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Original article

Intervention with preschool boys with gender identity issues

Intervention pour des garçons d'âge préscolaire ayant un trouble de l'identité de genre

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Abstract

This paper reviews the origins of gender identity issues in preschool boys and presents an overview of treatment strategies for working with parents of boys and with the boy. The goals of treatment are to reestablish a secure attachment relationship with both of his parents, to develop a range of coping mechanisms for handling separation anxiety and aggression, to help the child to understand and enjoy his temperament, to help the child to be able to have same sex friendships, to develop gender flexibility and most importantly, restore his self esteem and his sense of authenticity. Specific treatment interventions are reviewed.

Keywords: Gender identity disorder (GID); Family dysfunction; Separation anxiety; Unresolved intergenerational trauma; Gender flexibility; Self-esteem; Authentic sense of self

Gender is shaped by societal norms and is deeply rooted in the child's attachment experience. The child's awareness and understanding of gender as an attribute of self and others evolve through the lens of developmental stages in the context of the specific meanings of gender to his or her parents. Ordinarily, integrating gender into one's sense of self is experienced with positive affect in the child. Ideally, gender becomes a flexible and valued aspect of the self while receding in importance as an organizing schema as development proceeds into the school age. In a gender identity disorder (GID), the construct of gender becomes co-opted as a means of managing anxiety that is related to attachment security and is taken on in a rigid, inflexible and stereotypic form.

Fantasies of boys with GID differ from the passing cross-gender fantasies and enactments commonly encountered in most children by virtue of their persistence, intensity and duration. Further, GID is associated with significant suffering in the child and with impairment in flexible, adaptive functioning overall. In all these respects, it can be contrasted with a typical degree of cross-gender interests and behavior that occurs in nearly all children and with behavior that constitutes gender non-conformity, which involves flexible same- and cross-gender behavior that is not driven or compulsive in character. Understood from this perspective, extreme and rigid hyper-masculinity in boys and extreme and rigid hyper-femininity in girls are also disorders even if they are not classified as such.

Research has repeatedly shown that GID is associated with a high degree of psychopathology in the child and with significant parental psychopathology and with familial dysfunction [1–3]). The focal disturbance in the child's sense of gender must be understood in relation to this multiplicity of factors that are responsible for bringing it into existence and perpetuating it. Clinically, what one observes is that: the cross-gender behaviors are most often used to help reestablish an attachment relationship that has been put in jeopardy. The child's dysphoria with regard to his or her gender almost invariably bespeaks an inner unhappiness with the self. This is often experienced as not being what mommy really wanted, accompanied by the belief that she would be happier if he were a girl. This unhappiness frequently goes unobserved by others, because the overt cross-gender behaviors are often viewed as cute or charming. Yet in our experience many children readily express their suf-

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fering quite directly – even during the intake process. One little boy said: "I hate myself. I don't want to be me. I want to be a girl". Many others in various forms say I know my mom really wanted a girl. Many children experience this even when the wish is directly denied by the mother.

To be successful, treatment must address itself to the sources of the child's distress, demystify these in terms of their relation to gender constructs and enable the child to develop alternative means of managing anxiety while strengthening the child's sense of self within the context of his or her particular temperament. Moreover, parents unresolved internal conflicts that are impinging on the child's psyche must be addressed.

1. Etiology of GID in boys

GID typically emerges in the context of multiple predisposing factors that are simultaneously present during a sensitive period of cognitive and emotional development between the ages of one and a half to three years, before stable representations of self and other and gender constancy are established. During this developmental epoch, moreover, procedural and enactive modes of thought predominate.

The clinician should be attentive both to non-specific factors predisposing the child to anxiety and to difficulties regulating affect in general (see below) and to specific factors, in the child and in his environment, which have inadvertently encouraged the development of this particular disorder rather than of some other.

Non-specific and specific factors known to be associated with a gender identity disorder include the following.

1.1. Constitutional factors

Boys with GID are most often sensitive, shy and behaviorally inhibited children. Unlike most other boys, they are avoidant of rough-and-tumble play and have heightened sensory sensitivities especially to colors and odors [4]).

1.2. Concurrent psychopathology

Boys with GID have overall levels of psychopathology comparable to other clinic-referred children. Separation anxiety, symptoms of depression and difficulties in managing aggression are prominent [1,3]. The varying symptoms of disparate collateral psychopathology can coexist in the same child. Not infrequently, for example, a boy who will be timid and fearful, even panicked, in some situations will be capable of escalating into sudden rages in others. The cross-gender symptoms are often used to help contain the child's distress in these multiple different contexts. Thus one little boy, when asked what he did when he felt angry feelings, replied: "I put on my red, ruby shoes" (girls high heeled shoes). The same boy at the end of therapy sessions, when told it would soon be time to stop, would promptly begin combing and recombing a Barbie doll's hair. In most individual histories, it is possible to document the existence of significant stress around the time of the onset of GID. Once the GID is developed social ostracism becomes an additional, major source of distress for these children.

1.3. Parental psychopathology

Significant parental psychopathology occurs in nearly every case. In mothers, depression and anxiety are typical; in fathers, difficulties in regulating affect and problems with substance abuse are predominant [5,8]. In many instances, parental difficulties stem from unresolved mourning and/or unresolved trauma dating back to their own childhoods that have become coded – consciously or unconsciously – in gender constructions. These issues often have been dormant until reactivated in the process of parenting their child.

1.4. Severe family stress

Traumatic experiences during the first three years of the child's life have been documented in a very high percentage of families. Chronic, severe marital conflict is also very common. These stressors, besides compounding existing parental difficulties, often lead directly to a derailment of the child's relationship to his primary attachment figure(s) and, in many cases, can be directly implicated in the onset of the GID.

1.5. Parental encouragement of the cross-gender behaviours

This specific factor, which is the sine qua non for a GID to develop, can reflect a diversity of different dynamics in the parents. For a GID to become established, the child's enactment of the cross-gender role must serve some regulatory function within the family system (such as providing the mother with momentary relief from depression or reassuring her about her fears of aggressive men).

1.6. Isolation from peers

Boys with GID, for a variety of reasons including temperament, maternal attitudes and lack of opportunity, often have not developed relationships with male peers.

2. How these factors can interact?

For a GID to become established a number of risk factors must come together during a sensitive period of cognitive development, when the child is first learning to categorize self and other by gender, but before he has achieved gender constancy, gender stability, or the domain-specific knowledge that the genitals are the defining attribute of gender (Gender stability refers to the knowledge that gender does not change during development; gender constancy refers to the knowledge that gender does not change with a change in activity or dress). Children with GID have greater difficulty establishing a cognitive understanding of gender and often believe that they can change their gender through changes in their clothing or activity.

Beyond being a period of cognitive vulnerability in the domain of gender, the period for the onset of GID overlaps with the stage in the separation–individuation process in which the child's attachment to primary caretakers undergoes a major