Gender identity disorders in children and adolescents

Guidance for management

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Guidance for the management of gender identity disorders in children and adolescents

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The following professionals participated to an informal consultative meeting about this guidance following an international conference 'A Stranger In My Own Body – Atypical Gender Identity Development and Mental Health' in November 1996.

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Introduction

Gender identity disorders in children and adolescents are rare and complex conditions. They are often associated with emotional and behavioural difficulties. Intense distress is often experienced, particularly in adolescence.

Gender identity disorders can be seen as states in which, in the course of the young person's psychosexual development, there is an atypical gender identity organisation. The young person experiences their phenotypic sex as incongruous with his or her own sense of gender identity.

This predicament, which is commoner in boys, is characterised by:

- A desire to be of the other sex
- Cross-dressing
- Play with games, toys and objects usually associated with the other sex and avoidance of play normally associated with their sex
- Preference for playmates or friends of the sex with which the child identifies
- Dislike of bodily sexual characteristics and functions

It is important to consider these states as different from those seen in adults because:

(a) A developmental process is involved (physical, psychological and sexual).
(b) There is greater fluidity and variability in the outcome, with only a small proportion becoming transsexuals or transvestites, the majority of affected children eventually developing a homosexual orientation and some a heterosexual orientation without transvestism or transsexualism.

Similarly, pre-pubertal and post-pubertal groups need to be differentiated. There is greater fluidity and likelihood of change in the former.

Phenomenologically there is a qualitative difference between the way such children and young people present their predicament from presentations involving delusions or other psychotic symptoms. Delusional beliefs about the sexual body or gender can occur in psychotic conditions but they can be distinguished from the phenomena of a gender identity disorder as outlined in this paper.

There are issues of nosology because current classification systems seem to suggest that gender identity disorders in childhood are equivalent to those in adulthood and that the one inevitably leads to the other. This is not the case.

Management

Psychological and social interventions

In terms of management, we propose the following broad guidance:

1. A full assessment including a family evaluation is essential as other emotional and behavioural problems are very common and unresolved issues in the child's environment are often present e.g. loss. Separation problems are particularly common in the younger group.
2. Therapy should aim to assist development, particularly that of gender identity, by exploring the nature and characteristics of the atypical organisation of the child's or adolescent's gender identity. It should focus on ameliorating the comorbid problems and difficulties in the child's life and in reducing the distress being experienced by the child (from his or her gender identity problem and other difficulties).
3. Recognition and acceptance of the gender identity problem and removing the secrecy can bring considerable relief.
4. Decisions about the extent to which to allow the child to assume a gender role congruous to his or her sense of gender identity are difficult and the child and family need support in tolerating uncertainty and anxiety in relation to the gender identity development and how best to manage it.

   This includes problems of whether to inform others of the child's disorder and how others e.g. schools, in the child's life, should respond to the child (for example, if the child wishes to attend school using the clothing and name of the other sex). Professional network meetings can be very useful in finding appropriate solutions to these problems.

In all the above, therapeutic intervention as early as possible in a child's life is indicated and an optimistic approach to improving the child's life and, in some cases, altering secondarily the gender identity development.

The role of the child and adolescent mental health services may be three-fold:

- Direct assessment and treatment of the mental health difficulties of the child/adolescent.
- Where children or adolescents meet the criteria of a gender identity disorder under DSM–IV or ICD–10, there should be a referral for assessment and/or treatment in a multi-disciplinary gender identity specialist service which includes the input of child and adolescent mental health professionals.
- Provision of consultation/liaison arrangements with a paediatric endocrinologist for the purpose of physical assessment, education about

growth and endocrinological issues and involvement in any decision about physical interventions.

Physical intervention

This should be addressed in the context of adolescent development. Identity issues and beliefs in adolescents are complex. They may become firmly held and strongly expressed. This may give a false impression of irreversibility; more fluidity may return again at a later stage. For this reason, i.e. the possibility of change of outcome, and because the effect of early physical and hormonal treatments are unknown, physical interventions should be delayed as long as it is clinically appropriate.

Before any physical intervention is considered, extensive exploration of the issues to do with the psychological, family and social network aspects should be undertaken.

Pressure for physical interventions because of an adolescent's level of distress can be great and in such circumstances, a referral to a child and adolescent multi-disciplinary specialist service should be considered.

In order for adolescents and those with parental responsibility to make properly informed decisions, it is recommended that they have experience of themselves in the post-pubertal state of their biological sex. Where, for clinical reasons, it is thought to be in the patient's interest to intervene before this, this must be managed within a specialist service with paediatric endocrinological advice and more than one psychiatric opinion.

Broadly, physical interventions fall into three groups which can be thought of as stages:

(a) *Interventions which are wholly reversible* – these include hypothalamic blockers which result in suppression of oestrogen or testosterone production. They can suppress some aspects of secondary sexual characteristics.
(b) *Interventions which are partially reversible* – these include hormonal interventions which masculinise or feminise the body. Reversal may involve surgical intervention.
(c) *Interventions which are irreversible* – these are the surgical procedures.

The decision to move to physical interventions should be made, whenever possible, within the context of a multi-disciplinary specialist service including a child and adolescent psychiatrist, a paediatric endocrinologist and other child and adolescent mental health professionals.

The staged process recommended here is considered safe as it keeps options open through the first two stages. (A small minority of patients eventually come to regret gender reassignment.) Moving from one stage to another should not occur until there has been adequate time for the young person fully to assimilate the effects of intervention to date. Interventions which are irreversible

(surgical procedures) should not be carried out prior to adulthood at age 18. As adulthood is reached, any referral on should be to an adult gender identity specialist service. Any surgical intervention should not be carried out prior to adulthood, or prior to a real life experience for the young person of living in the gender role of the sex with which they identify for at least two years. The threshold of 18 should be seen as an eligibility criterion and not an indicator in itself for more active intervention as the needs of many adults may also be best met by a cautious, evolving approach.

Summary

Gender identity disorders in children and adolescents:

- Are rare
- Are commoner in boys
- Are developmental
- Involve psychological, biological, family and social issues
- Have an outcome that cannot be easily predicted
- Require early and careful assessment and attention to emotional and developmental needs
- The approach to requests for physical interventions should be cautious, involve extensive psychological, family and social exploration, take into account adverse affects on physical growth, and be undertaken only within specialist teams

A large element of management is promoting the young person's tolerance of uncertainty and resisting pressures for quick solutions.

Surgical intervention cannot be justified until adulthood.

Suggested reading list

American Psychiatric Association (1994) *Diagnostic and Statistical Manual of Mental Disorders* (4th edn) (DSM–IV). Washington, DC: APA.

Coates, S., Friedman, R. C. & Wolfe, S. (1991) The aetiology of boyhood gender identity disorder: A model for integrating temperament, development and psychodynamics. *Psychoanalytic Dialogues,* **1**, 481–523.

––– & Person, E .S. (1985) Extreme boyhood femininity: Isolated behaviour or pervasive disorder? *Journal of the American Academy of Child and Adolescent Psychiatry,* **24**, 702–709.

Cohen-Kettenis, P. T. & Van Goozen, S. H. M. (1997) Sex reassignment of adolescent transsexuals: A follow-up study. *Journal of the American Academy of Child and Adolescent Psychiatry*, **36**, 263–271.

Di Ceglie, D. (1995) Gender identity disorders in children and adolescents. *British Journal of Hospital Medicine*, **53**, 251–256l.

––– (ed.) (1998) *A Stranger in My Own Body – Atypical Gender Identity Development and Mental Health*. London: Karnac Books, in press.

Green, R. (1974) *Sexual Identity Conflict in Children and Adults. New* York: Basic Books.

––– (1994) Atypical psychosexual development. In *Child and Adolescent Psychiatry: Modern Approaches* (3rd edn) (eds M. Rutter, E. Taylor and L. Hersov), pp. 749–758. Oxford: Blackwell Scientific.

Money, J. (1994) The concept of gender identity disorder in childhood and adolescence after 39 years. *Journal of Sex and Marital Therapy*, **20**, 163–177.

Zucker, K. & Bradley, S. (1995) *Gender Identity Disorder and Psychosexual Problems in Children and Adolescents.* New York and London: Guilford