

Original article

## Children with gender identity disorder: Is there a best practice?

### Enfants avec troubles de l'identité sexuée : y-a-t-il une pratique la meilleure ?

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#### Abstract

Almost 50 years of clinical observation and research on children with gender identity disorder have provided useful information on phenomenology, diagnostic and assessment procedures, associated psychopathology, tests of etiological hypotheses, and natural history. In contrast, best practice guidelines and evidence-based therapeutics have lagged sorely behind these other domains. Accordingly, the therapist must rely on the “clinical wisdom” that has accumulated and to utilize largely untested case formulation conceptual models to inform treatment approaches and decisions. Because of this state of affairs, dogmatic assertions about best practice should be avoided.

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For several reasons, I think that it is timely to focus on therapeutics. We are now approaching the 50th “anniversary” of Green and Money’s [1] seminal paper on young children with gender identity problems. Since then, there have been considerable advances, on several fronts, in understanding these youngsters. During this time span, we have learned a great deal about phenomenology, assessment and diagnosis, identification of associated features (e.g., the most common comorbid behavioral problems), exploration of etiological hypotheses, and long-term follow-up [2–6]. Because there are not a lot of research clinicians working in this area, the advances have come slowly, from the persistent efforts of a few investigators.

Regarding therapeutics, a comparative developmental perspective on gender identity disorder (GID) is essential. In my view, the most general statement that can be made is this: the prospects for therapeutic change with regard to GID become considerably less malleable over the life course. If we start with adulthood, for example, the evidence is reasonably strong that psychotherapeutic interventions are not particularly successful. Although GID in adults may wax and wane [7], there is little direct evidence that this fluctuation results from specific psy-

chotherapeutic techniques or interventions. Very few adults with GID, as Chiland [8] has noted, are particularly interested in psychotherapy. The empirical evidence from adulthood suggests that gender dysphoria is best treated through hormonal and surgical interventions, particularly in carefully evaluated patients. The picture from adolescence is not that different from that of adults. In my view, many adolescents with GID are not particularly good psychotherapy candidates and there is certainly little in the way of empirical evidence, or even clinical experience, that psychotherapeutic techniques or interventions are particularly effective [9] although, again, the gender dysphoria may wax and wane. Cohen-Kettenis and her colleagues, in the Netherlands, have certainly provided some very nice empirical evidence that hormonal and surgical interventions may be the most effective way to resolve gender dysphoria in carefully selected adolescent patients [10–12].

In my view, the picture changes radically when it comes to children with GID. That is to say, it is my clinical impression that many of these youngsters, and their families, respond quite effectively to psychotherapeutic interventions. Although I have no doubt that the changes that one can observe in these youngsters can, in part, be attributed to “spontaneous remission”, if I dare use such a term, I believe that the situation is more complex than this. In other words, I think that therapeutics can work with young children with GID.

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However, here we face a serious problem. Although there is a reasonably large literature on therapeutic approaches (behavior therapy, psychotherapy and psychoanalysis, parent counseling, group therapy, etc.), a perusal of the treatment literature yields the sobering fact that there is not even one randomized controlled treatment trial for children with GID [13]. In the era of best practice and evidence-based therapeutics, this means that the highest standard of evidence (Level I: “evidence obtained from at least one properly designed randomized controlled trial”) has not been provided. Although there have been some treatment effectiveness studies, which might qualify as Level II standards (e.g., “evidence obtained from well-designed cohort or case-control analytic studies”), much is lacking in these investigations (for reviews, see [13–16]). To put it plainly: there is a large empirical black hole in the treatment literature for children with GID. As a result, the therapist must rely largely on the “clinical wisdom” that has accumulated in the case report literature and the conceptual underpinnings that inform the various approaches to intervention. This putative clinical wisdom is at Level III (“opinions of respected authorities, based on clinical experience, descriptive studies or reports of expert committees”). Of course, here one person’s wisdom may be deemed ignorance by another.

## 1. Case formulation

In the absence of best-practice therapeutic guidelines, the case formulation, i.e., the clinician’s underlying conceptual model, is what will organize the approach to treatment. In generating a case formulation, there are several factors that might be considered.

### 1.1. Biological influences

Some parents of children with GID (and therapists) can be characterized as “biological essentialists”. That is, these parents take the position that their child was “born that way”. A few years ago, there was a very interesting case in the United States that was publicized in the mass media that is illustrative of this point [17]. The parents of a six-year-old boy with GID, living in the state of Ohio, attempted to register their son, whose birth name was Zachary, at school as a girl, with the given name of Aurora. Someone at the school apparently was concerned about this and notified the child welfare authorities, who then took the child into care. Media reports indicate that the parents have had various concerns about their son, not just in the domain of gender identity, the parents have had a number of psychiatric difficulties themselves, and the father revealed to a reporter that he wished to have a sex change operation himself, etc. From the media accounts, the parents appeared to be of the view that their child was born this way and that they were simply acting in the child’s best interest by facilitating the transformation so as to reflect his true nature.

Since the story of Aurora was published in 2000, there have been a flurry of media articles and clinical essays about some parents and clinicians who have taken a very different stance from the more traditional approaches to therapeutics for GID

in children [18–25]. This alternative approach is characterized as “gender-affirming”: the diagnosis of GID is fiercely rejected and, in its place, terms such as “gender-variant” or “transgendered” have been used; the therapeutic approach has been to support the child in transitioning to living as the opposite sex. The novelty of this perspective is that some parents and therapists are adopting this approach with preschoolers and children just entering the school system, a developmental far cry from supporting transition among adolescents who appear to be locked into a cross-gender identity. Such children and their families have been highlighted on widely-watched television programs in the United States, including the Oprah Winfrey Show (May 12, 2004) and ABC’s *20/20* (April 27, 2007). Additionally, a new parent-initiated website (TransKids Purple Rainbow Foundation; <http://www.transkidspurplerainbow.org/>) has been launched for families who opt for this therapeutic approach.

Several years ago, Langer and Martin [26] made an interesting argument consistent with the essentialist paradigm. They argued that “attempting to change children’s gender identity [for the purpose of reducing social ostracism] seems as ethically repellant as bleaching black children’s skin in order to improve their social life among white children” (p. 14). This is an interesting argument, but I believe that there are a number of problems with the analysis. I am not aware of any contemporary clinician who would advocate “bleaching” for a Black child (or adult) who requests it. Indeed, there is a clinical and sociological literature that considers the cultural context of the “bleaching syndrome” vis-à-vis racism and prejudice. Interestingly, there is an older clinical literature on young Black children who want to be White [27] – what might be termed “ethnic identity disorder” – and there are, in my view, clear parallels to GID. Brody’s [27] analysis led him to conclude that the proximal etiology was in the mother’s “deliberate but unwitting indoctrination” of racial identity conflict in her son because of her own negative experiences as a Black person. Presumably, the treatment goal would not be to endorse the Black child’s wish to be White, but rather to treat the underlying factors that have led the child to believe that his life would be better as a White person.

The ethnic identity literature leads to a fundamental question about the psychosocial causes of GID. Just like Brody was interested in understanding the psychological, social and cultural factors that led his Black child patients to desire to be White, one can, along the same lines, seek to understand the psychological, social and cultural factors that lead boys to want to be girls and girls to want to be boys. Many contemporary clinicians have argued that GID in children is the result, at least in part, of psychodynamic and psychosocial mechanisms, which lead to an analogous fantasy solution: that becoming a member of the other sex would somehow resolve internalized distress [28–30]. I would argue, therefore, that it is as legitimate to want to make youngsters comfortable with their gender identity (to make it correspond to the physical reality of their biological sex) as it is to make youngsters comfortable with their ethnic identity (to make it correspond to the physical reality of the color of their skin) [31].

The biological essentialist perspective adopted by some parents, therefore, creates an interesting and challenging therapeutic

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