

Serving Transgender Youth: Challenges, Dilemmas, and Clinical Examples

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Historically, many gender variant individuals have lived in a chronic state of conflict between self-understanding and physical being, one in which there was a continual misalignment between others' perceptions of them and their internal self-perception of gender. Only recently have professionals from mental health and medical realms come together to provide services to these youth. This article describes an innovative program: the first mental health and medical multidisciplinary clinic housed in a pediatric academic center in North America to serve the needs of gender variant youth. We describe our model of care, focusing on the psychologist's role within a multidisciplinary team and the mental health needs of the youth and families assisted. We highlight clinical challenges and provide practice clinical vignettes to illuminate the psychologist's critical role.

Keywords: transgender, gender dysphoria, gender non-conforming, youth, adolescent

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Historically, many gender variant individuals have lived in a chronic state of conflict between self-understanding and physical being, with a continual misalignment between others' perceptions of them and their internal self-perception of gender. Only recently have professionals from mental health and medical realms come together to provide services to youth and, hopefully, some validation. As with other newly evolving fields of study, initial interventions were applied without the benefit of much research or precedent for guidance, and at times in an atmosphere of professional division (see [Drescher & Byne, 2012](#), for a summary of continued controversies).

The Disorders of Sexual Development-Gender Management Service (DSD-GeMS) evolved because of the dearth of available services for two distinct populations: (a) youth with Disorders of Sexual Development (DSD) and (b) gender variant youth. DSD refer to biological conditions in which anatomic sexual development is atypical ([Houk, Hughes, Ahmed, & Lee, 2006](#)) whereas gender variance refers to gender expression and/or identity inconsistent with prevailing societal expectations and norms ([Kulick, 1999](#)). The term transgender typically refers to those individuals for whom genotype and phenotype are mismatched. Therefore, biologically male children may self-identify as female and vice

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versa, or youth may not fit neatly into either category. This article will focus on the gender variant group served by DSD-GeMS. We highlight clinical challenges and provide clinical vignettes to illuminate the psychologist's critical role. Please refer to the online supplemental materials for further description of terms relevant to gender, sex, and sexuality, and a summary of suggested psychological evaluation recommendations.

The development of the DSD-GeMS Program was made possible because of the initiative of an endocrinologist with prior expertise treating transgender adults, and a strong passion to assist gender variant youth without access to care. As with any novel program, a vision and a sense of possibility are essential aspects of effective action. With a strong belief in the need for such a program in a multidisciplinary hospital setting, the DSD-GeMS service was developed, partially dependent upon the persuasive abilities of the founding physicians, but also within the structure of an institution that encouraged care for underserved youth and with clinic directors and hospital administrators who fostered innovation. The DSD-GeMS program became the first multidisciplinary mental health and medical program housed in a pediatric academic center in North America to serve youth with DSD or gender variance, and has forged a path for the development of other clinics in the United States. Many mental health professionals, medical students, pediatric house officers, endocrine fellows, and staff endocrinologists have participated in our program.

Program Development

The development of DSD-GeMS was a shared effort, requiring extensive multidisciplinary collaboration. Consultation was sought from urology, endocrinology, medical ethics, genetics, neonatology, gynecology, psychology, and hospital administration. When the program opened, it was codirected by a pediatric urologist with expertise treating children with DSD and a pediatric endocrinologist, working in tandem with a psychologist to provide evaluations and services for gender variant youth and their families. The remainder of the discussion will focus on the gender variant group in the GeMS program, with an emphasis on the crucial role of psychologists within this multidisciplinary team.

To develop our mental health protocols, our hospital supported the GeMS psychologist receiving training in Amsterdam from Peggy Cohen-Kettenis, Ph.D., and her team, pioneers in assessing and treating transgender youth. The purpose of the trip was to learn and adapt the Dutch protocol for use in the United States. The Amsterdam group opened the first specialized gender identity clinic for children and adolescents in 1987 (de Vries & Cohen-Kettenis, 2012) and have published numerous studies based on their protocol and interventions (e.g., Delemarre-van de Waal & Cohen-Kettenis, 2006; de Vries & Cohen-Kettenis, 2012; de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2011; Wallien & Cohen-Kettenis, 2008). During the training trip, the GeMS psychologist and endocrinologist participated in the first international Adolescent Gender Identity Research Group Meeting. Psychological measures were selected collaboratively for clinics to use in the evaluation of transgender youth, based on shared experience with this population, while each clinic adapted and added measures as needed for individual sites.

When opened, the GeMS clinic was flooded with inquiries from families, not only from the local region, but also from across the

nation and internationally. Notably, before the GeMS program existed, the demand for services was largely invisible. In addition, children and families struggled to identify resources (many of which were predominantly nonexistent) without the aid of trained professionals, while sometimes coping with significant and multifaceted psychosocial challenges. These could include a range of issues such as managing family responses, including anxieties and discord related to atypical gender expressions and/or disclosures of children; managing peer, school, and other social circumstances in contexts that were often less than accepting; and managing mental health issues. Numerous articles have been published outlining similar multifaceted issues gender nonconforming children and families may face (e.g., Dreger, 2009; Ehrensaft, 2007; Malpas, 2011; Menvielle, 2012). In response to the increasing volume of cases a social worker joined the team to conduct prescreening telephone intakes, aid families in finding resources, and to help develop written clinic protocols in collaboration with the psychologist.

Clinic Practice

The GeMS program, based on the model of care first developed and shaped in Amsterdam, continues to be adapted over time in response to new developments in the field and service demands. Our protocol relies on existing guidelines and standards for working with transgender individuals developed by various disciplines. For example, the World Professional Association for Transgender Health (WPATH) Standards of Care (Coleman et al., 2012), the Endocrine Society Guidelines (Hembree et al., 2009), the report of the American Psychological Association (APA) Task Force on Gender Identity and Gender Variance (2009; <http://www.apa.org/pubs/info/reports/gender-identity.aspx>), and the American Counseling Association Competencies for Counseling with Transgendered Clients (2010) each offer valuable recommendations for working with the transgender population. Generally, these guidelines and standards are similar in that they all recommend supporting transgender individuals in their affirmed gender identity, which often includes assisting in medical interventions that will help make the individual's body congruent with their affirmed gender. The APA Task Force report (APA, 2009) states support for the "efficacy, benefit, and medical necessity of gender-transition treatments for appropriately evaluated individuals . . ." (p. 67), a statement consistent with the goals of the GeMS team.

Nevertheless, many of these guidelines do not focus on issues specific to transgender youth. The Society for Adolescent Health and Medicine (2013) has issued recommendations for promoting the health and well-being of lesbian, gay, bisexual, and transgender adolescents, and the American Academy of Child and Adolescent Psychiatry (2012) has published practice parameters addressing gay, lesbian, bisexual, gender nonconforming, and gender discordant children and adolescents. The APA also published a helpful and accessible pamphlet regarding gender identity and gender expression, with some information about transgender youth (<http://www.apa.org/topics/sexuality/transgender.pdf>). They note that "it may be helpful to consult with mental health and medical professionals familiar with gender issues in children" (p. 3), while also emphasizing that "identifying as transgender does not constitute a mental disorder" (p. 3) and that "it is not helpful to force the child to act in a more gender-conforming way" (p. 3). This position is

aligned with our gender affirming approach to care (see [Hidalgo et al., 2013](#) for an elaboration of a gender affirming model) that views gender variations as part of an expected diversity, and not pathology. Mental health challenges may emerge related to cultural and social responses to a child or coexist with gender nonconformity. Consistent with much literature (e.g., [Hidalgo et al., 2013](#); [Steensma, McGuire, Kreukels, Beekman, & Cohen-Kettenis, 2013](#); [Wallien & Cohen-Kettenis, 2008](#)) we view gender as sometimes fluid over time, recognizing that not all gender nonconforming children fit neatly into male or female identities, and that gender identity (internal sense of self) and gender expression (outward expression of gender) may modify over time. Members of the GeMS team have played a role in the development of standards and guidelines, including as a member of the active APA Task Force to develop guidelines for psychological practice with transgender and gender nonconforming clients.

As time has elapsed, and our clinical expertise has developed, we have advanced to a more flexible, individualized approach to care than was utilized at the clinic's inception, which may evolve further with increasing research to inform best practices. Within our current model we continue to prioritize evaluation and treatment, mental health and readiness for medical treatment, but allow for a variable structure and account for the unique circumstances of the youth and family. Therefore, the model set forth below is adaptable, serving as a guide for care as opposed to an inelastic protocol. Clinical discretion and family needs are prioritized, as deemed appropriate by the psychologist working within a multidisciplinary team. In addition, as the field evolves, our future practices may vary from those delineated. However, we anticipate that our fundamental approach will endure, and can be described as the intertwining of mental health and medical expertise, each informing the other to best assist families and youth.

Intake

The initial telephone intake, conducted by a GeMS clinical social worker, includes gathering a substantial amount of information and allows the parent and/or guardian the opportunity to tell their story to a knowledgeable professional, often for the first time. The information includes reasons for concerns about gender variance, current crises, and developmental, medical, and mental health history. Other services include support, psycho-education, explanation of protocols, outside referrals, and scheduling a clinic appointment when appropriate. We believe that it is imperative for a qualified and experienced clinician to be the first point of clinical contact to set the roadmap for future care, and to act as an identified trusted individual to whom the family can turn. The intake frequently plants the seeds of hope, providing relief for families who have been enduring the stress of a situation for which they have had little preparation, often within a context of isolation. A description of the patient population presenting in GeMS through the year 2010 indicated that the mean age at intake was ~14, with a slight preponderance of genotypic female to male patients, many of whom (~44%) presented with a significant psychiatric history ([Spack et al., 2012](#)).

It is important to note that the earliest we medically treat children is when puberty has just begun, medically defined as Tanner Stage II ([Marshall & Tanner, 1969, 1970](#)). A youth's chronological age is less relevant than their biological develop-

ment and a cognitive level necessary to adequately assent to treatment. However, we do not accept new patients for treatment older than 18.

In the case of younger children who are not yet approaching puberty, guidance is often sought for gender related challenges, in which case we provide psycho-education, and offer referrals for families to receive supportive mental health counseling. These services may assist the youth in clarifying their gender identity, and help youth and families navigate the many anticipated and unanticipated issues they may confront, including whether or not to initiate a social transition (presenting in social settings as the affirmed gender). Children may experience anxiety and depression, often secondary to the social and familial ramifications of their gender questioning and/or atypical presentation, and a mental health professional with relevant expertise can be tremendously helpful.

When a child is seeking services closer to puberty, our current model typically recommends 3 to 6 months of psychotherapy. For some children who feel a compelling sense of urgency in light of impending physiological changes, this recommendation may be modified, especially when complicating factors are absent and the child is well supported. This aspect of the model reflects our recognition that many youth and/or parents seeking services in our clinic are in the early stages of gender exploration and consideration of medical intervention options, and need a safe forum in which to learn more about the issues involved, and treatment available. Further, we have found psychotherapy exceedingly helpful for treating co-occurring mental health issues and for exploring the child and/or adolescents' thought processes, family functioning, strengths, and support systems. In addition, psychotherapy enables a deeper exploration of the child's Gender Dysphoria (GD), the range of gender expression and gender identity questioning, and whether the subjective experience fits more into a model of binary identity (e.g., male or female) versus a fluidity of gender and gender nonconformity. Mental health intervention can also support problem-solving regarding the medical and social challenges that lie ahead. It helps facilitate discussion between families and other support systems (schools, extended family, and religious/sectarian community affiliates) as next steps are contemplated. Many authors also have noted the importance of mental health services (e.g., [Bernal & Coolhart, 2012](#); [Menvielle, 2012](#); [Tuerk, 2011](#)). [Drescher and Byne \(2012\)](#) emphasize that "the majority of adolescent persisters do well when they receive family and professional support for early interventions" (p. 504). Therefore, GeMS patients are asked to continue working with their outside mental health provider during the course of medical treatment in our clinic.

One of the purposes of the puberty blocking medical intervention (described below) is to buy time for the adolescent to continue exploring gender identity issues without the added stress of a puberty that is inconsistent with their self-identity. In our view, it is often unrealistic to expect an adolescent to sort through the myriad of issues related to gender variance without the help of a professional. Many of the challenges adolescents face regard the reactions of others to their gender identity and/or expression, but can also include gender-related questioning and confusion (see [Cohen-Kettenis, Steensma, & de Vries, 2011](#), for an interesting discussion of psychological interventions for adolescents with GD).

Psychological Evaluation

The goals of evaluation, conducted by a licensed psychologist, are to further understand the child and family's needs, and to inform medical treatment interventions. Before initiating the evaluation, we typically request a letter from the child's outside community therapist composed with the aid of a guide we provide. The therapist is asked to address their understanding of the patient's gender identity history, including length of time the patient has had gender questioning feelings, how long he or she has been living in the role of a different gender (if at all), and how persistent his or her identification with a different gender has been, if ever, over the course of time. The letter includes the therapist's impression of the patient's supports, the therapist's perception of other mental health issues or developmental concerns, and finally, the therapist's perception of benefits or drawbacks related to medical intervention.

Assuming that the therapist's letter is generally supportive of medical intervention, after review by our mental health clinicians, we move forward with an on-site psychological evaluation. This evaluation consists of extensive interviews of youth and families, and measures of anxiety, depression, self-concept, behavioral and social functioning, autism spectrum disorder (ASD), and gender identity. With consent, outreach is often made to collateral informants, and we review relevant documents (e.g., neuropsychological evaluations), as appropriate.

In the clinical interview, we address what the youth and parents hope to accomplish from the evaluation, family and developmental history, school and academic history, mental health and medical history, substance use, and trauma history. We gather an extensive gender history including the youth's subjective experience of gender across time, gender presentation, gender role expression, and sexual orientation. Considerable attention is paid to factors that make these cases more complicated, such as patients presenting with features of ASD, severe psychiatric concerns (e.g., suicidality, self-harming behaviors, psychosis, violence and aggression, and history of abuse or trauma), and/or complicated family factors (e.g., divorced parents, unsupportive family members). We assess support structures and strengths, familial attitudes about nontraditional gender roles and sexual orientation preferences, religious, cultural and ethnic background, and additional individual and family stressors. The youth's age at first signs of GD or disclosures is always noted; families may be caught off guard when their children first disclose gender questioning close to adolescence or after the onset of puberty, and often the evaluations of these youth and families are particularly complex.

Consistent with psychological evaluations in general, the rationale for numerous measures and methods of information gathering is to obtain the most authentic and comprehensive clinical picture possible. This is particularly critical, given that the results and clinical formulation play the primary role in deciding whether to move forward with a potentially life-changing medical intervention for the adolescent. We synthesize and interpret the information obtained, and use the evaluation as a way to understand the youth and family's state of mind, ambivalences, and overt and covert pressures. We also want to ensure that, to the extent possible, a youth's cultural and social environment will support their chosen gender identity and provide a safety net as they move forward. A full clinical report is written that integrates the information, and provides a formulation and recommendations. The

team psychologist then meets with the family to review this information. Medical interventions that often follow are either in the form of puberty blockers, and/or cross-sex hormone therapy, described below.

As noted above, continuing psychotherapy for youth is typically recommended by our protocol. At times we recommend family treatment and/or support groups to help with the family's adjustment to their child's transition. The GeMS team then remains in contact with community providers as clinical care dictates. In addition, youth treated in our program return for regular clinic visits, meeting with both mental health and medical team members, to provide continuity of care, and further assist adolescents and family members as needed.

Medical Intervention

Medical intervention with transgender youth in GeMS occurs under the auspices of a subdivision within the Endocrine Department. In brief, as alluded to above, with children who have recently begun puberty, puberty-blocking hormones are often prescribed. These are administered in the form of subcutaneous implants in the upper arm, which last 2 to 3 years, or monthly injections. These treatments are not routinely covered by health insurance in the United States and may range in cost from \$120 to over \$1,000 per month. Other medical services, laboratory tests, and sometimes cross-sex hormones may be covered by insurance.

In the absence of pubertal blockers, biological males with affirmed female identities may experience significant growth, permanent facial hair and vocal changes, and intolerable erections. A voice that has deepened cannot be raised through hormone therapy, and requires difficult and expensive speech therapy, to affect a higher voice. Similarly, without such intervention, biological females who identify as male may experience menstruation and breast development; the latter can only be modified through surgery. Nevertheless, an adolescent who has initiated puberty blockers can decide to terminate the intervention and allow physiological changes to occur as they would have, had the medical intervention never been initiated.

Only with an older adolescent, typically around age 16, are irreversible interventions initiated, and only after psychotherapy and a careful psychological evaluation has taken place. In this way, we try to ensure that an adolescent is not ambivalent, and that these interventions are well thought through and understood without coercion from others, and with full consent. When these conditions are met, an adolescent may be placed on cross-sex hormones (estrogen for genetic males and testosterone for genetic females), to facilitate a more complete transition into that individual's affirmed gender. When natal puberty has been previously blocked, the cross-sex hormones are even more effective in rendering a more gender consonant, "typical" presentation. For male-to-female (MTF) patients, treating with pubertal suppression in early puberty followed by estrogen in later adolescence causes enhanced breast development, vocal quality consistent with the affirmed gender, no development of a protruding larynx or "Adam's Apple," absence of male-typical facial or body hair, and diminished masculinization of the body frame and facial bones. For female-to-male (FTM) patients, pubertal suppression in early puberty followed by treatment with testosterone later in adolescence leads to development of facial and body hair, deepening of the voice, masculinization of

the body frame and facial bones, no need for mastectomies, and no menarche (see [Delemarre-van de Waal & Cohen-Kettenis, 2006](#) and [Shumer & Spack, 2013](#) for further information).

A common scenario is for GeMS to recommend puberty blockers, when the youth and/or the parent may feel that it would be best to start cross-sex hormone therapy instead. The delay of puberty, rather than the immediate onset of the puberty of choice (utilizing cross-sex hormones) is sometimes difficult for the youth or family to accept. This is an area where we currently have little research to guide us, and the decision of whether to block puberty, or instead move forward with an affirmed gender (i.e., cross—sex hormones) must be weighed carefully. Aside from the irreversible nature of cross-sex hormone initiation, this intervention has significant ramifications for fertility, whereas puberty blockers do not ([Lazar, Meyerovitch, de Vries, Phillip, & Lebanthal, 2014](#)).

Anecdotally, we have found that the GeMS evaluation has been invaluable by providing information to guide subsequent psychosocial and medical decision-making. In general, adolescence is marked by a search for identity and personal transformation, and at times impetuous decision-making. Given the implications of social transition and medical intervention, coupled with the developmental challenges of identity consolidation, we feel the need to progress with care and forethought, to ensure that all interventions proceed safely, to minimize medical and psychosocial contraindications or complications, and to make sure it is the appropriate timeframe for intervention. We also want to ensure that the child or adolescent who may be gender variant does not feel compelled to choose a gender (male or female), when in actuality they may not fit into a typically recognized gender identity. Nevertheless, these considerations always need to be balanced by the very real physiological ticking clock, especially for the younger child on the verge of a puberty that they deeply want to avoid.

Challenges and Dilemmas of Psychosocial Practice

Child and Family Expectations

When confronted by a gender variant child, a parent may be caught very much off guard, with no ability to rehearse the best response to such an unanticipated circumstance. In addition, for a parent, it may feel like a loss of the daughter or son to whom they became so bonded. Moreover, some families are aware of their child's GD in early childhood whereas others are surprised to learn about it when their child is in their teens. Both instances carry particular emotional impact for families. Many parents are resilient and loving in the face of these challenges, but may experience an understandable drive for rapid certainty and solutions. We have also encountered parents who are resistant to accepting this diagnostic picture, and believe their child's gender variance is a phase, or a manifestation of some other psychological issue that can be resolved, thus resolving the gender variance. Unfortunately, the problems and issues that often exist for gender variant children and their families are nuanced and indeterminate, and the resolutions may evolve through a time consuming process without a known end. This can add to the stress and consequent pressure to "solve" the issues (see [Bernal & Coolhart, 2012](#); [Dreger, 2009](#); [Menvielle, 2012](#) and [Tuerk, 2011](#) for further discussion of family issues).

It can be particularly challenging when two parents or guardians with legal custody are in dissent about how to proceed, especially

in contentious divorce situations when communication is minimal or hostile, yet medical consensus needs to be reached. Typically, our program requires consent of both parents before medical treatment can go forward and mental health and/or medical clinicians may need to be proactive in trying to resolve disputes with sensitivity.

Psychosocial Considerations

Any number of psychological, social, and cultural factors can impinge upon youth and their family, and influence decision-making, expectations and emotional reactions. The report of the [APA Task Force on Gender Identity and Gender Variance \(2009\)](#) summarizes some of these factors, including general behavior problems, peer related problems, and other mental health issues. Below we outline some of the common issues we have encountered in our work.

Not infrequently, children and adolescents are involved in meaningful activities, which will be likely impacted by a gender transition. Prominent among these are youth sports teams, which are typically grouped by gender. Adolescents are often loath to lose these areas of gratification, along with the opportunity for social bonding. Other hobbies and interests that are often impacted include dancing, theater, cheer leading and sleep-away camp, and children and families may be unable to forecast how they will weather these transitions. Therefore, a child may face the dilemma of losing the opportunity to sustain an ability or talent they value to live in a gender they embrace.

A youth's environment and culture is essential to consider when evaluating treatment options. Ideally, the family and community should provide every child safety, love and solace, and the support a gender questioning child and/or adolescent needs (as any youth does) to thrive into a healthy maturity. However, such youth often struggle for acceptance within their families and communities. We know from prior research ([Dean et al., 2000](#); [Fitzpatrick, Euton, Jones, & Schmidt, 2005](#); [Gibson & Catlin, 2011](#); [Grossman & D'Augelli, 2007](#); [Hass et al., 2010](#); [Spack et al., 2012](#)) that many children with GD become deeply anxious and depressed, and resort to suicide attempts. Others are at risk of leaving home and living a life with high costs and risks, including of exploitation, abuse, and as victims of violence, while obtaining hormones illicitly without the oversight of a qualified medical professional.

Even when families and children seek professional service and care, external factors beyond their control can impede access. Many geographic areas still lack basic services for children with GD, and traveling for access to medical care is not always an option for families living within modest means. Furthermore, schools and religious institutions vary in level of comfort dealing with transgender children, and may not have the understanding or training to navigate the complexities of their transgender student or member's needs. Learning to deal with social issues such as bullying and isolation, and practical issues such as bathroom and locker use, requires open and honest dialogue with experts familiar with gender issues; not all communities are able or willing to avail themselves to this kind of discussion.

One positive outgrowth of the Internet and widespread coverage of transgender issues is mainstream access to information about gender variance and dysphoria. Families can become much less isolated by accessing online social networks and organizations

such as Parents, Families, and Friends of Lesbians and Gays (PFLAG), even when there is not a chapter in their vicinity. However, the increased availability of differing professional standards and practices can sometimes also confuse families, who may specifically seek out professionals who seem open to providing services desired by the patient or parents, even if they are inconsistent with typical practice standards. This could result in circumventing the input of mental health professionals, or providing irreversible intervention for a young or ambivalent child.

Mental Health

Sadly, we know that transgender youth are at risk for anxiety, depression, self-harm, suicidal ideation, psychiatric hospitalizations, homelessness, exploitation, and abuse (Dean et al., 2000; Fitzpatrick, Euton, Jones, & Schmidt, 2005; Gibson & Catlin, 2011; Grossman & D'Augelli, 2007; Hass et al., 2010; Spack et al., 2012). In addition, the spectrum of issues that can present in any child or adolescent can present in gender variant youth, including history of trauma, oppositional defiant disorder or conduct disorder, and learning disabilities. These youth may do poorly in school, and/or have difficulty with socializing, and negotiating the normal developmental challenges of adolescence. Optimally, a pubescent child and adolescent should be stable, safe, and supported in advance of receiving medical interventions such as puberty blockers or cross-sex hormones. However, for many, medical intervention is an antidote for some of their mental health problems. This poses a dilemma for the clinician, who may be averse to going forward with medical intervention, but feel compelled to do so in case that is the critical step needed to jump start a child's recovery. Such intervention should only take place once the crisis of active suicidal ideation, behavior and/or self-harm has receded, and after a full psychosocial evaluation if it had not taken place already, as well as with close monitoring to ensure that the child is safe and that the dangers continue to remit. Delays can be particularly difficult and contribute to a child's distress because of the limited physiological time frame. At the very least, psychological services should help to ensure adequate support systems before any medical intervention occurs, and puberty blockers can buy time and allow for a child to make thoughtful decisions about his or her gender.

Finally, there appears to be a higher than expected incidence of co-occurring GD with ASDs based on clinical experience as well as research, although more empirical study needs to be completed (e.g., de Vries, Noens, Cohen-Kettenis, van Berckelaer-Onnes, & Doreleijers, 2010; Drescher, 2012; Spack et al., 2012). Very often adolescents on the autism spectrum know they are different from peers, but have only recently identified gender identity as a factor contributing to this divergence. Sometimes they and their families believe that a gender transition will solve all problems, and/or latch on to gender as the sole reason they are unlike their peers. Similarly, parents may believe that the GD is a manifestation of the ASD, and resist treatment. Parents of youth on the autism spectrum may be concerned that their child's intense focus on gender is a fleeting concern, particularly if their child has a history of transitory preoccupations. When children with an ASD are evaluated, it is often more difficult to discern the degree of gender variance given the relatively concrete and binary thought processes and communication patterns that typify this population. A child with an ASD already has challenges in social realms and is faced with an

additional unique and complex set of social circumstances. A comprehensive evaluation should help sort through these issues and it may be necessary to move forward cautiously. However, it is our opinion that treatment not be withheld indefinitely as these youth experience the same biological time constraints characteristic of all pubescent individuals, and therefore need to receive optimally timed interventions to the extent possible.

Service Gaps and Evolution of Practice

Watching clinical services grow is rewarding, especially when they translate into more contented and peaceful lives for youth and their families. Nevertheless, evidence-based practices are aspirational when a new field emerges with no guiding clinical precedent. Controversies among providers in the mental health and medical fields are abundant. Drescher and Byne (2012) and Stein (2012) provide excellent discussions of issues of consensus versus continued controversies. These include differing assumptions regarding whether early intervention with gender variant youth can encourage desistance, and whether that is an appropriate practice. Other areas of debate include the age at which children (or adolescents) should be encouraged or permitted to socially transition; whether cross-sex hormones and surgery should be offered to youth, and if so, at what age; whether parental consent be required for these medical interventions; and whether mental health involvement be required, including psychological evaluation, before each stage of medical intervention. These issues are complex and providers in the field continue to be at odds in their efforts to work in the best interest of the youth they serve. Addressing each of these controversies goes beyond the scope of this article; however, the GeMS team continues to stay abreast of these issues and actively participates in ongoing discussion and research (see Ehrensaft, 2012; Minter, 2012; Schwartz, 2012; Zucker, Wood, Singh, & Bradley, 2012, for discussions of some of the issues and differing viewpoints).

An important priority going forward is to develop research to enhance our understanding of what typifies this population of children, and their developmental course and patterns, and to examine the long-term outcomes of treatment. The field needs to better comprehend which children are most likely to have a life-long and persistent identification with a different gender than the one they were assigned versus those who cease to self-identify as transgender over the course of time. Although some information is available (e.g., American Psychiatric Association, 2000; Steensma, McGuire, Kreukels, Beekman, & Cohen-Kettenis, 2013; Zucker, Wood, Singh, & Bradley, 2012) much more research in this area is needed. Other high priority areas for systematic examination include the effects and side effects of various medical interventions, especially given that they are initiated with youth who may be on a lifetime course of hormone treatment, and psychosocial outcomes for youth who receive medical intervention during adolescence.

Finally, we can only report on children with access to services; youth may not have access because of geography and lack of availability, lack of financial means, and/or because of social structures that do not support them. As noted earlier, these children are at risk to be exploited, to be runaways, street youth, and sex workers, and to self-medicate and self-harm. Prevention and outreach, to shelter at-risk youth from damaging and avoidable trauma,

mas, and to improve access to mental health services, should be one of the highest priorities for health care providers.

Clinical Case-Composites

The following represent composites, not actual cases, to serve as examples of how GeMS has addressed common clinical scenarios.

Case Scenario #1: Early Puberty

Referral information. M is a 10-year-old Black natal female who identifies as male. He and his parents came to the clinic stating a desire to initiate puberty blockers to avoid feminizing.

History. Although only 10, M's pediatrician had put his pubertal development as Tanner Stage II (pubertal), and he was developing breasts. He had been living as a boy at school and elsewhere for 2 years, and was quite concerned that his pubertal changes might alert others to his natal gender, and was very also very assertive about his desire to avoid the onset of menstruation. He had been in therapy for 2 years, and was also being treated by a psychiatrist for anxiety symptoms. His therapist had written a letter in support of M living in his affirmed gender.

Psychological evaluation. The formal psychological evaluation indicated that M had a long-standing identification as male, which emerged in his early preschool years, as well as ongoing GD, which predominantly took the form of anxiety. His anxiety diminished, according to him and his family, as well as his therapist and psychiatrist, as he transitioned socially and began to live and be treated as a male at home and at school. Information from school revealed that he was viewed as normal and high functioning in all areas. As an example of a response to gender-related questions, M stated that he was not a transgender boy, but just a regular boy. M did report significant anxieties related to social situations, as well as to bathing and bathroom situations. M resides with two biological parents who were both supportive and in accord with pursuing medical treatment, although they reported that it initially had been difficult for them to accept his social transition.

Recommendations. Given his long-standing history of GD, positive adjustment at school, the consistency of data obtained from his psychiatrist, psychologist, both parents and himself, the GeMS team recommended puberty blockers, as well as continued psychological treatment to help diminish his anxiety and problem-solve social situations as they may arise. Follow-up with the GeMS psychologist indicated that his anxiety diminished as his impending puberty was forestalled, with strong acceptance for his affirmed gender from his family and others.

Case Scenario #2: Parent-Adolescent Conflict

Referral information. E is a 17-year-old Hispanic natal male who came to the clinic with her parents, who immigrated to the United States soon after E's birth. E was hoping to be able to be treated with puberty blockers and female hormones, while her parents were unified in believing that psychotherapy could resolve her GD, and were hoping to have this confirmed by a psychological evaluation.

History. E's parents were invested in her remaining male, partially because of the elevation of male status in their traditional culture. Reportedly, E had been interested in receiving care for her

gender dysphoria for several years before the current appointment, to avoid the onset of pubertal changes she was already experiencing. However, her parents had been resistant. She had been in therapy with a psychologist for many years, and her therapist was instrumental in helping to persuade her parents to bring her to the clinic.

Psychological evaluation. The evaluation revealed that E had identified as female since the age of 5, including using female pronouns, attempting to wear female underwear, playing with traditionally female toys, and identifying with female characters during pretend play. At present, E wore female clothing and had grown her hair, but appeared androgynous because of a deep voice and some light facial hair. She was generally assumed to be male at school and elsewhere, although her closest friends used her female name and pronouns at her request. The psychological evaluation revealed a strong cross-sex identification as female, and mild depression.

Recommendation. Puberty blockers were recommended, with possible cross-sex hormones in about 6 months. The psychologist spent considerable time with E's parents and with E, reviewing the results of the evaluation, and the basis for the recommendations. E's parents were distressed during discussion to learn that there was some urgency to proceed quickly, believing incorrectly that medical intervention could reverse pubertal changes. The treatment recommendations also included family therapy, to facilitate positive communication within the family and provide support and psycho-education for E's parents. We also recommended a continuation of psychotherapy for E, to help her adjust to personal and social changes, provide support, and to help her cope with family discord. E continues to be seen by the psychologist in our clinic for consultation, and is adjusting well to the initiation of hormone treatment.

Case Scenario #3: Ambivalence and Mental Health Complexity

Referral information. L is a 16-year-old White European American natal female who presents as male, and has chosen a male name and male pronouns. He has been in therapy since the age of 8, and was initially evaluated and put on pubertal blockers in our clinic at age 13. His mother called the clinic requesting that L be considered for cross-sex hormones. L was not seen for a full evaluation as he is an ongoing patient in our service, but for a screening related to his mother's request that cross-sex hormonal treatment be initiated.

History. L was adopted at the age of 1, and his early history is not known. He has been diagnosed with depression, anxiety, and Conduct Disorder. He has a history of self-harm related to depression, academic pressure, and of being bullied in school. His social, academic, and emotional functioning tends to be poor, and he is emotionally and behaviorally dysregulated, with periods of rage at school and at home, and some known drug use. He was recently suspended at school for cheating and for provoking physical altercations. His mother believes that cross-sex hormones would alleviate his distress and dysregulation,

Psychological screening. L's therapist, when contacted with the family's consent, indicated that L appears ambivalent about his affirmed gender, and therefore, did not believe that cross-sex hormones should be initiated. Other aspects of our evaluation also

suggested ambivalence on L's part. Although he ultimately agreed with his mother that he should start testosterone, he began the evaluation by suggesting it was "too early" to start them. In addition, L reported that he binds his breasts on occasion (1 × per week) to present convincingly as male, but mostly does not, and that he has been involved in an ongoing heterosexual romantic relationship as a male. He stated that this relationship has been very gratifying, and indicated concern about losing his girlfriend when he started testosterone. Although he stated that he wants to be viewed as male, L also stated that he did not look forward to the changes that testosterone would cause.

Recommendations. Given that L was initially resistant to the initiation of cross-sex hormones, and that his mother initiated the consultation, along with L's ambivalence about the changes that testosterone would precipitate, cross-sex hormones were not recommended at this juncture. Instead, we recommended that L continue to sort out his desires in his therapy relationship, while also addressing some of his other concerning behavioral and mental health issues. We also recommended family therapy, as it appeared that parental anxieties and pressures may have been impacting L's choices. We agreed to consult with L and his family again in 3 to 6 months.

Case Scenario #4: Autistic Spectrum Disorder

Referral information. B is a 12-year-old White European American natal male, Tanner Stage 1, who has been increasingly presenting as female for ~6 months to 1 year. She and her parents presented in our clinic seeking an evaluation and recommendations for treatment.

History. B was diagnosed with high functioning ASD at the age of 7, after experiencing social difficulties for several years. Although intellectually bright, B has not done well in school. B spends much of her spare time on the computer, investigating various subjects, and reporting the details to her parents. Her parents worry about her poor academic progress and her socialization, and she has been in treatment since her initial diagnosis. B disclosed that she was a girl to her therapist and her parents 6 months earlier, after increasing depression and suicidal feelings.

Psychological evaluation. The evaluation revealed that B strongly identified as female. B stated that this feeling had begun within the past year at the start of the school year.

Her parents indicated that they would support her if she were truly transgender, but expressed concern that B may be unhappy socially and using a transgender diagnosis as a means to attempt to resolve her social isolation, and as a result of self-hatred. They also expressed concern that B's identification as female is a passing phase, similar to other passing phases or obsessions she experienced throughout her life, rather than an enduring identification, and that B had limited understanding of the impact of changing genders. B's therapist was unsure of whether B should be treated with hormones yet, expressing similar concerns to her parents. School reports indicated that B was sometimes taunted by peers, apathetic about schoolwork, often inattentive, and increasingly isolated. All data consistently indicated depression and anxiety.

Recommendations. Because of the complexities of B's situation, including a relatively recent identification as female, and limited social understanding, we recommended continued psychotherapy and monitoring of her GD, with treatment addressing her

depression and anxiety, without immediate medical intervention. We also recommended that her therapist consult with her school to problem-solve solutions to isolation and bullying, and interventions to increase gratifying activities for B outside the home. We recommended a psychiatric consultation for possible psychopharmacological intervention as well, and a return visit in 3 months to monitor B's progress and her gender identification in light of the new interventions.

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Correction to Tishelman et al. (2015)

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