



Responding to Transgender Youth with Dignity and Respect

We in Catholic health care are committed to providing high quality and respectful care to all patients who come to us, including those who are experiencing gender dysphoria. There is a great deal we do not know about the transgender reality: few long-term studies exist, and neither the origins of transgenderism nor the outcomes of various treatment options are fully understood. The Catholic Church is carefully and conscientiously considering the clinical, biological and psychological information now available.

We have included the topic of transgender youth in this edition of Health Progress devoted to Young People at Risk, because of the unique risks and vulnerabilities that they experience. We believe this is important because our tradition values the real experience of these individuals, and good medical practice calls us to understand and care for our patients as fully as possible. Author Erin Kelsler's discussion and recommendations reflect her clinical and journalistic expertise in an area that merits much more study. The Catholic Health Association of the United States does not, however, represent or endorse a particular ethical position about transgenderism.

ERIN ARCHER KELSER, RN

Most of us think of our sex (our designation as biologically male or female at birth) and our gender (our concept of ourselves as masculine or feminine) to be the same. The great majority of us identify our biological sex with our gender. Scientifically, this is known as being “cisgender.”

When a person's sense of their own gender is incongruous with that person's sex assigned at birth, they are referred to as “transgender.” Data from the Centers for Disease Control and Prevention indicate that 0.6% of U.S. adults identify as transgender. That translates into roughly 1.4 million U.S. adults, double the estimate from 10 years ago. Prevalence varies by geography, but is consistently found to be rising among young adults.¹

By definition, transgender people are not people who have both male and female biological traits (previously called “hermaphrodites,”

now called “intersex”) or people who like to dress as the other gender (known as “transvestites” or “cross-dressers.”) By definition, transgender people have a deep-seated “gender identity” that is incongruent with their assigned biological/natal sex.²

Many transgender people identify as the opposite gender from that assigned at birth: “trans women” were born male, and “trans men” were born female. Others align themselves with both genders or neither gender. All of these people fall under the definition of “transgender.”

This article is intended to be a brief introduction to the current information available about transgender (often referred to as “trans”) people in the United States, a discussion of why trans people, and trans youth particularly, constitute a group at-risk, and the current medical and psychological recommendations for their care.

TRANSGENDER YOUTH = YOUTH AT RISK

Large studies have repeatedly shown that transgender people are at disproportionately high risk for family and social rejection, discrimination, violence, poor health outcomes, homelessness and poverty, drug and alcohol abuse and suicide.

In 2019, the CDC presented the results of a study in which almost 132,000 U.S. students in the 9th-12th grades were surveyed regarding sex, gender, violence and risk behaviors.

Almost 2% of the sample identified as transgender, which surprised the researchers. The researchers were particularly alarmed to find that, within the group who identified as transgender, 35% had attempted suicide in the last 12 months. These trans youth also were shown to be more likely to experience violence and bullying, substance use and to engage in sexually risky behaviors.³

Trans youth are consistently at a higher risk for homelessness. In 2015, the Williams Institute at the University of California, Los Angeles, found that 40% of homeless teens were LGBTQ (Les-

bian, Gay, Bisexual, Transgender, and Queer or Questioning), a number disproportionate to the estimated 5% LGBTQ percentage in the general population. Among homeless LGBTQ youth, the single greatest reason contributing to their homelessness was being forced out of their home or running away, specifically due to their families’ rejections of their sexual orientation or gender identity/expression.⁴

Many transgender people report violence and the everyday fear of violence. According to The Report of the 2015 U.S. Transgender Survey, or

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USTS, over 1/3 of trans people limit what they eat or drink in public, simply to avoid using public restrooms.⁵

In April 2019, the American Medical Association filed a legal brief with the 9th Circuit Court of Appeals regarding an Oregon case, stating that denying trans students bathrooms of their affirmed gender, “endangers their health, safety and well-being, leads to negative health outcomes and heightens stigma and discrimination.” The Oregon Medical Association, as well as a dozen other mental health and health care organizations, agreed, saying that denial of proper bathroom facilities leads to urinary tract infections and risk of chronic kidney disease, constipation, harassment and assault of trans students.⁶

The 28,000 respondents to the U.S. Transgender Survey indicated that many issues related to rejection and alienation can persist into adulthood. Data showed that trans people face much higher rates of discrimination, assault, joblessness and homelessness than the general population. Many trans people also lack access to health care. For those who have been rejected by their families, the rates of negative outcomes are much higher. Over 50% of respondents had attempted suicide in the course of their lifetimes, a rate approximately 9 times higher than the general population.⁷

Repeatedly, the most protective factor against these risks has been found to be affirmation and

TRANSGENDER CARE GUIDELINES

The WPATH Standards of Care: The World Professional Association for Transgender Health (WPATH) has been advocating for trans people and establishing guidelines since 1979. A link to version 7 of the WPATH standards is on its website: www.wpath.org.

The UCSF (University of California, San Francisco) Center of Excellence for Transgender Health has numerous guidelines: <http://transhealth.ucsf.edu>.

The Endocrine Society’s Guidelines for treating gender incongruent/gender dysphoric persons: <https://www.endocrine.org/guidelines-and-clinical-practice/clinical-practice-guidelines/gender-dysphoria-gender-incongruence>.



respect for their gender identity by the trans person's peers and family of origin. Family support has not been shown to be a determinant for whether or not someone is transgender, but it has been shown to be a determinant for improved mental health outcomes.⁸ Studies that had age and gender-matched control groups found that trans youth affirmed in their identities had rates of depression no different from their peers,⁹ presumably translating into lower risk for suicide.

GENDER AFFIRMATION

Many people assume that trans people are trying

to “choose” their gender, but transgender people almost always assert that they did not choose this path for themselves, would not have chosen willingly to be transgender. Most trans people report trying to repress their gender identity until it became a psychological and medical emergency. For this reason, “chosen gender” and “chosen pronouns” are not used in this article. In the current medical language of the day, “affirmed gender” will be used instead.

Most major medical societies, including the American Academy of Pediatrics, the American Medical Association, the American Academy of

HOW CAREGIVERS CAN SUPPORT TRANS YOUTH AND THEIR FAMILIES

- Realize, first and foremost, that transgender and gender-diverse people are human beings worthy of respect, quality care and compassion.
- Offer your help and support, realizing that the youth and/or their family have probably been struggling with these issues for quite a while, and they may be having a difficult time. Realize that they are not doing this to be “rebellious” and are probably just trying to preserve the life and happiness of the trans person.
- Reserve judgment and listen, just as you would with any other youth or parent who is struggling with a health issue.
- Realize that both cisgender and transgender people can present in a broad range across the gender spectrum. It's best not to assume anyone's gender identity based on how “masculine” or “feminine” they seem to you. Use cues like a person's first name to assess gender. Chances are that someone named Tiffany or Elizabeth uses female pronouns, for example. If you are unsure, it is okay to ask.
- Realize that many trans people have not yet changed their identity on all of their legal documents and insurance cards. Call them by their chosen name and feature it prominently in the chart. Calling a trans person by a birth name they no longer use (a.k.a. “dead-naming”) or by pronouns with which they no longer identify (a.k.a. “misgendering”) can “out” them to others and alienate a trans person, sometimes permanently.
- Realize that transgender people are in danger of being harassed, assaulted and constantly “outed” when made to use bathrooms that correspond with their birth sex. Making trans youth go to the nurse's office or to a bathroom that doesn't correspond to their gender identity is deeply stigmatizing and undermines affirmative care. Research shows that trans people are the ones at risk in public bathrooms, not other people. Having at least one all-gender bathroom in schools and public facilities is a good way around this issue.
- Realize that not all trans people desire medical interventions, like hormones or surgery. Each transgender person's path is individual, and it may be an ongoing and continuously evolving process.
- It is not okay to ask trans people if they've had “the surgery.” People (or their parents) often find it rude and creepy if a stranger asks them about their genitals (or their child's).
- Realize that transgender people do not think of themselves as “choosing” this path. Rather, many trans people actively tried to repress their gender identity for prolonged periods of time, often until they felt they could no longer do so. For most trans people, affirming their gender identity became a medical and psychological emergency.
- Don't be afraid to ask questions, but also don't expect trans people to educate you. To better understand trans people or the struggles of their families, try to find information that trans people helped to create.

— Erin Archer Kelsner

Child and Adolescent Psychiatry, the American Academy for Family Physicians, the American Psychiatric Association, the American Psychological Association and the Endocrine Society have spoken out recommending affirmation of a trans person's gender identity and access to gender-affirmative (also known as transgender or "cross-gender") care. They say that affirmation treatment is medically necessary, relatively safe and leads to vastly better outcomes for transgender people.

Although these large medical societies recommend that providers advocate for their trans patients, studies have shown that transgender people sometimes experience maltreatment by medical providers, including harassment and violence. Trans people who are denied care show an increased risk of suicide and self-harm.¹⁰

Some previous approaches, like trying to "wait-and-see" if gender identity changes, trying to "redirect" a youth to their natal gender or closer to neutral, or trying to "cure" a transgender person with "reparative" (a.k.a. "conversion") therapy are not currently recommended, due to the fact that these approaches have not been found to be helpful and may be deeply harmful. None of these approaches follow the child's lead about their gender identity, and the current medical and psychological establishments believe that these approaches induce shame, alienation and stigma in trans youth.¹¹

For some trans people, affirmation may involve medical intervention (hormones or surgery), but not for all. Social transitioning is when a trans person begins to present as their affirmed gender. Some transgender people, especially children, seek to "socially transition" temporarily while exploring their feelings and options. Others socially transition first before pursuing further medical treatment.

Particularly for adolescents and adults, a multidisciplinary team experienced with transgender issues should be utilized, but this is not always available. Ideally for adolescents, the multidisciplinary team should consist of behavioral health professionals (for example, child and adolescent psychiatrists, therapists), pediatric specialists (such as endocrinologists or pediatric medical gender specialists), and other medical/surgical specialists (such as gynecologists and urologists). Other specialties sometimes can include pelvic floor physical therapists and speech therapists. If

all of the specialties are not available at the same location, care can be carried out at different locations, using excellent communication and collaboration between them.¹²

WHAT CAUSES A PERSON TO BE TRANSGENDER?

Gender diverse behaviors are common in young children, but it appears that only a minority of gender diverse children will continue to identify as transgender and gender diverse (TGD) after puberty. When TGD people do not persist in a transgender identity, it is referred to as "desistance." Current research indicates that gender dysphoria in prepubertal children persists into adolescence/adulthood in a minority of cases, but is most likely with children who have been consistent, persistent and insistent in their transgender identity. In contrast to prepubertal TGD youth, gender dysphoria that intensifies with the onset of puberty rarely subsides.¹³

Being gender diverse and being transgender are not considered to be psychological disorders. In 2013, when the American Psychiatric Association released the fifth edition of the "Diagnostic and Statistical Manual of Mental Disorders," or the DSM-5, they removed the diagnosis of "gender identity disorder" and replaced it with the diagnosis of "gender dysphoria." Key to the diagnosis

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is the gender incongruence between the person's experienced gender and the gender assigned to them by others, lasting greater than six months. For children, the desire to be of the other gender must be "present and verbalized."

Specific to the diagnosis, the condition of gender dysphoria causes "clinically significant distress or impairment in social, occupational, or other important areas of functioning." Although the "gender dysphoria" diagnosis helps with access to affirmative care, the American Psychiatric Association has made clear that they left "gender dysphoria" in the DSM-5 primarily to preserve transgender people's access to care, not because they consider it to be a mental illness. Because of the way our medical and insurance systems are currently designed, diagnostic codes are needed to render care and to bill for it. The "gender dys-

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phoria” diagnosis allows for a range of ongoing physical and behavioral health care, even after transitioning.¹⁴

An increasing body of research indicates that some of the brain structures and hormones of trans people resemble those of their affirmed gender, providing possible biological explanations for transgender identities. In utero exposure to cross-sex hormones may also play a role, but these mechanisms are not yet completely understood.¹⁵

THE RANGE OF GENDER-AFFIRMATIVE CARE (“TRANSITIONING”)

Gender-affirmative treatment approaches range from fully reversible to fully irreversible. Gender affirming surgeries are not offered to people under the age of 18, and pubertal suppression or cross-sex hormone therapy is not offered to adolescents unless they have entered puberty and other psychological, medical or social problems have been addressed.¹⁶

(The discussion below is merely a brief overview. Guidelines for diagnostic criteria, dosages of puberty blockers and cross-sex hormones, ongoing lab tests needed and psychosocial interventions are discussed in the links to Transgender Care Guidelines on Page 46.)

Social transitioning (Fully reversible)

Social transitioning is when a trans person begins to present as their affirmed gender. Social transitioning is the first step for many transgender people, and the only gender-affirmative treatment for prepubertal children. Social transitioning generally involves changes of clothing, hair and other gender signifiers. Additionally, the person may change their name and their gender pro-

nouns. For many trans youth who are “consistent, insistent and persistent” in their identity, it can be very freeing to finally feel like they are living as themselves.

Although social transitioning is fully reversible physiologically, a cross-gender social transition is often recommended only for transgender youth who are “consistent, insistent and persistent” in their transgender identity. Behavioral health resources should be utilized by the youth and the whole family, in order to explore feelings around the gender transition, to cope with stigma and to develop a logistical and safety plan for the transition. Parents and other family members also should have access to counseling to explore any fears, resentments or feelings of loss and grief.

Pubertal Suppression (Fully reversible) (Often at age 11/12 to 15/16)

Trans youth most likely to persist as transgender into adulthood can experience profound distress at the onset of puberty. Because secondary sex characteristics can be difficult to hide once they manifest entirely (increased body hair, voice changes and an Adam’s apple in natal boys and breasts in natal girls), pubertal suppression is often recommended (for those for whom it is clinically indicated) at Tanner Stage 2, often determined by the presence of breast buds, testicular/penile enlargement, or hormone levels above prepubertal levels.¹⁷ (The Tanner scale is a measure of physical reproductive development.)

Some providers recommend that the trans youth have some experience with puberty (hence not assessing desire for suppression until Tanner Stage 2), as some youth “persist” with a transgender identity at this time, while others “desist” to the gender of their natal sex. For those who persist in their transgender identity during puberty, pubertal suppression appears to lead to less distress during adolescence and into young adulthood.¹⁸ Because pubertal suppression is fully reversible, a gender-diverse youth who decides not to pursue further hormonal treatment can stop treatment and resume the puberty of their natal sex.

Pubertal suppression also makes it more likely that the person will later be able to “pass” in their affirmed gender identity without needing extensive and uncomfortable treatments (for instance, extensive hair removal and voice lessons for trans women, and daily breast-binding or later breast removal for trans men).

There have been concerns that there may be loss of bone mass due to pubertal suppression, but bone mass accrual appears to resume when cross-sex hormone (CSH) therapy is started.¹⁹

**Cross-sex hormone therapy (Partially reversible)
(Often at age 15/16-18)**

Cross-sex hormone therapy strives to simulate hormonal levels in the affirmed gender, appropriate to age. This means that affirmed females might begin to grow breasts and that affirmed males might begin to grow facial hair. Although there have been risks to cardiovascular health during CSH in adults, there is not yet evidence of this occurring in adolescence.

**Gender affirmation surgeries (Irreversible)
(After age 18+)**

Trans health guidelines dictate that a country's legal age of consent be the absolute minimum age for any gender-affirmation surgeries. Surgeries are only offered to those who have persisted in social transitioning and CSH therapy for an extended period of time. Letters from medical and behavioral health providers are required, and insurance may not cover various surgeries.

Generally, transgender people discuss "top surgery" and "bottom surgery," as shorthand for surgeries involving chest reconstruction and genital reconstruction. Again, not all trans people will desire hormones or surgeries. Data from the USTS showed only 25% of trans people reported having had any kind of transition-related surgery,

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but approximately half of the respondents desired one or more surgeries. Seventy-eight percent of respondents desired hormone therapy, but only 49% had received it.²⁰ Each individual's path is different, depending upon their gender identity, their degree of dysphoria, their medical co-morbidities and their access to care and payment resources.

There is much that we still don't understand about gender-diverse experiences and transgender care. Recent years have given way to increased research, visibility and access to care for transgender people. The medical and psychological communities are in agreement that being transgender is not a disorder and should not be stigmatized. In order to help transgender people to survive and thrive, we may need to learn from their experiences and to reassess what constitutes quality health care that respects their innate human dignity.

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RESOURCES FOR FURTHER READING

About Transgender People (from the National Center for Transgender Equality):
<https://transequality.org/about-transgender>

2015 National Transgender Survey:
<http://www.ustranssurvey.org>

Stories about being transgender:
<https://www.nytimes.com/interactive/2015/opinion/transgender-today/stories>

About being transgender and Catholic:
<https://www.nytimes.com/interactive/2015/opinion/transgender-today/stories/nick-stevens>

The National Catholic Reporter trans stories:
<https://www.ncronline.org/social-tags/transgender>

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