GENDER DISPHORIA IN CHILDREN AND ADOLESCENTS

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The APA DSM-V described in chapter 302, the Gender identity disorders in children 302-6 and in adolescents. 302.85.

Gender Incongruence (in children)

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least 6* of the following indicators (including A1):

1. a strong desire to be of the other gender or an insistence that he or she is the other gender

2. in boys, a strong preference for cross-dressing or simulating female attire; in girls, a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing

3. a strong preference for cross-gender roles in make-believe or fantasy play

4. a strong preference for the toys, games, or activities typical of the other gender

5. a strong preference for playmates of the other gender

6. in boys, a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; in girls, a strong rejection of typically feminine toys, games, and activities

7. a strong dislike of one's sexual anatomy

8. a strong desire for the primary and/or secondary sex characteristics that match one's experienced gender

Subtypes

With a disorder of sex development

Without a disorder of sex development

GENDER INCONGRUENCE

1. It is proposed that the name gender identity disorder (GID) be replaced by "Gender Incongruence" (GI) because the latter is a descriptive term that better reflects the core of the problem: an incongruence between, on the one hand, what identity one experiences and/or expresses and, on the other hand, how one is expected to live based on one's assigned gender (usually at birth) (Meyer-Bahlburg, 2009a; Winters, 2005). In a recent survey that we conducted among consumer organizations for transgendered people (Vance et al., in press), many very clearly indicated their rejection of the GID term because, in their view, it contributes to the stigmatization of their condition.
2. The term "sex" has been replaced by assigned "gender" in order to make the criteria applicable to individuals with a DSD (Meyer-Bahlburg, 2009a, 2009b). During the course of physical sex differentiation, some aspects of biological sex (e.g., 46, XY genes) may be incongruent with other aspects (e.g., the external genitalia); thus, using the term "sex" would be confusing. The change also makes it possible for individuals who have successfully transitioned to "lose" the diagnosis after satisfactory treatment. This resolves the problem that, in the DSM-IV-TR, there was a lack of an "exit clause," meaning that individuals once diagnosed with GID will always be considered to have the diagnosis, regardless of whether they have transitioned and are psychosocially adjusted in the identified gender role (Winters, 2008). The diagnosis will also be applicable to transitioned individuals who have regrets, because they did not feel like the other gender after all. For instance, a natal male living in the female role and having regrets experiences an incongruence between the "newly assigned" female gender and the experienced/expressed (still or again male) gender.

302.85 Gender Identity Disorder in Adolescents or Adults
Gender Incongruence (in Adolescents or Adults)

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by 2* or more of the following indicators:

1. a marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or, in young adolescents, the anticipated secondary sex characteristics)

2. a strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or, in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics

3. a strong desire for the primary and/or secondary sex characteristics of the other gender

4. a strong desire to be of the other gender (or some alternative gender different from one's assigned gender)

5. a strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender)

6. a strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender)

Subtypes

With a disorder of sex development

Without a disorder of sex development

For the adult criteria, it is proposed, on a preliminary basis, the requirement of only 2 indicators. This is based on a preliminary secondary data analysis of 154 adolescent and adults patients with GID compared to 684 controls 7

In the upcoming fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), people whose gender at birth is contrary to the one they identify with will be diagnosed with gender dysphoria. This diagnosis is a revision of DSM-IV's criteria for gender identity disorder and is intended to better characterize the experiences of affected children, adolescents, and adults.

Respecting the Patient, Ensuring Access to Care

DSM not only determines how mental disorders are defined and diagnosed, it also impacts how people see themselves and how we see each other. While diagnostic terms facilitate clinical care and access to insurance coverage that supports mental health, these terms can also have a stigmatizing effect.

DSM-5 aims to avoid stigma and ensure clinical care for individuals who see and feel themselves to be a different gender than their assigned gender. It replaces the diagnostic name "gender identity disorder" with "gender dysphoria," as well as makes other important clarifications in the criteria. It is important to note that gender nonconformity is not in itself a mental disorder. The critical element of gender dysphoria is the presence of clinically significant distress associated with the condition.

CHARACTERISTICS

For a person to be diagnosed with gender dysphoria, there must be a marked difference between the individual's expressed/experienced gender and the gender others would

assign him or her, and it must continue for at least six months. In children, the desire to be of the other gender must be present and verbalized. This condition causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Gender dysphoria is manifested in a variety of ways, including strong desires to be treated as the other gender or to be rid of one's sex characteristics, or a strong conviction that one has feelings and reactions typical of the other gender.

The DSM-5 diagnosis adds a post-transition specifier for people who are living full-time as the desired gender (with or without legal sanction of the gender change). This ensures treatment access for individuals who continue to undergo hormone therapy, related surgery, or psychotherapy or counseling to support their gender transition.

Gender dysphoria will have its own chapter in DSM-5 and will be separated from Sexual Dysfunctions and Paraphilic Disorders.

Need for Change

Persons experiencing gender dysphoria need a diagnostic term that protects their access to care and won't be used against them in social, occupational, or legal areas.

When it comes to access to care, many of the treatment options for this condition include counseling, cross-sex hormones, gender reassignment surgery, and social and legal transition to the desired gender. To get insurance coverage for the medical treatments, individuals need a diagnosis. The Sexual and Gender Identity Disorders Work Group was concerned that removing the condition as a psychiatric diagnosis—as some had suggested—would jeopardize access to care.

Part of removing stigma is about choosing the right words. Replacing "disorder" with "dysphoria" in the diagnostic label is not only more appropriate and consistent with familiar clinical sexology terminology, it also removes the connotation that the patient is "disordered."

Ultimately, the changes regarding gender dysphoria in DSM-5 respect the individuals identified by offering a diagnostic name that is more appropriate to the symptoms and behaviors they experience without jeopardizing their access to effective treatment options.

WHAT WE SEE

A mother, concerned for some time about her young son's preference for female friendships, lack of male playmates, identification with the feminine such as an interest in Barbie dolls, finally decides to ask the pediatrician if these are signs of a potential problem. The pediatrician is reassuring and states: "This is just a phase. It's nothing to worry about. He will grow out of it." Unfortunately, the pediatrician is probably wrong. Gender confusion problems, including, cross-dressing, exclusive cross-gender play,

awkwardness with peers or siblings of the same sex or lack of same-sex friends should be treated as a sign that something may be wrong. What's usually wrong with such a child is that due to a number of specific stressful factors the boy or girl has psychological conflicts that interfere with embracing the goodness of his masculinity or her femininity.

Health professionals, educators and parents need to be aware that the child's conflicts may, in fact, may arise from an attempt to please a psychologically troubled mother or father.

DIAGNOSIS

The psychological conflict of young children identifying with the opposite sex and even desiring to become what they love, that is a sex opposite their own biological sex, is described as Gender Identify Disorder in the American Psychiatric Association's Diagnostic and Statistical Manuals, including in DSM III (1983), DSM III R, DSM IV and DSM IV R. DSM V (2015) has described children who have failed to identity with their biological as having Gender Dysphoria. This conflict was identified as a psychiatric disorder because of all the serious emotional, cognitive and behavioral suffering in these youth and the positive response to psychotherapy, as described by the leaders in the field Zucker and Bradley in Toronto. (Zucker, K. & Bradley, S. (1995) Gender Identity Disorder and Psychosexual Problems in Children and Adolescents. New York: Guilford Publications.)

Study of children and teenagers from gender identify center

A 2013 study from a gender identity service in Toronto that consisted of a sample of 577 children (ages 3-12) and 253 adolescents (ages 13-20) reported a number of findings.

For the adolescents, data on sexual orientation were available for 248 patients. The percentage of girls classified as homosexual was greater than the percentage of boys classified as homosexual (76.0% vs. 56.7%).

For the children, 66.4% were in two-parent families at the time of assessment compared with 45.8% of the adolescents,

Another parameter that struck them as clinically important was that a number of youth commented that, in some ways, it was easier to be trans than to be gay or lesbian.

Along similar lines, they have also wondered whether, in some ways, identifying as trans has come to occupy a more valued social status than identifying as gay or lesbian in some youth subcultures.

A center in the Netherlands reported the co-occurence of gender identify disorder and autism spectrum disorders (ASD) in a study of children and adolescents (115 boys and

89 girls, mean age.10.8) The incidence of ASD was 7.8%. The authors recommended a greater awareness finding and the challenges it generates in clinical management.1

FAMILY CONFLICTS

Drs. Zucker and Bradley in Toronto have been recognized as leaders in the study gender Identity disorder.2. They have identified a number of conflicts in the families of children with GID that included:

A composite measure of maternal psychopathology correlated quite strongly with Child Behavior Checklist indices of behavior problems in boys with GID.

The rate of maternal psychopathology is high by any standard and includes depression and bipolar disorder.3

The parents have difficulty resolving the conflicts they experience in their own marital relations, and fail to provide support to each other. This produces an intensified sense of conflict and hostility.

They also found that gender identity disorder youth had high rates of general behavior problems and poor peer relations.4

GENETICS

Dr. George Rekers at the University of S. Carolina Medical Schools studied 70 boys who were given thorough medical and psychological evaluations including chromosome analysis. No chromosomal abnormalities were found. 5

CAUSES

Not fully clear.

It was traditionally thought to be a psychiatric condition meaning a mental ailment. Now there is evidence that the disease may not have origins in the brain alone.

Studies suggest that gender dysphoria may have biological causes associated with the development of gender identity before birth.

More research is needed before the causes of gender dysphoria can be fully understood.

SEXUAL ORIENTATION

Gender dysphoria isn't the same as transvestism or cross-dressing and isn't related to sexual orientation. People with the condition may identify as straight, gay, lesbian, bisexual or asexual.

NATAL SEX

The number of adolescents referred to specialized gender identity clinics for gender dysphoria appears to be increasing and there also appears to be a corresponding shift in the sex ratio, from one favoring natal males to one favoring natal females.8

Sociological and sociocultural explanations are offered to account for this recent inversion in the sex ratio of adolescents with gender dysphoria.

TREATMENT

Puberty suppression by gonadotropin-releasing hormone analogs (GnRHa) is prescribed to relieve the distress associated with pubertal development in adolescents with gender dysphoria.

Psychological support and puberty suppression were both associated with an improved global psychosocial functioning in GD adolescents. Both these interventions may be considered effective in the clinical management of psychosocial functioning difficulties in GD adolescents.9

Surgery is performed usually after 18. It is strongly recommended to use ethical guidelines to make the decision. 10.

Education and training of the public in general, from a young age onward, starting in schools, and healthcare professionals in particular, is vital to increase understanding and tolerance, and improve the quality of life of trans people and their loved ones

BIBLIOGRAFIA

1. de Vries, AL, et. al. 2010. Autism spectrum disorders in gender dysphoric children and adolescents. J Autism Dev Disord, 40: 930-6.

2 Zucker KJ, Bradley SJ, Ben-Dat DN, Ho C, Johnson L, Owen A. (2003) Psychopathology in the parents of boys with gender identity disorder. J Am Acad Child Adolesc Psychiatry, 42:2–4

3. Kenneth Zucker, Susan Bradley Gender Identity and Psychosexual Problems in Children and Adolescents, NY: Gilford, 1995

4 Zucker, KJ, Bradley, SJ, et al. 2012. Demographics, behavior problems, and psychosexual characteristics of adolescents with gender identity disorder or transvestic fetishism. J Sex Marital Ther. 38: 151-89).

5. Rekers G, et al. 1979. Genetic and physical studies of male children with psychological gender disturbances, Psychological Medicine 9: 373-375.)

6. DSM-V. APA.2015 Sexual and Gender Identity Disorder

7 Deogracias et al., 2007; Singh et al., 2010

8. Aitken M, Steensma TD, Blanchard R, VanderLaan DP, Wood H, Fuentes A, Spegg C, Wasserman L, Ames M, Fitzsimmons CL, Leef JH, Lishak V, Reim E, Takagi A, Vinik J, Wreford J, Cohen-Kettenis PT, de Vries ALC, Kreukels BPC, and Zucker KJ. Evidence for an altered sex ratio in clinic-referred adolescents with gender dysphoria. J Sex Med 2015;12:756–763.

9. Costa R, Dunsford M, Skagerberg E, Holt V, Carmichael P, Colizzi M. Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria. J Sex Med 2015;12:2206–2214.

10. Milrod C. How young is too young: Ethical concerns in genital surgery of the transgender MTF adolescent. J Sex Med 2014;11:338–346.

11. Arcelus, j. Current and Future Direction of Gender Dysphoria and Gender Incongruence Research. . J Sex Med 2015;12:2226-2228