Child and Adolescent Gender Center: A Multidisciplinary Collaboration to Improve the Lives of Gender Nonconforming Children and Teens

_Pediatrics in Review_ 2012;33;273
DOI: 10.1542/pir.33-6-273

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“Why did God make a mistake? Why can’t he put me back in Mommy’s tummy and make me out a girl?”—Lament of a six-year-old gender nonconforming boy

The terms gender diverse, gender variant, and gender nonconforming are synonymous and refer to any child whose manifestation of gender in some aspect does not conform to societal norms. This designation would include a child whose dress, mannerisms, toys, or other preferences (ie, gender expression) are inconsistent with what is expected, and also would include a transgender child. Transgender individuals are a subset of this group whose internal sense (ie, gender identity) of their gender is opposite the gender they were assigned at birth.

Finally, it is also important to note that there are other individuals whose identity is not consistent with the gender assigned at birth but who do not identify strictly with the other, seeing themselves between the two ends of a binary scale, or off the scale entirely. Such individuals can be referred to as gender fluid or gender queer. Thus, gender cannot be considered as a binary concept. A critical notion emerging from this more nuanced language of gender is that gender becomes a complex spectrum that more accurately reflects the lived experiences of the children and youth it attempts to portray.

Although “sex” and “gender” often are used interchangeably, for gender nonconforming children, the two categories are not always aligned. Feeling like a girl in a boy’s body, or vice versa, can lead to confusion, low self-esteem, and eventually to serious problems, with transgender youth suffering from a higher prevalence of mental disorders than their cisgendered (ie, living in gender assigned at birth) peers in national samples. (1) Children who do not abide by the prescribed gender norms of their culture often face bullying and other forms of discrimination in preschool. There are also a growing number of studies pointing to the increased risks for suicidality among transgender individuals, (2)(3) who can develop depression and suicidality before even reaching puberty. Finally, we now have a sense of the long-range impacts on health of individuals harassed in schools based on their atypical gender. (4)

Although transgender youth often are grouped with lesbian, gay, and bisexual youth, the issues faced are actually different. Although lesbian, gay, and bisexual refer to identities of sexual orientation that develop generally in adolescence, gender identity (or the internal sense that one is male, female, both, or neither) can develop as early as toddlerhood. In addition, although sexuality and gender are often intertwined, they are distinct entities. Our sexuality has to do with desire, whether we desire people of the same or opposite gender as ourselves. Gender identity, however, is about how we incorporate our culture’s definitions about being male or female with our own internal preferences, desires, and recognition of who we are as a male, female, or...
another gender. Persons who are gender variant or transgender can be gay, straight, or bisexual (that is, they can desire people of any gender); thus, gender and sexual orientation are distinct aspects of their identities.

As a resident in the Pediatric Leadership for the Underserved program at the University of California, San Francisco, Ilana Sherer aligned herself with experts from different fields to address the lack of services for gender nonconforming children. The goal was the delivery of state-of-the-art multidisciplinary care for these children. The Endocrine Society Guidelines, released in 2009, advocate for mental health evaluation, followed by specific hormonal and other interventions: blocking puberty in its early stages; cross-hormone therapy several years later; and optional surgeries as an adult. (5) a protocol that has been used with wide success for three decades in the Netherlands. (6) Adapting this protocol to an American population, Norman Spack, director of the GeMS (Gender Management Service) Clinic at Boston Children’s Hospital, reports a reduction, if not total elimination, of depressive symptoms for children and youth receiving services in their program. Unfortunately, in the Bay Area, physicians providing these hormone treatments to children were few and far between, leaving families of these children and their pediatricians in desperate search of specialty care.

The Bay Area, with its distinct services for gender diverse youth, was already home to national experts. Gender Spectrum, an organization providing resources, training, and support for gender nonconforming youth and their families; Diane Ehrensaft, PhD, expert in gender development and therapist for families of gender nonconforming children; Dimensions, a county multidisciplinary clinic caring for Lesbian, Gay, Bisexual, Transgender, and Questioning youth; and Stephen M. Rosenthal, MD, Professor of Pediatrics and Director of the Pediatric Endocrine Clinics at University of California, San Francisco, came together to create a single consortium within which gender nonconforming children and families, and their providers, could access a full range of services: The Child and Adolescent Gender Center.

The Center opened its doors in 2011 with a dozen families receiving mental health, advocacy, and endocrine services, and expects to double and triple that number in the coming months as services start to be advertised. Currently, the Center has a consortium of >50 providers across Northern and Central California who meet periodically for peer education and interdisciplinary discussions. For patients, the Center offers a parent support group; pediatric, adolescent, and endocrine medical care; mental health referrals and treatment; case management; and legal and educational advocacy services. Education for community primary care pediatricians and a residency curriculum are being developed presently so that this work can be disseminated beyond the Bay Area. Through collaboration with similar programs in Los Angeles, Boston, the Netherlands, and beyond, the Center hopes to define best practices in caring for their population, as well as providing research on a gender acceptance model of care. In addition, members of the consortium are involved in advocacy within their professional societies to create increased visibility for transgender and gender variant children. (Ilana Sherer, MD, Assistant Medical Director, Child and Adolescent Gender Center, San Francisco, CA; Stephen M. Rosenthal, MD, Medical Director, Child and Adolescent Gender Center, Professor of Pediatrics, University of California, San Francisco, CA; Diane Ehrensaft, PhD, Mental Health Director, Child and Adolescent Gender Center, San Francisco, CA; Joel Baum, MS, Education Director, Child and Adolescent Gender Center, Director of Education and Training, Gender Spectrum, Oakland, CA)

SECTION EDITOR’S NOTE: DEALING WITH CONTROVERSY. Sonny and Cher’s daughter Chastity recently released an autobiography as an adult man named Chaz Bono. This action is a sign of transgender issues moving into the mainstream. For the time being, though, gender variance is a topic with which not all health professionals are comfortable. Child advocacy sometimes means confronting the controversial, as in this project. What helps in such cases is to frame the topic in terms of healthy physical, social, and emotional development, and to focus on what the scientific evidence shows will produce the best outcomes for children. Our intent in reporting on this work is not to make a moral statement, but to frame the topic in terms of healthy physical, social, and emotional development, and to focus on what the scientific evidence shows will produce the best outcomes for patients.

(C. Andrew Aligne, MD, MPH)

References

Suggested Reading

Ehrensaft D. Gender Born, Gender Made: Raising Healthy Gender-Nonconforming Children. New York, NY: The Experiment; 2011

Useful Online Resources for Parents Relevant to Topics Discussed in This Article

- http://www.safeschoolscoalition.org/RG-parents_guardians_glbq_youths.html
- http://www.cdc.gov/lgbthealth/youth-resources.htm

Correction
In the article "Encephalitis in the Pediatric Population" in the March 2012 issue (Pediatr Rev. 2012;33:122–133), quiz question #2 has listed the correct answer as "D. Temporal lobes." Based on information in Table 7, "B. Frontal lobes" would be a correct response also.

Clarification
In the article "Cytomegalovirus Infection" in the April 2012 issue (Pediatr Rev. 2012;33:156–163), quiz question #5 about the cytomegalovirus (CMV) therapy that carries the lowest risk of immunosuppression has listed the correct answer as "B. Foscarnet." Immunoglobulin, answer D, has a lower rate of myelosuppression than foscarnet. According to the authors of the paper, the question was supposed to refer to specific antiviral therapy for CMV, and within that group, foscarnet has the lowest myelosuppressive effect. Immunoglobulins are used for prophylaxis and adjunct therapy, but strictly speaking are not CMV-specific antiviral therapy. The editors apologize for the ambiguity.
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