Gender Variant and Gender Dysphoria in Two Young Children

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CASE: Alexandra is 5 ½ years old, the youngest of four girls, and lives with her parents. She is described by her teachers as a thoughtful, imaginative girl with a good sense of humor, and strong literacy and math skills. Parents describe her typical mood as happy and easy going. She has many friends and engages in a variety of play activities.

At 18 months, Alexandra insisted on wearing boys’ underwear before she would complete toilet training. At 3 years, she told her parents that she “should have been a boy,” and insisted on wearing boys’ clothes. Alexandra now refuses to wear dresses and wears a coat and tie to formal occasions, which has led to conflicts with her grandparents. During make-believe play, Alexandra always chooses to play the male roles. She keeps her hair short and her dress and mannerisms are so masculine that people who do not know her assume that she is a boy. Alexandra makes frequent statements about being or wishing she were a boy. When asked directly she says “I’m a girl, but I’m a boy inside.”

Her parents have recently become alarmed because Alexandra has begun saying “I hate myself,” and once said that when her breasts grow she will “slice them off.” She has recently asked her parents to call her “Alex.” There is no apparent bullying or teasing from other children. Alex’s parents are understanding and supportive of her quandary, though they have questions and concerns about the long-term implications of these behaviors and choices.

Chris is a 9-year-old boy, referred because of his preference for traditionally feminine clothing, toys, and activities. Chris’s parents are divorced; he lives with his father and paternal grandparents, visiting his mother once a week.

Chris met developmental milestones on time and always seemed “smart” and eager to learn. By 2 years of age, his family noticed that he was attracted to pretty and shiny things like dresses, sequins, and glitter, although he has always worn boys’ clothing without complaint. During the next few years, he asked for Barbie dolls for his birthday and seemed fascinated by long blond hair. When coloring, he preferred pink and purple crayons and usually drew female characters, very decorated and with long hair. In comparison, his drawings of himself were small and plain. He occasionally said “I know I’m a boy, but I’m a girl in my head.”

His pediatrician advised the family to throw out the dolls and “girlish” toys, emphasize “male” activities, and insist that he draw boys as well as girls. Chris was so distraught by this that he was allowed to keep one Barbie doll, as long as he only played with it indoors and did not talk about the doll with friends.

In kindergarten and first grade, Chris played mostly with girls and was not interested in sports or rough-and-tumble play. He was teased by other children and had few friends, mostly girls. He started to have sudden outbursts at home and at school that seemed beyond his control, sometimes kicking walls and punching himself in the head.

At the beginning of third grade, Chris agreed to join the soccer team as his father wanted. His family no longer sees him playing with Barbies and he has agreed to a few play dates with new boys in his class. Chris is quieter than he used to be, with fewer outbursts. For his birthday, he privately asked his father’s fiancé for a blond long-haired wig, but when his father confronted him, he denied it. His father reports that “the phase” has finally passed.

DISCUSSION
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These two children display patterns of intense, pervasive, and persistent interests and behaviors characterized as typical of the opposite gender,1 defining them as “gender variant (GV).” Some children with GV also have “gender dysphoria,” a persistent discomfort with their biological sex. GV children present a unique challenge to parents and physicians because gender is such a defining characteristic and because the evidence available on the natural history and recommended management of GV is still incomplete.

Although the onset of gender variance is typically before 3 years of age,2 parents may not present their concerns to a physician until they realize that the behaviors are not transient, or they become a source...
of tension and/or embarrassment. By kindergarten, most children maintain friendships and choose activities among children of the same sex: sports teams are defined by sex, bathrooms are assigned by sex, and even walking to lunch may require joining the male or female line. For a child with gender variance/dysphoria, these activities may present emotional challenges, compounded by the stigma that is typically associated with variations in gender expression and sexual orientation. This stigma may lead to ostracism and social isolation, which may contribute to damaged self-esteem and the development of internalizing and/or externalizing symptoms.

The natural history of GV is poorly understood. As children struggle with external pressures to fit in during elementary school, many outward symptoms may diminish temporarily. Early data suggest that 75% to 80% of boys with GV behavior endorsed a homosexual or bisexual orientation as adults, and most of the remainder were comfortable with a gender identity consistent with their anatomic sex. In a recent report, 27% of children who were gender dysphoric at a young age were still gender dysphoric as adolescents or young adults.

Advice for the parents of GV children begins with the advice we would give to parents of all children: provide a nurturing environment that encourages the child’s individuality to build healthy self-esteem. Parents often want concrete guidance as to whether to allow girls to have short hair or boys to wear makeup or dresses, and wonder if they should force girls to wear dresses to church and boys to join the soccer team. Under most conditions families should follow children’s lead in these issues, making compromises in dress and hair style to fit the family’s comfort and context. In general, they should avoid labeling activities or toys as “for girls” or “for boys,” and they should help children to develop interests and skills that are shared by all (e.g., swimming, cycling, art, and drama). In addition, parents of children with GV may need help to identify and deal with their own conflicting emotions and attitudes to demonstrate support and acceptance of their child. Then they can help educate and foster an atmosphere of acceptance among extended family, teachers, neighbors, and the larger community.

Parents can help to protect their child from the harms of stigma at school by discussing potentially hurtful responses from peers and teachers, and suggesting and practicing helpful responses. Although some children can understand the wisdom of not displaying GV behaviors with friends or at school, even young children may recognize the things they can do “only at home” are somehow “bad” and shameful, so parents should be mindful that such directives should be advised carefully and with explanation.

On account of uncertainty regarding long-term outcomes for these children, the best approach for families to take is one of curiosity, empathy, and active acceptance of gay, lesbian, bisexual, and transgender individuals. Watching TV programs and reading books together that include gay, lesbian, bisexual, and transgender people or commenting on newspaper stories about same sex parents are some ways that parents can subtly indicate their acceptance of diverse gender identities and sexual orientations. Local discussion/support groups and broader listserves may counteract parents’ isolation and worries (The Children’s National Medical Center Gender and Sexuality Advocacy and Education Program provides outreach and education for families and professionals, as well as a downloadable online brochure that addresses frequently asked questions about children’s gender behaviors. It is available at: https://www.childrensnational.org/DepartmentsandPrograms/default.aspx?Id=6178&type=Program&Name=Gender%20and%20Sexuality%20%20Psychosocial%20%20Programs) (Assessed November 24, 2009).

REFERENCES


**Norman Spack, MD**

I will focus my comments on Chris, because he is approaching puberty and therefore raises interesting questions about medical management. Similar issues exist for girls who are gender variant (GV) and gender dysphoric.

First, one might consider the influence of Chris’ “absent” mother and her feelings about her son’s gender variance. It is tempting to blame transgender behavior on family circumstances (e.g., alleged gender preference of parents, birth order, and gender of sibs). However, there is no evidence that parental wishes or behavior can “create” a transgendered child. Since Chris is 9 years old and still exhibiting cross-gender inclinations, family counseling is urgent, to include Chris, both parents, and dad’s fiancè. At this age, many boys “go underground” with their gender identity conflicts but engage in distressing private behaviors like stealing underwear from relatives, or sisters of friends, and urinating seated. Many dislike being bare chested in public. They are usually mercilessly bullied by schoolmates. Young gender dysphoric kids who may be transgender need even more support than gay and lesbian youth whose sexual orientation is not usually manifest until middle or high school. Untreated and
rejected gender dysphoric teens have startling high suicide rates and are over represented as “street youth” and the sex industry.  

Increasingly, parents of children like Chris, as well as their mental health clinicians and physicians, are considering the benefits of delaying the onset of puberty for several years. The reasoning for this approach is that the physical evidence of puberty often creates extreme distress for young adolescents who are already gender dysphoric, or articulating a belief that they are more like the opposite sex in core characteristics (i.e., transgender). Facial hair or breast enlargement may give rise to self-mutilation and even suicide. In addition, reversing the physical effects of puberty after they are complete requires complex, lengthy, and expensive hormonal and surgical interventions, and the results are usually suboptimal.

Medical intervention generally begins when the child reaches Tanner stage 2 puberty (for genetic males, testes 4–6 mL without phallic enlargement, typically age 12–14 years; for genetic females, breast buds, areola slightly widened and projecting as small mound, typically age 10–12 years). At this time, pubertal suppression with a gonadotropin-releasing hormone (GnRH) agonist is the recommended method to buy time. This entire reversible treatment is started after intensive psychological testing by a trained mental health clinician. Although on the GnRH agonist, he or she should remain in counseling until age 15 to 16 when they can better comprehend the irreversible effects, including infertility, from taking cross-sex steroids.

The GnRH agonist protocol, suppressing puberty reversibly for 3 to 5 years, has been used successfully in the Netherlands for several years. Candidates must have supportive parents, a history of counseling, and no significant psychiatric comorbidities. None of the 100 Dutch teenagers on agonist treatment has changed his/her intentions after initiating this treatment.  

Around age 16, after repeat psychometric testing, all subjects opted for cross-gender sex steroids to develop the body of their affirmed gender. This protocol has been recently endorsed by the Endocrine Society with cosponsorship from the most international organizations of pediatric and adult endocrinologists. Consultation with an endocrinologist knowledgeable in the management of this protocol is a wise adjunct to continued family therapy and supportive counseling.

REFERENCES


RECOMMENDED FOR PROFESSIONALS


Martin T. Stein, MD

Twenty-five years ago during a well-child care visit, a mother confided that she was concerned about her 6-year-old boy’s preference for her clothes and makeup as well as a preference to play with her sister’s girlfriends rather than other boys. At the time, I was not prepared to counsel him; my own pediatric training and clinical experience in this area was limited. This case was discussed in a previously published Challenging Case.

The field of gender identity in young children has progressed since that time. The definition of a gender identity problem as “gender variant (GV)” provided in the first commentary (patterns of intense, pervasive, and persistent interests and behaviors characterized as typical of the opposite gender) is clear and clinically useful. Knowledge about the natural history of GV is also helpful. That as many as 75% of young children with GV behavior endorsed a homosexual or bisexual orientation as adults in one study points out the counterproductive advise given by Chris’s pediatrician.

Dr. Spack introduced a new therapy that may seem radical to some readers. It is recommended as an option when a child with significant gender dysphoria reaches Tanner stage 2 in order to temporarily suppress puberty. The gonadotropin-releasing hormone (GnRH) agonist used in the treatment is a synthetic peptide modeled after the hypothalamic neurohormone GnRH. It interacts with the GnRH receptor to stimulate the release of follicle stimulating hormone and leutinizing hormone from the pituitary gland. As the agonist form of GnRH does not quickly dissociate from the GnRH receptor, an initial (about 10 day) increase in follicle stimulating hormone and leutinizing hormone occurs followed by a significant hypogonadal effect. This process occurs through down-regulation of the receptor producing a reversible form of hypogonadism. (Refer references 2 and 3 in Dr. Spack’s commentary.)

When a pediatrician encounters a similar patient, a clinical perspective that recognizes the wide variation of human development in all domains is the most therapeutic approach. My initial appointment with the parents
would focus on an empathic discovery of their concerns and understanding of Chris’s behavior. A referral to a mental health professional, who has worked with children with gender identity concerns, should be considered when there is evidence of gender dysphoria, coexisting anxiety or depression, or significant interpersonal conflicts with peers (e.g., bullying) or parents. The commentaries highlight the importance of engaging parents in therapy. This is particularly important for those parents who remain uncomfortable with their child’s behaviors; it may also helpful for parents to have an outlet to express their feelings and discover ways to support their child.

REFERENCE