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Opinion

A Nurse and Parent's Perspective on the Medical/Nursing Approach to Transgender Youth

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I am a registered nurse in the maternal/child/obstetrical area. I have often encountered families who are non-traditional, such as two mothers, or two fathers plus a surrogate, however I have not yet had the pleasure of caring for childbearing families where one or more of the parents were transgender. However, I knew there were reports of transmit (men who were assigned female at birth) who carried and gave birth to their own children, and in some cases even breast-fed their infants. I am now an assistant professor teaching women's health/obstetrics and have been careful to include LGBTQ and other alternative family arrangements in my teaching material. I even began to work with a team of professors to include LGBTQ and sexual health across our nursing school curriculum. This is especially pertinent as we are located in San Francisco, which has a large community of LGBTQ individuals.

Four years ago, after I had begun this work, my child who assigned female at birth told me that he was not a girl. He was nine. I had begun to see signs of this in the year prior as he began to receive education around puberty and realized the reality that he could not accept these particular changes in his body. He socially transitioned immediately (short hair, masculine clothing, pronoun and name change). We were fortunate in that we were part of a medical system that had a gender reassignment services, and more importantly a youth gender program. Unfortunately, it was not a comprehensive youth gender clinic with all services in one location, which was the case with the adult gender services in this system. We started seeing a therapist who assessed

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him and affirmed him as a transgender boy. He was able to express his issues around his gender and was given the diagnosis of "gender dysphoria", which is defined as the stress related to their body not matching their identity. Specifically the DSM-5 criteria states.

In children, gender dysphoria diagnosis involves at least six of the following and an associated significant distress or impairment in function, lasting at least six months.

- A strong desire to be of the other gender or an insistence that one is the other gender
- A strong preference for wearing clothes typical of the opposite gender
- A strong preference for cross-gender roles in make-believe play or fantasy play
- A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender
- A strong preference for playmates of the other gender
- A strong rejection of toys, games and activities typical of one's assigned gender
- A strong dislike of one's sexual anatomy
- A strong desire for the physical sex characteristics that match one's experienced gender

American Psychological Association [1], this diagnosis was necessary for him to begin to receive medical therapy. It was also useful in obtaining legal documentation of his new name and gender marker (in the form of a passport at this point). Care providers who knew him pre-transition had, understandably, to go through the same process his friends and family did in switching to using "he" and his new name, though they did so successfully. Unfortunately, despite the fact that his medical record was changed to reflect his gender and his new name, there were care providers who saw the gender information in his record and misgendered him as "her". At one point he opted to enroll in a study of transgender youth and their physiology, and in that medical system (different from the system we use), they still identified him by his birth name and gender on paper work, and one tech administering a test persistently used "she", despite me correcting her every time she said it. Ironically this was within a medical group that did house a comprehensive youth transgender clinic, and when I wrote a letter to the medical doctor in charge of the study she was appalled and mortified. More recently my son was roomed with a female patient when admitted to the hospital, because the staff felt that this was somehow more "okay" than rooming her with another male, or more appropriately giving him and the female patient separate rooms - even if it meant that they had no roommate. My son continues to be anxious about being misgendered at medical or psychiatric appointments and is especially stressed by physical exams which involve checking for puberty signs (a peak in the underwear). This is consistent with the findings of one qualitative study which described both medical and mental health care providers being unsupportive and lacking the tools to know how to best care for transgender youth [2].

I belong to a community of parents of transgender children and these stories are not uncommon. These children are vulnerable, their emotional state is volatile. They already feel wrong in their bodies, many have comorbidities as a result of their dysphoria, including body dysmorphic disorder, depression, and significant anxiety. This is consistent with current research [3,4]. As nurses, we can do better, especially in the hospital. We should be advocates, making positive change for these kids. Russell and colleagues found that the simple intervention of using the correct name decreases the risk of suicide attempts and symptoms of depression and suicidal thoughts (2018). In line with that, specific recommendations include changing intake assessments to reflect questions such as "what name and pronoun would you like me to use today?" The inclusion of "today" allows for those people who are considered gender fluid or gender queer, a non-binary gender identity, whose pronoun of preference may change from day to day. Preferred names and pronouns should be used despite what is on the child's medical record. Appropriate room assignments should be made, private rooms if possible, otherwise trans males should be with other males, and trans females with other females. Care providers should never "out" a trans person, that is reveal their transgender status, to anyone who does not need to know. The sad irony is that transgender children are most commonly hospitalized for psychological reasons, and therefore their dysphoria is only worsened when these events occur. One small study looks at affirmational care - where the children are completely accepted in their gender identity - and despite the small sample size of eight participants, they found significantly decreased depression scores, and there were indications that other positive mental health outcomes might be significant in larger studies [5], which supports what I am putting forward here.

On an additional note, transgender status is completely separate from their sexual preference. Some transboys will be gay, and be attracted to boys, and likewise transgirls can be attracted to girls, identifying as lesbian. Therefore, avoiding any assumptions for transkids is just as important (and maybe more so) as it is for cisgender (where gender identity is in alignment with birth assigned sex) children.

As a last request, any nurse who finds themselves unable to pack away bias or prejudice towards LGBTQ kids of any variety should be able to recognize that in them self and request not to be assigned to care for that child and their family. While we would all like to think we don't carry bias, the truth is we all come into our work with whatever background experiences and perspectives that we have. Some people find it easier than others to set those aside than others. However, it does more harm than good if you accept the care of one of these children, and your bias leaks into your care, even in subtle ways. So please be willing to accept that and know that the best thing you can do is removing yourself from caring for them.

References

1. American Psychological Association (2016) What is gender dysphoria? American Psychological Association, Massachusetts, USA.
2. Schimmel-Bristow A, Haley SG, Crouch JM, Evans YN, Ahrens KR, et al. (2018). Youth and caregiver experiences of gender identity transition: A qualitative study. *Psychology of Sexual Orientation and Gender Diversity* 5: 273-281.
3. Olson J, Schrager SM, Belzer M, Simons LK, Clark LF (2015) Baseline physiologic and psychosocial characteristics of transgender youth seeking care for gender dysphoria. *J Adolesc Health* 57: 374-380.
4. Russell ST, Pollitt AM, Li G, Grossman AH (2018) Chosen name use is linked to reduced depressive symptoms, suicidal ideation, and suicidal behavior among transgender youth. *J Adolesc Health*.
5. Austin A, Craig SL, D'Souza SA (2018) An AFFIRMative cognitive behavioral intervention for transgender youth: Preliminary effectiveness. *Professional Psychology: Research and Practice* 49: 1-8.