Prepubescent Transgender Children: What We Do and Do Not Know

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Since "A" was 2 years old, she has been calling herself a girl, despite being a natal male with typical sex development. Her parents ignored or corrected her perceived "mis-gendering" but, after a year of tantrums and increasing anxiety, allowed her to grow out her hair and wear the clothing of a girl. When strangers called her a girl, A was thrilled. All her friends at school were female, and she continued to ask why God gave her a boy body when she was really a girl. After another year of discussions and increased social withdrawal, her parents decided to begin a "social transition," introducing her as a girl and registering her for kindergarten as a girl. Since that time, she has become more outgoing and boisterous, with no indications of mental health challenges.

A is a transgender child—a child who consistently, persistently, and insistently identifies as female despite, in this case, being a natal male. (Note: Although *transgender* can be used to mean a broader class of children, I use it in the lay sense of referring only to people who have a binary—male or female—identity and for whom that identity is the "opposite" of their sex at birth. Although children who identify as other genders also are important to study, much less is currently known about them.) Such children are increasingly visible through media stories, legal proceedings, school board rulings, and in the clinics of psychologists and psychiatrists. As a result, scientists, researchers, and clinicians are becoming involved in debates about the best care for children like A—should they be affirmed in their gender identities or given therapy with the goal of aligning their gender identity with their natal sex? To date, many of the arguments used have been built on what I argue are faulty interpretations of past research published on children with what was historically called *gender identity disorder* (GID) and is currently called *gender dysphoria* (GD). Here, I focus on 2 frequent misunderstandings that lead to considerable confusion in the literature: that transgender identity largely desists during development and that we do not know which gender-dysphoric children will have a transgender identity in adulthood. Closer inspection of the extant data suggests neither conclusion is fully warranted. See Supplement 1, available online, for a version of this Clinical Perspectives article that features an expanded list of references for further reading on this topic.

Historically, the dominant view about transgender children has been that these children are confused about their gender identity or that they are displaying some form of psychopathology, but that with proper treatment or over the course of their continued development, their gender identities will come to align with their natal sex (which is assumed to be a more desirable outcome from this view). These claims are bolstered by studies showing that children with GID/GD often have high rates of psychopathology (e.g., anxiety, depression) and by longitudinal studies showing that anywhere from 60% to 90% of children showing significant gender dysphoria in childhood will not identify as transgender adults.[1-3]

An alternative view is that a transgender identity is a normal variant of human gender identity, and that transgender children are expressing their "true" identities. Under this view, the therapist's role is to support and affirm their identities. This view is based primarily on findings that familial support is associated with better mental health outcomes in transgender individuals; a belief that earlier affirmation of their identities will decrease rates of psychopathology; and clinical experience and emerging data indicating that affirmed transgender children are happy and healthy.

What do the data actually show? Perhaps the most cited number in discussing outcomes of transgender youth is the statistic that (roughly) 80% of these children will desist from their ("incorrect") gender identity and will "realign" their gender identity with their natal sex by adolescence. Presumably, if most of these children will "desist" from their gender identity, then why not try to change it sooner?

The 3 largest and most-cited studies have reported on the adolescent or adult gender identities of cohorts who had, in childhood, showed gender "atypical" patterns of behavior.[1-3] Of those who could be followed up, a minority were transgender: 1 of 44,[1] 9 of 45,[2] and 21 of 54.[3] Most of the remaining children later identified as gay, lesbian, or bisexual (although a small number also was heterosexual).

However, close inspection of these studies suggests that most children in these studies were not transgender to begin with. In 2 studies, a large minority (40%[2] and 25%[3]) of the children did not meet the criteria for GID to start with, suggesting they were not transgender (because transgender children would meet the criteria). Further, even those who met the GID diagnostic criteria were rarely

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transgender. Binary transgender children (the focus of this discussion) insist that they are the "opposite" sex, but most children with GID/GD do not. In fact, the *DSM-III-R* directly stated that true insistence by a boy that he is a girl occurs "rarely" even in those meeting that criterion, a point others have made.[2] When directly asked what their gender is, more than 90% of children with GID in these clinics reported an answer that aligned with their natal sex,[4] the clearest evidence that most did not see themselves as transgender. We know less about the identities of the children in the third study,[1] but the recruitment letters specifically requested boys who made "statements of wanting to be a girl" (p. 12), with no mention of insisting they were girls. Barring evidence that the children in these studies were claiming an "opposite" gender identity in childhood, these studies are agnostic about the persistence of an "opposite" gender identity into adulthood. Instead, they show that most children who behave in gender counter-stereotypic ways in childhood are not likely to be transgender adults.

Another statement made by clinicians, researchers, and members of the public is that there is no way to predict which subset of children with GD will identify as transgender adults. However, studies have found that children showing the most "extreme" signs of GD—the ones who show more gender nonconformity (e.g., more behavioral preferences, more insistence on the "other" identity)—are the most likely to identify later as transgender.[3] More specifically, Steensma *et al.*[5] suggested that the distinction between children who believe themselves to be the other gender and those who wish they were a member of the "other" gender appears to be a key predictor of persistence. They reported that "explicitly asking children with GD with which sex they identify seems to be of great value in predicting a future outcome…"[5] (p. 588). Thus, knowing whether a child consistently claims the "other" gender identity might be the best single predictor of later transgender identity.

The only way to draw clear conclusions about the life course and identity persistence of transgender children is to conduct prospective studies of children who state that they are members of the "other" gender group consistently over time. Studies with these samples can help us to truly answer the question about persistence of "opposite" gender identities. These prospective studies can help to address other important, practical questions that are being raised about transgender children. For example, families (like A's) are increasingly deciding to allow their transgender children to socially transition or present to others as their gender identity, use that pronoun, and change their names. The medical and therapeutic communities are fairly split on whether to support these decisions. Some studies have reported positive outcomes in socially transitioned children. Others have worried that supporting a transgender child's gender identity will lead to greater persistence of that identity, which is seen by critics as an undesirable outcome, or, if their transgender identity does not persist, will lead a child to need to "transition back," which could be socially difficult for a child.[5] These are the kinds of issues that can finally be addressed when studies of transgender children, including those who do and do not socially transition, are followed prospectively—studies that can finally give us an evidence-based answer to the questions of whether transgender identities are persistent and what practices are in the best interest of the transgender child. &

Accepted December 2, 2015.

Dr. Olson is with University of Washington, Seattle.

While writing this article, the author was supported by an internal grant from the University of Washington's Royalty Research Fund and by the National Science Foundation (grant 1523632). Any opinions, findings, and conclusions expressed in this material are those of the author and do not necessarily reflect the views of the National Science Foundation.

The author thanks Katie McLaughlin, PhD, Shannon Dorsey, PhD, Kevin King, PhD, and Lily Durwood, BA, of the University of Washington, and Diane Ehrensaft, PhD, of the University of California—San Francisco, for feedback on previous versions of this article.

Disclosure: Dr. Olson reports no biomedical financial interests or potential conflicts of interest.

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http://dx.doi.org/10.1016/j.jaac.2015.11.015

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