

**A pervasive, consistent, persistent and insistent sense of being the other gender and some degree of gender dysphoria are unique characteristics of transgender children.**

## **FACT SHEET**

### **Gender Diversity and Transgender Identity in Children**

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**GENDER DIVERSE** children (also known as gender non-conforming, gender creative, or gender variant) express their gender in ways that are not consistent with socially prescribed gender roles or identities. Their preferences for toys, clothing, sports, activities, playmates, hair length and style, and/or accessories are not expected in the culture based on their sex assigned at birth. Gender diverse children are usually perceived to be feminine boys and masculine girls. In fact, some gender diverse children may occasionally talk about wanting to be or wishing they were the other gender or saying they are the other gender. Some gender diverse children occasionally talk about being “half” boy or “half” girl (e.g., “I’m a boy on the bottom, and a girl on the top”).

**TRANSGENDER** children typically consistently, persistently, and insistently express a cross-gender identity and feel that their gender is different from their assigned sex. They may begin talking about their gender as soon as they begin to speak and some may express dissatisfaction with their genitals. Transgender children are more likely to experience gender dysphoria (i.e., discomfort related to their bodies not matching their internal sense of gender) than gender diverse children, although some transgender children are comfortable with their bodies. Transgender children may state that they are really the other gender, or that someone (e.g., the doctor or a religious authority) made a mistake in their gender assignment.

Whether a child is transgender or gender diverse may not be readily apparent. Transgender and gender diverse children may exhibit similar preferences, may both desire to have another gender than the one they were assigned and may draw themselves as another gender in self-portraits. A pervasive, consistent, persistent and insistent sense of being the other gender and some degree of gender dysphoria are unique characteristics of transgender children.

Although there is more recent awareness of gender diverse and transgender children in our society today, these children are not part of a “new” phenomenon. Cross-gender behavior has existed throughout history in every continent and within a wide range of cultures for thousands of years. Although no consensus exists on the etiology of gender diversity, neurobiological evidence for sex-specific brain differences in transgender people is being explored. One’s gender identity is very resistant, if not immutable, to any type of environmental intervention. Like with non-transgender people, transgender and gender diverse people will establish their sexual identity as either gay, bisexual, queer, or heterosexual.

### **PREVALENCE AND COURSE**

To date, the prevalence of children who either present as gender diverse or identify as transgender is unknown. There is some existing data from clinical samples of children referred for gender dysphoria. These studies estimate that 5 to 12% of girls and 2 to 6% of boys exhibit cross-gender behavior. In these samples, boys are three to six times more likely to be referred for treatment for gender dysphoria than girls, which may be due, in part, to greater social acceptability for participation in cross-gender behaviors by girls. Rates of gender diversity in children appear to decrease with age. This change may be related to adolescents attempting to conform to peer and family expectations about cross-gender behavior, and therefore may not indicate a true change in gender identity. It also may have to do with gender exploration morphing into sexual identity exploration and consolidation, as is the case with those gender diverse children who develop into non-transgender gay, bisexual, or queer adults.

For many children, identification with a gender begins around two years old. Individual trajectory of persistent cross-gender identification is variable. Although there is no way to predict the constancy of cross-gender identification through adolescence and adulthood, it is more likely to persist for individuals who first demonstrated gender dysphoria as toddlers. In clinical samples, gender dysphoria and cross-gender identification persisted into adulthood in up to 27% of cases, with people assigned female at birth being more likely to persist than those of a male natal sex; however, the frequency of persistence in non-clinical samples is unknown.

### **HEALTH AND PSYCHOSOCIAL CONSEQUENCES**

Both internalizing concerns, such as depression and anxiety (particularly social anxiety), as well as behavioral concerns, such as attention deficit hyperactivity disorder and oppositional defiance, can accompany cross-gender identification. Functional impairment may occur within the family and/or at school, and social functioning may be affected. This impairment is often the direct result of negative societal reactions to gender presentation. Addressing gender issues in a supportive and non-judgmental manner has been associated with reductions in internalizing and externalizing behaviors. In addition, significantly higher rates of autism spectrum disorders have been found to exist in the population of gender diverse and transgender children. No clear explanation is yet available for this finding, although speculations are that children on the autism spectrum may have a different trajectory of gender development that is less influenced by social expectations or cues, and alternatively,

there may be a brain association where both autism and gender nonconformity or influenced by the same brain mechanisms or structures. Research suggests that family support and a sense of positive future are resilience factors that protect against negative health and psychosocial outcomes.

## EVIDENCE-BASED ASSESSMENT

Early intervention may improve outcomes for gender diverse and transgender children who are experiencing emotional distress. Comprehensive assessments of biopsychosocial influences on children may be indicated. Working within an interdisciplinary team of psychologists, physicians, educational specialists and advocates and other health care and mental health providers who have been trained to work with gender diverse and transgender children is recommended. Continued research on appropriate assessment is currently underway. Given the extraordinary undertaking of a full assessment that is often sought as a consultation, it is recommended that all assessments be conducted by a specialist with gender and sexuality competence.

## CULTURE, DIVERSITY, DEMOGRAPHIC, AND DEVELOPMENTAL FACTORS

Gender diversity and transgender identity occur in all cultural, ethnic, and racial groups. There is no single trajectory of development of gender diversity or transgender identity. Many gender diverse children will later identify as LGBTQ in adolescence and adulthood.

Gender identity development occurs much earlier than the development of sexual orientation. Children usually have a sense of their gender identity between age 2 to 5 and they typically become cognizant of their sexual orientation around age 9 or 10, although this self-awareness is occurring at earlier ages, particularly as it is a topic more widely discussed and available to younger children. Transgender and gender diverse children may begin to play in a way that is not expected for children of their sex from a very young age. Gender diverse boys typically experience more negative reactions from their parents and experience more victimization at school than gender diverse girls. This is due to the great latitude given to girls expressing masculine behaviors in a society that overvalues male behaviors and undervalues female behaviors.

## AFFIRMING PSYCHOLOGICAL INTERVENTIONS

There are three main approaches to psychological intervention with gender diverse children including a “gender affirmative” approach, a “wait and see if these behaviors desist” approach, or actively discouraging gender non-conforming behavior. The gender affirmative model is grounded in the evidence-based idea that attempting to change or contort a person’s gender does harm. Psychological interventions should aim to help children understand that their gender identity and gender expression are not a problem. Providers should aim to non-judgmentally accept the child’s gender presentation and help children build resilience and become more comfortable with themselves, without attempting to change or eliminate cross-gender behavior. Children who experience affirming and supportive responses to their gender identity are more likely to have improved mental health outcomes. Gender identity is resistant, not impervious to environmental manipulation. Moreover, attempts to change a child’s gender may have a negative impact on the child’s well-being.

Individualized treatment plans based on the child’s specific situation and needs should be created for each case. Individual therapy with the child is not always indicated, and most of the therapeutic work in these cases is with the parent(s). However, individual play therapy may help children to therapeutically explore and further develop their gender identity in a safe and healthy manner. Family therapy may also be advisable, along with support groups for children where they can have an opportunity to meet other children like themselves

and receive peer support. Providers should advocate for children to be safe in schools while exploring gender diverse expression. Fully reversible interventions such as a social gender transition including changing clothing, name change, new pronouns, or changes in haircuts may be indicated for some gender diverse and transgender children.

Psychologists’ work with family can include assisting them to seek support and move toward acceptance, encouraging the child’s gender exploration and expression, speaking with the child about gender in a developmentally appropriate manner, speaking to other family members and friends about the child, and advocating for the child in school and community settings. Often, the most important intervention is helping the family to cope with and live for some time with the uncertainty about the child’s gender and sexual identity development.

No gender-related medical interventions are necessary with young children. The earliest a child should be referred for medical treatment of gender dysphoria is just before the onset of puberty if the child desires to go through a different puberty than their body would ordinarily experience. Puberty blocking medication can be used to put a temporary halt on puberty and not only allow a child to stop an unwanted puberty but also to buy the child more time to explore gender before moving into a time when the secondary physical effects of the puberty associated with the assigned sex of the child take effect. Providers can work to develop a network of referrals including supportive and competent medical professionals, community groups, parent support groups, and other professionals.

## KEY REFERENCES

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### RESOURCE ORGANIZATIONS

American Academy of Child and Adolescent Psychiatry (AACAP)

American Counseling Association (ACA)

American Gay and Lesbian Psychiatric Association (AGLP)

American Psychological Association (APA)

Family Acceptance Project

Lesbian and Gay Child and Adolescent Psychiatric Association (LAGCAPA)

National Association of School Psychologists (NASP)

World Professional Association for Transgender Health (WPATH)