Fifteen-minute consultation: The prepubescent gender-diverse child: how to answer parents' questions

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ABSTRACT
Parents and caregivers may seek help with different questions or concerns on how to handle the diverse gender expressions of their children. Sometimes the issue may be evident while seeking medical advice for other concerns. Because of the many uncertainties around this topic, clinicians need to know what to say and what can be done to provide the best possible care for gender-diverse children.

Key messages

- Gender-diverse behaviours are observed in young prepubescent children but are not definitive predictor of any later outcome related to gender or sexual identity.
- Most of gender-diverse children identify according to their biological sex in early adolescence.
- Childhood gender-diverse behaviour should not be pathologised and parents need to be encouraged and supported to give their child an age-appropriate nurture and let them develop without pushing to any direction.

INTRODUCTION
Parents and caregivers may seek help with different questions or concerns on how to handle the diverse gender expressions of their children: they might not fit the culture or social expectations for boys or girls (eg, the clothes they wear, the toys they play with and how they behave) or even dislike or refuse their sex characteristics or wish for the characteristics of the experienced gender. Sometimes the matter may be evident while seeking medical advice for other concerns. Because of the many insecurities around this topic, clinicians need to know what to say and what can be done to provide the best possible care for gender-diverse children. The suggested standards of care are based on the principles highlighted by the World Professional Association for Transgender Health (WPATH).[1]

CASE VIGNETTE
The parents of an 8-year-old boy ask for help from their family paediatrician. Since he was 2 years of age, their child preferred games or activities stereotypically engaged in by girls and for dressing up using towels or scarves as clothes. In fantasy games, he identified with female characters; at the carnival, he asked to dress up in princess dresses. Already in kindergarten, he had a preference for female friends; he asked for dolls and a Snow White puppet as presents for Christmas and birthdays. At the age of 4 years, he told his father that he would like to be a girl. Last year, responding to his sister who challenged the fact that he would never become a girl, he said he felt 'boy on the outside and girl on the inside'. This year, he will start ballet and he has already expressed the desire to wear the ballet tutu. Even though he did not seem to be struggling emotionally, in the last period, his friends and older sister have begun to exclude him from their circle as a male. Moreover, he started to close doors while dressing. He became shy and introverted with strangers.

'IS MY CHILD NORMAL?'
Gender is probably the earliest identity and social category to emerge in development, and acquiring gender knowledge is considered a critical component of early childhood development. By 2–3 years of age, most children can say whether they are a girl or boy as well as the gender of other people ('gender labelling').[2] The understanding of 'gender stability' from infancy to adulthood (ie, boys will grow up to be men and girls grow up to be

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women) is thought to be established in the preschool years, and this is thought to be a central factor in motivating strong gender preference.[2] By about age 6 or 7 years, children begin to understand that sex is permanent across changes in appearance (like hair length or clothes) and cannot change over time ('gender constancy')[2] (see box 2).

However, most of the work on gender development has been conducted with gender-typical children. Developmental research has demonstrated that gender diversity can be observed and identified in young prepubescent children, with gender behaviours (including toy, role play and activity preferences) that consistently differ from their peers.[3] This group of children is less likely to believe that their gender is stable over time or changes in appearance compared with others' gender.[4] However, it is important to underline that childhood gender diversity (CGD) (see box 1 for definitions) is not a disease or mental illness but rather an expected developmental aspect,[1] and also that behaviours and preferences assumed typical of a male or a female person of any age likely have a social origin.[5]

'WHAT ARE THE ODDS?'

Clear epidemiological data are not easy to find because formal epidemiological studies have not been conducted. However, CGD does not appear to be rare. An estimate of the prevalence of CGD can be derived from studies using the Child Behaviour Checklist (CBCL), a parent-completed questionnaire widely used to identify problem behaviour in children; from these samples, the prevalence of CGD range from 1% to 10% based on the question asked ('behaves like the opposite sex' and 'wishes to be opposite sex'), gender and country.[6] In the Netherlands, the prevalence of CGD, as measured by the maternal report of behaving like or wishing to be the opposite sex over approximately 14 000 7-year-old twins, was 3.2% for males and 5.2% for females,[7] while in Italy it was 5.2% in males and 3.9% in females assessed through direct administration of the Gender Identity Interview for Children by a trained child psychologist in 350 preschool children (3–5 years).[8]

'WHOSE FAULT IS IT? WHY DOES IT HAPPEN?'

It is important to clarify that it is nobody's fault because there is no fault to seek, and gender diversity is not a disease. It is believed that gender outcomes are the result of the interaction between biological, psychological and social factors.[9] However, the assumption of a biological basis for gender variance has not been confirmed. For example, apart from the bigger size of the brain in males, sex explains only about 1% of the total variance and human brain size sex difference between genders is generally small, unreliable and insignificant once individual body size is accounted for.[10] Therefore, contrary to what has been believed

Box 1 Definitions

Childhood gender diversity (CGD) is the definition used in Standards of Care Version 8 by the World Professional Association for Transgender Health (WPATH) and refers to a phenomenon in which prepubescent children do not conform to the social norms and the expression typical for their biological sex. The term is used to describe children who endorse cross-gender behaviours or more generally behaviours that differ from the sociocultural characteristics of a specific gender. CGD has been defined as a 'natural variation of human gender expression'.

Gender incongruence (GI) of childhood is the term used in the International Classification of Diseases-11th Revision. It is characterised by a marked incongruence between an individual's experienced/expressed gender and the assigned sex in prepubertal children. It includes:

- A strong desire to be a different gender than the assigned sex.
- A strong dislike of the child's part of his or her sexual anatomy or anticipated secondary sex characteristics and/or a strong desire for the primary and/or anticipated secondary sex characteristics that match the experienced gender.
- Make-believe or fantasy play, toys, games, or activities and playmates that are typical of the experienced gender rather than the assigned sex.

The incongruence must have persisted for about 2 years, and cannot be diagnosed before age 5 years. Gender-variant behaviour and preferences alone are not a basis for assigning the diagnosis.

GI has not been included anymore in mental health but in the section 'Persons encountering health services in other circumstances' to destigmatise the condition.

Gender dysphoria is a formal diagnosis in the Diagnostic and Statistical Manual of mental disorders-5th Edition (DSM-5) and it is separately defined for children compared with adolescents and adults. It is defined by:

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6-month duration, as manifested but at least six of the following (one of which must be criteria A1):
   1. A strong desire to be of the other gender or an insistence that he or she is the other gender (or some alternative gender different from one's assigned gender).
   2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire or, in girls (assigned gender), 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 play or fantasy play.
   4. A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.
   5. A strong preference for playmates of the other gender.
   6. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play or, in

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Box 1 Continued

girls (assigned gender), 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.

B. The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

It should be specified if the above criteria are in addition to a disorder of sex development (eg, a congenital adrenogenital disorder such as congenital adrenal hyperplasia or androgen insensitivity disorder).

The DSM-5 articulates explicitly that 'gender non-conformity is not in itself a mental disorder'. Therefore, the presence of gender variance is not the pathology, but dysphoria is from the distress caused by the body and mind not aligning and/or societal marginalisation of gender-variant people.

for years, the human brain is not 'sexually dimorphic' (male brain/female brain) and neither a continuous gradient from masculine to feminine, but rather a multidimensional 'mosaic' of countless brain attributes that differ in unique patterns across all individuals.[11]

'COULDN'T THIS JUST BE A PHASE?'

It is important to keep in mind that CGD may or may not continue in adolescence and later in adulthood and there are no reliable ways of predicting gender evolution. This is why the term 'gender diverse' (also known as gender non-conforming, gender creative or gender variant) should be preferred in children and prepubescent, for this group's future behaviours cannot be predicted, and they may evolve.[1 12] Indeed, gender diversity will desist by early adolescence for most of them (up to 84%) will ultimately not identify as transgender later in life.[12] Because most of gender-diverse children identify according to their biological sex when puberty starts, parents need to be encouraged to give their child age-appropriate nurture and let them develop without pushing in any direction.

Nevertheless, the pubertal phase might be delicate because of the distress caused by the development of unwanted secondary sex characteristics. The critical window for persistence or desistance in adolescence and adulthood is between 10 and 13 years of age, and the factors that contribute are the physical changes associated with puberty, the changes in the social environment and being treated more openly as a member of the assigned gender, the discovery of sexuality.

Studies have correlated CGD with eventual homosexuality, as a majority of individuals who identify as gay or lesbian self-report CGD as children.[13] However, it should be avoided to make any prediction in terms of what pathway the child is likely to take in terms of

Box 2 The four components of sexual identity[1]

Sexual identity is composed of:

- **Biological sex (or sex assigned at birth):** refers to a person's status as male, female or intersex based on physical characteristics. Sex is usually assigned at birth based on the appearance of the external genitalia. AFAB is an abbreviation for 'assigned female at birth'. AMAB is an abbreviation for 'assigned male at birth'.
- **Gender identity:** refers to a person's deeply felt, internal, intrinsic sense of their own gender.
- **Gender expression:** refers to how a person enacts or expresses their gender in everyday life and within the context of their culture and society. Expression of gender through physical appearance may include dress, hairstyle, accessories, cosmetics, hormonal and surgical interventions as well as mannerisms, speech, behavioural patterns and names. A person's gender expression may or may not conform to a person's gender identity.
- **Sexual orientation:** refers to a person's sexual identity, attractions and behaviours concerning people based on their gender(s) and or sex characteristics and those of their partners. Sexual orientation and gender identity are distinct terms.

both adult gender identity and sexual orientation (see box 2).

'WHAT ARE THE RISKS FOR MY CHILD?'

Gender-diverse children seem to be at greater risk of experiencing psychological difficulties than their peers as a consequence of confronting detrimental events. The presence of strongly expressed opposite-sex feelings and behaviours in childhood has been associated with an increased risk of abuse (not only sexual but also physical and psychological) and psychiatric disorders (post-traumatic stress disorder, depression, anxiety) regardless of gender identity or sexual orientation as adolescents or adults (included gender-diverse children who are later heterosexual cisgender).[14] However, it should be highlighted that this information is based on retrospective studies that carry a great risk of recall bias and that these associations with abuse and psychiatric disorders have not been confirmed by prospective studies so far. Nevertheless, families (as well as healthcare professionals, caregivers and teachers) should consider this possibility to provide appropriate support in order to prevent or intervene if needed.

'WHAT SHOULD WE DO?'

The prepubescent children who are well accepted in their gender-diverse identities are generally well adjusted; therefore, children need to be kept safe and supported in each setting they frequent.[1] Consultation with mental health professionals (MHPs) and/or psychotherapy is not compulsory for all gender-diverse children and families but may be requested by the family or should be offered as a chance to support

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Box 3 A parent journey

Our daughter started to show her inclination towards the male world very early. She was not even 2 years old when her preference for male clothes was absolutely clear and the last time she accepted to wear a skirt, she was 3 years. For her entire childhood until now, she played with her twin sister interpreting male roles: the sister was (and is) the princess, while she was (and is) the knight. We as parents never fought against such preferences, recognising them as fully natural, and besides some initial small embarrassment (eg, when she wanted to buy a boy swimsuit), we let her free to express herself.

A significant change happened when she turned 7 years, because at that time she moved from just preferring male clothes, plays and roles, to seeing herself as a boy. She chose her male name and asked us to start calling her as a boy. She/he started to express her/his belief in being a boy and her/his desire of having a boy body (eg, in the letter for Santa for last Christmas).

While we managed to find an internal balance, by openly talking, and so we agreed to use both male and female names in the family and we tried to give the message that our support will always be there, such a transition from 'liking' to 'being' was not an easy step for us. The level of worry and concern raised a lot, also because we started to think about the personal cost, weight and impact of a real transition process and imagining our kid going through that is absolutely scary.

At that point, we thought we needed some support, mostly to have an expert external point of view (to confirm or not what we were seeing) but also to have some suggestions on the best way to manage her/his request (also besides the family, for example, at school). So, we first had a psychological assessment run via our hometown health service, which fully confirmed the signals and messages we identified, and then we have been directed to a specialised multidisciplinary service for gender-diverse children. Overall, both steps have been positive and helpful for us. The environment has been quite welcoming and she/he was always very happy to participate. We had a chance to exchange ideas and get confirmation about a proper way of managing this period as well as an idea about the possible future steps. This did not cancel our concern and worry, but definitively helped us in having a more solid ground and consistency in our approach.

So far, considering we are just at the beginning of the story, the most important step for us was to always let her/him express herself/himself freely. She/he clearly understood we are supporting and will always be there, whatever will be the future. And, besides being a kid, this is true also for her/his sister, who accepted the process as natural: simply her sister is like this and has always been. And the sister too has been part of the multidisciplinary evaluation, which helped her to feel the importance of her role.

So she/he felt free to talk openly with us when she/he was ready and this is the most important point for us to be sure we can help and build her/him stronger for whatever future she/he will choose.

the well-being and development of children and their families (see box 3).[1]

With regard to children, guidance from MHPs with expertise in gender care for children can facilitate sustaining positive adaptation and detecting gender-related needs over time. Psychological interventions should aim to help children understand that their gender identity and gender expression are not a problem, build their resilience and become more comfortable with themselves, without attempting to change or eliminate cross-gender behaviour.[1]

Parents and family should also be supported to sustain what can be a confusing and challenging period. Family acceptance predicts greater self-esteem and prevents depression, substance abuse and suicidal ideation and is associated with positive young adult mental as well as physical health.[15] Parents of gender-diverse children often need continued support and follow-up for emotional support, advice and further recommendations. These may include keeping home a safe place, advocating with family and friends, avoiding 'boy' or 'girl' labels for activities, colour or toys, reading and discussing books and watching movies that include gender-diverse teens and adults. What should also be highlighted is that to obtain successful emotional development, gender-diverse children not only need acceptance from their parents but also from siblings and the extended community (see box 3).

Besides family support, bullying reduction is associated with better mental health outcomes.[16] Parents should also be informed about the existence of guidelines for schools to make them a safer and inclusive place. Training with teachers at school and in recreational and sports contexts should be performed to encourage the acceptance of gender-diverse children. When relevant, information regarding the pros and cons of social transitioning should be provided, knowing that so far, no significant effects of social transition or name change on mental health status have been reported in studies.[1 17]

'WHAT SHOULDN'T WE DO?'

Any attempts to coerce through words and/or actions a gender-diverse child to identify or behave in accordance with the sex assigned at birth are harmful. 'Conversion' therapies (a set of practices that aim to change or alter an individual's sexual orientation or gender identity) for gender diversity in children are unacceptable because they lack medical and scientific validity and likely to have adverse physical and psychological consequences.[18]

The use of hormonal treatments (such as GnRH analogues) is not appropriate for prepubescent children. If family enquire, they should be made aware that guidance for hormonal treatment is present for use only from early stage of puberty (Tanner stage 2: the beginning of breast development in girls and testicular volume >4 mL in boys) but even then it needs careful consideration.[1 19 20]

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CONCLUSION

Gender-diverse children and their families might face different challenges. As clinicians, it is important to inform them adequately about what can be done to best support their children since this is associated with better health and social outcomes.

RECOMMENDED READING AND RESOURCES

Websites

- Gender-diverse and transgender children: website with some useful definitions and explanations (https://www.healthychildren.org/English/ages-stages/gradeschool/Pages/gender-diverse-transgender-children.aspx)
- Fact sheet–Gender diversity and Transgender identity in Children (https://www.apadivisions.org/division-44/resources/advocacy/transgender-children.pd)
- Parenting a gender-diverse child—hard questions answered: website for parents with answers to some of the most common questions about gender non-conformity (https://www.healthychildren.org/English/ages-stages/gradeschool/Pages/parenting-a-gender-diverse-child-hard-questions-answered.aspx)
- Gender spectrum: website with several excellent resources (https://www.genderspectrum.org)
- The Trevor Project: website with useful information about gender identity (https://www.thetrevorproject.org)

Books for parents

- The transgender child: a handbook for families and professionals by Stephanie A Brill and Rachel Pepper
- The Gender Book: https://thegenderbook.com/the-book

Books for children

- Call me tree by Gonzalez, Maya Christina
- I am Jazz! by Herthel, Jessica
- Jacob's new dress by Ismail, Yasmeen
- My princess boy by Kilodavis, Cheryl
- Sparkle boy by Newman, Leslea
- Who are you? The kid's guide to gender identity by Pessin-Whedbee, Brook

Movies and TV series

- A kid like Jack (2018)
- Butterfly (2019)
- Cowboys (2020)
- First day (2020)
- I am Jazz: a family in transition (2011)
- Ma vie en rose or My Life in Pink (1997)
- Petite fille or Little girl (2020)
- Tomboy (2011)
- Transhood (2020)

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Test your knowledge

1. Which of the following better describes childhood gender diversity?
   A. It is a natural variation of human gender expression
   B. It is a formal diagnosis in the Diagnostic and Statistical Manual of mental disorders-5th Edition
   C. It is a disease included in the International Classification of Diseases-11th Revision
2. What is the estimated prevalence of gender diversity in children by the age of 7 years?
   A. Less than 1%
   B. Around 5%
   C. Around 25%
3. What is the future for gender-diverse children?
   A. They will always continue to experiment with gender diversity.
   B. By early adolescence they will all revert to a gender identity congruent with the sex assigned at birth.
   C. Gender diversity will desist with the onset of puberty, but they will always develop a homosexual orientation.
   D. They may or may not continue to experiment with this gender diversity in adolescence and later in adulthood.
4. What kind of psychological approach should not be taken into account?
   A. Support to gender-diverse children
   B. Support to parents
   C. Support to family (eg, siblings)
   D. Conversion therapy
5. When is the use of GnRH analogues suitable?
   A. As soon as gender dysphoria is diagnosed
   B. Only in individuals who have evidence of puberty on clinical examination and fulfil established criteria
   C. Only by the age of 16 years

Answers to the quiz are at the end of the references.

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Answers to the multiple choice questions

1. (A) True; (B) False; (C) False.
2. (A) False; (B) True; (C) False.
3. (A) False; (B) False; (C) False; (D) True.
4. (A) False; (B) False; (C) False; (D) True.
5. (A) False; (B) True, (C) False.

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