Gender dysphoria and gender identity disorder in children and adolescents

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Cultural factors

- Influence what is “male and female typical behavior”
- In Westernized societies “typical” activities have changed considerably
- Women are more likely to tackle “masculine jobs’’ and more men accept to undertake “feminine’’occupations
CULTURAL factors

• In some cultural groups more tolerance for ‘atypical” behavior
• There may be a concept of a third gender
• E.g. fa’afafine concept in Samoa (men attracted to men “in the manner of woman”)
• Culture very tolerant to feminine males
Epidemiology

• Important distinction between childhood and adult disorder
• They are not the same
• Gender identity disorder does not necessarily (only in minority) lead to transexualism in adult
Epidemiology

- It must be considered a “rare disorder” in children
- In adults estimation of prevalence of “transexualism in adults”
  Men: 1 in 24000 to 37000 men
  Women: 1 in 103000 to 150000.
(Meyer-Bahlburgh, 1985)
Prevalence

• Netherlands, inferred prevalence from people receiving cross-gender hormonal treatment. For “transexualism in adults” (Bakker, Van Kesteren, Gooren and Bezemer, 1993)

• Men. 1 in 11 000
• Women. 1 in 30 400
Prevalence

- Probably underestimate
- Not all persons receive treatment
- Not all children with gender dysphoria will become transexual
- The problem may not persist into adulthood
- There may be many gender dysphoric adults who do not go to treatment
Epidemiology

- Almost no studies of prevalence in children
- Gender identity disorder in childhood is however, strongly associated with homosexual orientation
Population studies

- Old surveys of homosexual orientation
- Kinsey, Pomeroy and Martin (1948)
  37% adult males in US had at least one postpubertal homosexual experience leading to orgasm
Population surveys. Newer studies

- Voeller (1990), “an average of 10% of the population - men and women combined’ could be designated as homosexual
Population surveys, newer

- Prevalence rates
- 2-6% of homosexuality for men
- 2% for women (Diamond, 1993, Fay turner, Klassen and Gagnon, 1989)
- Distinction between “behavior” and “fantasies” (e.g. masturbatory fantasies)
Adolescent survey. Minnesota

Adolescent Health Survey

- Remafedi, Resnick, blum and Harris, 1992)
- Response rate 69%, 36 741 adolescents. Age range 12-18 years
- Explored sexual fantasy, sexual attraction and self-labelling
- FANTASY. 2.2% males and 3.1% females: bisexual or homosexual fantasy
- SEXUAL ATTRACTION. 4.5 males, 5.7% females reported bisexual or homosexual feelings
- SELF-LABELING. 1.1% of participants described themselves as bisexual or homosexual
- Participants who were unsure of their sexual orientation varied with age (25.9% of 12 years old were unsure, and 5% of 17 years olds)
• Maternal Report of cross-gender behaviour in boys aged approximately 7 years old.
• Behavior Number % Positive
• Desire to be female 7%
• Feminine Dressing 13%
• Wearing Lipstick 7%
• Doll Playing 15%
• Preference for girl playmates 2%
• Aversion to boy's games 3%
• (Zuger and Taylor, 1969)
Diagnostic features of GID

- A strong and persistent cross-gender identification
- not merely a desire for any perceived cultural advantages
- of being the other sex
Diagnostic features (group A)

- 1 Repeatedly stated desire to be, or insistence that he/she is, the other sex.
- 2 In boys, preference for cross-dressing or simulating female attire; in girls, insistence on only wearing stereotypical masculine clothing.
Diagnostic features (Group A)

- 3 Strong and persistent preferences for cross-sex roles in make-believe play or persistent fantasies of being the other sex.
- 4 Intense desires to participate in the stereotypical games and pastimes of the other sex.
- 5 Strong preferences for playmates of the other sex.
Diagnostic criteria (group A)

• In adolescents and adults, symptoms such as stated desire to be the other sex,
• frequent passing as the other sex
• desire to live and be treated as the other sex
• or the conviction that he/she has the typical feelings and reactions of the other sex.
Diagnostic features (Group B)

- Persistent discomfort
- with his/her sex
- or sense of inappropriateness
- in the gender role of that sex.
Diagnostic features (Group B)

- in boys,
- assertion that his penis and testes are disgusting or will disappear,
- or assertion that it would be better not to have a penis,
- or aversion towards rough-and-tumble play
- and rejection of male stereotypical toys, games and activities
Diagnostic features (Group B)

- In girls
- the rejection of urinating in a sitting position
- assertion that she has or will grow a penis
- or assertion that she does not want to grow breasts or menstruate
- or marked aversion towards normative female clothing.
Diagnostic criteria (group B)

• In adolescents and adults
• preoccupation with getting rid of primary and secondary sex characteristics
• or belief that he/she was born the wrong sex.
Diagnostic criteria (c)

- The disturbance is
- not
- concurrent with a physical intersex condition
Diagnostic criteria (d)

- The disturbance
- causes clinically significant distress
- or impairment in social, occupational or other important areas of functioning
Diagnostic criteria (ICD 10)

- the diagnosis requires a profound disturbance of the normal gender identity;
- mere tomboyishness in girls or girlish behavior in boys is not sufficient.
Clinical course

• Most females with gender identity disorder will develop homoerotic attraction

• Among boys, about half develop attraction to other men and half attraction to women in adulthood (Blanchard 1987, 88, 89. Blanchard, Clemmensen & Steiner, 1987)
Course

- Most children with GID (but not all) develop homosexual orientation (Zucker and Bradley, 1995)
- “Early onset” cases, more likely to be homoerotic
- “Late onset” cases, more likely to be heterosexual
Comorbidity

- It has been shown that children with gender identity disorders also present separation anxiety, depression and other emotional and behavioral difficulties
- (Coates et al, 1985)
Etiology. Unknown. Probably multifactorial

- Hormonal influences?
- In the brain during fetal life
- Androgens would masculinize the brain at the critical period of 6 weeks in fetal life
- In utero and genetic influences in interactin with postnatal factors
Hormonal influences?

• Testosterone role during pregnancy
• Testosterone affects gender development
• And Ratio of 4D to 2D
• Significant difference in ratio in adult women with GID (but not in men or in children)

• (Wallien, Zucker, Steensma, Cohen-Ketenis, 2008)
Hormonal influences?

• 2\textsuperscript{nd} digit (index) length, ratio to length of 4\textsuperscript{th} (anular) finger.
• Genitals and fingers under influence of same gene (homeobox genes)

• In women both fingers usually same length, in men usually 4\textsuperscript{th} finger longer than the 2\textsuperscript{nd}.
• Observable in children 2 years of age and stable
Genetic factors?

- Higher risk in identical twins
- But also discordance in identical twins, therefore, other influences
- Perhaps 62% gender identity disorder attributable to inheritance factors, rest to nonshared environmental influences

(Coolidge et al., 2002)
Etiology?

- Anterior hypothalmus is larger in the male.
  - Levay (1991): in the brain of homosexual men this nucleus is similar in size to that of women and about half the volume of that in heterosexual men.
Etiology?

• Stoller (1968): family constellations
• For the boy there is an over-close relationship to mother and a distant father.

• For the girl there is a depressed mother during the early months of the child's development and a father who is absent and does not support the mother,

• but pushes the child to assuage the mother's depression.
Etiology?

• The parents' wish for a child of the other sex
• or direct parental pressure in rearing the child
• in the gender role opposite to the biological sex
• is not sufficient on its own to produce a marked gender identity disorder
• (De Ciegle)
Intervention

- Behavior therapy, individual psychotherapy,
- family therapy and group therapy
- have been used with these children and their families.
- Their efficacy is unclear
- (De Ciegle)
Behavior therapy

- Question of “why’ and “values”
- Traditionally based on moral/ethical, Christian values
- “prevent homoeroticism”
- Prescription of desired behaviors and play
- Proscription of undesirable behaviors
- Positive and negative reinforcements
Psychotherapy

• Help the child explore his/her interests
• Explore possibilities of play in other areas than typically interested in
• If present, reduce conflicts regarding perception of men, women, adult relationships, what is a man or a woman?
• Deal with unresolve issues individually
Family therapy

- Suggestion to encourage different play
- Suggestion to curtain cross-dressing behavior
- Discourage play with some toys or typically masculine or feminine activities
Group approaches

• Group sessions for parents
• Mutual support
• Coping strategies
• Dealing with family issues
• Monthly sessions
  (Di Ciegli et al, 2006)
Groups. For children

- Improvement of peer relationships
- Reduce feeling of isolation
- Encouragement of positive interactions with peers of same gender
- Expand repertoire of possible games
- Positive reinforcement and sharing
Intervention. Possible goals

- To foster recognition and non-judgemental acceptance of the gender identity features
- To ameliorate associated emotional, behavioural and relationship difficulties (Coates et al 1985)
- To deal with the issue of secrecy
Intervention. Possible goals

- To activate interest and curiosity by exploring the impediments to them: i.e. expand repertoire of play, dress, friendships without excessive pressure or criticism.
- To enable the expand capacity for symbol formation and symbolic thinking (Segal, 1957).
- To promote separation and differentiation, self esteem and self acceptance.
- To enable the child or adolescent and the family to tolerate uncertainty in the area of gender identity development.