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CONFERENCE PROCEEDINGS HORMONES, IDENTITIES, AND CULTURES: CLINICAL ISSUES IN TRANSGENDER YOUTH

Formation of Transgender Identities in Adolescence

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There is little information about the formation of transgender identities in adolescence. Diagnosis and treatment of transgender adolescents is often surrounded by confusion and controversy on the part of clinicians and family. This paper identifies some of the issues that arise in these treatments and offers some guidelines. The importance of understanding and embracing the diversities of outcomes of gender variant children is stressed, as is the concept of affirmative and adaptive treatment approaches for these children and their families, in order to foster more positive self-esteem and identity formation as these children become adolescents.

KEYWORDS gender atypical behavior, cross-gender, transsexual, transgender, adolescents, mental health treatment

INTRODUCTION

It is important to review some definitions. *Gender identity* is a sense inside oneself of one's masculinity, femininity, and anything in between. *Gender role* is the outward manifestation of gender, what a society normally holds as stereotypes of what is masculine and what is feminine, such as wearing a tie, having a beard, wearing a skirt, or having long or short hair. These stereotypes that a society holds may be very different than an individual's own sense of his or her gender identity. For example, a child may feel very

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different inside than she shows outwardly in her dress, her mannerisms, and/or her behavior. The term *cross-gender* is used to describe a person who goes beyond the stereotypical behavior and interests of his or her gender and exhibits behavior stereotypical of the other gender. An example of cross-gender behavior would be if I wore lipstick and a dress. Sometimes we refer to cross-gender behavior as *gender atypical* or *gender variant behavior*.

Transsexual is used to refer to a person who transitions to the other sex. *Transgender* is a newer term that is much more encompassing of the range and the spectrum of genders that people experience or feel. There are many different names that people use to describe the experience of being transgender, including *two spirit, tranny, gender-queer,* and *in-between*. When people use terminology to describe their gender, it is important to ask them to describe how they are using the term and how they see themselves, rather than to assume that you know what they are talking about when they use these terms, including the general term *transgender*. I try not to assume that I know what someone means when they use such terms. This article will discuss *sexual orientation* rather obliquely, in the general sense of erotic attraction an individual has to one sex or the other. *Sexual identity* is more of a loose term; most researchers use this term to refer to a gestalt of sexual orientation plus sexual behavior plus gender identity plus gender role, in other words all these things in one person.

Transsexualism is thought to be rather uncommon. Transgenderism is more common because it is a bigger umbrella term of a spectrum of identities and behavioral manifestations, and it includes transsexualism. There are various estimates of prevalence of transgenderism ranging from 1 in 30,000 to 1 in 5,000 (van Kesteren et al., 1997). A recent paper suggested that the prevalence is much more common, 1 in 500 (Olyslager & Conway, 2007). For prepubertal kids, substantial and long-lasting childhood gender variance is uncommon; however, there are no epidemiological data to suggest the actual prevalence.

Most clinicians are quite inexperienced working with gender variant adults, adolescents, and prepubertal children. However, as people become more open to talking with mental health providers and to coming out to others about their gender variance, there are more and more requests for clinicians who can work with these populations. There is no grand theory of transgender development, but, of course, as people become more open to talking about their experiences of gender, there is a need for more encompassing theories.

Crossdressing and transsexualism are not new concepts. These phenomena go back to the oldest recorded histories. However, the terminology used today to describe the phenomena is new: the term transsexual was first used by Magnus Hirschfeld in 1923, and Caldwell used it in the English language for the first time in 1949 (Caldwell, 1949). The term transgender originated in the 1970s.

Psychiatric diagnoses relating to these conditions have changed over time, both in the International Classification of Diseases (ICD; World Health Organization, 1989) and in the Diagnostic and Statistical Manual of Mental Disorders (DSM; American Psychiatric Association, 2000), and there has been great controversy about these diagnoses. In the DSM-III (American Psychiatric Association, 1980) and IIIR (APA, 1984), there were three diagnoses to describe gender variance: gender identity disorder of childhood (GIDC), gender identity disorder of adolescents or adulthood, nontranssexual type (GIDAANTT, which no one ever used), and transsexualism. In DSM-IV (1994), the sexual and gender disorders committee decided to lump these three diagnoses into one diagnosis called gender identity disorder (GID); therefore, children with gender variance were lumped in with the adults, and adult transsexuals lost the diagnosis of "transsexual" and now had the label "gender identity disorder," resulting in much dissatisfaction among transsexual adults, parents of gender variant youth, and by some professionals as well (Pleak, 1999).

It is not clear what the nosology in the upcoming DSM-V will be. A workgroup has recently been formed and the process has started. There are some people who are advocating to remove GID from DSM, or to remove the diagnosis for children, or to maintain some parts of it that are not as pejorative as the current system. Therefore, today the various lay terms discussed are used, but the only clinical term for transsexuals and transgendered people is GID. Of course, being cognizant of repercussions involving insurance issues and medical records is important when using a diagnostic term such as GID, especially when working with younger people whose records may follow them to schools or be involved in confidential proceedings later in life, such as applying for a top security clearance or in a professional setting (Pleak, 1999; Pleak, 2009).

Some of the early factors associated with the development of transsexualism or transgenderism bring into question the concept of nature versus nurture; that is, to what extent genetics or biology and to what extent the environment impact on the development of gender identity. Most theoretical ideologies that have been proposed over the decades to attempt to explain how gender identity develops have not been supported by data. The only theory that is backed by empirical data, based on the research of Dr. Kenneth Zucker, is that boys who are gender variant, that is, boys who have cross-gender behavior, are more likely to have older brothers (Zucker et al., 1997). However, this research finding has not yet been replicated, mainly because there are few people working in this area. In my clinical practice, I have not found this to be the case. Another consistent finding of Zucker's is that gender variant boys are more often described as "babies," "pretty boys," or "beautiful boys," and the gender-variant girls are described in infancy as less attractive than their peers. All the other factors that have been theorized to be associated with transgenderism or transsexuality have not been

verified, such as excessive stress during the pregnancy while the fetus is in the womb, early separation from the mother, early hospitalization of the child, having a domineering mother or absent father, and the like.

If we look not at transgender or transsexual adults but at gay males, there is a higher concordance of homosexuality in twins and a higher prevalence of homosexuality in maternal male relatives, such as uncles and cousins (Whitam et al., 1993). These correlations have not been found with transsexual people. One problem is that there are few reported twin studies with transsexual people; in fact, in the studies that have been done, the researchers have only looked at one to four sets of twins. There is simply not good data for twin studies of transgenderism or transsexuality. With retrospective studies of transsexual adults, we find that almost all participants recall that they had childhood gender variance. Often, families of the participants of these studies verify that their family member as a child was more feminine or masculine (i.e., cross-gender) than the expected norms. If we look at retrospective studies of gay and lesbian adults, a small number of adults recall substantial childhood gender variance, not nearly as high a percentage as for transsexual adults.

DEVELOPMENT OF GENDER

For some children, gender variant behavior and fantasies begin around the age of one and half to two years old. In preschool, some of these gender variant children will make open statements about feeling that they are or wish to be the other sex, such as the wish to lose their genitalia and have the genitalia of the other sex. They may play preferentially with other sex peers. When playing pretend games, they may pretend that they are the other sex. Parents usually tolerate this behavior as "a phase" that the child is going through, often until the child is four or five years old, when most parents get concerned that the behavior is no longer a phase.

Commonly, problems with a child's gender-variant behavior arise when the child begins school. As a result, many gender variant children are brought in by their families to psychiatrists around this age. From first to third grades, gender variant children start to experience some degree of isolation. Gender variant boys become more isolated because girls begin to form their own cliques, excluding gender variant boys, and a little later the boys form their own cliques, further isolating the gender variant boy. This happens with gender variant girls as well, although not to the same extent as with gender variant boys. Therefore gender variant children tend to become fairly isolated beginning around first to third grades of school, unless they are supported very well in school and at home.

The ages of eight to ten years old are a major time for kids to tease and malign each other. Gender variant behavior is a real target for teasing. Gender variant children become victims of intolerance, bullying, and violence. These ages coincide with the time of ego formation in terms of moral development and the development of the superego. Because of the real fear of harassment and violence, gender variant children become more adept at hiding their feelings and behaviors. Studies looking at what happens to these children as they grow older include those done over the past 30 years by Green, Zucker, and Cohen-Kettenis (reviewed by Cohen-Kettenis & Pfafflin, 2003). All of these studies have similar findings in terms of what happens to gender variant children as they grow older: a small number will remain gender variant into adolescence, while the majority will exhibit more gender typical behavior as they become adolescents. Therefore, just because an individual is gender atypical as a prepubertal child does not mean he or she will be gender variant as an adolescent or adult.

There is a growing international consensus that once kids pass through the period of pubertal changes that begin at the ages of 10 to 12, by Tanner stage two or around the age of 11 to 13, gender atypicality or gender variance is not going to change much going forward. There is now a degree of international consensus about considering these youngsters as likely continuing to be transgender or transsexual as they grow older. We can also begin to think about how we assess other issues such as sexual orientation in these individuals. Much of the assessment of these issues is complicated by suppression by the families and by the individuals themselves. Many gender variant kids may not be open to sharing with clinicians, peers or their families the degree of their gender variance. This fact can make the assessment of adolescents very complicated in terms of determining whether they are indeed more gender typical, are beginning to feel more gender typical, or are remaining gender atypical.

There is a tendency of the lay press and internet sources to equate childhood gender variance with later homosexual sexual orientation, which may influence and distort the histories given by adolescents and their parents. However, reality is not so simple. Few adult gay men report having had cross-gender behavior as children. There is a much stronger relationship between adult gender variance and childhood gender variance: the people who are gender variant as adults have much greater histories of gender variance as childhood than not.

I have discussed how most transgender people have histories in their childhood of transgender or cross-gender behavior. There are also some transgender adults who do not recall having transgender feelings or behaviors in childhood. Furthermore, their families corroborate the histories given by the family member. Therefore, for these individuals the origin of cross-gender identity may occur later, as late as in adolescence or even adulthood. This is not a common finding, but it does occur. For example, I am currently

treating a college student who is transitioning from male to female. He and his parents describe little, if any, cross-gender behavior when he was three to five years old.

There is also the controversial concept of *autogynephilia*, which is basically love of oneself as a female. This is a concept that Blanchard developed in 1989, and it has remained controversial since he first described it (Blanchard, 1989). *Autogynephilia* is a theory that explains transgenderism in some males as having an erotic arousal origin, in which a male, as a teenager, starts feeling eroticized while wearing female garments and who continues to be aroused as he fantasizes about being dressed as a girl and about being a girl. A clinical example would be a boy who starts wearing female garments in a fetishistic way. As the individual gets older, the behavior becomes more generalized. He becomes more comfortable and eventually less sexually aroused by the female undergarments, and begins to feel that wearing female garments is more of an indication of who he is in terms of gender identity. There is great controversy about this theory, but there are some cases I have seen and some described by others in which their histories have generally followed the description laid out by Blanchard in 1989. We have to remember, however, that such histories have been obtained retrospectively, and suppression and active denial by study participants about many of these things may influence how we view the person's origins of transgenderism.

ADULT OUTCOMES

Most children are gender typical and the outcome for most of them is to become gender typical, heterosexual adults. Some gender-typical children will become gender typical gay adults, and a minority will become transgender adults. Then there is the smaller group of gender-atypical children: most of them will become gender typical gay or lesbian adults, some will become gender typical heterosexual adults, and very few of them will become transgender adults (Green, 1987; Cohen-Kettenis & Pfafflin, 2003). The important point is that if you follow gender-atypical children into adulthood, most of them will not be gender atypical or transgender adolescents or adults. Green's and other studies find that about 65% of these children became gender-typical gay men (we will focus on the boys in the studies), about 25% became heterosexual men, and maybe 5–10% became transgender adults (Green, 1987). Therefore, there are no clean and easy predictors for these children; rather, there is a diversity of developmental outcomes that become a very important concept when working with families of these children in order to help them to embrace that diversity. In my work with these families, I often try to be creative with this discussion by saying that "these categories are boxes that are not quite descriptive of everybody." So

the gender variant male child may become a gender atypical heterosexual man (that is the so-called effeminate heterosexual man), a gender atypical or effeminate homosexual male, a gender typical homosexual man, or a transgender person or transsexual woman.

We can also think about the concepts of *androphilic* and *gynephilic* transgender people in terms of which genders they are attracted to sexually. Every time we start thinking about the diversity of gender experience and gender development, we realize that we cannot think about box categories any more for adults or for kids. We can eliminate many of these boxes that are used to try to explain gender development and become much more encompassing by saying that children have a chance to become just about anything when they grow up.

Children who are not supported in their environment have more difficulty as they grow older with consolidating a positive gender identity or sexual orientation. Not consolidating a positive identity can be damaging to a child's self-esteem and can lead to problems such as suicidal, risk taking, and dangerous behavior as the child grows older. As children progress through puberty, it is particularly important to assess how they feel about the changes that are happening in their bodies, what their aspirations for changes to their bodies are, and how these changes affect their self-esteem and sense of identity.

Clinically we often need to address with children and families how to deal with reactions from peers and how to foster support from authorities in their schools and communities. For example, having a boy who dresses as a girl and prefers to be identified with a female name go to a school where the teachers and principal insist on recording or using the male name, identifying him as "male," or grouping him with the boys can create a great deal of difficulty for that child. How teachers or authority figures address these kids is very important, as well as how the child is allowed to dress and where he or she may dress or use the bathrooms. I treat a teenager who refuses to go to the bathroom for the entire day when she is at school, and another who uses the bathroom only in the nurse's office. What bathrooms do they use if they live in a dorm? Should they live in a male or a female dorm? Which clubs or groups may be available to them for support? Is there a gay/straight alliance in their schools? If so, is it helpful for transgender kids? Regional disparities in civil rights laws can be important, especially as kids grow older. Some places, such as New York City and Washington, D.C., have very progressive rights for transgender people. But not far away in my medical center in Nassau County, N.Y., there are no legal protections for transgender individuals.

Treatment aimed at prevention of gender variant youth from growing up to be transgender or gay adults is mostly discredited today, but is still recommended by some. Behavioral treatment was advocated strongly in the 1970s by people such as Bentler, Lovaas, Rekers, and others (reviewed by

Pleak, 1999). Rekers used religious persuasion in his treatment throughout the 1980s and 1990s, with the prevention effort focused on preventing these kids from becoming homosexual (Rekers, 1995). He wrote, "There are numerous inter-related reasons for intervening in the life of a boy diagnosed with a gender disturbance. The first reason for treatment is the psychological maladjustment of gender-disturbed children. The second reason is to prevent severe sexual problems of adulthood, such as transsexualism and homosexuality that are highly resistant to treatment in later phases of development" (Rekers, 1995). In the 1960s, analysts such as Charles Socarides and Joseph Nicolosi founded the National Association for Research & Treatment of Homosexuality (NARTH), which advocated for the treatment of gender variant children to prevent them from becoming homosexual as they grow up. This organization is still active. They disagree with the de-pathologization of homosexuality that happened in 1973 (Bayer, 1987).

Other analysts, such as Susan Coates and Paulina Kernberg, also advocated for analytic treatment, although with somewhat different goals. Zucker and Heino Meyer-Bahlburg have advocated for a treatment modality sometimes called "fading," which is designed to assist children to not persist in their gender variant behavior (Zucker, 2004). Meyer-Bahlburg has advocated parent-centered fading, working mostly with the parents to facilitate "fading" of the child's cross-gender behavior (Meyer-Bahlburg, 2002). Over the past 15–20 years, concepts that have been seen as more positive, affirmative, and adaptive for the families and children began to be generated by Dennis Anderson, Katherine Tuerck, Edgardo Menvielle, and myself (Menvielle & Tuerk, 2002; Pleak, 1999). These more affirmative and adaptive therapies are designed to prevent gender-variant children from developing a damaged self-esteem and to help them have a positive identity as they grow up, whatever that identity may become.

In terms of treatment, a therapist needs to focus on issues of self-esteem, relationships in the family, derailment of normal development, suicidality, substance abuse, sexualization, and, in extreme cases, prostitution, violence, and murder. There have been several recent cases of young people who have been murdered because of their gender identity. A therapist should focus the therapy on facilitating the establishment of a solid gender identity. Hormone therapy may also play an important role in this work, as has been shown in the pioneering work by Cohen-Kettenis and her group in the Netherlands (Cohen-Kettenis et al., 2008). The American Academy of Child & Adolescent Psychiatry is working to develop practice parameters for treating children with gender issues.

There are many support services for kids and families who are struggling with these issues, such as PFLAG (www.pflag.org), a wonderful organization for parents and other family members to support and educate each other. There are many good books that can be helpful for kids and families struggling with these issues, including *Sissies & Tomboys* by Matthew Rottnek

(Rottnek, 1999) and *Gender Identity: The Ultimate Teen Guide* by Cynthia Winfield (Winfield, 2006).

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