OBJECTIVES: To describe the patients with gender identity disorder referred to a pediatric medical center. We identify changes in patients after creation of the multidisciplinary Gender Management Service by expanding the Disorders of Sex Development clinic to include transgender patients. METHODS: Data gathered on 97 consecutive patients <21 years, with initial visits between January 1998 and February 2010, who fulfilled the following criteria: long-standing cross-gender behaviors, provided letters from current mental health professional, and parental support. Main descriptive measures included gender, age, Tanner stage, history of gender identity development, and psychiatric comorbidity. RESULTS: Genotypic male:female ratio was 43:54 (0.8:1); there was a slight preponderance of female patients but not significant from 1:1. Age of presentation was 14.8 +/- 3.4 years (mean +/- SD) without sex difference (P = .11). Tanner stage at presentation was 4.1 +/- 1.4 for genotypic female patients and 3.6 +/- 1.5 for genotypic male patients (P = .02). Age at start of medical treatment was 15.6 +/- 2.8 years. Forty-three patients (44.3%) presented with significant psychiatric history, including 20 reporting self-mutilation (20.6%) and suicide attempts (9.3%). CONCLUSIONS: After establishment of a multidisciplinary gender clinic, the gender identity disorder population increased fourfold. Complex clinical presentations required additional mental health support as the patient population grew. Mean age and Tanner Stage were too advanced for pubertal suppressive therapy to be an affordable option for most patients. Two-thirds of patients were started on cross-sex hormone therapy. Greater awareness of the benefit of early medical intervention is needed. Psychological and physical effects of pubertal suppression and/or cross-sex hormones in our patients require further investigation.


OBJECTIVES: Childhood gender nonconformity has been associated with poorer relationships with parents, but it is unknown if childhood gender nonconformity is associated with childhood abuse or risk of posttraumatic stress disorder (PTSD) in youth. METHODS: We examined whether gender nonconformity before age 11 years was associated with childhood sexual, physical, and psychological abuse and lifetime risk of probable PTSD by using self-report questionnaire data from the 2007 wave of the Growing Up Today Study (n = 9864, mean age = 22.7 years), a longitudinal cohort of US youth. We further examined whether higher exposure to childhood abuse mediated possible elevated prevalence of PTSD in nonconforming children. Finally, we examined whether association of childhood gender nonconformity with PTSD was independent of sexual orientation. RESULTS: Exposure to childhood physical, psychological, and sexual abuse, and probable PTSD were elevated in youth in the top decile of childhood gender nonconformity.
compared with youth below median nonconformity. Abuse victimization disparities partly mediated PTSD disparities by gender nonconformity. Gender nonconformity predicted increased risk of lifetime probable PTSD in youth after adjustment for sexual orientation.

CONCLUSIONS: We identify gender nonconformity as an indicator of children at increased risk of abuse and probable PTSD. Pediatricians and school health providers should consider abuse screening for this vulnerable population. Further research to understand how gender nonconformity might increase risk of abuse and to develop family interventions to reduce abuse risk is needed.

Risk ratio 1.4 to 2.8 for combined abuse.

Most youth in the top decile of gender nonconformity were heterosexual (59.6% heterosexual, 2.2% heterosexual with same-sex partners, 24.5% mostly heterosexual, 4.2% bisexual, 9.5% gay/lesbian). Children with physical disability more risk of sexual abuse (ref).

Recent research has found that the mothers of firstborn homosexual sons produce fewer subsequent offspring than do the mothers of firstborn heterosexual sons. It was hypothesized that a subset of mothers of firstborn homosexuals may be responsible for this finding. If there is a subset of mothers whose immune reactions cause their first male fetus to be homosexual and their subsequent fetuses to die, then their immune reactions should also cause their first male fetus to have a lower birth weight. This leads to the prediction that, within the population of firstborn homosexual men, those with no younger siblings should also tend to have lower birth weights.

This prediction was tested using a previously published sample of 1,445 firstborn subjects: 929 heterosexual females, 47 homosexual females, 409 heterosexual males, and 60 homosexual males. The results showed that firstborn homosexuals with no younger siblings (i.e., only children) did have lower birth weights compared with all the other subjects, but the finding applied to firstborn lesbian women as well as firstborn gay men.

[Blanchard has already a rather large theoretical edifice built up to explain the homosexuality of later-born sons. This tries to extend it for first born sons and introduces yet further layers of speculation. There are many reasons why first born children might be low-birth weight, or why such might be ultimately homosexual, and readers are hereby advised to be quite sceptical about this paper.]
Reference List

