

Gender Identity Disorder in Childhood: *Inconclusive Advice to Parents*

BY ALICE DREGER

For purposes of this essay, let's invent a contemporary American child named William Lee. William is five years old and, as far as anyone can tell, his body is that of a typical male. But William has long acted in a fashion

more typical of girls: he likes to play with “girl” toys like Barbie dolls and My Little Pony; he strongly prefers playing with girls to playing with boys; and he likes to dress up like a conventionally pretty woman, in pumps and dresses, with jewelry and make-up. He increasingly insists he is really a girl and indicates a belief—or a desperate hope—that he will grow up to be a woman. He wants to be called “Julie” and to go to school as Julie. He exhibits what psychologists call gender dysphoria. This stresses out his parents; it is not easy to have a child who challenges social norms, especially norms about gender.

If William's parents are not living in a media-free universe, they will know that there are two basic models of thought about what they should do. One, which I'll call the therapeutic model, maintains that William is showing all the signs of gender identity disorder (GID) and that he should be treated by a mental health professional. Or rather, *his family* should be treated by mental health professionals because, according to the typical contemporary therapeutic perspective, William needs—and lacks—a family that is functioning well psychologically and emotionally. If his mother is depressed or clingy, if his father is physically or emotionally absent, if his parents' marriage is a stressful mess, William is going to keep suffering from gender role confusion, and secondarily from the anger, shame, disappointment, anxiety, and guilt that his parents may exhibit in response. Although the therapeutic model does not point to a single cause of GID, it does see familial dysfunction as an aggravating factor in virtually all cases.

Under the therapeutic model, mental health professionals will attend to the relevant family members—particularly William and his parents—and will try to help move William toward a less stressful, more sustainable family environment and gender identity. William will be given gender-neutral toys to replace his Barbie and My Little Pony and will, ideally, be led to develop friendships with other boys—not boys of the rough-and-tumble, army-toy-obsessed type, since William will never relate well to those boys, but boys of the calmer, gentler variety. William will implicitly learn that he can be a boy without having to be aggressive and competitive. As part of the new family discipline, William's mother and father will learn to act like a loving mother and father should, and William will not be allowed to go to school as a girl or to otherwise pretend he is a girl. Thus, the therapeutic approach assumes that William's desire to grow up as a woman represents a kind of problematic fantasy and that, with the right interventions, it can be made to dissipate.¹ Evidence that this approach makes GID dissipate is lacking.

The second model of thought, which I'll call the accommodation model, presumes that there is nothing wrong with William—or rather, Julie—and nothing wrong with the Lee family, either, except perhaps the largely unnecessary suffering they experience from failing to understand that William really is Julie. According to this model—but not according to any strong scientific evidence—Julie was born with a female brain in a male body. The problem is not the child, nor the family, but the culture, and so the culture must learn to accommo-

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date Julie as she grows to become a woman. The role of medicine, according to the accommodation model, is not to “resolve” Julie’s “gender identity disorder,” but to provide her, when the time comes, with the hormones and surgeries she will need to make her body into what it should have always been and with the psychological support to help cope with a hostile world.²

Now, if the Lees were to ask me, “What should we do?” I honestly would not know what approach to suggest. But I do know what I would want them to consider. This essay lays out those points. It does not recommend any one approach, partly because we lack evidence as to which is best for children in the long run, and partly because children, families, and their social realities necessarily vary.

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The Lees should be aware that both the therapeutic model and the accommodation model are mired in long histories of identity politics. The therapeutic model emerged out of a clinical milieu in which homosexuality was considered (at least by several influential psychiatrists and psychologists) problematic and perhaps “curable.” In the 1960s, parents and mental health care professionals who met at what would now be called “gender clinics” were more worried about gender-atypical children ending up gay than about gender-atypical children ending up transsexual.

That’s because they knew intuitively what we now can say with more scientific conviction: gender-atypical young children are far more likely to end up homosexual than gender-typical young children, and they appear to be much more likely to end up nontransgender gay men or lesbian women than transgender men or women. This is especially true with boys. Most feminine-acting young boys end up as gay men, not as straight men or transsexual women. Relatively speaking, masculine-acting young girls end up all over the map, but are more likely than girly girls to turn out to be lesbian or bisexual women or transsexual men.³

What we’ve also learned in the last thirty years is that you apparently cannot change a person’s sexual orientation, though you can change others’ views about sexual orientation. Indeed, since 1973, the American psychiatric profession has officially maintained that there is nothing wrong with being gay; before that, “homosexuality” counted as a mental disorder, but not any more. Although most university-based “gender” clinicians today will still, in their studies, track GID patients’ ultimate sexual orientations, they do not attempt to

“prevent” or “cure” homosexuality the way they try to “cure” the child’s gender dysphoria.

In fact, the demedicalization of homosexuality has functioned as the inspiration for the accommodation model.⁴ Today, many transgender activists will say: Look at how homosexuality used to be seen as a mental disorder, and how society had to just get over it. There was nothing wrong with homosexual people, and there’s nothing wrong now with gender dysphoric children. According to the accommodation model, children with gender dysphoria are not “disordered.” The stress they feel, like the mental health problems they experience, are the result of the rejection of who they naturally are. So the TransKids Purple Rainbow Foundation, which supports the accommodation model, says “GID is something a child can’t control and it is society that needs to change.”⁵

What’s all this got to do with your child, if you have a child like William? Good question. Actually, it should not have anything to do with your child because children should not have to get caught up in adult politics of sex, gender, and sexual orientation. And in fact, if you asked strong proponents of the two models, nobody would say they are playing politics with your child; they just want what’s best for him or her. And I think they believe that when they say it.

But the truth is proponents of both models have inherent conflicts of interest. Both groups have a good bit of their identities staked on knowing the “truth” about sex and gender. Most transgender activists do not want to hear that most children with gender dysphoria end up nontransgender; they want transgender to be understood as a biological, permanent, unchangeable, acceptable, natural variation. They want to welcome your child to their team and to their paradigm. Therapeutic clinicians do not want to hear that they are failing to help—even hurting—families like yours, nor that the studies they and their mentors have authored are fundamentally flawed. They want to welcome your child to their clinics and to their paradigm.

And to make things even more complicated, you have your own conflicted interests. You want what’s best for your child, of course, but your identity is also implicated in this difficult situation. Just the seemingly simple matter of whether you have a son or a daughter is going to matter to your identity. Having a child who is gender atypical, or gay, or transgender will matter even more; not only is this likely to make your child different from you and different from the child you expected, but the social shame attributed to these children gets mapped onto you, the parent.⁶

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You'll notice that the advocates of the accommodation model act as if theirs is the "progressive," even gender-radical approach. So the TransKids Purple Rainbow Foundation says that they "will strive to encourage families to allow their children the ability to grow up free of gender roles."⁷ Sounds good in theory, at least to most parents who think of themselves as "progressive." But in fact, the accommodation approach moves your child from being a girly boy or a boyish girl to being a girly girl or a boyish boy. Using the accommodation approach means going from having a William-in-a-dress to having a Julie-in-a-dress. And that may seem pretty attractive to you—no matter what your identity—since it might allow your family to look "normal," taking away the unrelenting stress of having a "different" child, reducing the cruelty you and your child encounter from those who cannot bear a William-in-a-dress. The accommodation approach might also mean you are more likely to end up with a straight daughter than a gay son, and again, that might take some of the stress off you. (This, by the way, is the approach taken in some very conservative societies, like Iran, where being homosexual is utterly unacceptable, to the point that homosexual people are pressured to transition sex to keep everyone appearing straight.)

By contrast, the therapeutic approach might in the long run leave you with a child who more obviously challenges social norms of gender. And, in the short run, the therapeutic model implies that your family is the problem, that you all have work to do. That, again, might make you more inclined to settle for the accommodation approach, which says your child and your family are not the problem.

There is reason to believe, as accommodation proponents claim, that the stress children and their families feel when the children have GID is caused by social intolerance. Some of that evidence comes from Samoan culture. If a young Samoan boy acts very girlish and identifies with girls, he is incorporated into the category of *fā'afafine*, or what Westerners would call a "third gender" category. *Fā'afafine* literally means "in the manner of a woman." A biological male living as a *fā'afafine* adopts a more feminine gender role, and this includes choosing male sexual partners (who are themselves considered straight by all concerned). The vast majority of *fā'afafine* have no interest in a biological sex change; they are happy living without biological interventions. Researchers Paul Vasey and Nancy Bartlett have shown that most *fā'afafine* children do not suffer distress over gender atypicality; the culture has a system that accommodates their "difference."⁸ (A similar system exists in some Mexican subcultures with the category of

"muxe," although whether muxe children experience distress has not been well studied.)



Ask for evidence that an intervention will result in benefits or harms. Consider biases. Try to put your child's interests above what would make you proudest.

So why shouldn't you just go with the accommodation model? Well, mostly I am hesitant to endorse that approach because we do not know what will happen with that approach. We don't live in Samoa, and we have no stress-free *fā'afafine* category; we live in a place where most feminine boys end up as gay men. So what if it turns out, as it seems to with many American men who were gender dysphoric as children, that your child's dysphoria dissipates within a few years and he stops insisting he's a girl? Well, if you've followed the accommodation approach for those years, you now appear to have a daughter named Julie, in a dress, with a penis, insisting she's a gay boy. One clinician told me that she has seen adolescents in this situation—adolescents who, as children, were "accommodated" with a public gender change, who then had their gender dysphoria dissipate as they grew. She is concerned that they cannot seem to bring themselves to tell their parents they don't want to change sex after all, after all the family has already gone through.

And what if the therapeutic approach—or even just avoiding the accommodation approach—*could* eventually make William feel comfortable with his natural-born body? Wouldn't that be a good thing? It would mean that he keeps his penis and his testes—and, therefore, his full sexual sensation and his fertility; that he does not have to go on lifelong hormonal replacement therapy; and that you all can skip the challenges of changing his sex medically, legally, and socially. All other things being equal, that seems pretty good. That might seem worth the work and social cost of avoiding accommodation. As Ken Zucker, an advocate of the therapeutic approach has pointed out, if yours were a black family and William were insisting he is white, the right approach would not be to ask doctors to help make William white.⁹ Zucker and his colleagues would advocate helping Williams learn, instead, that they can be comfortable with their bodies.

On the other hand, Zucker (like most therapeutic clinicians who treat GID) accepts the overwhelming evidence that adults who are transsexual are better off after medical sex reassignment, and he recognizes that a number of children with GID will "persist" in their transgenderism. Thus, proponents of both models—therapeutic and accommodation—would agree that, if it turns out that William is going to end up as Julie, knowing and accepting that early will make your child's

life easier. For one thing, you will make the emotional adjustment earlier, presumably causing your child to feel less conflict and rejection. But there's an even more important reason for early acceptance of eventual transition: If clinicians believe early enough that your child is going to transition sex eventually, then they might use Lupron, a drug that reduces production of estrogen in females and testosterone in males, to delay onset of natural puberty.¹⁰ That would mean William/Julie will not enter full-blown puberty and thus will not become more masculine from a natural male hormonal surge. Later, in adolescence, Julie could start using feminizing hormones to go through something more like a feminine puberty. That would mean prevention of masculine secondary sex characteristics—like a deep male voice, an Adam's apple, and masculine facial and body hair—which would mean Julie would not have to work to try and undo those traits later. As you would suspect, evidence suggests that transsexual adults who “pass” better do better socially, and your child will pass better if she or he can begin planning for the physical transition early. The challenge, of course, is identifying the children in which gender dysphoria will persist.

There are two important points you need to take into account here: First, although gender dysphoria sometimes dissipates after early childhood, if it persists into adolescence, it appears to be here to stay. Second, the use of Lupron for puberty-delay in children with GID is an off-label use. It has not been approved by the Food and Drug Administration for that purpose, and we have no good data about possible long-term negative physical or cognitive effects of using the drug this way. And some children have trouble tolerating Lupron physically. It is not a magic pill.

Notably, we are beginning to see clinics emerge that take a sort of revised therapeutic approach, probably best represented in the work of psychologist Peggy Cohen-Kettenis in Amsterdam.¹¹ This approach seeks to be less concerned with gender atypicality than both the traditional therapeutic and accommodation approaches are, and most concerned with the child's and family's functioning. The idea here is to diagnose and treat functional problems (such as separation anxiety, disorganized parenting, and depression) if they exist, so that regardless of which gender the child ultimately exhibits, the family is well. Cohen-Kettenis and her colleagues report that the gender dysphoria of the children in her clinic population sometimes dissipates. (Whether this happens because of the clinical interventions remains unclear.) But when a patient's gender dysphoria persists, Cohen-Kettenis and her colleagues assist the child and family with psychological and medical preparation for sex reassignment. This is basically a pragmatic approach that tries to leave children and their families as well off as they can be; it privileges individuals' well-being over particular identity outcomes (gay, straight, transsexual or not).

The final batch of advice I would give parents of children with GID is the advice I give all parents facing optional interventions: Try to identify the real “problem.” Is it that your child is not a typical boy, or is it that he is anxious, sad, or constantly wanting more attention than you give him?¹² Fig-

ure out exactly what you are worried about and what your goals are. How do you want your child to end up? When answering that question, try to come up with an answer that is in your child's best interests while keeping in mind that you will also be subtly inclined to do what makes your own life easier, better, or happier. (That's the nature of human parenting.) Then find out the goals of the person recommending a particular intervention, see if they match yours, and *ask what evidence there is* that the intervention will result in particular benefits or harms. (Anecdotes are not reliable forms of evidence.) Consider the possible conflicted interests of the recommender; that doesn't mean you give up on that person, it just means you be aware of biases. Don't believe anyone who tries to sell you a sure bet. Parenting is fundamentally about uncertainty, and no one can change that.

Lastly, try, if at all possible, to put what is best for your child above what would make you proudest. I think if you consider the matter long enough, you may agree that children do not ask to come into our lives to make us proud; they do not ask to come into our lives at all. Instead, what they want is for *us* to make *them* proud by loving them through difficulty. The shape love should take is often unclear, but love is what we as parents must shape out of our fears, anxieties, desires, and hopes.

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

2. M.L. Brown and C.A. Rounsley, *True Selves: Understanding Transsexualism for Families, Friends, Coworkers, and Helping Professionals* (San Francisco, Calif.: Jossey-Bass, 1996).

3. K.J. Zucker, “Gender Identity Disorder in Children and Adolescents,” *Annual Review of Clinical Psychology* 1 (2005): 467-92.

4. D. Rudacille, *The Riddle of Gender: Science, Activism, and Transgender Rights* (New York: Random House, 2005).

5. TransKids Purple Rainbow Foundation, “TransKids Purple Rainbow Foundation Mission Statement and Goals,” 2008, at <http://www.transkidspurplerainbow.org/mission.htm>.

6. For an exploration of these parenting issues, see *Surgically Shaping Children: Technology, Ethics, and the Pursuit of Normality*, ed. E. Parens (Baltimore, Md.: Johns Hopkins University Press, 2006).

7. TransKids Purple Rainbow Foundation, “TransKids Purple Rainbow Foundation Mission Statement and Goals.”

8. P.L. Vasey and N.H. Bartlett, “What Can the Samoan ‘Fa’afafine’ Teach Us about the Western Concept of Gender Identity Disorder in Childhood?” *Perspectives in Biology and Medicine* 50, no. 4 (2007): 481-90.

9. H. Rosin, “A Boy's Life,” *The Atlantic* (November 2008), at <http://www.theatlantic.com/doc/200811/transgender-children>.

10. P.T. Cohen-Kettenis, H.A. Delemarre-van de Waal, and L.J. Gooren, “The Treatment of Adolescent Transsexuals: Changing Insights,” *Journal of Sexual Medicine* 5, no. 8 (2008): 1892-97.

11. P.T. Cohen-Kettenis and F. Pfäfflin, *Transgenderism and Intersexuality in Childhood and Adolescence: Making Choices* (Thousand Oaks, Calif.: Sage Publications, 2003).

12. For help in sorting out the various “problems” subsumed under a diagnosis of “gender identity disorder in childhood,” see N.H. Bartlett, P.L. Vasey, and W.M. Bukowski, “Is Gender Identity Disorder in Childhood a Mental Disorder?” *Sex Roles* 43, no. 11/12 (2000): 753-85.