Affirming gender: Caring for gender-atypical children and adolescents

Pediatricians are in a powerful position to promote health and provide positive outcomes for children with issues of gender identity and expression.

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Case 1

*Your patient Mark comes to his 3-year-old well-child checkup wearing a dress and also barrettes in his hair. During the visit, you mention to the parents, “I notice Mark’s creative outfit today. Is that something you want to talk more about?” The parents mention that Mark has been wearing this dress every day since his female cousin came to visit. He likes to tell people that his name is “Katie” and that when he grows up he wants to be a girl like his cousin. When adults correct him, he doesn’t really seem to mind, saying, “I’m just playing pretend.”*

Case 2

*It is time for your patient Alex’s 8-year-old well-child checkup. Alex was assigned female at birth, but since he was able to talk, he has been insistent that he is a boy. He was so distressed when adults corrected him that he told his parents he wanted to die. Alarmed, and conscious of what their child was telling them, Alex’s parents facilitated his enrollment in kindergarten as a boy and allowed him to wear typical “boy” clothing. They trained the school staff about gender issues, and his state’s law recognizes gender as a protected class. The children have not had any problems adjusting. Alex is a top student and plays on the boys’ T-ball team.*

Case 3

*Your patient Nicole comes to his 12-year-old well-child visit, and you immediately notice something different. He will not make eye contact beneath his baseball cap. Assigned female at birth, he has told his parents that he is a lesbian. When you meet with Nicole alone, he says that he knows that he is attracted to girls but does not feel like a lesbian. Instead, he feels like a boy (thus the use of male pronouns per his request). He says he has felt this way for a long time but just thought it meant he was a tomboy. Now that he is getting breasts, he has become very depressed about feeling as if he is going through the wrong puberty.*

Families who are concerned or seeking information about their child’s gender expression or identity often turn to their primary care providers (PCPs) for help. As pediatricians, we are in a powerful position to promote health and positive outcomes for these children; however, few of us have received any formal education or training to grapple with this increasingly common issue. The goals of this article are to help the general pediatrician develop a basic understanding of gender, and offer ways to approach gender-expansive and transgender children or adolescents.

The first step is to examine our own feelings, attitudes, and beliefs about gender and consider how these affect our work with youth. Equally important is educating ourselves on the diversity of gender in our...
patients and the corresponding interventions available for supporting them. Adopting supportive, affirming practices, such as intake forms that allow for the patient’s preferred name and pronouns (and using them accordingly), is another critically important step for helping young persons feel comfortable. In addition, medical professionals can be effective advocates for their transgender patients’ needs and rights in settings outside the clinic, such as home and school.²

**What is gender?**

“Gender identity” is defined as the internal sense of oneself as male or female or other. Numerous studies support the concept that gender identity is not simply a psychosocial construct but likely reflects
a complex interplay of biologic, environmental, and cultural factors. Most individuals have a gender identity that is aligned with the sex that was assigned at birth based on external genitals. The term “cisgender” is often used to describe those who have a gender identity aligned with anatomic sex. Children are aware of their gender identity generally by age 2 years or younger. “Gender expression,” on the other hand, refers to the way an individual communicates his or her gender within the community and culture, and can include name, haircut, pronouns, and clothing, among others.

Many children display periods of nonconforming gender expression, which typically does not persist into grade school years. Some children, at very young ages, recognize that their gender is different from the sex they were assigned at birth, conveying this sense through their identity, expression, or both, and sometimes correcting the adults around them, such as Alex in case 2. These children may be referred to as “gender expansive,” or sometimes “gender creative,” “gender nonconforming,” or “gender independent.” Regardless of the label, this is a naturally occurring phenomenon representative of the diversity of human experience. If met with rejection, suspicion, or negative responses, children may internalize that there is something wrong or shameful about their sex-gender discrepancy. This internalization can lead to high rates of depression, anxiety, and other negative health outcomes.

“Transgender” is an umbrella term that refers to an individual with a gender identity that does not conform to expectations based on the sex they were assigned at birth. Some transgender children will eventually seek out medical therapies at or after puberty, including hormone blockers, cross-sex hormones, and surgery, to establish an external appearance that more closely aligns with their gender identity. Still other children, called “gender fluid,” do not identify clearly as completely male or female, but as somewhere else on a spectrum of gender.

(For a list of definitions regarding these and other terms, see "Appendix: Definitions" at the end of this article.)

**Prevalence and natural course**

Epidemiologic studies documenting the prevalence of transgender adults have been inconclusive and are nonexistent for transgender youth. It is clear, however, that referrals of gender-expansive and transgender children to specialty pediatric centers such as the Child and Adolescent Gender Center (CAGC) at the University of California, San Francisco (UCSF) Benioff Children’s Hospital are rapidly increasing, although it is not known whether this is because of increased prevalence or increased recognition or acceptance.

Gender-nonconforming behavior and gender expression in young children are common, with gender-atypical behavior reported in about 23% of boys and 39% of girls. Research shows that most of these children will not become transgender adults. Some of them may grow up to be gay or bisexual, as several studies have shown associations between early gender-nonconforming behavior and later same-sex attraction. All these children are at high risk for adverse health outcomes if not met with supportive and affirming environments. It is clear that although professionals and parents can influence the youth to change their external presentation of gender, they cannot change the young person’s internal sense of self and such pressure can lead to alarming mental health consequences, including high rates of suicidal ideation.

Although more research is needed to provide predictive variables regarding which gender-expansive children will become transgender adults, some unifying trends are evident among those young children whose gender-nonconforming expression predicts later transgender identity. These factors include
persistence, insistence, and consistency in affirmations of their cross-gender identity early in life; tendency to make declarative statements such as “I am a boy (or girl)” rather than “I want to be (wish I were) a boy (or girl)”; significant distress about their body (often referred to as “body dysphoria”); cross-gender expressions not as play but as authentic expression of affirmed gender; and later great distress when either undergoing pubertal changes in the “wrong” gender or when forced to present themselves as a gender that does not align with their internal sense of self.\textsuperscript{13}

**Gender identity vs sexual orientation**

Although often discussed together, gender identity is a separate developmental track from sexual identity or orientation. Gender, the internal sense of self as male/female/other, appears very early in life. Sexual orientation, or one’s attraction to other people, generally does not appear until later childhood. Transgender individuals can have any sexual orientation. That is, they can be attracted to people of the same, different, or any gender. When discussing the sexual orientation of a transgender individual, it is appropriate to use that person’s affirmed gender as opposed to their sex assigned at birth.

Some gender-expansive children are diagnosed with gender dysphoria (GD), characterized by “a marked incongruence between one’s experienced/expressed gender and assigned gender of at least 6 months duration.”\textsuperscript{14} For this diagnosis, assigned gender refers to the “natal gender,” based on the “initial assignment as male or female,” typically based on the physical sex characteristics present at birth. Prior to the 2013 revisions of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, this diagnosis appeared as gender identity disorder (GID), and the shift from GID to GD resulted from a complex discourse among mental health researchers and practitioners. Many providers, including the American Psychiatric Association, as well as the authors of this article, do not consider gender-expansive or transgender identities to be pathologies, instead recognizing them as a normal variation of human experience. The dysphoria is recognized as resulting from a mismatch of body and mind and resultant psychosocial stresses, and very often resolves with medical transition and/or with greater acceptance from the communities surrounding these youth.\textsuperscript{4}

Although controversial because of the implication of disease, the diagnostic criteria have allowed for standardization of research studies as well as access to mental health and medical services for this population. As time has passed, we have seen more children presenting as transgender or gender nonconforming without any associated dysphoria. We see this as a sign of change in public support and understanding. This is also a sign that these children are being raised in healthy, affirming environments. We suspect that this will become more common in the future and we will see more positive outcomes for these children.

**Gender-affirming pediatric practices**

Following is a review of issues faced by gender-expansive and transgender children across various ages, along with suggestions for how pediatricians can respond in a manner that affirms the patient’s gender experience.

**Ages 0 to 4 years**

Children in this age group, such as Mark in case 1, are generally aware of their gender and able to express it to the adults around them. Exploration of sexual organs and all forms of gender expression are very common in this age group and a normal part of all children’s development. Pediatricians can ask, in a nonjudgmental manner, “Do you have any concerns about your child’s sexual or gender
development you’d like to discuss today?” When parents express concerns, it is important to reassure
them that their child’s gender exploration is a healthy and normal part of development and should be
supported. Both providers and parents, however, should avoid labeling this as “just a phase.” Even
though it likely will be short-lived, it sends the message that we are waiting for the child to grow out of
undesirable behavior. Given that gender is a part of every child, it is appropriate to ask nonjudgmental
questions about gender for any child, regardless of their outward appearance or behavior.

Children who show a persistent identification with a gender that does not conform to their assigned sex
and become upset when approached with rules that limit their gender expression may be at high risk for
the internalized distress described earlier. Parents should take extra caution with these children, because
efforts to restrict their child’s gender expression and impose the parents’ wishes (eg, forcing a natal girl
to wear a dress or a natal boy to cut his hair) can create significant psychological problems.

**Ages 5 to 9 years**

School-aged children typically have a strong sense of their gender identity and choose activities,
playmates, hairstyles, and clothing that align accordingly. At this age, a girl whose gender expression
includes male hairstyle or clothing is generally labeled a tomboy. In some communities this is socially
acceptable, but in others this may be met with rejection. Some of these tomboys may indeed be
transgender children whose gender variance has persisted beyond their preschool years, although some
of them will eventually become cisgender women. Many boys at this age who are perceived to be more
feminine are bullied, and both boys and girls who are gender nonconforming face high levels of peer
rejection and school victimization.15

Although some of these youth may have their gender affirmed and supported by the adults around them,
many others will change their gender expression to conform to social norms and align with the
expectations of their peers. The pediatrician should be mindful for signs of stress, including depression,
anxiety, poor school performance, and various forms of acting out. Many school-aged children show
distress by harming their bodies through either attempted mutilation of their genitals or suicidal
attempts or gestures.5,6 Therefore, it is critically important for pediatricians to screen school-aged
children for any distress associated with gender variance. Pediatricians can ask children and parents,
“Do you feel more like a boy or a girl or maybe something in-between?” and “Do adults or other
children ever pick on you for how you express being a boy or a girl?” Pediatricians may be surprised
how many children answer “yes” to this latter question, because gender-based bullying is disturbingly
common for all children.

**Social transition**

Many prepubertal gender-expansive children will undergo what is often called a “social transition.”
This means that these children will change their name, pronouns, and external appearance to align with
their affirmed gender, such as Alex did in case 2. This generally involves efforts by the parents, school,
and other institutions affecting the child to come to agreement about the child’s care and support. These
social transitions are completely reversible if the child, with family support, later desires to transition
back or forward to some other iteration of gender. Experience has shown, however, that not allowing
such transitions can have serious negative consequences; that very few, if any, children later
detransition; and that early social transition can significantly reduce psychological distress and replace it
with well-being.4 It is also important to keep in mind how the child’s transition will play out for the
child at school.
Ages 8 to 14 years (early puberty)

Early puberty can be a distressing time for all children as their bodies change and youth become aware of their attractions to others. At this point, many gender-expansive children will not persist as transgender adolescents. For transgender teenagers, however, who often feel as if their bodies are betraying them as they undergo the “wrong” puberty, this is a time of increased suicidal attempts and ideation, depression, and anxiety. Assigned females with a male gender identity, such as Nicole in case 3, who may have previously been accepted as a tomboy, are now developing breasts and starting to menstruate, changes that can feel horrifying to them. For transgender girls (assigned male at birth with a female gender identity), many of puberty’s changes, including voice deepening, body hair, stature, and facial masculinization, are similarly distressing and will be irreversible after they occur.

Unfortunately, far too many gender-expansive youth face rejection or worse at home, in school, and from their community at large. These vulnerable young people are at great risk of entering child welfare or juvenile justice systems, where they may have few if any advocates who understand their complex needs. Pediatricians should be alerted that some of the older gender-nonconforming youth in their care

Previously, the assumption was that schools and other institutions were unsafe for a transgender child who has socially transitioned. Families faced 2 problematic choices: change location and attempt to enter a new school maintaining complete privacy (an uncertain prospect at best), or accept that their child would need to continue unhappily going to school as the “wrong” gender.

Increasingly, however, transgender children and caregivers are navigating a third, more positive course: working with schools to support a student's gender transition. Facilitated by intentional and systematic planning, a growing body of practice and resources are developing that can create conditions in which a young person's gender transition can successfully take place publicly. Through a carefully crafted gender support plan, a team-based approach, and effective training by organizations such as Gender Spectrum (www.genderspectrum.org) and the Gay, Lesbian, and Straight Education Network (www.glsen.org), schools across the country are navigating this new territory.

In working with their transgender patients, pediatricians must be able to help them envision the possibility of living authentically and to connect them with the necessary resources to do so.
are in such situations, which will require an even greater level of sensitivity and affirmation. Special consideration should be given to both their medical needs and their psychological care. Further, it is incumbent on any provider to be aware of and be able to make referrals to community support programs wherever possible.16

Puberty blockers and medical transition

For transgender children, both the Endocrine Society (ES) and the World Professional Association of Transgender Health advocate using gonadotropin-releasing hormone (GnRH) agonists as puberty blockers to delay the onset of irreversible changes of puberty (Table).17,18 These medications are completely reversible, putting a pause on physical puberty changes and giving the child (and caregivers) more time and emotional room for making long-term decisions. This period allows the child to explore gender identity and develop the adolescent cognitive skills needed to make further decisions about changing his or her body. It also gives the family time to come to a better understanding of their child’s experience.
Youth undergoing treatment with puberty blockers and then deciding to begin cross-sex hormone therapy later in puberty can avoid undesirable changes such as breast development, voice changes, facial masculinization, and body hair growth that may require expensive and often disappointing surgical procedures to correct. Earlier medical transitions are associated with more satisfactory outcomes and a greater facility to blend into the affirmed gender, resulting in less social stigma.\textsuperscript{19–21}

The GnRH agonists are available as either depot 1- or 3-month injections or as yearly implants, and are approved by the US Food and Drug Administration for central precocious puberty. They have been used for transgender youth in the Netherlands for over 20 years with excellent outcomes and safety profiles.\textsuperscript{18–21} These GnRH agonists are now used off label in the United States for this purpose.\textsuperscript{2,4,7}

\begin{table}
\centering
\begin{tabular}{|c|c|c|c|c|}
\hline
\textbf{CATEGORY} & \textbf{MEDICATIONS USED} & \textbf{DESIRED EFFECTS} & \textbf{ADVERSE EFFECTS} & \textbf{MONITORING} \\
\hline
Hormone blockers (puberty suppression) & \begin{itemize}
\item GnRH agonists: leuprolide acetate depot (IM or SQ 1-3 months)
\item Histrelin acetate implant (annual, may have longer effectiveness)
\end{itemize} & \begin{itemize}
\item Suppression of secondary sex characteristics
\end{itemize} & \begin{itemize}
\item Temporarily decreased bone density compared with age-matched peers
\item Fertility considerations
\end{itemize} & \begin{itemize}
\item Height, weight, sexual maturity rating
\item Gonadotropins (LH, FSH), sex steroids (estradiol, testosterone)
\item Bone health/DXA scan
\end{itemize} \\
\hline
Feminizing hormones & \begin{itemize}
\item 17 \textbeta}-estradiol (use with antiandrogen)
\item Transdermal
\item Oral formulation dissolved sublingually
\end{itemize} & \begin{itemize}
\item Breast growth
\item Body fat redistribution
\item Decreased muscle mass
\item Decreased testicular volume, libido, erections, sperm count
\item Softens skin and terminal hair
\end{itemize} & \begin{itemize}
\item Weight gain
\item Migraine headaches
\item Increased risk of venous thromboembolism
\item Hyperprolactinemia
\item Increased blood pressure
\item Abnormal lipid changes and possible insulin resistance
\end{itemize} & \begin{itemize}
\item Estradiol
\item Prolactin
\item Lipids
\item Blood pressure
\item Hemoglobin A\textsubscript{1c} and fasting glucose
\end{itemize} \\
\hline
Antiangdrenes & \begin{itemize}
\item Spironolactone oral
\end{itemize} & \begin{itemize}
\item Blocks androgen synthesis and effect
\end{itemize} & \begin{itemize}
\item Hyperkalemia, low blood pressure
\end{itemize} & \begin{itemize}
\item Blood pressure, potassium, creatinine
\end{itemize} \\
\hline
GnRH agonists & \begin{itemize}
\item Effects listed above
\end{itemize} & \begin{itemize}
\item Listed above
\end{itemize} & \begin{itemize}
\item Listed above; must continue to monitor bone density
\end{itemize} & \\
\hline
Masculinizing hormones & \begin{itemize}
\item Testosterone
\item Depot IM or SQ every 1-2 weeks
\item Daily transdermal preparations (gel, patch) also available
\end{itemize} & \begin{itemize}
\item Voice deepening
\item Amenorrhea
\item Increased muscle mass
\item Increased libido
\item Fat redistribution
\item Vaginal atrophy
\end{itemize} & \begin{itemize}
\item Mood changes
\item Weight increase
\item Atherogenic lipid profile
\item Hypertension
\item Insulin resistance
\item Polycythemia
\item Acne
\item Male pattern baldness
\end{itemize} & \begin{itemize}
\item Blood pressure, weight monitoring
\item Testosterone
\item Lipids
\item Hemoglobin
\item Fasting glucose, hemoglobin A\textsubscript{1c}
\end{itemize} \\
\hline
\end{tabular}
\caption{Medications Used for Medical Transition}
\end{table}

Abbreviations: DXA, dual-energy x-ray absorptiometry; FSH, follicle-stimulating hormone; GnRH, gonadotropin-releasing hormone; IM, intramuscular; LH, luteinizing hormone; SQ, subcutaneous.

From Hembree WC, et al; Coleman E, et al; University of California, San Francisco Center of Excellence for Transgender Health.\textsuperscript{21}
Although generally administered under the care of a pediatric endocrinologist starting at early puberty (sexual maturity rating 2 or 3), family practitioners, adolescent medicine specialists, and pediatricians also can prescribe them, especially in areas where a pediatric endocrinologist with competency in transgender issues is not readily available. One major downside of GnRH agonists is the cost, which can be prohibitive for some families. These medications, however, are increasingly covered by insurance plans.

Potential risks of using GnRH agonists in early pubertal transgender youth are lack of pubertal accrual of bone density (which is likely reversed with cross-sex hormone treatment or cessation of therapy), compromised fertility, and unknown effects on brain development.\(^3\)\(^,\)\(^2\)\(^1\) Given these possibilities, it is important to review risks, benefits, and expectations with the child and the parents prior to starting therapy, and to ensure adequate intake of vitamin D and calcium with routine monitoring of bone health.

Before beginning these medications, children should undergo a psychological evaluation with an experienced gender-affirming therapist who adheres to the practice of enhancing a child’s authentic gender, rather than attempting to change the child’s gender to conform with social norms.\(^2\)\(^2\) The assessment is conducted primarily to document the youth’s gender nonconformity and/or dysphoria; ensure there are no underlying psychiatric disorders that may worsen with treatment; and assess levels of support for the child. In addition, ongoing therapy may be helpful for some children who are unclear regarding their gender identity or the level of medical intervention they desire.

For parents who are opposed to or uncertain about consenting to use hormone blockers, it is important to explore their feelings and reassure them about the reversibility of blockers as well as the potential harms averted (depression and suicidality) when these are initiated. Often it is the parents more than the child who need psychological support from a mental health professional during this time. In addition, it is typical for parents to be concerned about later feelings of regret for these decisions, especially if their child moves on to cross-sex hormones. They can be reassured that follow-up studies have shown that few, if any, individuals have regretted their decision to transition and that mental health improves with access to medical intervention.\(^4\)\(^,\)\(^1\)\(^9\)

**Ages 14 to 18 years (late puberty)**

By later in puberty, many adolescents are developing a more mature and focused sense of themselves and their life goals. At the same time, they may be experimenting with sexuality and substances, and conflicts with caregivers may be escalating. Transgender adolescents are experiencing all these changes as well as living in a body that may not fit their conception of their gender. They may have already gone through their natal puberty, or they may be on GnRH agonists and considering starting cross-sex hormones.

The ES guidelines recommend initiating cross-sex hormone therapy at age 16 years. In the United States, many providers are starting these medications at age 14, and some even at ages 12 or 13, mainly because of the earlier ages at which children are transitioning to their affirmed gender and the concerns over allowing teenagers to go through a puberty concurrent with their peers. For adolescents who already have been on hormone blockers for some years, there is also a concern about enabling bone density normalization.\(^3\) An adolescent who is already on hormone blockers can choose to continue on these and then initiate cross-sex hormone therapy, or can go off the hormone blockers and initiate cross-sex hormones as a monotherapy (if a natal female, undergoing phenotypic transition to male), or in combination with an androgen blocker (if a natal male undergoing phenotypic transition to female).
At the UCSF Benioff Children’s Hospital CAGC, we prefer to have teenagers who elect to proceed to cross-sex hormone treatment continue on their hormone blockers if financial considerations allow it. The rationale for combination treatment is that lower doses of cross-sex hormones may be used to achieve phenotypic transition, with correspondingly lower risks for adverse effects of cross-sex hormones.

For those seeking a female transition, puberty is initiated with 17 b-estradiol as transdermal patches or oral pills taken sublingually. The transgender female will also need a separate medication to block the body’s androgen production, such as GnRH agonists or spironolactone. The latter medication blocks androgen production as well as androgen action. For those seeking a masculine transition, puberty is initiated with testosterone propionate or cypionate via subcutaneous or intramuscular injections. These medications are increased gradually over 2 to 3 years to simulate a natural pubertal progression. Longitudinal studies in the Netherlands show excellent psychosocial, medical, and quality-of-life outcomes and no major adverse effects with early use of puberty blockers followed by cross-sex hormones.19

Many times, youth have already gone through their biological puberty by the time they seek medical transition. For these youth, we use the same medications but titrate them more quickly. The Primary Care Protocol for Transgender Patient Care of the UCSF Center of Excellence for Transgender Health is a helpful on-line resource for the risks and benefits of these medications, expected physical changes, and dosing protocols.23

Sexuality

It is important to counsel transgender teenagers about substances and sexuality with the same care and sensitivity as you would counsel all adolescents. Specific screenings for sexually transmitted infections and pregnancy should be based on the genitals the youth has and uses for sex. All teenagers who have a vagina and a uterus should be aware of the potential for unintended pregnancy because many transgender males do not consider themselves at risk. All teenagers should be counseled on condom use and barriers such as dental dams for any body part that comes into contact with a partner’s body part.

Adolescents and their parents also may have questions about disclosure and safety for transgender youth who are dating. Sadly, the potential for violence is very real for transgender young persons in these situations, and it is critical that parents anticipate this possibility and support their child to plan accordingly. Although there are many ways to approach these questions, it is important that adolescents and their caregivers feel comfortable talking openly and that the caregivers initiate this conversation with their teenager as early as possible, before initiation of dating and sex. A good resource for trans youth sexuality is the book Trans Bodies, Trans Selves.24

Fertility

Many parents and children will be concerned about the fertility implications of starting cross-sex hormone treatment. Puberty suppression will prevent ovulation and spermatogenesis. If a child then proceeds directly to cross-sex hormones, use of their own gametes in the future for fertility is not likely with current technology, although options for cryopreservation for prepubertal ova do exist. If a child decides to stop hormone blockers and go through endogenous puberty until at least Tanner stage 4, it will expand the options for future fertility, although the child will also experience undesirable and irreversible pubertal changes. It is important for the provider to discuss these options with the family and the youth, as well as alternative pathways to creating families (eg, adoption or potential reproductive technologies) to make the best possible decision. For many youth, preventing undesired
puberty changes is so important that they are willing to forgo the potential for using their own eggs/sperm and will eventually pursue other options in family building.

**Surgery**

At the end of puberty and beginning of adulthood, many transgender individuals will seek out surgical changes to their body. The most common surgical procedures are those attempting to reverse pubertal changes that make it challenging for youth to blend in their affirmed gender, such as breast removal or facial feminization and electrolysis. For youth who have previously been on hormone blockers and not undergone these changes, these surgeries will not be necessary. Genital confirmation surgeries are generally more complex and costly and require lengthy hospitalization and recovery. Not all transgender adults will choose to undergo surgery, and the decisions are complex and individual. It is important for the provider to respect the affirmed gender of the person without regard to their genital status.

**Conclusion**

As gender diversity crosses every culture and geographic area, most pediatricians will encounter a gender-expansive or transgender patient at some point in their career. Because general pediatricians are often the first point of contact within the healthcare system for gender-nonconforming/gender-expansive and transgender children and teenagers, it is essential that such providers are familiar with the psychological and medical approaches to care for this population.
Although most youth and families will continue to work with their primary provider to ensure the best possible care, often these patients benefit from a multidisciplinary specialty approach in partnership with their PCP. There are now specialty centers such as UCSF Benioff Children’s Hospital CAGC for transgender youth in all regions of the country, with a comprehensive list available. Given the complexity of issues facing this vulnerable population, working in unison across all domains of a young person’s life will be our best approach to strengthening the gender health of our young patients.

REFERENCES


5. Roberts AL, Rosario M, Corliss HL, Koenen KC, Austin SB. Childhood gender nonconformity: a


APPENDIX: DEFINITIONS

- **Biological/anatomic sex:** The physical structure of the reproductive organs or chromosomes used to assign someone as male, female, or intersex at birth.
- **Blending:** The ability of a transgender individual to exist in society as his/her affirmed gender, sometimes also referred to as “passing.”
- **Cisgender:** Describes individual for whom gender and physical sex characteristics are in alignment. The prefix “cis” means “on the same side as.”
- **Gender expansive:** Umbrella term used for persons who broaden their own culture’s commonly held definitions of gender, including expectations for its expression, identities, roles, and/or other perceived gender norms. Gender-expansive individuals include those who identify as transgender, as well as anyone whose gender in some way is seen to be stretching society’s notions of gender. Sometimes referred to as “gender nonconforming,” “gender variant,” or “gender creative.”
- **Gender expression:** The way an individual communicates his/her gender within his/her community and culture; can include name, haircut, pronouns, clothing, etc.
- **Gender fluid:** An individual whose gender identity changes over time or is not a fixed binary. Some individuals may self-identify as “gender queer.”
- **Gender identity:** One’s innermost core concept of self, which can include male, female, a blend of both, neither, and more—how individuals perceive themselves and what they call themselves.
- **Gender role:** The set of roles, activities, expectations, and behaviors commonly associated with females and males by society. Our culture recognizes 2 basic gender roles: masculine (having qualities typically attributed to males) and feminine (having qualities typically attributed to females). Both gender expression and gender roles can be described as “socially constructed” concepts.
- **Gender spectrum:** The acknowledgment that gender identity exists on a nonbinary scale and that individuals can identify as male, female, both, neither, or another gender.
- **Intersex or disorders of sex development:** Refers to a group of medical conditions in which an infant’s or child’s reproductive organs are not clearly male or female, affecting the way sex is assigned. This is separate from transgender or gender identity.
- **Sexual orientation:** The tendency to be romantically or physically attracted to persons of the same or other gender or sex. Can include homosexual, bisexual, heterosexual, as well as pansexual, queer, asexual, and other terms. Distinct from gender identity and expression.
- **Transgender:** An umbrella term used to describe persons whose gender identity, expression, or behaviors fall outside culturally defined norms for their biological sex. More narrowly, describes an individual who has a gender identity “opposite” of his/her assigned sex at birth. Often called “trans” or “trans*.” A person with a female gender identity and male assigned sex would be called a “transgender girl/woman” or “MTF” (male to female). A person with a male gender identity and female assigned sex would be called a “transgender boy/man or FTM.”
- **Transition:** The process by which a transgender individual strives to have a physical presentation more closely aligned with gender identity. Transition can occur in 3 ways: social transition, through nonpermanent changes in such things as clothing, hairstyle, name and/or pronouns; medical transition, through the use of medicines such as hormone blockers or cross hormones to promote gender-based body changes; and/or surgical transition, in which an individual’s body is modified through the addition or removal of gender-related physical traits.

**Terms/phrases of which to be wary:**
Some of the following terms have layered and often negative meanings that have changed over time and imply different ideas depending on the communities using them. These are typically best avoided, especially because many do not apply to children or teenagers:

- **Biologically male/female; genetically male/female; born a man/woman:** Phrases such as these assert the notion that biology, specifically chromosomes and genitalia, trumps all when thinking about someone’s gender, and tend to repudiate or put patients on the defensive about their authentic sense of self.
- **Preoper(ative), postoper(ative):** This inaccurately suggests that one must have surgery to transition. In general, avoid overemphasizing surgery when discussing transgender persons or the process of transition.
- **Sex change operation:** If necessary, refer to “sex reassignment surgery (SRS)” or “gender affirmation surgery.”
- **Tranny, she-male, he/she, it, shim:** These are labels that have been used as defamatory slurs.
- **Transsexual:** This is an older term still in use by individuals who have physically altered their bodies, either through hormones or surgery.
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In the summer of 2013, Dr. Jack Drescher published an editorial opinion about gender-nonconforming children in the *New York Times* in which he stated: “Currently experts can’t tell apart kids who outgrow gender dysphoria (desisters) from those who do not (persisters), and how to treat them is controversial” [Drescher, 2013, p. 1]. As members of a four-site child gender clinic group, we concur with Dr. Drescher regarding the controversy, but take issue with his assessment of experts and their inability to differentially assess “persisters” and “desisters” in childhood. We would like to take this opportunity to outline the gender affirmative model from which we practice, dispel myths about this model, and briefly outline the state of knowledge in our field regarding facilitators of healthy psychosocial development in gender-nonconforming children. The major premises informing our modes of practice include: (a) gender variations are not disorders; (b) gender presentations are diverse and varied across cultures, therefore requiring our cultural sensitivity; (c) to the best of our knowledge at present, gender involves an interweaving of biology, development and socialization, and culture and context, with all three bearing on any individual’s gender self; (d) gender may be fluid, and is not binary, both at a particular time and if and when it changes within an individual across time; (e) if there is pathology, it more often stems from cultural reactions (e.g., transphobia, homophobia, sexism) rather than from within the child.

Our goals within this model are to listen to the child and decipher with the help of parents or caregivers what the child is communicating about both gender identity and gender expressions. We define gender identity as the gender the child articulates...
as being – male, female, or something else. Research and our clinical experience suggest that many children develop a strong sense of gender identity at a young age. In most children, that identification will match the sex assigned on the child’s birth certificate, but in a small minority the affirmed gender will be other than that assignment. Learning from the work of Milton Diamond [2000], we understand gender identity, both in its match and mismatch with assigned natal sex, as primarily informed by a child’s cognitions and emotions, rather than by genitalia and observable external sex characteristics. Gender identity is then to be differentiated from gender expressions: the manner in which a child presents gender to the world – physical appearance, toys chosen, preferred playmates and activities. The category “gender-nonconforming children” embraces all children exploring, questioning, or asserting their gender identities and/or their gender expressions outside of cultural expectations. By differentiating gender expressions from gender identities, we have a tool for sorting out the children who are insistent, persistent, and consistent in their affirmation of a cross-gender identity from those children who are either asserting or exploring gender-nonconforming expressions within acceptance of their natal gender assignment.

We have worked to dispel the myth that gender identity formation is synonymous with sexual identity formation (i.e., sexual orientation). Simply put, sexual identity refers to the gender(s) one is romantically and/or sexually attracted to, while gender identity has to do with what gender you are. These are two separate lines of development, albeit ones with crossovers for certain children. For example, many young boys explore the margins of gender identity on the way to later discovering their gay sexual identities; these boys will often fall within the category of desisters, shedding either their earlier gender nonconformity or dysphoria and developing into males who identify as gay [Ehrensaft, 2011].

In this model, gender health is defined as a child’s opportunity to live in the gender that feels most real or comfortable to that child and to express that gender with freedom from restriction, aspersion, or rejection. Children not allowed these freedoms by agents within their developmental systems (e.g., family, peers, school) are at later risk for developing a downward cascade of psychosocial adversities including depressive symptoms, low life satisfaction, self-harm, isolation, homelessness, incarceration, posttraumatic stress, and suicide ideation and attempts [D’Augelli, Grossman, & Starks, 2006; Garofalo, Deleon, Osmer, Doll, & Harper, 2006; Roberts, Rosario, Corliss, Koenen, & Bryn Austin, 2012; Skidmore, Linsenmeier, & Bailey, 2006; Toomey, Ryan, Diaz, Card, & Russell, 2010; Travers et al., 2012]. While the developmental impact of our approach has yet to be rigorously studied, some evidence suggests that gender-nonconforming children are negatively impacted when given the message by therapists, doctors, or families that their gender expression must conform to traditional gender roles associated with their birth-assigned gender [Hill, Menvielle, Sica, & Johnson, 2010]. Psychotherapies attempting to tweak a child’s gender identity or expressions have been shown to suppress authentic gender expression and create psychological symptoms [Bryant, 2006; Green, Newman, & Stoller, 1972]. What we can deduce is that these psychotherapies are unsuccessful because they aim to alter a child’s emerging gender identity (i.e., an internal sense of self) by attempting to change the child’s nonconforming gender expression (i.e., a behavior). Similar behavioral efforts to change aspects of sexual identity (i.e., reparative psychotherapies for homosexuality) have also proven unsuccessful.
ful, deleterious, and lacking in efficacy [for a review, see Anton, 2010]. Professional health organizations, including the American Academy of Pediatrics (AAP), the American Psychiatric Association (APA), and the American Psychological Association, recommend against implementing such change efforts in clinical care [AAP, 1993; Anton, 2010; APA, 2000].

Newly emerging evidence indicating the positive influence of family acceptance on the psychosocial well-being of gender-nonconforming and transgender youth supports our gender-affirming model of care [Ryan, Russell, Huebner, Díaz, & Sánchez, 2010; Travers et al., 2012]. In a study of lesbian, gay, bisexual, and transgender young adults, reports of family acceptance related to sexual and gender identity/expression during adolescence were associated with positive self-esteem, increased social support, and overall health in early adulthood [Ryan et al., 2010]. Family acceptance was also found to protect youth against negative psychosocial health vulnerabilities commonly faced by gender-nonconforming and transgender youth (including depression, substance abuse, and suicidality). More recently, in a sample comprised exclusively of gender-nonconforming and transgender youth, those who reported their families as being strongly supportive of their gender identity and expression in childhood endorsed more positive mental health, less depressive symptoms, high self-esteem and life satisfaction in later adolescence compared with those whose families were non-supportive [Travers et al., 2012]. As concluded by the authors: “… anything less than strong support may have deleterious effects on a child’s well-being” (p. 3). If that is so, we need to dispel the myths that confuse families and prevent that support from occurring.

**Myths about the Gender Affirmative Model**

Two myths regarding a gender-affirming approach misrepresent its underlying beliefs and assumptions. We outline these myths here.

**Myth No. 1: Gender-affirming approaches conflate gender identity and gender expression; therefore, any child who exhibits gender nonconformity is believed to be transgender.**

Nothing could be further from the truth. Given that the gender affirmative model purports that gender presentations are diverse and varied, gender identity itself is multiple in its possibilities, and can be paired with infinitely varied presentations. We recognize that non-transgender individuals express their identities in manifold ways, and embrace the welcome diversity that this facilitates. We also acknowledge that the majority of gender-nonconforming children presenting for clinical care related to gender dysphoria are desisters unlikely to mature into transgender individuals [de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2011; Drummond, Bradley, Peterson-Badali, & Zucker, 2008; Green, 1987; Steensma, McGuire, Kreukels, Beekman, & Cohen-Kettenis, 2013; Wallien & Cohen-Kettenis, 2008; Zucker & Bradley, 1995]. Thus, we dispute the notion that any child who exhibits nonconforming gender expression be considered transgender. Our stance, as gender-affirming practitioners, is that children should be helped to live as they are most comfortable. For a gender-nonconforming child, determining what is most comfortable is often a fluid process,
and can modify over time. Therefore, in a gender affirmative model, gender identity and expression are enabled to unfold over time, as a child matures, acknowledging and allowing for fluidity and change. Support, problem-solving, communication and acceptance can facilitate a child’s self-understanding and choices, and allow time and space for exploration and self-acceptance within an infinite variety of authentic gender selves, whether it be in identity, expression, or both. To the extent possible, parents and others should be supported to endure what can be a confusing and socially challenging period.

Myth No. 2: The gender affirmative model asserts that gender identity and gender expression are immutable and removed from social context or influence.

This myth of “essentialism” suggests that our approach endorses gender identity as fixed at or before birth and that no outside forces help shape or influence a child’s identity or expression. To the contrary, we recognize that all elements of a child’s sense of self – their self-beliefs, emotional responses, cognitions, perceptions, expressions and assertions – develop and are informed by a complex interplay of cultural, social, geographic, and interpersonal factors [Bronfenbrenner, 1979]. The gender affirmative model holds central an awareness of prevailing societal norms pertaining to gender identity and gender expression. These norms, present even in language and pronoun structures, support a binary interpretation of gender (e.g., male vs. female). Children with nonconforming gender expression (whether or not they exhibit gender dysphoria) are at odds with prevailing gender norms. Those whose behaviors (and/or dysphoria) “persist” do so even while vulnerable to facing considerable isolation and disdain from family, peers and others, and often without many media models or others with whom to identify. This suggests a strong constitutional component for gender-nonconforming children, albeit one never exempt from environmental forces. Our objective is to support gender-nonconforming children in what may be fundamental to all elements of their sense of self. This understanding informs our model’s premises that gender presentations are fluid and changing over time as well as our orientation that, to the extent possible, children should be comfortable to freely explore a range of gender identities and expressions without external and rejecting forces impinging upon them.

From Shattering Myths to Taking Action

The fields of medicine and psychology are only beginning to uncover the developmental trajectory of gender identity and expression in gender-nonconforming children. We have much to learn about the healthy development of these children and their families. For example, what are the comparative developmental outcomes of the various approaches for treating gender-nonconforming children and youth? Can we provide a fuller, accurate developmental picture distinguishing gender-nonconforming children who are transgender from gender-nonconforming children who may not be transgender? Is there any psychological harm done if a child transitions from one gender to another and then transitions back? What are the outcomes of receiving (or not receiving) psychosocial or medical interventions characteristic of gender-affirming support, which may include reversible pubertal suppression.

We invite other theoreticians and practitioners to consider the premises we have laid forth for the gender affirmative model, and the rationale supporting them. We also encourage the development of informal, multidisciplinary networks, such as our own, comprised of providers who abide by a gender-affirming model of care, are curious about finding answers to the questions about the gender-nonconforming children and youth we serve, and are eminently guided by the oath of our professions: to “do no harm.” Together, we hope to make a positive difference in the lives of these children and families and in society at large so that gender in all its iterations can flourish.

References


Characteristics of Gender Inclusive Facilities and Offices*

There exist a variety of ways in which medical and mental health providers can convey and openness and understanding of gender diversity to their patients. Below are some of the ways in which to do so. Remember: The whole is greater than the sum of its parts!

Visual Images and Written Materials of Recognition and Acceptance
- Positive signs (i.e. All Genders Welcome, Think Outside the Boxes, etc.)
- Magazines, pamphlets and articles about gender diversity
- Posters of gender diversity from around the world

All Gender Bathrooms
- Single stall restrooms
- Multi-stall restrooms with non-gendered signage (All Gender, Gender Neutral)
- Explicit messaging about why you have these restrooms

Gender Literate Staff
- Avoid using gendered language (How are you today? Can I help you?)
- Ask all patients for their names and pronouns and be able to explain why you are doing so
- If “thrown off” by name, respectfully inquire (Perhaps your chart is filed using a different name?)
- If mistakes are made, apologize respectfully and move on (I’m sorry I just used the incorrect pronoun; I did not mean to disrespect you)
- Use “they” pronouns when unsure of the pronouns someone is using

Gender Inclusive Intake Routines
- Explicit language welcoming patients and stating commitment to be inclusive of all forms of diversity with specific mention of sex, gender identity and gender expression
- Forms that include two-step inquiry for sex and gender (Sex assigned at birth; Gender Identity)
- Systematized process for “flagging” transgender and non-binary patients in EMR
- Clear protocols for handling questions or issues that arise, including identified staff person who is on point for addressing them

Posted Non-discrimination Commitments
- Policy statements explicitly citing sex, gender identity and gender expression
- Clearly stated processes for registering concerns, including formal complaint procedures

Ongoing Training
- Routine gender literacy training as part of new employee orientations
- In-depth trainings for staff providing direct care to patients
- Institutional support for advanced trainings and conferences
- Participation in transgender and other gender-based networks and online communities (i.e. WPATH, Gender Spectrum Lounge, Mind the Gap)

*adapted from UCSF Center of Excellence for Transgender Care and Fenway Institute

www.genderspectrum.org • 510-788-4412 • info@genderspectrum.org
Introduction to the transgender community

Gender identity is our internal understanding of our own gender. We all have a gender identity. The term “transgender” is used to describe people whose gender identity does not correspond to their birth-assigned sex and/or the stereotypes associated with that sex. A transgender woman is a woman who was assigned male at birth and has a female gender identity. A transgender man is a man who was assigned female at birth and has a male gender identity. For many transgender individuals, the lack of congruity between their gender identity and their birth sex creates stress and anxiety that can lead to severe depression, suicidal tendencies, anti-social behavior, and/or increased risk for alcohol and drug dependency. Transitioning - the process that many transgender people undergo to bring their outward gender expression into alignment with their gender identity - is a medically necessary treatment strategy that can effectively relieve this stress and anxiety.

Transgender people are medically underserved

Access to affordable, quality health care is central to avoiding negative health consequences, yet most insurance companies exclude medically necessary care and services for transgender people, including mental health therapy, hormonal therapy, and surgeries. In addition, many transgender people have had negative experiences in health care settings, including providers and office staff who have lacked the information necessary to provide sensitive services. Discrimination in the provision of services causes transgender people to delay or avoid necessary health care, including care that is not transition-related, often to the point of putting their overall health at severe risk.

Medical Protocols

The World Professional Association for Transgender Health (WPATH) publishes Standards of Care for the treatment of gender identity disorders, available at www.wpath.org. These internationally recognized protocols are flexible guidelines designed to help providers develop individualized treatment plans with their patients.

Another resource is the Primary Care Protocol for Transgender Patient Care produced by Center of Excellence for Transgender Health at the University of California, San Francisco. You can view the treatment protocols at www.transhealth.ucsf.edu/protocols. These protocols provide accurate, peer-reviewed medical guidance on transgender health care and are a resource for providers and support staff to improve treatment capabilities and access to care for transgender patients.
Transgender Law Center recognizes that many health care providers are eager to provide a safe, welcoming treatment environment for members of the transgender community, yet may not have had the opportunity to access information about the needs and experiences of this marginalized population. With this barrier in mind, we have created this pamphlet to work in partnership with providers to improve quality of care and provider-patient outcomes.

1. WELCOME TRANSGENDER PEOPLE BY GETTING THE WORD OUT ABOUT YOUR SERVICES AND DISPLAYING TRANSGENDER-POSITIVE CUES IN YOUR OFFICE. You can use LGBT community centers, services, newspapers, and Internet resources to advertise your services. Posters, buttons, stickers, and literature about transgender people can demonstrate that you are transgender-friendly. You can rewrite your intake form to include "chosen name" in addition to "legal name," as well as a third, blank option for "sex/gender" where someone can more accurately describe their gender. And single-use restrooms are a welcome addition for many, including transgender people.

2. TREAT TRANSGENDER INDIVIDUALS AS YOU WOULD WANT TO BE TREATED. You can show respect by being relaxed and courteous, avoiding negative facial reactions, and by speaking to transgender clients as you would any other patient or client.

3. REMEMBER TO ALWAYS REFER TO TRANSGENDER PEOPLE BY THE NAME AND PRONOUN THAT CORRESPONDS WITH THEIR GENDER IDENTITY. Use "she" for transgender women and "he" for transgender men, even if you are not in the patient's presence.

4. IF YOU ARE UNSURE ABOUT A PERSON'S GENDER IDENTITY, OR HOW THEY WISH TO BE ADDRESSED, ASK POLITELY FOR CLARIFICATION. It can be uncomfortable to be confused about someone's gender. It can also feel awkward to ask someone what their gender is. However, if you let the person know that you are only trying to be respectful, your question will usually be appreciated. For instance, you can ask, "How would you like to be addressed?" or "What name would you like to be called?" In order to facilitate a good provider-patient relationship, it is important not to make assumptions about the identity, beliefs, concerns, or sexual orientation of transgender and gender non-conforming patients.

5. ESTABLISH AN EFFECTIVE POLICY FOR ADDRESSING DISCRIMINATORY COMMENTS AND BEHAVIOR IN YOUR OFFICE OR ORGANIZATION. Ensure that all staff in your office or organization receive transgender cultural competency training and that there is a system for addressing inappropriate conduct.

6. REMEMBER TO KEEP THE FOCUS ON CARE RATHER THAN INDULGING IN QUESTIONS OUT OF Curiosity. In some health care situations, information about biological sex and/or hormone levels is important for assessing risk and/or drug interactions. But in many health care situations, gender identity is irrelevant. Asking questions about a person's transgender status, if the motivation for the question is only your own curiosity and is unrelated to care, is inappropriate and can quickly create a discriminatory environment.

7. KEEP IN MIND THAT THE PRESENCE OF A TRANSGENDER PERSON IN YOUR TREATMENT ROOM IS NOT ALWAYS A "TRAINING OPPORTUNITY" FOR OTHER HEALTH CARE PROVIDERS. Many transgender people have had providers call in others to observe their bodies and the interactions between a patient and health care provider, often out of an impulse to train residents or interns. However, like in other situations where a patient has a rare or unusual finding, asking a patient's permission is a necessary first step before inviting in a colleague or trainee. Many transgender patients wish to maintain control over who sees them unclothed. Therefore, when patients are observed without first asking their permission, it can quickly feel like an invasion of privacy and creates a barrier to respectful, competent health care.

8. IT IS INAPPROPRIATE TO ASK TRANSGENDER PATIENTS ABOUT THEIR GENITAL STATUS IF IT IS UNRELATED TO THEIR CARE. A person's genital status—whether one has had surgery or not—does not determine that person's gender for the purposes of social behavior, service provision, or legal status.

9. NEVER DISCLOSE A PERSON'S TRANSGENDER STATUS TO ANYONE WHO DOES NOT EXPLICITLY NEED THE INFORMATION FOR CARE. Just as you would not needlessly disclose a person's HIV status, a person's gender identity is not an item for gossip. Having it known that one is transgender can result in ridicule and possible violence towards that individual. If disclosure is relevant to care, use discretion and inform the patient whenever possible.

10. BECOME KNOWLEDGEABLE ABOUT TRANSGENDER HEALTH CARE ISSUES. Get training, stay up to date on transgender issues, and know where to access resources.
Establishing Trust with Youth Seeking Gender Affirmative Medical Care

General Principles
Remember: the young person (and their caregiver) has a gender history when they come to their appointment. This history may create a barrier to their feeling safe with you, and could compromise your ability to provide informed and affirmative care.

Your most important skill in your work with transgender, non-binary and gender-expansive youth is your ability to LISTEN!!

Use open-ended questions to establish rapport

Getting Started
Begin by asking about your patient’s interests and strengths
- What do you like at school?
- What do you like to do during your free time?
- What is something that you feel like you’re really good at?

Transition to more personal questions about gender identity
- Tell me about your gender history
- When did you start thinking about this?
- Has your feelings about your gender changed over time?
- How does your gender feel in terms of your body, or in terms of changes to your body?

Gauging Gender Dysphoria.
Seek to identify the patient’s current sense of living in their own body
- Are you having any sad feelings about your gender? Can you describe them?
- Are you feeling anxious? In what ways?
- Are there experiences at home or at school related to gender that are making you feel unsupported or depressed?
- Are there specific parts of your body that are causing these feeling?
  - Breast development?
  - Menstrual cycle?
  - Erections?
  - Hair growth?

Establishing Goals
Clarify the patient’s goals related to their gender expression
- In the best-case scenario, how could I support you?
- What are you looking for?
  - Social transition?
  - Non-pharmacological changes?
Medications?
Body changes you’re seeking?

Conducting Physical Examinations
Conducting a physical exam can be an incredibly stressful experience for a young person. There are some ways to decrease this discomfort:
- Remind them that you are there for them, and that your only interest is in helping them achieve their goals and be healthy.
- Explain specifically what will be taking place and why.
- If pubertal development is a priority, make sure patient knows what puberty is and how it is measured.
  - Consider using pictures and asking which looks most like their body now. “Where do you think your body is?”
- Describe the connection between the physical exam and the goals they have stated.
- Describe each step that will take place during the examination, and ask permission to proceed:
  - “Now I would like to measure the size of your testes; is it ok for me to look in this area?”
- Provide patient a sense of control over what is taking place with their body:
  - If anxiety is too high, offer the option of doing exam on next visit.
  - If they’re willing to do the exam, offer options for how it will be conducted:
    - “We can do the exam at any time during the appointment. Do you want to do it now, and get it over with? Or we can wait until you feel more ready. Which option do you prefer?”
    - “To get the information I need to help you reach your goals, I only need to do __________. Would that be ok for today?”
    - “Would you prefer for me to examine you under a cover?”

Summarizing the Visit
Your patient, and most likely their caregiver, may be feeling overwhelmed simply by being at the appointment. They have also absorbed a great deal of information. It is critical they leave with clear directions about next steps:
- Provide a “roadmap” illustrating the necessary steps for meeting their goals:
  - Are there other providers or professionals with whom they will need to work?
  - Are there specific labs or other steps they will need to take?
  - What might be the expected time frame?
- Identify potential barriers of which they need to be aware:
  - Insurance?
  - Medical guidelines?
- Ask for their feedback:
  - How was today’s visit for you?
  - When I see you next time, is there something you would like for me to do differently?
  - Do you have any advice for me about how I can be as supportive as possible for my gender patients?
Principles of Gender Affirmative Care and Support

As individuals and organizations comprising the Gender Center Consortium, we are committed to ensuring that all young people are affirmed in their efforts to understand, express and identify their gender in an authentic manner. We start with the assumption that all children and youth have a fundamental right to determine for themselves who they are, and what, how and when to communicate about their gender with others. We understand that, alongside development, a confluence of socio-cultural factors—familial, religious, racial, ethnic, social, linguistic, regional, and many more—impact how a young person’s gender will be perceived, responded to, and sometimes challenged or repudiated by others. Therefore, we are also committed to providing the adults who love and care for young people with the necessary knowledge, skills, and resources to affirm and assist them in their efforts to support the gender health of all children and teens, defined as a youth’s ability to express gender with freedom from restriction, aspersion or rejection.

As members of this Consortium, we:

1. Recognize gender diversity as a universal aspect of humanity.
2. Advocate for and support the development of the authentic, self-defined gender of all children and teens.
3. Consider any professional’s attempt to alter a child’s gender identity or gender expression to align with socially stereotypical norms to be inconsistent with current standards of care, unethical, and potentially harmful.
4. Promote healthy development by providing integrated, collaborative care and advocacy throughout and across all domains of a young person’s life, including: familial, educational, legal, medical, mental health, recreational, social, and spiritual.
5. Take responsibility for helping young people and their families access services by advocating with entities (i.e. medical, mental health, insurance, governmental, etc.) that provide the funding or approval necessary for young people to obtain care and support.
6. Commit to ensuring access to all aspects of affirmative care and support for the disproportionate numbers of gender-expansive youth who are homeless, in foster care, group home, juvenile detention and other out-of-home settings.
7. Conduct, share and stay informed about research related to gender-affirmative care within and across disciplines.
8. Participate in, and initiate policy level advocacy to de-pathologize gender diversity and ensure gender-affirmative practices occur across all domains of a young person’s life.
9. Begin where parents, caregivers and professionals are in their understanding and support of transgender and other gender-expansive young people, and work collaboratively to enhance the child’s gender health.
10. Seek to identify and support other professionals committed to doing work in service of greater gender acceptance for all children and teens, and promote the inclusion of gender diversity issues in all professional preparatory and training programs.
11. Participate in and lead efforts to educate the public about the needs of gender-expansive young people to foster acceptance and ensure necessary resources are available for their care and support.