Identity of Transgender Children : A Clinician's Perspective

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INTRODUCTION

Since “X” was a very small child, she has been calling herself a girl, though being a natal male with typical development of sex. Her parents ignored at first, then corrected her perceived other gendering but, after a year of temperament, allowed her to grow out her hair and wear the clothing of a girl. When strangers started calling her a girl, X was happy. All her friends at school were girls, and she continued to ask why God gave her a boy body when she was really a girl. When parents decided to take her for a consultation with a psychiatrist and referred for counselling, two year of discussions and increased social withdrawal, her parents finally took the decision to begin a “social transition,” started introducing her as a girl and registering her now as a girl after her struggle for almost 16 years to gain this recognition. Since then she became more extrovert, confident and absolutely no indication for mental health challenges.

X is a transgender child – a child who always identifies as female though being a male (though ‘transgender’ is the common term, I used layman words for people who have binary – male or female identity.) Such children are increasingly visible everywhere such as media stories, legal process, school boards and of course in clinical settings of PSWs, clinical psychologists and psychiatrists. As a result, researchers and clinicians are becoming involved in debates about possible treatment care for children like X – should they be affirmed in their gender identities or given therapy with the aligning their gender identity with natal sex?

DISCUSSION

Till now, many of the arguments used in previous researches have based on faulty interpretations of past researches published on children with what typically called gender identity disorder (GID) and is now currently called Gender Dysphoria (GD). Here I focused on about two common misunderstandings discussed in five papers and chapters that led to considerable confusion in the literature: that transgender identity largely leave off during development and that we do not know which gender-dysphoric children will have a transgender identity in adulthood. Previous researches suggest neither outcome is fully guaranteed.

From a very long time, predominant point of view of transgender children has been that these children are depressed or not satisfied about their gender identity or that they are showing some form of other psychopathology, but that with proper treatment or over the course of their continued development, their identities will come to align with their birth or natal sex (which is assumed to be a more desirable outcome from this view). These outcomes are established by studies telling that children with GID/GD most of the time have stress and other psychopathology like depression, anxiety etc. By other longitudinal studies showing that anywhere from 65% to 90% of the children showed significant gender dysphoria in childhood will not identify as transgender adults⁽¹⁻³⁾.

There is other view as well to state that an identity of a transgender child is a typical variety of human

and that they identify and are conscious about their identity expression. Under this kind of situation, the clinician's role is to support their identities. This view is based mainly on findings that primary family support is associated with better mental health in transgender individuals, it is a proof that earlier support of their identities will decrease rates of mental illness; and clinical experience and secondary data indicating that supported transgender children are happy and healthy.

Now we need to discuss what data actually shows. Perhaps the mostly discussed outcomes of transgender youth is the statistic that roughly 80% of these children will desist from their (incorrect) gender identity with their birth sex by adolescence. Presumably, if most of these children will desist from their gender identity, then why not try to change it sooner!

There are 3 large studies which have reported on the adolescent or adult gender identities who had, in childhood, showed gender typical patterns of behaviour. Those who could be followed up, a minority were transgender: 1 of 441, 9 of 452 and 21 of 543. Most of the remaining children later identified as gay, lesbian or bisexual (although a small number also was heterosexual).

However, close inspection of these studies suggests that most children in these studies were not transgender to begin with. In 2 studies, a large minority (40%² and 25%³) of the children did not meet the criteria for GID to start with, suggesting they were not transgender (because transgender children would meet the criteria). Further, even those who met the GD diagnostic criteria were rarely transgender. Binary transgender children which is the focus of this discussion; insist that they are the 'opposite' sex, but most children with GID/GD do not. In fact, DSM – IV directly stated that true instance by a boy that he is a girl occurs 'rarely' even in those meeting that criterion, a point others have made². When directly asked what their gender is, more than 90% of children with GD in clinical set

ups reported an answer that aligned with their birth sex⁴, there I can see that most of them did not see themselves as transgender. We know less about the identities of the children in the third study, but the recruitment letters specifically requested boys who said about wanting to be a girl, with no mention of insisting they were girls. Clear evidence that the children in these studies were claiming an 'opposite' gender identity in childhood, these studies were agnostic about the persistence of an 'opposite' gender identity in adulthood. Instead, they show that most children who behave in gender counter-stereotypic ways in childhood are not likely to be transgender adults.

Another statement made by clinicians, researchers and members of the public is that there is no way to predict which children with GD will identify as transgender adults. However, studies have found that children showing the most 'extreme' signs of GD – the ones who show more gender nonconformity (e.g., more behavioural preferences, more insistence on the 'other' identity) are the most likely to identify later as transgender. More specifically, Steensma et al. suggested that the distinction between children who believe themselves to be the other gender and those who wish they were a member of an 'other' gender appears to be a key predictor of persistence. They reported specially about asking children with GD with preferred sex they identify will be helpful in future⁵. Thus, knowing whether a child consistently claims the 'other' gender identity might be the best single predictor of later transgender identity.

CONCLUSION

The only way to draw clear conclusions about the life course and identity persistence of transgender children is to conduct prospective studies of children who state that they are members of the 'other' gender group consistently over time. Studies with these samples can help us to truly answer the question about persistence of 'opposite' gender identities. These prospective studies can help to address other important, practical questions that are being

raised about transgender children. For example, families like X's are increasingly deciding to allow their transgender children to socially transition or present to others as their gender identity, use that pronoun and changed their names. The medical and therapeutic communities are fairly divided on whether to support these decisions. Some studies have reported positive outcomes in socially transitioned children. Others have worried that supporting a transgender child's gender identity will lead to greater persistence of that identity, which is seen by critics as an undesirable outcome, or, if their transgender identity does not persist, will lead a child to need to back transition, which could be socially difficult for a child. These are the kinds of issues that can finally be addressed when studies of transgender children, including those who do and do not socially transition, are followed prospectively-studies that can finally give us an evidence based answer to the questions of whether transgender identities are persistent and what practices are in the best interest of the transgender child.

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