

Gender Identity Issues in Children and Adolescents

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ABSTRACT: Gender Identity Disorder (GID) is an identifiable morbidity which is manifest by a child or adolescent as a belief that they are born into the body of the opposite sex. When this occurs in the young child, the gender confusion resolves in the majority of patients by the time puberty ensues. Currently a number of professional societies have developed recommendations that these young children be encouraged to change their gender permanently prior to puberty. A review of current literature and research provides no scientific support for this concept. However, scientific literature does provide for the development of a logical set of guidelines to help these troubled patients such that they might avoid the known morbidities associated with premature decisions to change their gender with hormonal manipulation and surgical procedures. For the small number of patients with persistence of GID into young adulthood, specific guidelines, based on clinical research, and the body of existing medical knowledge are presented. The American College of Pediatricians acknowledges the difficulties faced by children and families confronted with GID, and promote developmentally appropriate, evidence-based practices to support these children into late adolescence or young adulthood when resolution or treatment can be ethically supported.

The determination of the sex of an infant is usually straightforward, noted and recorded at the moment of birth, based on appearance of the external genitalia. For the majority of the world's cultures, there is an expectation that a child is born either a boy or a girl and that life proceeds. There are well-known rare variations in appearance of the external genitalia. These are caused by inborn errors of metabolism or inherent refractoriness to hormones expected to bring about complete virilization of the genital anlagen. Male and female pseudohermaphrodites have been well-studied in terms of their emotional adaptation to the physical changes that were innate and the surgical manipulations aimed at creating appearance and function of the genetically determined gender.¹

The term "Gender Identity Disorder" (GID) was coined by Dr. Kenneth J. Zucker to describe patients who believe they were born into the body of the wrong sex. This diagnosis has held Diagnostic and Statistical Manual of Mental Disorders (DSM) status since 1984. GID is much more common in young children and resolves in the vast majority (80-98%) of these patients once

they reach adolescence and experience the effects of their innate sex hormones.² Psychological co-morbidities are numerous in these patients and need to be fully addressed by mental health professionals who have no social or politically-driven agendas to "recruit" the patient to a specific sexual orientation. Fluidity of a child's future erotic orientation leaves the child vulnerable to such manipulation.

In cases of GID, typically the parents or the primary care provider may note that the

patient acts in ways that are stereotypic of the opposite sex. This might be a boy playing with and dressing up female dolls and wearing female clothing more typical of adult women, or it might be a girl who cuts her hair short, wears boys clothing and exhibits "tough guy" play. These children often experience a great deal of negative feedback from their families, other adult caretakers, and from their peers. Many of these children come from families where there is significant psychopathology in one or both parents.

At present, most of these “gender confused” children either work through and resolve their opposite-sex role playing themselves, or bury their dysfunction and compensate with other maladaptive behaviors.² These children are generally discontent during this portion of their lives. When gender-confused children reach adolescence most XY individuals feel their maleness and most XX feel female. They often, however, continue to experience same-sex attraction and live lives that range from completely psychologically healthy to completely pathologic. They may also live a heterosexual or bisexual lifestyle with or without some degree of psychological morbidity.^{2,3,4,5}

With the advent of synthetic hormone therapy utilizing estrogenic and androgenic preparations, patients could be theoretically “transformed” from one sex to another. With refinement of genital and plastic surgical techniques, some degree of satisfactory physical change can be made to organ systems that are not transformed with hormone therapy alone. In the 1970’s, John Money, a PhD psychologist at Johns Hopkins, wrote much on the subject of sex change in adults based on the theory that one’s sexual orientation was completely malleable in the hands of social forces.⁶ A critical review of the dismal psychological outcomes of his adult patients who had been transformed both hormonally and surgically has discredited his theories.⁷

Recently, there has been a flurry of activity to address the gender-disordered patient. There are recommendations from some professionals to encourage the child’s gender-atypical behavior inside and outside the home (i.e. school) and to create an environment of “tolerance for different lifestyles” by encouraging cross-dressing and by teaching students from kindergarten upward that human sexual orientation is just a continuum and maleness and femaleness are arbitrary endpoints.⁸ There are no studies to support this concept. The adolescent brain has been shown to mature

progressively and not necessarily in the same fashion in all patients.⁹ Thus, allowing a pre -to-mid adolescent the option of making such irreversible life-changing decisions is a grave mistake.

In an effort to provide wisdom, the Endocrine Society, in conjunction with the Lawson Wilkins Pediatric Endocrine Society, has published a position paper.¹⁰ This is clearly a step in the right direction, but it is colored by a few unequivocal recommendations that are founded on principles without evidence, reflecting, perhaps, personal bias and not sound science.

It is the position of the American College of Pediatricians that young children who present with a complaint of feeling as if they were born into the body of the opposite sex, or who exhibit behaviors predominantly identified with the opposite sex be evaluated extensively, along with their nuclear families. This should be done by a competent mental health professional who can sort out and address psychopathology and who does not have a bias to recruit the patient to an opposite gender identity. In addition, the nuclear family should be allowed to establish limits on when and where cross-gender activity is displayed. There is published evidence that psychotherapy can realign the patient to heterosexual orientation if that is what the patient and family wish to do.¹¹

For those patients who persist into adolescence with disordered gender identity, no medical treatment should be instituted before the patient reaches at least Tanner stage II of true puberty. For patients experiencing significant psychological morbidity or unbearable social pressure, it *may*¹² be reasonable at that point to temporarily arrest further pubertal development with the use of gonadotropin super-agonist therapy since all effects of such an intervention are reversible when it is discontinued (including accretion of bone mineral density). This course of action

should only be undertaken in the absence of psychopathology in both the patient and family.

Institution of cross-gender sex steroid therapy should be discouraged and certainly not be instituted until the age of consent, 18 years, since such therapy can cause irreparable changes and can be harmful, if certain parameters are not monitored (i.e. Prolactin levels in male-to female patients

who receive estrogen therapy, and lipid levels in female-to-male patients on androgen therapy).¹³ Similarly, surgical changes should also be discouraged and not considered until the age of consent. Given the established evidence of significant morbidity in those patients who do undergo hormonal transformation and eventual surgery,^{14,15,16,17} psychotherapy should be continued throughout adult life.

Principal Author: Quentin Van Meter, MD, FCP, FAAP

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