality & development chapter)

SANDYFORD
caring about sexual, reproductive and emotional health

NHS Greater Glasgow and Clyde

Gender Identity Disorder of Childhood (F64.2)

For girls:

1. persistent and intense distress (> 6/12) about being a girl, and has a stated desire to be a boy or insists she is a boy

2. either of the following must be present:
   a. Persistent marked aversion to normative feminine clothing and insistence on wearing stereotypical masculine clothing
   b. Persistent rejection of female anatomical structures, as evidenced by at least one of the following repeated assertions:
      - that she has, or will grow, a penis
      - rejection of urination in a sitting position
      - that she does not want to grow breasts or menstruate

3. not yet reached puberty

SANDYFORD
caring about sexual, reproductive and emotional health

NHS Greater Glasgow and Clyde

Gender Identity Disorder of Childhood (F64.2)

For boys:

1. persistent and intense distress (>6/12) about being a boy and has a desire to be, or insists that he is a girl

2. either of the following must be present:
   a. Preoccupation with stereotypic female activities, e.g. cross-dressing or simulating female attire, or an intense desire to participate in the games/pastimes of girls and rejection of stereotypical male activities.
   b. Persistent rejection of male anatomical structures as evidenced by at least one of the following repeated assertions:
      - that he will grow up to become a woman
      - that his penis or testes are disgusting or will disappear
      - that it would be better not have a penis or testes

3. not yet reached puberty

SANDYFORD
caring about sexual, reproductive and emotional health

NHS
Greater Glasgow and Clyde

Differences in timing of onset

GD in childhood does not inevitably persist into adulthood

- persists in ~ 16%, disappearing around onset of puberty (Ristori & Steensma, 2016)
- 'persisters' have stronger intensity of GD and more likely to be natal female (Steesma et al, 2013)
- natal males are more likely to identify as gay/bisexual in adulthood
- Therefore management is supportive, leaving options open for change

GD in adolescence is much more likely to persist

- studies suggest dysphoria persists in almost 100% given puberty blockers

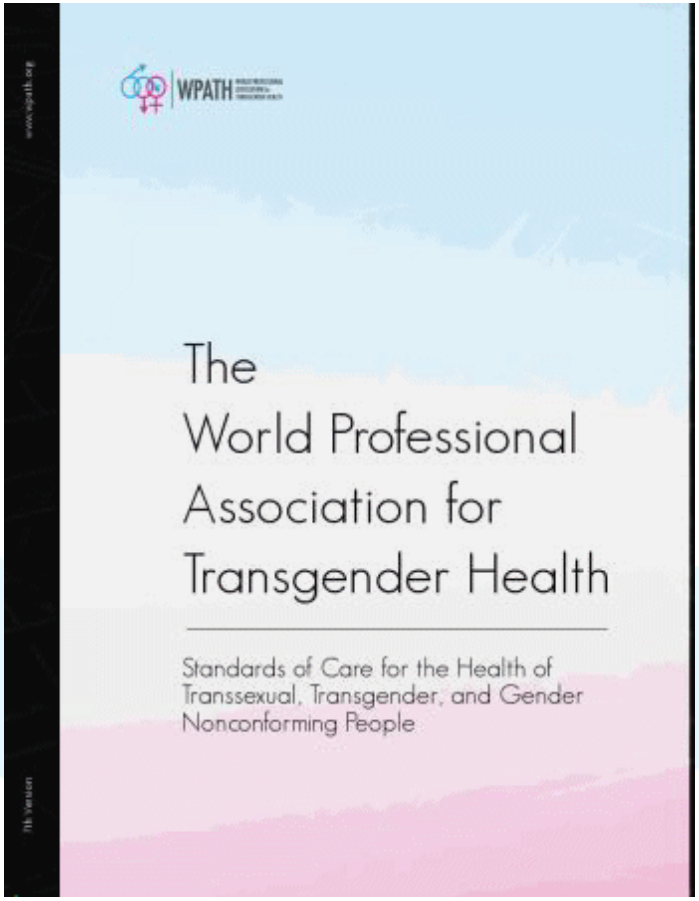
Differences in sex ratio

- Pre pubertal children — M:F ratio ranges between 6:1 to 3:1
- Adolescents — M:F ratio is close to 1:1

SANDYFORD
caring about sexual, reproductive and emotional health

NHS
Greater Glasgow and Clyde

WPATH Standards of Care, 7th version (Sept 2011)



- www.wpath.org
- To promote evidence-based care, education, research, advocacy, public policy and respect for transgender health

SANDYFORD
caring about sexual, reproductive and emotional health

NHS
Greater Glasgow and Clyde

WPATH SoC

- to provide clinical guidance for health professionals to assist transsexual, transgender and gender nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves, in order to maximise their overall health, psychological well-being and self-fulfilment
- Acknowledges that gender dysphoria in C&A population is different from adult population and has guidelines specific to this population
- Accepts it adopts a Western perspective - guidelines are flexible and adaptable
- **NHS Scotland Gender Reassignment Protocol** (adult pathway)
  - **launched in July 2012**
  - **www.sehd.scot.nhs.uk/mels/CEL2012-26.pdf**

SANDYFORD
caring about sexual, reproductive and emotional health

NHS
Greater Glasgow and Clyde

Staged approach of intervention

Stage 1 - Therapeutic exploration of the nature of gender identity

- i.e. assessment and ongoing review
- Looking for a ‘persistent, consistent and insistent’ history

Stage 2 – Puberty suppression

- fully reversible interventions

Stage 3 – ‘Gender affirming’ hormones

- partially reversible interventions
- if GID persists and aged 16+
- +/- referral for facial hair removal and SLT input (M-F)
- +/- bilat mastectomy & chest reconstruction surgery (F-M)

Stage 4 – Gender Reassignment Surgery

- irreversible interventions (not considered before 18)

SANDYFORD
caring about sexual, reproductive and emotional health

NHS
Greater Glasgow and Clyde

Assessment & Review

- Huge variability in referrals
- Assessment takes a number of appointments
- Age/stage of presentation & developmental issues
- Important to consider the YP in the context of their network and support systems (family, school, etc)
- Encourage input from family members
- Persist, Consistent and Insistent dysphoria
- Consent and capacity issues - expectations
- Ongoing support/review with seamless transition to adult services

SANDYFORD
caring about sexual, reproductive and emotional health

NHS
Greater Glasgow and Clyde

Working with Families

Best outcomes if good family support

- “Just a phase?” - Huge variability in the level of acceptance and support offered by/within different families – can lead to significant conflict and inability to progress with transitioning
- Feelings of loss, shame, guilt/responsibility, uncertainty
- Impact of parental or sibling mental health
- Value of Mermaids and TransparenTsees

For parents/carers of younger children

- How to support and manage ‘uncertainty’ with potential for change
- ‘transitioning by stealth’ or more explicit, intermittent, or not at all
- Issue of puberty blockers before puberty

SANDYFORD
caring about sexual, reproductive and emotional health

NHS
Greater Glasgow and Clyde

Working with Education

Important that the educational environment is proactive and supportive

- gendered activities, uniforms
- toilets and changing rooms (frequently advised to use disabled facilities)
- timing of ‘coming out’
- Identified staff member to contact
- Zero tolerance policy to transphobic bullying
- Training for staff

Legal aspects

- Name changes
- Passports
- Gender Recognition Certificate – not till 18

SANDYFORD
caring about sexual, reproductive and emotional health

NHS
Greater Glasgow and Clyde

Stage 2: Puberty suppression

- Fully reversible interventions
- GnRH analogues to produce a state of biological neutrality
- Importance of experiencing some early pubertal change
- 'Window of opportunity'
- provide breathing space to explore options
- better psychosocial functioning (Costa et al, 2015)
- should not be assumed all will progress to Stage 3
- Not a 'neutral' act
  - Physical consequences: growth, bones, flushes
  - Psychological maturation (+ consent/capacity re long term choices)
  - Fertility issues
  - Consequences for future reassignment surgery
- close liaison with paed endocrinology colleagues who monitor blockers and titrate gender affirming hormones if indicated

SANDYFORD
caring about sexual, reproductive and emotional health

NHS
Greater Glasgow and Clyde

Stage 3: Gender affirming (Cross Sex) Hormones

- Partially reversible interventions possible from age 16+
- if ongoing distress with biological gender and demonstrate some commitment to living in their perceived gender
  - e.g. social transition for > 6 months
  - Note: society more ready to accept F-M transition than M-F
- need to demonstrate ‘capacity’
  - at Sandyford Services, all YP’s require further assessment from another team member prior to initiating hormone therapy
  - Gradual process of change – some quicker, others over years
  - some hormone-induced changes are not readily reversible, e.g. deeper voice, breast development, cliteromegaly, male pattern baldness

SANDYFORD
caring about sexual, reproductive and emotional health

NHS
Greater Glasgow and Clyde

Gender affirming Hormones – practical points

- Regimens differ from adult population to reflect the somatic, emotional and psychological development of adolescence
- Use lower doses and preparations that allows more flexibility initially
  - F-M: Sustanon 125mg im injection 3-4 weekly (monitor trough level - ideally in lower 3rd of normal male range)
  - M-F: Oestradiol valerate 1mg daily (aim for range 200-600pmol/l). Androgen suppression recommended after 6 months if this does not happen with oestrogen alone.

- More gradual initiation of hormones if on GnRH analogues
  - Growth spurt on lower doses
  - Better results from more gradual change

- Issues of 'bridging hormones' e.g. self prescribing – GMC guidance
- Challenges of YP's who identify as 'non-binary gender' – how to best meet their needs?

SANDYFORD
caring about sexual, reproductive and emotional health

NHS
Greater Glasgow and Clyde

Stage 4 – Gender Reassignment Surgery

- irreversible interventions
- not considered before 18, though other procedures can be considered, e.g. Bilat mastectomy & chest reconstruction

Outcome (de Vries et al, 2014)

- 55 young transgender adults followed through Stages 2-4.
- 1 year post-surgery, gender dysphoria was alleviated, psychological functioning improved and well-being comparable to same-age peers

Value of the staged approach

- provides a containing framework and a sense of direction and hope
- progression across stages allows for assimilation of change
- recognises that gender identity beliefs, while firmly held, can become less so with time

SANDYFORD
caring about sexual, reproductive and emotional health

NHS Greater Glasgow and Clyde

Gender dysphoria in YP

Prevalence estimates for adults range from 1:12,000 -1:45,000 in men & 1:30,000 - 1:200,000 in women

GID in C&A previously thought to be rare/unusual

- Suggested UK Incidence of 1:80,000 in <16 yr olds (CAP Surveillance System - GID in C&A; Preliminary findings for Nov 2011 – June 2013). [This is an UNDERESTIMATE = only 12 cases/yr in Scotland]

BUT

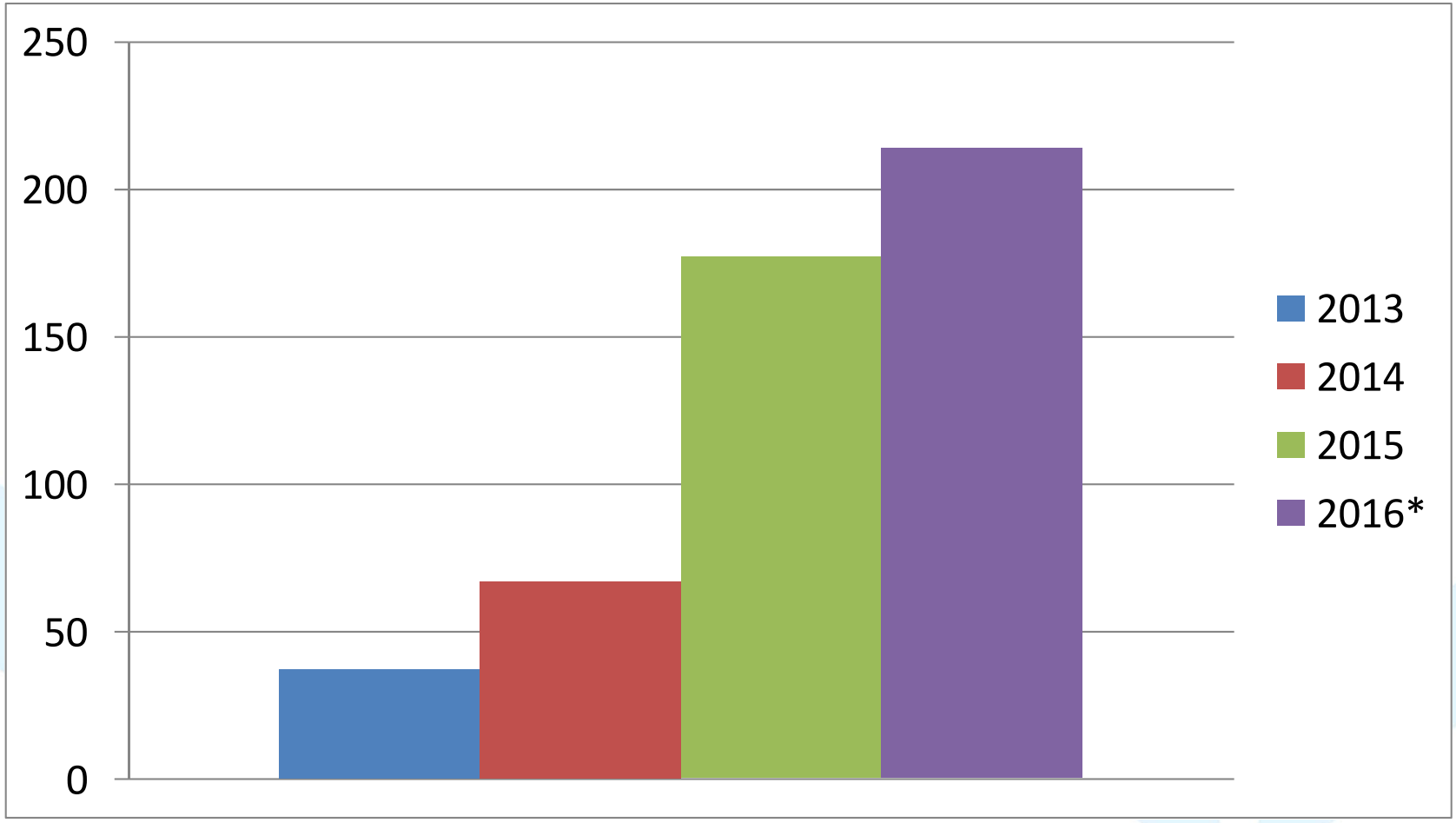
- Increasing numbers of referrals to YP gender services worldwide
- Mirrored in figures for Scottish YP service

- WHY? – media/publicity, internet, society more accepting, knowledge something can be done...

SANDYFORD
caring about sexual, reproductive and emotional health

NHS
Greater Glasgow and Clyde

Referrals/year (* not all 17 yr olds)



SANDYFORD
caring about sexual, reproductive and emotional health

NHS
Greater Glasgow and Clyde

Trends for increasing numbers of:

- Younger adolescents in early puberty
  - role for puberty blockers
  - Increasing pressure on endocrinology services
  - In gender service for longer, too
- Pre-pubertal children
  - Supportive role and developing consultation to local services
  - More potential for fluidity so physical intervention till early puberty

Unlikely to be just a phase...

SANDYFORD
caring about sexual, reproductive and emotional health

NHS
Greater Glasgow and Clyde

The importance of timely intervention

- ‘Window of opportunity’ in early puberty
- Recognised increased prevalence of associated mental health difficulties in young trans population
  - Even higher than in young LGB population
  - Self harm and suicide (Skagerberg et al, 2013)
  - Low mood
  - Bullying and stigmatisation (Holt, Skagerberg & Dunsford, 2016) – 70% in school in Scotland
  - Higher prevalence of social communication difficulties

SANDYFORD
caring about sexual, reproductive and emotional health

NHS
Greater Glasgow and Clyde

Sexual health issues in young trans* people

Refers to physical, mental and social wellbeing

- until recently physical health has been a largely unresearched (and unrecognised?) area
- tendency to be grouped into LGBT population, e.g. Young MSM, but very different specific issues (Madden et al, 2014)
- personal observations are that many young trans people tend to avoid sexual contact and relationships due to dysphoria
- 2017 LGBT Youth “Life in Scotland Survey” separates sexuality and gender for the first time (still recruiting till end of Match 17)
- An area for future research...

SANDYFORD

caring about sexual, reproductive and emotional health

NHS

Greater Glasgow and Clyde

NGICNS

National Gender Identity Clinical Network for Scotland

SANDYFORD
caring about sexual, reproductive and emotional health

NHS
Greater Glasgow and Clyde

NGICNS

- www.ngicns.scot.nhs.uk
- Representative on Steering Group
- Current activities include:
  - Produce a treatment pathway relating specifically to the YP service, including guidance from endocrinology about puberty blockers
  - Develop information leaflets about the service for young people, their families/carers and clinicians, with input from young people
  - Helping to develop the website

SANDYFORD
caring about sexual, reproductive and emotional health

NHS
Greater Glasgow and Clyde

Implications for me?

- This is not just a phase...
- There will be increasing numbers of younger transgender individuals graduating to all adult services...
- How confident/comfortable do you feel?
- Knowledge base re trans issues?
- Service issues to minimise barriers to health care?

Thank you

SANDYFORD
caring about sexual, reproductive and emotional health

NHS
Greater Glasgow and Clyde

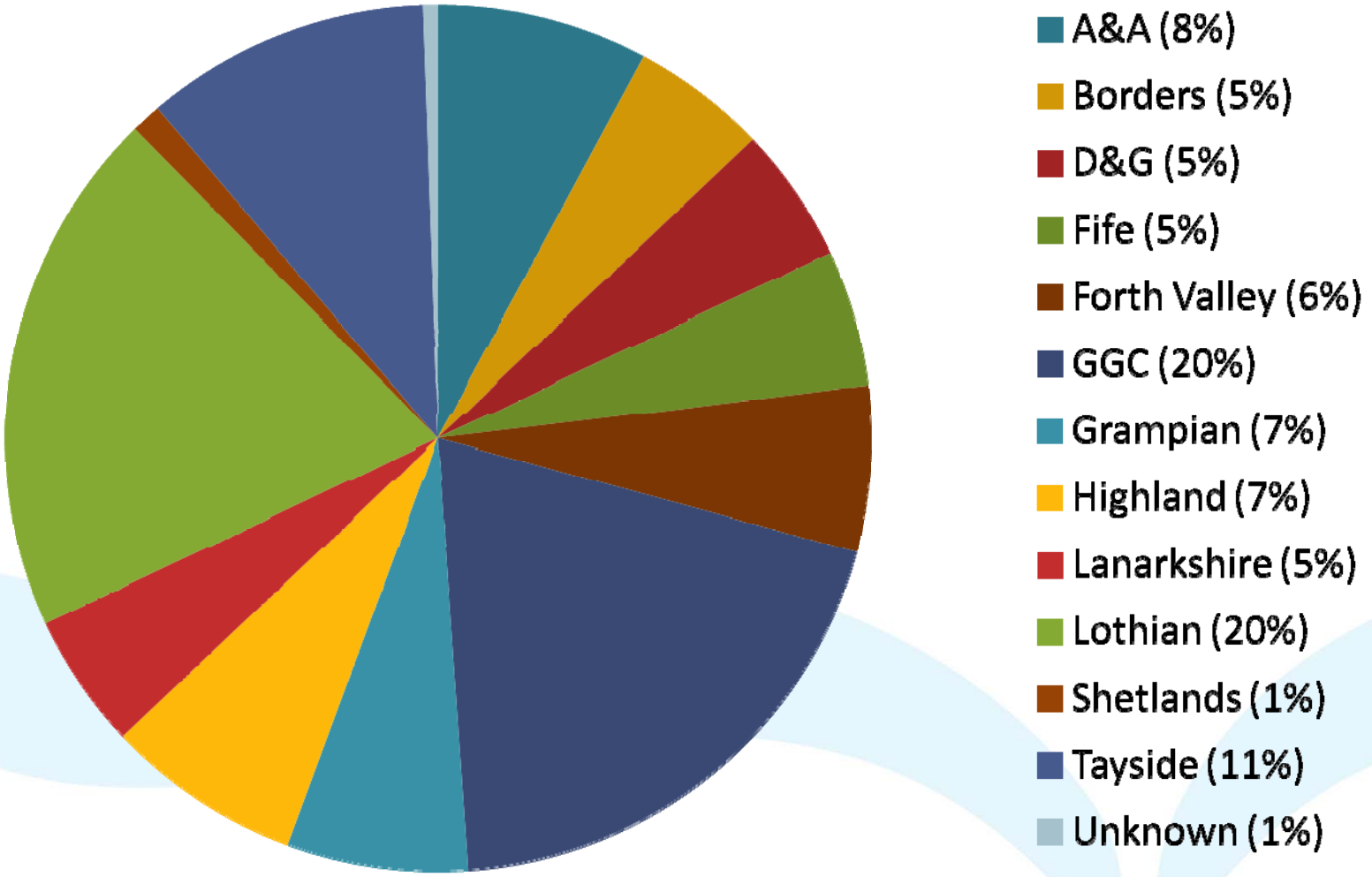
References

- Costa, Dunsford, Skagerberg, Holt, Carmichael & Colizzi (2015). Psychological Support, Puberty Suppression and Psychosocial Functioning in Adolescents with Gender Dysphoria. *Journal of Sexual Medicine* 12, 2209-2214
- de Vreis, Noens, Cohen-Kettenis, van Berckelaer-Ohnes & Doreleijers (2010). Autism Spectrum Disorder in Gender Dysphoric Children and Adolescents. *Journal of Autism and Developmental Disorders* 40, 930-936
- de Vreis, Doreleijers, Steensma & Cohen-Kettenis (2011). Psychiatric comorbidity in gender dysphoric adolescents. *Journal of Child Psychology and Psychiatry* 52, 1195-1202
- de Vreis, McGuire, Steensma, Wagenaar, Doreleijers & Cohen-Kettenis (2014). Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment. *Pediatrics* 134, 696-704
- Holt, Skagerberg & Dunsford (2016). Young People with Features of Gender Dysphoria: Demographics and Associated Difficulties. *Clinical Child Psychology and Psychiatry* 21, 108-18
- Madden, Harris, Tomkinson, Brown & Timpson (2014). A Targeted Sexual Health Needs Assessment for the LGBT Community and Ethnic Minority Groups across the Life Course in Warrington. Public Health Institute (*www.cph.org.uk/publications*)
- Skagerberg, Parkinson & Carmichael (2013). Self-harming thoughts and behaviours in a group of children and adolescents with gender dysphoria. *International Journal of Transgenderism* 14, 86-92
- Steensma, McGuire, Baudewijntje, Beekman & Cohen-Kettenis (2013). Factors associated with Desistence and Persistence of Childhood Gender Dysphoria: A Quantitative Follow-Up Study. *Journal of the American Academy of Child & Adolescent Psychiatry* 52, 582-90
- Wallien, Swaab & Cohen-Kettenis (2007). Psychiatric comorbidity among children with gender identify disorder. *Journal of the American Academy of Child & Adolescent Psychiatry* 46, 1307-1314

SANDYFORD
caring about sexual, reproductive and emotional health

NHS
Greater Glasgow and Clyde

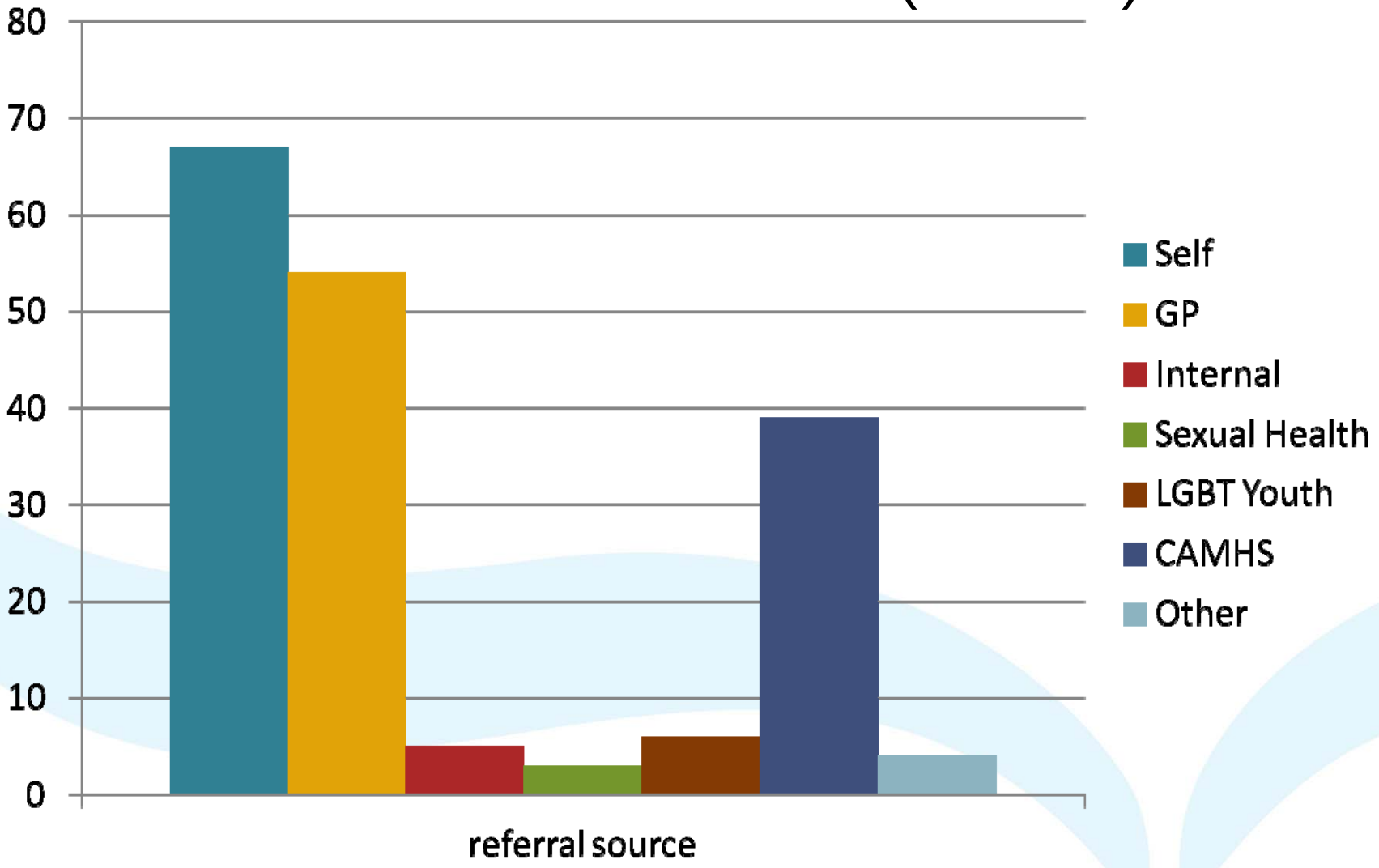
YP Healthboards 2015 (n = 178)



SANDYFORD
caring about sexual, reproductive and emotional health

NHS
Greater Glasgow and Clyde

YP referral source 2015 (n = 178)



Masculinising Hormones

Effect	Expected Onset[b]	Expected Maximum Effect[b]
Skin oiliness/acne	1-6 months	1-2 years
Facial/body hair growth	3-6 months	3-5 years
Scalp hair loss	>12 months[c]	variable
Increased muscle mass/strength	6-12 months	2-5 years[d]
Body fat redistribution	3-6 months	2-5 years
Cessation of menses	2-6 months	n/a
Clitoral enlargement	3-6 months	1-2 years
Vaginal atrophy	3-6 months	1-2 years
Deepened voice	3-12 months	1-2 years

Feminising Hormones

TABLE 1B: EFFECTS AND EXPECTED TIME COURSE OF FEMINIZING HORMONES [a]

Effect	Expected Onset[b]	Expected Maximum Effect[b]
Body fat redistribution	3-6 months	2-5 years
Decreased muscle mass/ strength	3-6 months	1-2 years[c]
Softening of skin/decreased oiliness	3-6 months	unknown
Decreased libido	1-3 months	1-2 years
Decreased spontaneous erections	1-3 months	3-6 months
Male sexual dysfunction	variable	variable
Breast growth	3-6 months	2-3 years
Decreased testicular volume	3-6 months	2-3 years
Decreased sperm production	variable	variable
Thinning and slowed growth of body and facial hair	6-12 months	> 3 years[d]
Male pattern baldness	No regrowth, loss stops 1-3 months	1-2 years

Potential risks

TABLE 2: RISKS ASSOCIATED WITH HORMONE THERAPY. BOLDED ITEMS ARE CLINICALLY SIGNIFICANT

Risk Level	Feminizing hormones	Masculinizing hormones
Likely increased risk	Venous thromboembolic disease[a] Gallstones Elevated liver enzymes Weight gain Hypertriglyceridemia	Polycythemia Weight gain Acne Androgenic alopecia (balding) Sleep apnea
Likely increased risk with presence of additional risk factors[b]	Cardiovascular disease	
Possible increased risk	Hypertension Hyperprolactinemia or prolactinoma	Elevated liver enzymes Hyperlipidemia
Possible increased risk with presence of additional risk factors[B]	Type 2 diabetes[a]	Destabilization of certain psychiatric disorders[c] Cardiovascular disease Hypertension Type 2 diabetes
No increased risk or inconclusive	Breast cancer	Loss of bone density Breast cancer Cervical cancer Ovarian cancer Uterine cancer