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Glen Elliott, MD, PhD
Editor-in-Chief

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IN THIS ISSUE

Gender Dysphoria in Children and Adolescents

Learning Objectives
After reading these articles, you should be able to:
1. Describe some of the current approaches used to assess and diagnose gender dysphoria in children and adolescents.
2. Discuss some of the issues surrounding the evolution of the current gender dysphoria diagnosis.
3. Summarize some of the current findings in the literature regarding psychiatric treatment for children and adolescents.

Promoting Children's Gender Health: A Guideline for Professionals

Diane Ehrensaft, PhD
Director of mental health, Child and Adolescent Gender Center, associate professor of pediatrics, University of California San Francisco

Dr. Ehrensaft has disclosed that she has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

Monique is an African-American 16-year-old youth from a small city in Southern California who lives with her foster parents. She was referred to a community-based mental health provider because of significant depression and anxiety. In working with her, the therapist discovers that gender worries are at the core of her psychiatric distress.*

Continued on page 2

In Summary

- An interdisciplinary team approach is currently recommended for optimal care of gender-nonconforming children.
- Paying attention to what a child reveals about both gender identity and gender expression can help clinicians determine appropriate treatment.
- Clinical tools such as mirroring and suspension in a state of not knowing can help clinicians understand and treat gender-nonconforming children.

Q&A With the Expert

Gender Dysphoria Diagnosis in Children and Adolescents
Jack Drescher, MD

Clinical professor of psychiatry & behavioral sciences at New York Medical College; member of DSM-5 work group on sexual and gender identity disorders; member ICD-11 World Health Organization working group

Dr. Drescher has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

CCPR: What do we know about how gender identity forms for the average person? When does it emerge, and is there a developmental component to gender identity?
Dr. Drescher: Many people have theorized about gender identity, but I would say that in our current state of knowledge about how one forms a gender identity, the answer is that we don't know.
CCPR: There is also, I understand, an increasing belief that, like with sexual preference, that it's not a binary system, that there are people who identify somewhere along a spectrum between feminine and masculine. Do you agree with that?
Dr. Drescher: Yes, there are modern identities today, people who call themselves "gender queer" or "gender fluid," and new terms are emerging all the time. Even the DSM-5, in discussing the symptom checklist for gender dysphoria, for example, talks about people who feel that they are another gender or some alternative gender.
CCPR: Could you say more about "alternative gender"? What does that mean?

Continued on page 3

Promoting Children's Gender Health: A Guideline for Professionals

Continued from page 1

Assigned male at birth, Monique has felt for several years that she is not male, but female. The therapist, recognizing that she has not been trained as a gender specialist, continues to treat Monique but makes a referral to a specialized gender clinic, where Monique gains access to a clinician who can better understand her core gender issues in the context of her other psychological symptoms.

**The patient's name has been changed for privacy purposes.*

The young woman in the case was referred to our clinic, the University of California San Francisco Benioff Children's Hospital Child and Adolescent Gender Center Clinic, an interdisciplinary program serving the needs of gender-nonconforming children since 2011. Similar clinics are opening across the country. Why the proliferation of these programs within the past decade? Because there has been a need for them. More and more children are expressing to their parents questions, worries, or declarations about their gender. At our clinic, we are referred approximately 20 new patients per month.

Approach to assessment and diagnosis

Our experience is that medical, mental health, educational, and legal expertise all contribute to optimal care of gender patients. Gender clinics typically use a team approach; patients are cared for by a large interdisciplinary team that includes psychologists, psychiatrists, social workers, pediatricians, pediatric endocrinologists, nurse practitioners, educational specialists, and legal advisors.

Let us circle back to Monique. If the gender clinic provider had gone into the assessment equipped only with teaching received in medical or graduate school about gender development, she might have walked out of the session with deep concerns about Monique's mental health. Monique told the provider that, although born a boy, she knew from the time she was 1 year old that "boy" did not feel right. By the time she was 3, she, then a child named Samuel, was borrowing her sister's toys and clothes. By seventh grade, she could no longer live as a boy and announced that she was a girl. She had identified as a girl ever since—not as a transgender girl, but as just a girl. She was sure she had never been male; she had a body with a penis but had a girl self.

The mental health provider's early training might have suggested that Monique was delusional, that she had failed to receive the gender socialization that would have allowed her to accept her boy body and her male sex assignment, and that the traumas and attachment disruptions in her early life had set her askew in her—or rather, his—normative gender development.

Instead, the assessment uncovered the following: Monique had a very early history of female gender identification; it had never wavered; it went far beyond just wanting to do girl things and extended to the very core of her being. Corroborated by her foster parents' report, she had not said, "I want to be a girl" but rather, "I am a girl"—this certainty is one of the signifiers that differentiates transgender children from children who are simply exploring their gender identity. From an early age, Monique had been distressed about having a penis (another signifier). Puberty was highly stressful for her, if not traumatic, as her body betrayed her by sprouting male secondary sex characteristics.

The mental health team member's retraining as a gender specialist assured her that there was nothing delusional about Monique. She suffered from gender stress, distress, and dysphoria. More importantly, she met all the criteria indicating that she was a transgender girl, including the signifiers listed above and a persistent, consistent, and insistent declaration of her female gender identity from an early age. The cure for Monique's gender stress (a stress that met all the requirements for a DSM-5 diagnosis of gender dysphoria), along with treatment for her generalized anxiety, was to facilitate her full transition to her eloquently articulated and authentic gender self—and that would be a female self.

Given all the information about Monique's history and a letter of support from her current therapist—a requirement of the clinic before a youth can be approved for any kind of medical treatment in gender care—the mental health provider recommends that Monique would benefit from receiving estrogen at this time to better align her body with her psyche.

The gender-affirmative model

In order to improve our understanding of transgender issues, the NIH funded a four-site longitudinal study of

Continued on page 3

Promoting Children's Gender Health: A Guideline for Professionals

Continued from page 2

the physical and mental health effects of puberty blockers and cross-sex hormones. One concrete product of that collaborative effort has been to outline the parameters of the gender-affirmative model, which informs best practices for serving these nonconforming children and adolescents (Hidalgo MA et al, *Human Development* 2013;56(5):285–290).

Using the gender-affirmative model (see accompanying list on page 8), we define gender health as a youth's opportunity to live in the gender that feels most real and/or comfortable; or, alternatively, a youth's ability to express gender with freedom from restriction, aspersion, or rejection. To that end, interdisciplinary treatment goals are as follows: 1) facilitating an authentic gender self, 2) alleviating gender stress or distress, 3) building gender resilience, and 4) securing social supports (Ehrensaft D. *The Gender Creative Child.* New York, NY: The Experiment; 2016). We also recognize that to think clinically is to first think developmentally. For example, at age 4, the child exploring gender is in the stage of magical thinking where frogs can become princes (or princesses) and old genitals can be easily traded for new ones at the pharmacy. This situation is very different than the teenage patient who is in the throes of identity consolidation vs. confusion, and who now has gender as one more aspect of identity to negotiate.

Treatment

When it comes to treatment, a single guiding light pertains: Discovering a child's authentic gender is not for us to say but for the child to tell. The major challenge is to decipher what the child is showing us in word, affect, and action about two aspects of gender: gender identity and gender expression. Gender identity is quite basic: Who am I—male, female, or other? Gender expression refers to how I present my gender to the world—the toys I like to play with, the children I like to have as friends, the activities I like to do, the clothes I like to wear, and so forth. This is not to be confused with a child's sexual development, which is a separate although sometimes criss-crossing developmental track—a confusion that typically takes the form of, "He likes to wear makeup and jewelry, so he's going to be gay." That may be true, but there are other potential meanings of that behavior. He may be trying to communicate that he is not the boy we think he is, and that he is in fact a girl who likes makeup and jewelry. Or, he may be a boy who simply likes jewelry and makeup, period. Nature, nurture, and culture all come together to create the core of the child's authentic gender self. We must keep all this in mind as we sharpen our translation skills to better understand the messages children deliver to us about their gender.

How can we as clinicians better understand and treat these gender-nonconforming children? In general, the clinical tools needed are no different from the ones we learned to use with any child: listening, mirroring, play, interpretation, suspension in a state of not knowing, monitoring our countertransference feelings, applying cultural sensitivity, and collaborating with parents and other professionals. But two of those tools, mirroring and suspension in a state of not knowing, have proven to be the most critical in this population. Mirroring helps because the greatest assault on a gender-nonconforming child's psyche is the distorted gender image reflected back to the child based on the other person's perceptions, needs, or beliefs rather than the child's inner knowing of the self. Suspension in a state of not knowing is important because it shows the child that you are not being judgmental, and that you are willing to let the child take the lead as you help in understanding the child's gender identity.

Continued on page 8

Expert Interview

Continued from page 1

Dr. Drescher: It means that some people identify as neither male nor female; they reject the binary concept of being male or female.

CCPR: So, they are gender neutral in some sense.

Dr. Drescher: "Neutral" might not be the right word, although it is possible some people might describe themselves that way. People come up with all different types of descriptions that reflect how they perceive themselves, how they subjectively feel.

CCPR: What's your sense of that perception of gender self? Does it solidify at some point, or does it evolve over time? Obviously, there must be social pressures as well.

Dr. Drescher: Again, we really don't have a good research base from which to draw an answer. We know, for example, in older adolescents and adults who present with gender dysphoria, that in many cases—in most cases, perhaps—the transgender identity seems to be fairly solid and not amenable to trying to change the person's feelings or change the person's mind. That's pretty much why, since the middle of the 20th century, the standard of care increasingly has been to help a person make physical changes to accommodate the felt gender identity.

CCPR: That approach is a fairly major change, though, from the psychiatric perspective, correct?

Dr. Drescher: Well, in the sense that the gender diagnosis—what used to be called transsexualism and gender identity disorder—actually first appeared in 1980 in DSM-III. Prior to that, Richard Green, a pioneering gender theorist, did a survey in the 1960s of about 400 physicians in different specialties (Green R. Attitudes toward transsexualism and sex-reassignment procedures. In *Transsexualism and Sex Reassignment,* eds. R. Green & J. Money. Baltimore: The Johns Hopkins University Press, pp. 235–251;1969). At that time, most medical professionals didn't believe in offering gender transition services, but I believe that now the majority of clinicians and psychiatrists have moved to supporting the decision to transition.

Continued on page 4

Expert Interview

Continued from page 3

CCPR: From your experience, is there an age at which there's a consensus that gender identity is sufficiently stable that the person's desire should be followed?

Dr. Drescher: This is still an area of controversy. There are existing standards of care for prepubescent children, for example, who present as transgender who are being given puberty-suppressing medications so that they do not enter into the puberty of the gender that they don't feel themselves to be (Hembree W et al. Endocrine treatment of transsexual persons: An Endocrine Society clinical practice guideline. *J. Clinical Endocrinology and Metabolism* 2009;94(9):3132–3154). Puberty suppression is a medical intervention that has been around for about 20 years. It was started by the Dutch Gender Clinic, but it's being done here in the U.S. too. Some remain opposed to puberty suppression, but those who do it see it as a reversible technique. Some prepubescent children who present as transgender desist (meaning they change their minds about their gender)—they are called "desisters"—and no longer feel gender dysphoria somewhere in the age range of 12 to 14. For such individuals, evidence suggests that one can stop the puberty suppressors without any known adverse effects, except for late-onset puberty.

"Unlike a diagnosis such as depression, where we have interventions to rid the patient of symptoms, in the case of gender identity disorder, the intervention is to change the person's body, not the person's mind."

Jack Drescher, MD

CCPR: And the contrary view?

Dr. Drescher: Others are opposed because we don't know definitively about the long-term effects of puberty suppressors. Still, the medications have been in use for 20 years in the Netherlands, and they haven't seen any major problems with them.

CCPR: So potentially one could make interventions relatively early?

Dr. Drescher: Yes, but only these types of medical interventions. Because we're dealing with prepubertal children, no one is recommending cross-sex hormone treatments or gender surgery.

CCPR: So they are just delaying pubertal changes?

Dr. Drescher: Right. So, the question becomes with adolescents, when is the appropriate time to do more? Some places are comfortable with intervening at age 16; others won't do anything until age 18; some places are now beginning to provide cross-sex hormones at a younger age, feeling confident that the child is not going to change his or her mind. Again, these are areas of controversy. The sample sizes are very small, and there hasn't been a lot of systematic research to really say what the correct answer is. So people are in boots-on-the-ground situations, responding to exigent circumstances.

CCPR: There have been some major controversies—even outright scandals—within this area because of work that initially suggested gender identity was very much an environmentally determined phenomenon. Do you believe that came out of more of a psychodynamic formulation initially, or were there other factors?

Dr. Drescher: Absolutely, dynamic formulations had an influence. I don't keep track of them, even though I'm a psychoanalyst, because I'm not really interested in formulaic theories—other than perhaps learning Freud's oedipal complex from a historical perspective. Personally, I don't see much of a point in delving into speculative dynamics that can neither be proven nor disproven. One of the earliest theories of gender identity formulation was put forth by John Money, a psychologist who was not an analyst. In the 1950s, Dr. Money was working with children who were born with intersex conditions that we today call disorders of sex development. His theory was that, if a baby was born with ambiguous genitalia, a gender assignment had to be made right away, and the parents had to believe in the assignment, or else the gender assignment would not "take," a process that supposedly was complete by age 3. Few people today accept Money's theory. Although there have certainly been cases of children with intersex conditions whose gender identity developed in a manner that conformed to this theory, we now know that other children who were given gender assignments that the parents may have believed in nevertheless still developed gender dysphoria.

CCPR: Can you explain the rationale for the change from "gender identity disorder" in DSM-IV and DSM-IV-TR to "gender dysphoria" in DSM-5? How does that reflect on where psychiatry is moving?

Dr. Drescher: I was on the DSM-5 work group on sexual and gender identity disorders. More specifically, I was on the sub–work group for gender identity disorders. The challenge we faced was how to find a balance between the need to continue providing access to care for people with gender dysphoria vs. giving people a psychiatric diagnosis that was stigmatizing. So, when all the appointments for our work group were completed in 2008, there was a lot of press from the lesbian, gay, bisexual, and transgender community. There were people who argued that the diagnosis should be taken out of DSM altogether, just as homosexuality was removed in 1973 from the DSM-II. The perception, which is correct in my opinion, was that removal of homosexuality from the DSM was a major factor in destigmatizing it in the general culture (Drescher J, *Archives of Sexual Behavior* 2010;39:427–460). So many activists felt that the same thing should be done with gender identity diagnoses.

CCPR: But the work group disagreed?

Dr. Drescher: Taking homosexuality out of the DSM—that is, declaring that it was not a disorder—was fine because mental health or medical "treatment" became a non-issue. With a gender diagnosis, in contrast, accessing care such as hormone treatment, surgery, or even mental health services requires a diagnosis. In addition, some transgender advocacy organizations told

Continued on page 5

Expert Interview

Continued from page 4

our work group privately that they didn't want the diagnosis removed from the DSM because of legal issues. For example, in the prison system, transgender inmates have sued to gain access to care based on the argument that this is a medical condition requiring treatment and that denying inmates needed medical treatment is a form of cruel and unusual punishment. And, indeed, such lawsuits have been increasingly successful because of the actual DSM diagnosis.

CCPR: Can you give us a specific example?

Dr. Drescher: Sure. In May of 2014, the U.S. Department of Health and Human Services reversed an outdated 1981 ruling that classified medical treatment for gender reassignment as "experimental." Classified as such, these treatments were not reimbursable by Medicare. This reversal was based, in part, on the reasoning that gender identity disorder in DSM-IV-TR and gender dysphoria in DSM-5 represented the view of American psychiatry that gender identity disorder/gender dysphoria is a medical condition (see http://www.hhs.gov/dab/decisions/dabdecisions/dab2576.pdf, March 22, 2015). In my opinion, our work group's decision to prioritize access to care by keeping the diagnosis in the DSM was vindicated.

CCPR: How did the work group resolve these various perspectives?

Dr. Drescher: The group made changes in the diagnostic categories (Zucker KJ et al, *Archives of Sexual Behavior* 2013;42:901–914). For example, there was an effort to tighten diagnostic criteria so that just having some gender-atypical behavior or gender-atypical interest would not be sufficient in and of itself for a diagnosis. Actually, the term "gender dysphoria" has a long-standing history within the treatment community for the psychological experience of not being comfortable with one's gender. So, the word "disorder" was taken out of the name and replaced with gender dysphoria. Most people following the DSM-5 revision process were quite happy with the name change.

CCPR: What do you predict for the future?

Dr. Drescher: I'm a member of the World Health Organization working group that's revising ICD-11, which is scheduled to come out in 2018. As you know, the DSM is a catalogue strictly of psychiatric disorders, and whether a diagnosis remains in or out is a binary decision. The ICD is not so binary, because it includes all diagnoses that physicians and other health care professionals use, regardless of specialty. That means ICD can do something DSM cannot: Our work group recommended moving the gender diagnosis from the mental disorder section and putting it somewhere else. The current suggestion is to create a new section for ICD-11 that is medical, not psychiatric, called "Conditions Related to Sexual Health." Gender issues would be called "gender incongruence" and be part of that new chapter (Reed GM et al, *World Psychiatry* 2016;15:205–221). So that removes the mental health stigma but retains a treatable diagnosis that will enable access to care, but it will not be categorized as a mental disorder.

CCPR: So, in some not-too-distant future, mental health professionals might focus not on gender identity as a disorder, but on symptoms arising from the perception of being in the wrong body.

Dr. Drescher: Right, which is really how the condition has been treated. During the DSM-5 revision process, we realized that gender identity disorder was a very unusual psychiatric diagnosis. Unlike a diagnosis such as depression, where we have interventions to rid the patient of symptoms, in the case of gender identity disorder, the intervention is to change the person's body, not the person's mind. That was unique in DSM.

CCPR: Are there precedents in ICD for creating such a diagnosis?

Dr. Drescher: Yes, ICD already includes some diagnoses that are not medical conditions, but do sometimes come to medical attention: Single spontaneous delivery (O80) and menopausal and female climacteric states (N95.1) both are phenomena that were "medicalized" long ago to provide access to care despite being natural rather than "pathological" life events.

CCPR: Returning to child psychiatry, if a clinician has a prepubertal child who begins to discuss discomfort with his or her gender designation, what would be a reasonable response? How would a clinician approach that?

Dr. Drescher: Gender dysphoria is not a commonplace clinical presentation, meaning that most clinicians will not have much exposure to working with anyone who presents with it. Potentially, that is a problem: It can create a kind of fascination on the clinician's part without the needed knowledge base of how to be helpful. In such cases, clinicians too often make it up as they go along. Clinicians without experience in working with gender issues who plan to do it on their own are, in my opinion, doing

Continued on page 7

Clinical Resources for Gender Issues

Resource	Website	Description
Endocrine Society	https://www.endocrine.org/	Organization that represents professionals from the field of endocrinology.
World Professional Association for Transgender Health (WPATH)	http://www.wpath.org/	Nonprofit, interdisciplinary professional and educational organization devoted to transgender health. Regularly publishes guidelines for standards of care.

Research Updates IN PSYCHIATRY

Section Editor, Bret A. Moore, Psy.D, ABPP

Dr. Moore has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

OCD

SSRIs May Work More Quickly in Pediatric OCD Than You Realize

REVIEW OF: Varigonda A et al. *Journal of the American Academy of Child & Adolescent Psychiatry* 2016; ahead of publication.

STUDY TYPE: Systematic literature review and meta-analysis

The pharmacological treatment of obsessive-compulsive disorder (OCD) for adults is pretty well worked out. Selective serotonin reuptake inhibitors (SSRIs) are the gold-standard treatment. We have multiple randomized, placebo-controlled trials to back this up. However, we know less about medication treatment of OCD for children.

In a prior research update, we reported that SRIs and CBT are the treatments of choice for pediatric OCD (*CCPR,* March 2015). For this meta-analysis, researchers dug deeply into the SRI literature to answer five practical questions about the pharmacological treatment of childhood OCD: 1) How quickly do SSRIs work; 2) Are higher doses of SSRIs more effective; 3) Is one SSRI better than another; 4) Are SSRIs better than clomipramine; and 5) Are there differences between the response of children and adults to SSRIs?

To answer these questions, PubMed was mined for randomized controlled trials that compared SSRIs or clomipramine to placebo and used the Children's Yale-Brown Obsessive-Compulsive Scale as an outcome measure. Trials had to be double-blinded, and participants could not have received behavioral therapy while engaged in pharmacotherapy. Nine studies totaling 801 children were analyzed.

RESULTS

Eighty-five percent of the improvement on SSRIs occurred within the first two weeks and topped out at around week 6. Maximum dosing of SSRIs revealed no therapeutic benefit over lower doses. There were no differences between the effectiveness of fluoxetine, fluvoxamine, sertraline, and paroxetine. Clomipramine was statistically better than SSRIs. And there were no significant differences between the level of response to SSRIs in children and adults.

CCPR'S TAKE

This meta-analysis reveals some important information about treating pediatric OCD. Most notable is the relatively rapid onset of therapeutic benefit. This challenges the notion that we must wait several weeks to determine efficacy. Other findings, however, are suspect. For example, the lack of a dosing effect may be a result of limited pediatric trials with insufficient participants to adequately compare fixed doses. And, even though clomipramine fared better than the SSRIs, this could easily be because it was the first OCD medication on the market and hasn't been put through the wringer with treatment-resistant cases, as the SSRIs have been. Also, the relative increased side effect profile of clomipramine must be balanced against possible increased benefits.

PRACTICE IMPLICATIONS

The biggest clinical takeaway is that you should be looking for improvements in your OCD pediatric patients earlier than you may previously have planned.

AUTISM

Metformin Use in Autistic Children Taking Atypical Antipsychotics

REVIEW OF: Anagnostou E, Aman MG, Handen BL, et al. *JAMA Psychiatry* 2016;73:928–937.

STUDY TYPE: Double-blind, placebo-controlled, randomized clinical trial

Atypical antipsychotics are commonly used to reduce irritability and agitation in children with autism spectrum disorder (ASD). Although effective, these medications lead to weight gain and other metabolic problems. Strategies like tailored diet plans and exercise can help, but they are often not enough. If not interrupted early, for many, continued weight gain will lead to diabetes, hypertension, and heart disease later in life.

A promising approach for managing antipsychotic-associated weight gain is metformin. Through its ability to suppress glucose production in the liver, metformin stabilizes blood sugar levels, reduces hunger, and promotes fat loss. Previous studies with adults reveal that metformin can indeed stop or reverse weight gain associated with the use of atypical antipsychotics. Similar data exist for children as well, but we know little with respect to those with ASD. To explore this issue, researchers randomized 61 children with ASD between the ages of 6 and 17 to receive metformin (n = 29) or placebo (n = 32). Nearly all were on either risperidone (60%) or aripiprazole (38%). The children were tracked for 16 weeks for changes in body mass index (BMI) and adverse events. For kids between 6 and 9, metformin and placebo were initially titrated to a maximum of 500 mg twice daily (1,000 mg/d average); older children received up to 850 mg twice daily (1,587 mg/d average).

RESULTS

Metformin beat placebo, but not dramatically so. Patients on placebo had no weight loss over the 16-week trial, whereas those on metformin had an average decrease in BMI of 5%. Three of the 28 kids on metformin (11% of the sample) achieved an 8%–9% BMI reduction, but four children on metformin dropped out due to increased agitation, and one dropped out because of sedation. Gastrointestinal (GI) distress was also noted in 25% of those on metformin, versus less than 7% on placebo.

CCPR'S TAKE

These results are consistent with previous research on metformin and weight gain. It's certainly useful to have additional data for our youngest patients with ASD. However, this is a small study, making it difficult to generalize. GI discomfort is a known side effect of metformin and is often cited as a reason for early discontinuation. It's important to remember that children with ASD have a difficult time reporting physical discomfort: some may have suffered through 16 weeks of GI distress with no one the wiser.

PRACTICE IMPLICATIONS

Metformin may be a reasonable choice for reducing weight gain in your patients with ASD who need to be on an atypical antipsychotic, but any weight loss is likely to be rather small. If you are unsure whether metformin is appropriate for your patient, consult with an endocrinologist.

CME Post-Test

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Below are the questions for this month's CME/CE post-test. This page is intended as a study guide. Please complete the test online at www.TheCarlatChildReport.com. Note: Learning Objectives are listed on page 1.

1. Treatment of prepubertal patients who believe their body does not accurately reflect their true gender identity may include: (LO #2)
   [ ] a. Gender-altering surgical procedures
   [ ] b. Intensive psychotherapy to change their gender perception
   [ ] c. Puberty-suppressing medications to delay the onset of puberty until it is clear that the patient's discomfort does not desist in early adolescence
   [ ] d. Cross-hormonal treatments to begin the transition to the other gender

2. The gender-affirmative model includes all of the following elements except: (LO #1)
   [ ] a. Gender variations are not disorders
   [ ] b. Gender pathology lies more in the culture than in the child
   [ ] c. Gender presentations are diverse and vary across cultures
   [ ] d. Gender is binary and constant

3. Which of the following is a key therapeutic activity for clinicians treating patients with gender dysphoria? (LO #1)
   [ ] a. Careful history-taking of parental attitudes and child-rearing practices
   [ ] b. Mirroring and suspension in a state of not knowing
   [ ] c. Cognitive behavioral therapy to help change self-perception
   [ ] d. Pushing back about gender attitudes to assess strength of patient's conviction

4. The change from gender identity disorder in DSM-IV to gender dysphoria in DSM-5 suggests that: (LO #2)
   [ ] a. The possession of a gender identity different than that assigned at birth is not a disorder but may lead to emotional or behavioral disturbances that require care
   [ ] b. Anyone wanting to change gender must have a psychiatric disorder
   [ ] c. Gender identity is a psychological rather than a physical or biological issue
   [ ] d. The major focus of treatment should be on helping patients accept their current gender

5. According to a recent study on SSRIs and pediatric OCD, 85% of children showed improvement on SSRIs within which time period? (LO #3)
   [ ] a. 2 weeks [ ] b. 4 weeks [ ] c. 8 weeks [ ] d. 10 weeks

Expert Interview

Continued from page 5

the patient a disservice. It really requires, I think, some exposure and some knowledge. For those who want to learn about care, or simply more about the condition, there are resources available (see the table on page 5).

CCPR: So it's a good idea to refer to an expert on the topic with clear cases. But what about a situation where a kid is saying, "I don't want to be a boy; I want to be a girl"? Does every such case merit a referral?

Dr. Drescher: Such a child may not be gender-dysphoric; not everybody who has an interest in another gender is gender-dysphoric. Some children may express such a desire because they perceive there are more social advantages to being a member of the other gender. Or they may have gender-atypical interests and think that's the only way to get access to the toys or garments of the other gender. Even so, as I said, this is a highly specialized kind of treatment for a very small patient population; I would recommend that if you don't know anything about evaluating such children, seek out consultation with someone who does.

CCPR: What about the clinician's role in working with the parents and family? It's not always easy for caregivers to accept a difference they're not counting on or prepared for, and I think many parents have little exposure to someone who is gender-atypical or transgender.

Dr. Drescher: Right. With children and adolescents, you have to work with the parents and sometimes the extended family and social environment too. It is vital that the whole family be involved. In these instances, parents need guidance to help them better understand what is happening and learn about resources they can use. And, again, this is another reason for retention of diagnostic codes that will allow families to access care. We also encourage parents to reach out to other families. There are organizations such as PFLAG, which has national and local chapters, that connect families who have gay children and transgender children (https://www.pflag.org/).

CCPR: Thank you, Dr. Drescher, for providing this valuable information.

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This Issue's Focus:
Gender Dysphoria in Children and Adolescents

Next Time in *The Carlat Child Psychiatry Report:*
Autism in Children and Adolescents

Promoting Children's Gender Health: A Guideline for Professionals

Continued from page 3

Basic Premises of the Gender-Affirmative Model

1. Gender variations are not disorders
2. Gender presentations are diverse and varied across cultures, requiring cultural sensitivity
3. Gender involves an interweaving, over time, of biology; development and socialization; and culture and context
4. Gender may be fluid; it is not always binary
5. If present, individual psychological/psychiatric problems are more often than not secondary to negative interpersonal and cultural reactions to a child
6. Gender pathology lies more in the culture than in the child

CCPR VERDICT: Whether you are a general practitioner or a gender specialist, your gender-nonconforming child or adolescent patient will rely on you to use the two primary skills well—mirroring and the ability to remain suspended in a state of not knowing. If you do, you will find a child blossoming in gender discoveries, protected from the risks of anxiety, depression, self-harm, and suicidality that might develop in the absence of robust gender supports (Grossman AH and D'Augelli AR, *Suicide and Life Threatening Behavior* 2007;37(5):527–537; Roberts AL et al, *Pediatrics* 2012;129(3):410–417).

Isn't that what we would want for all our patients?