Gender development and clinical presentation of gender diversity in children and adolescents

Authors: Michelle Forcier, MD, MPH, Johanna Olson-Kennedy, MD
Section Editors: Diane Blake, MD, David Brent, MD, Mitchell E Geffner, MD
Deputy Editor: Mary M Torchia, MD

All topics are updated as new evidence becomes available and our peer review process is complete.

Literature review current through: Jan 2023. | **This topic last updated:** May 10, 2022.

INTRODUCTION

Children generally are designated a gender at birth based upon genital anatomy or chromosomes. For most children, gender designation correlates with gender identity, which is the innate sense of maleness or femaleness. However, some children have a gender identity that does not correlate with designated gender. These children are called transgender or gender-diverse (TGD) youth. (See 'Terminology' below.)

We support a gender-affirmative model of care for TGD children and adolescents. The gender-affirmative model encourages parents and communities to support each child's unique perspective and to help them explore their authentic gender self in a safe and loving environment. It explicitly conveys that gender-exploring youth will be safe, loved, and valued for their authentic self wherever their trajectory leads. Gender affirmation meets the youth where they are, with a goal of helping them thrive at home, at school, and in other environments.

The trajectory of gender diversity in childhood is unpredictable; some TGD children will grow up and be TGD adults, and some will grow up and be cisgender adults (ie, adults in whom gender identity matches genital anatomy). (See 'Trajectory' below.)

This topic will provide an overview of gender development and the clinical presentation of TGD children and adolescents. An overview of the management of gender diversity in children and adolescents and issues related to gender in children with disorders of sex development are presented separately. (See "Management of transgender and gender-diverse children and adolescents" and "Management of the infant with atypical genital

appearance (difference of sex development)", section on 'Overview of decisions about sex of rearing'.)

CULTURAL CONTEXT

Cultural differences in concepts of gender, the language used to describe gender, and attitudes toward transgender or gender-diverse (TGD) people may affect expressions of gender identity [1,2]. Many Western societies view gender as binary: male or female. This ideology sets an expectation that gender expression must conform to one or the other and may contribute to the pathologization of gender diversity [2]. When the gender expression of a child or adolescent does not fit neatly into the societal construct of male or female in congruence with their designated gender, the child and family may be ostracized or stigmatized.

Alternate perspectives view gender as a continuum from male to female, suggesting a spectrum of gender identities with varying proportions of maleness and femaleness and a wide "world" of opportunities to explore gender, including neither male nor female, or something else entirely [3]. Societies that view gender according to this more fluid or developmental perspective may be more accepting of gender variations [1]. Health care provider recognition and validation of the gender continuum and acceptance of individuals no matter where on the spectrum they identify may help to increase tolerance in families and communities [4].

TERMINOLOGY

Human gender and sexuality are broad and intersecting concepts that embody interactions among anatomy, hormones and physiology, psychology, interpersonal relationships, and sociocultural influences (figure 1) [5].

Terms that may be used to describe various aspects of gender and sexuality are listed below (table 1) [6-11]. These are cultural and descriptive terms, not diagnostic terms.

- **Designated gender or sex** – Typically designated before or at birth, according to chromosomes or external genitalia.
- **Gender identity** – An individual's innate sense of feeling male, female, neither, or some combination of both.

  Improved understanding of gender and human development indicates that the brain may be the main source of gender identity, which is not always congruent with visible anatomy or chromosomes. For most individuals, gender identity is aligned with

designated sex/gender and anatomy. For others, gender identity may not match designated sex/gender and anatomy.

- **Gender expression** – How gender is presented to the outside world (eg, feminine, masculine, androgynous); gender expression does not necessarily correlate with birth-designated gender or gender identity. In addition, gender expression varies across geography, culture, and time. Some individuals may present their gender differently within different environments.

- **Gender diversity** – Variation from the cultural norm in gender identity, expression, or gender role behavior (eg, in choices of clothing, hairstyle, toys, playmates). "Gender diversity" acknowledges the spectrum of gender identities and replaces "gender nonconformity," which has negative and exclusionary connotations [12].

- "**Transgender**" ("trans" as an abbreviation) – Umbrella term that is used to describe individuals whose gender identity is different from their birth-designated sex. "Transgender" is used as an adjective ("transgender people"), not a noun ("transgenders"), or a verb ("transgendered").

- **Gender dysphoria or incongruence** – Distress or discomfort that may occur if gender identity and birth-designated sex are not congruent.

- **Transsexuals** – Older, clinical term that has fallen out of favor; historically, it was used to refer to transgender or gender-diverse (TGD) people who sought medical or surgical interventions for gender affirmation.

- **Sexual orientation** – An individual's pattern of physical and emotional arousal (including fantasies, activities, and behaviors) and the gender(s) of persons to whom an individual is physically or sexually attracted (gay/lesbian, straight, bisexual); sexual orientation is an entirely different construct than gender identity but is often confused with it; the sexual orientation of TGD people is based upon their identified gender (eg, a transmasculine individual who is attracted to other men might identify as a gay man; a transfeminine individual who is attracted to other women might identify as a lesbian).

- **Sexual behaviors** – Specific behaviors involving sexual activities that are useful for screening and risk assessment; many youth reject traditional labeling (homo-, hetero-, bisexual) but still have same-sex partners. (See "Lesbian, gay, bisexual, and other sexual minoritized youth: Epidemiology and health concerns", section on 'Health risks' and "Lesbian, gay, bisexual, and other sexual minoritized youth: Primary care".)

- **Transgender man/transman/transmasculine individual** – Person with a masculine gender identity who was designated a female sex at birth.

- **Transgender woman/transwoman/transfeminine individual** – Person with a feminine gender identity who was designated a male sex at birth.

- **Nonbinary gender identity –** Person of any birth-designated sex who has a gender identity that is neither masculine nor feminine, is some combination of the two, or is fluid. Other terms that may be used for nonbinary gender identity include genderqueer, gender-creative, gender-independent, bigender, noncisgender, agender, two-spirit, third sex, and gender blender, among others.

As the understanding of gender identity grows and becomes more sophisticated, professionals and the community struggle to keep pace providing a sensitive and descriptive lexicon that reflects the expanding body of evidence that supports and affirms the child's or adolescent's authentic self and gender identity [13]. As an example, many in the TGD community use the terms "affirmed female" or "transwoman" to describe birth-designated males with a female gender identity and "affirmed male" or "transman" to describe birth-designated females with a male gender identity [7]. TGD individuals may choose different terms than those listed above to describe themselves [1,14]. The terms that are used by professionals are less important than being sensitive to the individual patient's psychosexual profile and desired paradigm.

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) identifies a diagnostic entity "gender dysphoria," which lists a series of experiences commonly endorsed by TGD individuals, followed by the association of distress caused by the incongruence of designated sex and gender identity [15]. In the fourth edition, this was called "gender identity disorder" [16]. Core components of the DSM-5-TR diagnosis of gender dysphoria include long-standing discomfort with designated gender and interference with social, school, or other areas of function.

Although the DSM-5-TR criteria for gender dysphoria may provide some insight into the experience of some TGD persons, there are many TGD persons for whom a diagnosis of gender dysphoria is neither accurate nor appropriate. The ongoing debate about whether or not gender diversity should be considered a "disorder" is beyond the scope of this topic review [17-19]. Viewing gender diversity from a developmental, fluid, or emerging perspective rather than a diagnostic and pathologic perspective promotes understanding that all children may experience gender-diverse play and experimentation and may help to reassure families and professionals that exploring gender is a normal component of human development for many youth and adults. (See 'Cultural context' above.)

GENDER DEVELOPMENT IN CHILDHOOD

It is not clear exactly how young children learn about gender [20]. Nonetheless, they are aware of gender differences in infancy [21]. At approximately two-and-one-half years of age, they have the ability to label faces as male or female. Children between two and four years of age begin to understand gender differences, use gendered pronouns such as "him" and "her," and can identify their own gender. By this age, most children also play with toys and games that typically correlate with their anatomic sex [22]. Initially, children may view gender as subject to variation and change; by five to six years of age, their view of gender becomes more constant [21,23].

Young children assume gender stereotypes for themselves and others; preschoolers begin sex segregation, playing more with same-sex peers, and furthering generalizable social constructs and gender-conforming roles and rules [6,24,25]. In the school-age years, children may relax gender rules and regard gendered activities with more flexibility and choice [24]. However, peer groups generally continue to be same sex; following rules, fitting in, and peer group acceptance is important in school-aged children.

Exploring gender and sexual behaviors is a normal part of child development [26,27]. At some point in childhood, many children experiment with gender expression and roles (eg, interest in cross-gender toys and games, cross-dressing) [17,28]. However, for unknown and probably multifactorial biologic and psychosocial reasons, in some children, cross-gender behavior and expression is more consistent, persistent, and insistent than it is among their peers [29-31]. These are not choices per se, but reflect an innate preference of the child. Gender development appears to be similar in transgender children and their cisgender peers. In a cohort study, transgender children living in their affirmed identity were similar to their cisgender peers with regard to interests, preferences, and emerging identity development [32]. (See 'During childhood' below.)

EPIDEMIOLOGY

Formal epidemiologic studies on gender diversity are lacking [1]. Accurate estimation of prevalence is hampered by the social stigma of gender diversity and lack of a standardized definition [33]. Estimates range widely depending upon the definition and the population studied.

Review of the available research highlights two key points: 1) the number of children and adolescents seeking care for evaluation and management of gender dysphoria is increasing [30,34-37]; and 2) while many children and adolescents sometimes behave or dress outside of typical gender norms, a significantly smaller number of them will go on to desire physical or social gender transition in adolescence or adulthood [20,38].

In a review of 10 studies from eight countries focusing on individuals who present for gender-transition care at specialist centers, the prevalence ranged from 1:11,900 to 1:45,000 for transgender females (birth-designated males) and 1:30,400 to 1:200,000 for transgender males (birth-designated females) [1]. However, more recent studies indicate increasing numbers of birth-designated females presenting for care. In population-based studies from 2012 to 2017, the prevalence of transgender adolescents and adults ranged from 0.5 to 1.8 percent and was similar in designated-sex males and designated-sex females [39,40].

Responses to two questions ("behaves like opposite sex" and "wishes to be opposite sex") on the Child Behavior Checklist (a 118-question parent-report behavior screen) have been used to estimate the prevalence of gender diversity among children in the general population [41]. In population-based studies using these questions, parents of children (ranging in age from 4 to 18 years) reported that 2 to 4 percent of boys and 3 to 10 percent of girls sometimes behaved like the opposite sex; wishing to be the opposite sex was reported less frequently (0 to 1 percent in boys and 1 to 4 percent in girls) [29,38,42,43].

In a 2011 population based survey, 1.3 percent of middle school students (grades six through eight) in San Francisco self-identified as transgender when asked, "What is your gender?" and were provided with the following responses: "female," "male," and "transgender" [44]. The proportion of youth who self-identified as transgender increased with increasing age (0.6 percent at age 11 or younger and 1.7 percent at age 13). In a 2016 survey of 80,929 high-school students in Minnesota, 2.7 percent of respondents self-identified as transgender or gender diverse [45].

In clinically referred populations of gender-dysphoric prepubertal children, the ratio of birth-designated males to birth-designated females ranges from 3:1 to 6:1 [46]. This may reflect a broader range of acceptable gender behaviors in prepubertal birth-designated females (ie, "tomboys") than in birth-designated males [7,47]. After puberty, the proportion of birth-designated females increases, with some studies demonstrating a ratio of birth-designated females to birth-designated males of approximately 2:1 [34-37,47,48]. Changes in the ratio of birth-designated males to birth-designated females in older children in clinically referred populations may reflect the effects of puberty, development of secondary sexual characteristics, and menstruation that occurs with adolescence.

CLINICAL PRESENTATION

Transgender or gender-diverse (TGD) children may present in a variety of ways depending upon their personalities, the flexibility of their environment, and their culture [14,49]. (See 'Cultural context' above.)

During childhood — Some young TGD children may prefer clothing, hairstyles, toys, activities, and playmates that usually are stereotypically considered more appropriate for the opposite sex [34,50-52].

- TGD birth-designated males may describe an interest in dolls, dresses, wigs, makeup, and feminine characters as role models.
- TGD birth-designated females may dislike girls' clothing, prefer short haircuts, role-play in traditionally male roles during dramatic play, and participate in more physical activities.

Other TGD children may prefer to express a gender identity without binary limitations (eg, a gender identity that is fluid, a combination of masculine or feminine, or neither masculine nor feminine).

Demonstration of gender-diverse behaviors and expression is not a choice per se; it reflects an innate preference of the child. However, strong social pressures to conform to same-sex gender stereotypes may suppress the child's desire to express in a cross-gendered or nonbinary way [17,53]. The child's parents and even the child may try to reshape and redirect gendered interests to be more socially acceptable [28]. (See "Management of transgender and gender-diverse children and adolescents", section on 'Mental health interventions'.)

TGD children often do not experience gender dysphoria as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (ie, clinically significant distress or impaired social, school, or other important area of function [15]), particularly after undergoing social role/presentation transition in order to live in a gender role that feels most authentic. They may lack a clear understanding that their internal gender identity does not match their genitals, and the primary distress is related to the inability to be perceived by others as their authentic gender. Gender dysphoria may intensify or emerge as they begin to understand the constancy of designated gender (this generally develops by age five or six years). However, gender dysphoria is unlikely to be recognized if the child is unable or unwilling to express it through activity or verbalization. Children who do not have the language or sophistication to express gender concerns may present in other ways (eg, mood or behavior problems).

Although it is impossible to predict the trajectory of gender identity or expression for an individual child, one characteristic that may distinguish long-term TGD identity from a passing phase is the desire for genitals that correspond with gender identity. TGD designated-sex males sometimes try to hide, or even cut off, their penises. TGD designated-sex females may ask for a penis from their parents or pray that they wake up with one. Some children tell their parents that a mistake was made and they are in the wrong body. Consistent, persistent, and insistent gender-diverse behaviors and expression in prepubertal

children appear to be associated with continued gender dysphoria after puberty [51,54-56]. (See 'Trajectory' below.)

During adolescence — The physical changes of puberty usually are exceptionally difficult for TGD youth. The development of unwanted secondary sexual characteristics is described by many as a betrayal of one's body, the final confirmation that they must live in an adult version of a body that is not reflective of their true self. In the authors' experience, many TGD adolescents have difficulty functioning academically and socially as puberty ensues.

For various reasons, some TGD individuals may present for the first time in adolescence. TGD youth who have lived "gender-neutral" childhoods may only realize that they are TGD at the onset of puberty [34]. Others, who suppressed feelings and expression of gender diversity during childhood, may experience feelings of gender dysphoria with increased intensity during pubertal development. For such youth, the addition of the incongruence of designated sex to the physical, social, and emotional changes of adolescence can be overwhelming, leading to isolation, anxiety, depression, suicidality, and dangerous behavior (eg, illicit drug use, unprotected sexual activity) [14,33,49,57-62]. (See 'Associated concerns' below.)

Gender dysphoria that intensifies with the onset of puberty rarely subsides [30,34,56,63].

Associated concerns — The response to children and adolescents with gender diversity plays an important role in their psychological, social, and sexual development. Those who experience fear of and contempt toward their physical self, instinctual behavior, and sexual maturation may develop functional or mental health problems [54]. Stigma and discrimination have significant impacts on mental health and social opportunities [64,65]. In a cohort of TGD adolescents, youth with high levels of internalized transphobia and more obvious physical discordance with their appearance were more likely to meet criteria for depression and anxiety on a behavioral health-screening questionnaire [65].

Children and adolescents with gender diversity are at risk for multiple psychosocial problems including [33,40,57,58,60-62,65-83]:

- Poor relationships with parents, family rejection, and loss of financial support
- Social isolation and peer rejection
- Verbal and physical victimization, including sexual assault and intimate partner violence
- Decreased sense of wellbeing and self-esteem
- Academic and school problems
- Symptoms of depression and anxiety
- Self-harm and suicidality
- Homelessness and sexual exploitation

Feeling uncomfortable with one's body and outside the gender norms may contribute to a child's feeling isolated and not fitting in with any particular peer group. The segregation according to perceived anatomic sex that occurs in the early school years (eg, sports and activity teams, bathrooms) may be emotionally challenging for TGD children [6]. During junior high and high school, restrictive restroom and locker room policies may be associated with increased risk of sexual assault [84]. Children and adolescents who openly express their desire for toys and clothing that do not correlate with their designated gender may be ostracized, criticized, and victimized by those around them [6,85]. This may contribute to damaged self-esteem, poor adjustment, and the development of internalizing (eg, depression, anxiety) and/or externalizing symptoms (eg, aggression, hyperactivity) [23,86].

Family rejection has negative health outcomes in lesbian, gay, and bisexual youth [87]; in clinical experience, this is also true for TGD youth. Self-harm (eg, cutting and burning), suicidal thoughts, and suicide attempts are common among TGD youth [34,81,88,89]. In a national survey of >120,600 adolescents age 11 to 19 years, the rate of self-reported suicide attempt was increased among TGD youth [88]. The overall suicide attempt rate was 14 percent but varied substantially with self-reported gender identity: 51 percent in transmasculine adolescents, 42 percent in nonbinary adolescents, 30 percent in transfeminine adolescents, 28 percent in questioning adolescents, 18 percent among female adolescents, and 10 percent among male adolescents.

TGD youth from conservative families or who live in socially rigid environments may be bullied, harassed, ostracized, discriminated against, physically assaulted, or even killed [90,91]. In a longitudinal cohort survey, gender diversity before 11 years of age was associated with self-reported increased risk of childhood sexual, physical, and psychological abuse and lifetime risk of posttraumatic stress disorder at age 19 to 27 years, and increased risk of depressive symptoms and/or mild or moderate depression between age 12 to 30 years [92,93]. The increased risk of posttraumatic stress disorder and depressive symptoms were partially mediated by physical and emotional bullying and abuse [82,93,94].

Many youth seeking care in the authors' transgender clinics were forced to leave home because of gender diversity. Homelessness and lack of financial support are associated with other health risks (eg, engagement in sex work, increasing the risk of human immunodeficiency virus [HIV] and other sexually transmitted infections) [95-97].

Disclosure — The age at which a TGD individual (table 1) fully acknowledges their gender identity varies from childhood to old age [98]. In retrospect, many youth acknowledge that early in childhood they felt as if something was "different" about them compared with their peers, but they did not have the words or concepts to describe the discordance between their body and their identity. Many youth begin to recognize this discordance and TGD identity as they listen to and observe other TGD persons in the media or social networking

websites. In addition, delayed acknowledgment may be related to a fear of stigmatization, victimization, or rejection by family, friends, and employers. Some youth may internalize negative and rejecting social messages and are themselves transphobic (ie, fearful of gender diversity), creating further psychological dissonance. Other barriers to disclosure include concerns about confidentiality or decreased access to care.

Specific concerns related to disclosure depend upon the timing of disclosure and social milieu. For a young person who is coming out and disclosing for the first time as a teenager, there are very real and concerning dangers. Planning for both safety and social support are critical to disclosure and transitioning. (See 'Associated concerns' above.)

Mental health therapists and medical providers can assist youth in developing a support and safety plan around disclosure (table 2). Youth may want to work in conjunction with advocacy organizations (eg, TransYouth Family Allies, Trans Youth Equality Foundation) to facilitate disclosure to family members, friends, schools, and other organizations with whom the youth and family have contact. It is important for youth and providers to avoid making assumptions about who will or will not be supportive in the disclosure process. Many TGD youth are surprised by family members and friends who become truly supportive and allies; many are devastated by the variety of responses that invalidate or deny their true identity. It is also important to explore networks and allies for parents as they proceed through their own cognitive, emotional, and social processing of their child's "new" identity. Social, religious, and emotional support may help parents and families who are struggling with these changes. (See 'Role of the medical provider' below and 'Role of the mental health provider' below.)

Many young people disclose to their parents in a letter. Some parents find out about their child's true gender identity from social networking websites. The choice of how to disclose to one's parents largely depends upon the existing relationship between parent(s) and the child. Writing a letter allows a young person to fully plan out what words to use and also does not require the young person to witness the parent's reaction. Because reactions from parents vary widely from overwhelming sadness, to disappointment, to anger and outrage, letter writing has become a popular strategy for disclosure.

The internet has provided some young people with a virtual environment in which to "practice" disclosure and live as one's true self with less risk of harm. This is probably why many young people initially disclose on a social media website. The disadvantage of disclosing first to one's cyberfriends is that parents may discover the information inadvertently and feel angry or hurt that their child has not shared the information with them. In many instances, parents or caregivers are most concerned about how they will be perceived as parents by family members, friends, and even strangers. While ultimately most parents care about the happiness of their child, this initial hurdle often causes great distress

for the family. Disclosure decision-making strategies may benefit from the involvement of an experienced mental health therapist. (See 'Role of the mental health provider' below.)

TRAJECTORY

Prepubertal children — It is impossible to predict with certainty whether gender diversity in an individual child will continue into adolescence or adulthood [42,49,99]. Regardless of the trajectory, strong parental and social support while youth explore gender and their authentic selves is critical to healthy overall child development. (See 'Education and support' below.)

Review of the evidence from prospective and retrospective follow-up studies suggests that gender dysphoria in prepubertal children continues into adolescence/adulthood in a minority of children [30,55,100]. However, children with consistent, persistent, and insistent gender-diverse behaviors and expression may be more likely to maintain diverse gender identities in the long term [51,54-56,101]. In a cohort of 317 transgender children age 3 to 12 years who lived in their affirmed gender identity from early childhood, patterns of gender development were coherent (eg, stereotypical toy preference correlated with stereotypical clothing preference) and duration of time living in affirmed identity had minimal to no effect on gender identity or preference [32].

As with gender identity, the trajectory of sexual orientation is impossible to predict in an individual transgender or gender-diverse (TGD) youth. Predicting the trajectory of sexual orientation is complicated by the lack of clarity about what is meant by "heterosexual" or "homosexual" in TGD youth (ie, is the categorization made according to birth-designated gender or gender identity?) and the broad concepts of sexual identity (eg, pansexuality; asexuality; other nonbinary, more fluid ways to be sexual).

Longitudinal studies (most of which were performed in birth-designated males) suggest that among individuals with gender diversity in childhood who eventually affirm a gender identity congruent with anatomic gender, there is an increased likelihood of attraction to sexual partners of the same anatomic sex or to partners of both sexes compared with individuals without gender diversity during childhood [42,55,100]. In the author's (JO's) experience, approximately one-half of birth-designated females with masculine gender identities report being attracted exclusively to female partners, and one-half of birth-designated males with a feminine gender identity report being attracted exclusively to male partners.

After puberty — In contrast to prepubertal gender diversity, gender dysphoria that intensifies with the onset of puberty rarely subsides [30,34,56,63]. In prospective follow-up of a cohort of 70 gender dysphoric youth who underwent suppression of endogenous puberty with gonadotropin-releasing hormone analogs (to prevent the development of

unwanted secondary sexual characteristics), all of the patients elected to proceed with cross-gender hormones [100].

ROLE OF THE MEDICAL PROVIDER

Primary care providers often are the first stop for parents with questions or concerns about gender-diverse behaviors [12]. Primary care providers are in a unique position to promote healthy and positive outcomes for children with gender diversity [33].

Primary care providers may play an important role in the recognition of gender diversity, monitoring for associated concerns, providing education and support, recognition of mental health problems and health risk behaviors, and facilitating appropriate referrals for the patient and family members [12,33,34,102]. They also may coordinate care and provide clinical and laboratory monitoring for patients receiving hormonal interventions. (See "Management of transgender and gender-diverse children and adolescents", section on 'Overview of hormonal interventions for adolescents'.)

Individual clinicians may have different levels of comfort or expertise with transgender or gender-diverse (TGD) youth. Clinicians who are neither comfortable nor sufficiently knowledgeable to treat TGD patients should refer them to more experienced colleagues [33,98]. Given the increasing numbers of youth who seek gender-related care services, we encourage all pediatric health care providers to maintain an updated gender lexicon and be familiar with ways to interview youth that support gender diversity, knowledge, and skills that may not have been provided during medical education and training [103,104].

Identification — Early identification of children who are struggling with gender identity may help to prevent adverse mental and/or physical health consequences. Early identification permits psychosocial support for the child or adolescent and their family members. Family rejection has negative health consequences for TGD youth [87,95,96]. Families who are open to working with a therapist experienced in gender care can get the necessary support and resources to best help their child and keep the family unit together [51].

Early identification also allows the option of medical intervention (for appropriate patients) to avoid the development of permanent unwanted secondary sexual characteristics, the alteration of which may otherwise involve costly future interventions or surgeries. (See "Management of transgender and gender-diverse children and adolescents", section on 'Suppression of endogenous puberty'.)

Gender is a ubiquitous aspect of the human experience. During routine well-child visits, it is important for primary care providers to screen for concerns about gender development and to ask parents and children about the child's play, activities, and how the child feels about

their gender identity, upcoming puberty, maturing body, and other changes that accompany puberty and adolescence. (See 'Resources' below.)

In some cases, gender diversity is apparent to the clinician; in others, the patient or parents may raise the issue of gender diversity. In these cases, further exploration of gender diversity may be warranted (table 3). Simple assertion that the child will "grow out of it" without further exploration may result in delayed referral, evaluation, and professional support [105].

Because some children and adolescents are reluctant to disclose or outwardly express their gender diversity, it is also important to ask specific questions about gender and perceived gender identity in children who are visibly gender diverse as well as those who have nonspecific mood or behavior concerns.

For younger children, the concept may be introduced as follows:

- "Most kids have a feeling about whether they are a boy or a girl. How do you feel? Do you feel more like a boy, girl, someone in between, or someone different?... PAUSE... Tell me more, since I talk with a lot of kids whose body and brain may not be exactly on the same page when it comes to being a boy or girl?"

For older youth or teens, practitioners might ask [4,106,107]:

- "Many young people have questions about and sometimes struggle with gender. Is this an issue for you?"
- "Some teens explore who they are in terms of their gender or try to figure out whether they identify more as a male, female, or someone and somewhere in between. How do you identify yourself?"
- "Many young people are impacted by gender and sexuality. It is normal for kids to explore these ideas and their identity. I ask everyone about it. Anything you say about gender and sexuality will be kept private. We are here to help you figure things out in a safe and healthy way."
- "Out of respect for my patients' right to self-identify, I ask all patients what gender pronoun and name they would like me to use for them. What pronoun and name would you like me to use for you?"

Finally, it is important to ask patients with gender diversity about associated concerns, such as (see 'Associated concerns' above) [9,17,106,108]:

- Degree of social isolation, bullying

- Declining school performance
- Disrupted family relationships
- Running away/homelessness
- Risk-taking behaviors (unsafe sex, promiscuity, substance use, self-harm, suicidal ideation) (see "Substance use disorder in adolescents: Epidemiology, pathogenesis, clinical manifestations and consequences, course, assessment, and diagnosis", section on 'Screening' and "Suicidal behavior in children and adolescents: Epidemiology and risk factors", section on 'Sexual orientation')
- Medically unsupervised use of hormones or "herbal" hormones (eg, phytoestrogens or androgen-like compounds sold as dietary supplements)

Gender dysphoria in children and adolescents is often, but not always, diagnosed by mental health providers trained in child and adolescent developmental psychopathology [10]. Key aspects include distress or discomfort when gender identity and anatomic sex are not completely congruent. Primary care providers can screen, identify, and refer TGD children to supportive mental health providers in order to help children continue to explore their identity and parents' ability to support them. (See 'Role of the mental health provider' below.)

Confidentiality — It is important to know and understand national, state, and institutional laws and policies regarding confidentiality [102]. Most states have laws protecting confidentiality regarding testing for HIV and other sexually transmitted infections. However, states may not protect confidentiality regarding gender and sexuality. Privacy and working with youth to allow full honest disclosure requires trust, respect, and some assurances of privacy. Privacy regarding gender, sexual orientation, and sexual behaviors is promoted by major health professional societies (eg, American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, and the Society for Adolescent Medicine) [66,109-111]. (See "Confidentiality in adolescent health care" and "Sexual development and sexuality in children and adolescents".)

Education and support — The primary care clinician can be an influential source of information, support, and guidance for the patient and family members [4,33,49,112,113]. Given the potential mental and physical health consequences of gender diversity in an unaccepting environment, it is important for health care providers to be nonjudgmental and to support their patients in their asserted gender identity [12,13].

Specifically, the health care provider can [6,14,30,33,49,112,114,115]:

- Use their identified name and pronouns.

- Help parents and caregivers understand that the trajectory of gender diversity in prepubertal children is not predictable and that the most important task is supporting the child and making them feel loved. Children who are not accepted and supported by their parents risk isolation and increased anxiety. (See 'Associated concerns' above.)

- Acknowledge the range of emotions that parents may experience when presented with a TGD child (rage, confusion, shock, grief at the loss of expectations that they had for their child) and help the parents to support their child while working through their own concerns with a mental health provider. Therapy or parent-to-parent support groups may be helpful in this regard. (See 'Resources' below.)

- Suggest that the family follow the child's lead with respect to clothing and hairstyles, making compromises to fit the family's comfort and cultural context.

- Encourage parents and families to embrace a wide range of appropriate behaviors for all children and to understand and accept behaviors that fall outside the cultural norms for birth-designated sex, emphasizing that gender variance is possible without necessarily altering one's gender identity or body; parents can demonstrate their acceptance of gender and sexual differences by sharing books or watching programs that feature gender or sexual minoritized characters in a positive light. (See 'Resources' below and "Management of transgender and gender-diverse children and adolescents", section on 'Approach in prepubertal children'.)

- Recognize that TGD youth will look for information about transitioning, hormones, and surgical interventions on the internet because such information may not be available through traditional means.

- Provide reliable information about the various treatment approaches, highlighting the importance of the parents following the child's lead and allowing for the possibility of the child's journey changing over time; when discussing the possibility of puberty suppression, it is important that the patient and parents know the signs of early puberty (bearing in mind that TGD children may limit opportunities to be seen naked). (See "Management of transgender and gender-diverse children and adolescents", section on 'Types of interventions'.)

- Help the child and family create plans for safety, responses to bullying (including cyberbullying), and other social biases (discuss potentially hurtful responses from peers and teachers and suggest and practice helpful responses).

- Help youth and parents plan for disclosure to extended family, friends, and social contacts, work with the mental health therapist to develop a safety plan around disclosure. (See 'Disclosure' above.)

- Help the family determine if or when a social and/or a physical affirmation should occur and to prepare for all aspects of the affirmation process (eg, school issues, reactions of extended family members, friends, neighbors, religious community). (See "Management of transgender and gender-diverse children and adolescents", section on 'Social transition'.)

- Provide medical documentation for name change, gender change, and other official documents as necessary; the TransYouth Family Allies website, among others, provides information about what to include in the medical documentation. (See "Management of transgender and gender-diverse children and adolescents", section on 'Types of interventions'.)

- Advocate for the child or adolescent in the school system and community (eg, by providing letters of support for the child's expression of their gender identity, educating staff and students within the school system).

Referral — Primary care providers can help with referrals for TGD youth and/or their family members.

Referral to a specialized clinic for children with gender diversity may be warranted for children and adolescents with consistent, persistent, and insistent gender-diverse behaviors and expression. Such a clinic can provide comprehensive care for TGD youth. (See "Management of transgender and gender-diverse children and adolescents".)

Referral to a mental health provider who has worked with children and adolescents with gender identity concerns may be warranted for youth with evidence of gender dysphoria (eg, aversion to aspects of their body associated with sex; wish to live as opposite sex); anxiety, depression, or suicidality; or significant interpersonal conflicts with peers (eg, bullying) or parents [6,107]. (See 'Role of the mental health provider' below.)

Referral to a mental health provider or parent support groups also may be warranted for parents of TGD children and adolescents who are uncomfortable with their child's behaviors or identity [6,49]. Parents may experience a range of emotions when presented with a TGD child. It is common for parents to have rage, confusion, shock, and grief. They may mourn the loss of expectations they had for their child. (See 'Resources' below.)

ROLE OF THE MENTAL HEALTH PROVIDER

Mental health therapists who have experience working with children with gender-identity concerns are an essential part of the health care team for transgender or gender-diverse (TGD) youth. However, referral to a mental health provider is not a requirement for access to consent-based patient- and family-centered care for TGD youth.

Mental health therapists may play several roles, including [1,9,14,112,116-118]:

- Assessing gender identity in the context of the youth's psychosocial and family milieu and evaluating extent of gender dysphoria
- Educating about and modeling acceptance of diversity and fluidity in gender and sexuality
- Addressing the negative impact of gender dysphoria and stigma on mental health [119]; alleviating internalized transphobia (ie, fear of gender diversity)
- Providing support and helping to build the resiliency/coping skills necessary to navigate difficult social, educational, and professional situations (see 'Associated concerns' above)
- Evaluating and treating mental health symptoms or conditions that may diminish self-esteem or impede successful transition (eg, depression, anxiety, substance abuse)
- Providing support to parents and family members who have difficulty adjusting to the child's "new" identity
- Providing information about gender diversity to parents, family members, teachers, schools, and other communities
- Assisting in the development of a safety plan around disclosure (see 'Disclosure' above)
- Assisting in transition preparation and planning (see "Management of transgender and gender-diverse children and adolescents", section on 'Social transition')

RESOURCES

Resources for patients, families, and providers include:

- Children's National Health System Gender Development Program
- Gender spectrum
- National Center for Education in Maternal and Child Health at Georgetown University
- TransYouth Family Allies
- Trans Youth Equality Foundation
- University of California, San Francisco Center of Excellence for Transgender Health

- TransActive Gender Center
- World Professional Association for Transgender Health
- Supporting & Caring for Transgender Children (produced in partnership between the Human Rights Campaign Foundation, the American Academy of Pediatrics, and the American College of Osteopathic Pediatricians)
- Gender Identity Research and Education Society

Books for children and adolescents [112]:

- It's Perfectly Normal: Changing Bodies, Growing Up, Sex and Sexual Health by Robie H. Harris and Michael Emberley (Candlewick 2009)
- Changing Bodies, Changing Lives: Expanded Third Edition: A Book for Teens on Sex and Relationships by Ruth Bell (Three Rivers Press 1998)

SOCIETY GUIDELINE LINKS

Links to society and government-sponsored guidelines from selected countries and regions around the world are provided separately. (See "Society guideline links: Transgender health" and "Society guideline links: Adolescent sexual health and pregnancy".)

SUMMARY

- Children who have a gender identity (innate sense of maleness or femaleness) that does not correspond with their designated gender (based upon genital anatomy or chromosomes) are referred to as transgender or gender-diverse (TGD) (table 1). (See 'Terminology' above.)
- It is not clear how young children learn gender, but they are aware of gender differences in infancy. Many children experiment with gender expression and roles at some point during childhood. Gender development is similar in TGD children and their cisgender peers. (See 'Gender development in childhood' above.)
- TGD children present in a variety of ways depending upon their personalities, the flexibility of their environment, their culture, and their gender identity (eg, male, female, nonbinary, fluid). Prepubertal children with gender diversity may prefer clothing, hairstyles, toys, activities, and playmates that usually are typical for the opposite sex and may desire genitals that correspond with their gender identity. Pubertal youth and adolescents may present with increased distress related to the

physical changes of puberty. Children and adolescents who are unable to express their gender concerns may present with emotional or behavioral problems. (See 'Cultural context' above and 'Clinical presentation' above.)

- Minority stress appears to be an underlying source for multiple psychosocial problems in TGD youth, including poor relationships, social isolation, verbal and physical victimization, decreased sense of wellbeing, school problems, symptoms of depression or anxiety, self-harm and suicidality, and homelessness. Disclosure of gender diversity requires planning for continued options for care along with maintaining safety in home, school, and community settings. (See 'Associated concerns' above and 'Disclosure' above.)

- It is impossible to predict with certainty whether gender diversity in an individual child will continue into adolescence or adulthood. Regardless of the trajectory, strong parental and social support while youth explore gender and their authentic selves are critical to healthy overall child development. Gender dysphoria that intensifies with the onset of puberty rarely subsides. (See 'Trajectory' above.)

- Primary care providers may play an important part in the recognition of gender diversity, monitoring for associated concerns, providing education and support, and facilitating appropriate referrals for the patient and family members. (See 'Role of the medical provider' above.)

- Referral to a mental health provider who has worked with TGD children may be valuable for youth and families who are struggling to come to terms with gender diversity. However, referral to a mental health provider is not a requirement for access to consent-based patient- and family-centered care for TGD youth. (See 'Role of the mental health provider' above.)

REFERENCES

1. World Professional Association for Transgender Health (WPATH). WPATH Standards of C are for the Health of Transsexual, Transgender, and Gender Nonconforming People, 7th Version. Available at: www.wpath.org/documents/Standards%20of%20Care_FullBook_1g-1.pdf (Accessed on November 27, 2012).
2. Wylie K, Knudson G, Khan SI, et al. Serving transgender people: clinical care considerations and service delivery models in transgender health. Lancet 2016; 388:401.
3. HIll MR, Mays J, Mack R, et al. The Gender Book, Marshall House Press, 2014.

4. Turban J, Ferraiolo T, Martin A, Olezeski C. Ten Things Transgender and Gender Nonconforming Youth Want Their Doctors to Know. J Am Acad Child Adolesc Psychiatry 2017; 56:275.
5. Brown RT. Adolescent sexuality at the dawn of the 21st century. Adolesc Med 2000; 11:19.
6. Perrin EC. Sexual Orientation in Child and Adolescent Health Care, Springer, New York 2002.
7. Edwards-Leeper L, Spack NP. Psychological evaluation and medical treatment of transgender youth in an interdisciplinary "Gender Management Service" (GeMS) in a major pediatric center. J Homosex 2012; 59:321.
8. Levine DA, Committee On Adolescence. Office-based care for lesbian, gay, bisexual, transgender, and questioning youth. Pediatrics 2013; 132:e297.
9. Adelson SL, American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). Practice parameter on gay, lesbian, or bisexual sexual orientation, gender nonconformity, and gender discordance in children and adolescents. J Am Acad Child Adolesc Psychiatry 2012; 51:957.
10. Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. J Clin Endocrinol Metab 2017; 102:3869.
11. Liszewski W, Peebles JK, Yeung H, Arron S. Persons of Nonbinary Gender - Awareness, Visibility, and Health Disparities. N Engl J Med 2018; 379:2391.
12. Rafferty J, COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH, COMMITTEE ON ADOLESCENCE, SECTION ON LESBIAN, GAY, BISEXUAL, AND TRANSGENDER HEALTH AND WELLNESS. Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents. Pediatrics 2018; 142.
13. Russell ST, Pollitt AM, Li G, Grossman AH. Chosen Name Use Is Linked to Reduced Depressive Symptoms, Suicidal Ideation, and Suicidal Behavior Among Transgender Youth. J Adolesc Health 2018; 63:503.
14. Vance SR Jr, Ehrensaft D, Rosenthal SM. Psychological and medical care of gender nonconforming youth. Pediatrics 2014; 134:1184.
15. American Psychiatric Association. Gender Dysphoria. In: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision, American Psychiatric Association, Washington, DC 2022. p.511.
16. American Psychiatric Association. Gender identity disorders. In: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, 4th ed, American Psychiatric Association, Washington, DC 2000. p.576.

17. Mallon GP, DeCrescenzo T. Transgender children and youth: a child welfare practice perspective. Child Welfare 2006; 85:215.
18. Meyer-Bahlburg HF. From mental disorder to iatrogenic hypogonadism: dilemmas in conceptualizing gender identity variants as psychiatric conditions. Arch Sex Behav 2010; 39:461.
19. Zucker KJ. The DSM diagnostic criteria for gender identity disorder in children. Arch Sex Behav 2010; 39:477.
20. Shechner T. Gender identity disorder: a literature review from a developmental perspective. Isr J Psychiatry Relat Sci 2010; 47:132.
21. Martin CL, Ruble DN. Children's search for gender cues: Cognitive perspectives on gender development. Curr Dir Psychol Sci 2004; 13:67.
22. Zosuls KM, Ruble DN, Tamis-Lemonda CS, et al. The acquisition of gender labels in infancy: implications for gender-typed play. Dev Psychol 2009; 45:688.
23. Egan SK, Perry DG. Gender identity: a multidimensional analysis with implications for psychosocial adjustment. Dev Psychol 2001; 37:451.
24. Carver P. Gender identity and adjustment in middle childhood. Sex Roles 2003; 49:95.
25. Maccoby EE. The Two Sexes: Growing Up Apart, Coming Together, Harvard University Press, Cambridge, MA 1998.
26. Bullough VL. Children and adolescents as sexual beings: a historical overview. Child Adolesc Psychiatr Clin N Am 2004; 13:447.
27. Kinsey AC, Pomeroy WB, Martin CE. Sexual Behavior in the Human Male, WB Saunders Co, Philadelphia 1948.
28. Piper J, Mannino M. Identity formation for individuals in transition: A narrative family therapy model. J GLBT Fam Stud 2008; 4:75.
29. van Beijsterveldt CE, Hudziak JJ, Boomsma DI. Genetic and environmental influences on cross-gender behavior and relation to behavior problems: a study of Dutch twins at ages 7 and 10 years. Arch Sex Behav 2006; 35:647.
30. de Vries AL, Cohen-Kettenis PT. Clinical management of gender dysphoria in children and adolescents: the Dutch approach. J Homosex 2012; 59:301.
31. Heylens G, De Cuypere G, Zucker KJ, et al. Gender identity disorder in twins: a review of the case report literature. J Sex Med 2012; 9:751.
32. Gülgöz S, Glazier JJ, Enright EA, et al. Similarity in transgender and cisgender children's gender development. Proc Natl Acad Sci U S A 2019; 116:24480.
33. Olson J, Forbes C, Belzer M. Management of the transgender adolescent. Arch Pediatr Adolesc Med 2011; 165:171.

34. Spack NP, Edwards-Leeper L, Feldman HA, et al. Children and adolescents with gender identity disorder referred to a pediatric medical center. Pediatrics 2012; 129:418.

35. Akkermans R. The UK gender identity clinic for young people. Lancet Child Adolesc Health 2018; 2:851.

36. Klein DA, Roberts TA, Adirim TA, et al. Transgender Children and Adolescents Receiving Care in the US Military Health Care System. JAMA Pediatr 2019; 173:491.

37. Handler T, Hojilla JC, Varghese R, et al. Trends in Referrals to a Pediatric Transgender Clinic. Pediatrics 2019; 144.

38. Meyer WJ 3rd. Gender identity disorder: an emerging problem for pediatricians. Pediatrics 2012; 129:571.

39. Winter S, Diamond M, Green J, et al. Transgender people: health at the margins of society. Lancet 2016; 388:390.

40. Johns MM, Lowry R, Andrzejewski J, et al. Transgender Identity and Experiences of Violence Victimization, Substance Use, Suicide Risk, and Sexual Risk Behaviors Among High School Students - 19 States and Large Urban School Districts, 2017. MMWR Morb Mortal Wkly Rep 2019; 68:67.

41. Zucker KJ. Gender identity. In: Developmental-Behavioral Pediatrics: Evidence and Practice, Wolraich ML, Crotar DD, Dworkin PH, Perrin EC (Eds), Mosby Elsevier, Philadelphia 2008. p.825.

42. Steensma TD, van der Ende J, Verhulst FC, Cohen-Kettenis PT. Gender variance in childhood and sexual orientation in adulthood: a prospective study. J Sex Med 2013; 10:2723.

43. Achenbach TM. Manual for Child Behavior Check List/4-18 and 1991 Profile. University of Vermont Department of Psychiatry, Burlington, VT 1991.

44. Shields JP, Cohen R, Glassman JR, et al. Estimating population size and demographic characteristics of lesbian, gay, bisexual, and transgender youth in middle school. J Adolesc Health 2013; 52:248.

45. Rider GN, McMorris BJ, Gower AL, et al. Health and Care Utilization of Transgender and Gender Nonconforming Youth: A Population-Based Study. Pediatrics 2018; 141.

46. Zucker KJ. Gender identity development and issues. Child Adolesc Psychiatr Clin N Am 2004; 13:551.

47. Cohen-Kettenis PT, Owen A, Kaijser VG, et al. Demographic characteristics, social competence, and behavior problems in children with gender identity disorder: a cross-national, cross-clinic comparative analysis. J Abnorm Child Psychol 2003; 31:41.

48. Sequeira GM, Ray KN, Miller E, Coulter RWS. Transgender Youth's Disclosure of Gender Identity to Providers Outside of Specialized Gender Centers. J Adolesc Health 2020;

66:691.

49. Reilly M, Desousa V, Garza-Flores A, Perrin EC. Young Children With Gender Nonconforming Behaviors and Preferences. J Dev Behav Pediatr 2019; 40:60.
50. Fridell SR, Owen-Anderson A, Johnson LL, et al. The playmate and play style preferences structured interview: a comparison of children with gender identity disorder and controls. Arch Sex Behav 2006; 35:729.
51. Malpas J. Between pink and blue: a multi-dimensional family approach to gender nonconforming children and their families. Fam Process 2011; 50:453.
52. Teurk CM, Menvielle E, de Jesus J. If you are concerned about your child's gender behaviors. Outreach Program for Children with Gender-Variant Behaviors and their Families, Children's National Medical Center, Washington, DC. Available at: www.childrensnational.org/files/PDF/DepartmentsandPrograms/Neuroscience/Psychiatry/GenderVariantOutreachProgram/GVParentBrochure.pdf (Accessed on November 27, 2012).
53. Bussey K, Bandura A. Social cognitive theory of gender development and differentiation. Psychol Rev 1999; 106:676.
54. Pearson K. Personal communication. Executive Director of TransYouth Family Allies.
55. Wallien MS, Cohen-Kettenis PT. Psychosexual outcome of gender-dysphoric children. J Am Acad Child Adolesc Psychiatry 2008; 47:1413.
56. Steensma TD, McGuire JK, Kreukels BP, et al. Factors associated with desistence and persistence of childhood gender dysphoria: a quantitative follow-up study. J Am Acad Child Adolesc Psychiatry 2013; 52:582.
57. Grossman AH, D'Augelli AR. Transgender youth and life-threatening behaviors. Suicide Life Threat Behav 2007; 37:527.
58. Alanko K, Santtila P, Witting K, et al. Psychiatric symptoms and same-sex sexual attraction and behavior in light of childhood gender atypical behavior and parental relationships. J Sex Res 2009; 46:494.
59. Landolt MA, Bartholomew K, Saffrey C, et al. Gender nonconformity, childhood rejection, and adult attachment: a study of gay men. Arch Sex Behav 2004; 33:117.
60. Plöderl M, Fartacek R. Childhood gender nonconformity and harassment as predictors of suicidality among gay, lesbian, bisexual, and heterosexual Austrians. Arch Sex Behav 2009; 38:400.
61. D'Augelli AR, Grossman AH, Starks MT. Childhood gender atypicality, victimization, and PTSD among lesbian, gay, and bisexual youth. J Interpers Violence 2006; 21:1462.
62. Rijn AB, Steensma TD, Kreukels BP, Cohen-Kettenis PT. Self-perception in a clinical sample of gender variant children. Clin Child Psychol Psychiatry 2013; 18:464.

63. Steensma TD, Biemond R, de Boer F, Cohen-Kettenis PT. Desisting and persisting gender dysphoria after childhood: a qualitative follow-up study. Clin Child Psychol Psychiatry 2011; 16:499.

64. Testa RJ, Habarth J, Peta J, et al. Development of gender minority stress and resilience measure. Psychol Sex Orientat Gend Divers 2015; 2:65.

65. Chodzen G, Hidalgo MA, Chen D, Garofalo R. Minority Stress Factors Associated With Depression and Anxiety Among Transgender and Gender-Nonconforming Youth. J Adolesc Health 2019; 64:467.

66. Committee On Adolescence. Office-based care for lesbian, gay, bisexual, transgender, and questioning youth. Pediatrics 2013; 132:198.

67. Khatchadourian K, Amed S, Metzger DL. Clinical management of youth with gender dysphoria in Vancouver. J Pediatr 2014; 164:906.

68. Clark TC, Lucassen MF, Bullen P, et al. The health and well-being of transgender high school students: results from the New Zealand adolescent health survey (Youth'12). J Adolesc Health 2014; 55:93.

69. Olson J, Schrager SM, Belzer M, et al. Baseline Physiologic and Psychosocial Characteristics of Transgender Youth Seeking Care for Gender Dysphoria. J Adolesc Health 2015; 57:374.

70. Reisner SL, Biello KB, White Hughto JM, et al. Psychiatric Diagnoses and Comorbidities in a Diverse, Multicity Cohort of Young Transgender Women: Baseline Findings From Project LifeSkills. JAMA Pediatr 2016; 170:481.

71. Aitken M, VanderLaan DP, Wasserman L, et al. Self-Harm and Suicidality in Children Referred for Gender Dysphoria. J Am Acad Child Adolesc Psychiatry 2016; 55:513.

72. Reisner SL, Katz-Wise SL, Gordon AR, et al. Social Epidemiology of Depression and Anxiety by Gender Identity. J Adolesc Health 2016; 59:203.

73. Eisenberg ME, Gower AL, McMorris BJ, et al. Risk and Protective Factors in the Lives of Transgender/Gender Nonconforming Adolescents. J Adolesc Health 2017; 61:521.

74. Perez-Brumer A, Day JK, Russell ST, Hatzenbuehler ML. Prevalence and Correlates of Suicidal Ideation Among Transgender Youth in California: Findings From a Representative, Population-Based Sample of High School Students. J Am Acad Child Adolesc Psychiatry 2017; 56:739.

75. Garthe RC, Hidalgo MA, Hereth J, et al. Prevalence and Risk Correlates of Intimate Partner Violence Among a Multisite Cohort of Young Transgender Women. LGBT Health 2018; 5:333.

76. Lowry R, Johns MM, Gordon AR, et al. Nonconforming Gender Expression and Associated Mental Distress and Substance Use Among High School Students. JAMA

Pediatr 2018; 172:1020.

77. Walls NE, Atteberry-Ash B, Kattari SK, et al. Gender Identity, Sexual Orientation, Mental Health, and Bullying as Predictors of Partner Violence in a Representative Sample of Youth. J Adolesc Health 2019; 64:86.
78. Baams L, Wilson BDM, Russell ST. LGBTQ Youth in Unstable Housing and Foster Care. Pediatrics 2019; 143.
79. Lipson SK, Raifman J, Abelson S, Reisner SL. Gender Minority Mental Health in the U.S.: Results of a National Survey on College Campuses. Am J Prev Med 2019; 57:293.
80. Peng K, Zhu X, Gillespie A, et al. Self-reported Rates of Abuse, Neglect, and Bullying Experienced by Transgender and Gender-Nonbinary Adolescents in China. JAMA Netw Open 2019; 2:e1911058.
81. Thoma BC, Salk RH, Choukas-Bradley S, et al. Suicidality Disparities Between Transgender and Cisgender Adolescents. Pediatrics 2019; 144.
82. Ross-Reed DE, Reno J, Peñaloza L, et al. Family, School, and Peer Support Are Associated With Rates of Violence Victimization and Self-Harm Among Gender Minority and Cisgender Youth. J Adolesc Health 2019; 65:776.
83. Strauss P, Cook A, Winter S, et al. Mental Health Issues and Complex Experiences of Abuse Among Trans and Gender Diverse Young People: Findings from Trans Pathways. LGBT Health 2020; 7:128.
84. Murchison GR, Agénor M, Reisner SL, Watson RJ. School Restroom and Locker Room Restrictions and Sexual Assault Risk Among Transgender Youth. Pediatrics 2019; 143.
85. de Vries AL, Doreleijers TA, Steensma TD, Cohen-Kettenis PT. Psychiatric comorbidity in gender dysphoric adolescents. J Child Psychol Psychiatry 2011; 52:1195.
86. Yunger JL, Carver PR, Perry DG. Does gender identity influence children's psychological well-being? Dev Psychol 2004; 40:572.
87. Ryan C, Huebner D, Diaz RM, Sanchez J. Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual young adults. Pediatrics 2009; 123:346.
88. Toomey RB, Syvertsen AK, Shramko M. Transgender Adolescent Suicide Behavior. Pediatrics 2018; 142.
89. Jackman KB, Caceres BA, Kreuze EJ, Bockting WO. Suicidality among Gender Minority Youth: Analysis of 2017 Youth Risk Behavior Survey Data. Arch Suicide Res 2021; 25:208.
90. Greytak EA, Kosciw JG, Diaz EM. Harsh Realities: The Experiences of Transgender Youth i n Our Nation’s Schools. Gay, Lesbian and Straight Education Network 2009. Available at: www.glsen.org/binary-data/GLSEN_ATTACHMENTS/file/000/001/1375-1.pdf (Accessed on November 27, 2012).

91. McCabe S. D.C. police investigating death, attacks on transgender people. The Examiner 2011. Available at: www.washingtonexaminer.com/d.c.-police-investigating-death-attacks-on-transgender-people/article/118236 (Accessed on February 23, 2012).
92. Roberts AL, Rosario M, Corliss HL, et al. Childhood gender nonconformity: a risk indicator for childhood abuse and posttraumatic stress in youth. Pediatrics 2012; 129:410.
93. Roberts AL, Rosario M, Slopen N, et al. Childhood gender nonconformity, bullying victimization, and depressive symptoms across adolescence and early adulthood: an 11-year longitudinal study. J Am Acad Child Adolesc Psychiatry 2013; 52:143.
94. Roberts AL, Rosario M, Corliss HL, et al. Elevated risk of posttraumatic stress in sexual minority youths: mediation by childhood abuse and gender nonconformity. Am J Public Health 2012; 102:1587.
95. Wilson EC, Garofalo R, Harris RD, et al. Transgender female youth and sex work: HIV risk and a comparison of life factors related to engagement in sex work. AIDS Behav 2009; 13:902.
96. Garofalo R, Deleon J, Osmer E, et al. Overlooked, misunderstood and at-risk: exploring the lives and HIV risk of ethnic minority male-to-female transgender youth. J Adolesc Health 2006; 38:230.
97. Turner CM, Ahern J, Santos GM, et al. Parent/Caregiver Responses to Gender Identity Associated With HIV-Related Sexual Risk Behavior Among Young Trans Women in San Francisco. J Adolesc Health 2019; 65:491.
98. Spack N. Transgenderism. Med Ethics (Burlingt Mass) 2005; 12:1.
99. Drescher J, Byne W. Gender dysphoric/gender variant (GD/GV) children and adolescents: summarizing what we know and what we have yet to learn. J Homosex 2012; 59:501.
100. de Vries AL, Steensma TD, Doreleijers TA, Cohen-Kettenis PT. Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study. J Sex Med 2011; 8:2276.
101. Rae JR, Gülgöz S, Durwood L, et al. Predicting Early-Childhood Gender Transitions. Psychol Sci 2019; 30:669.
102. Alderman EM, Breuner CC, COMMITTEE ON ADOLESCENCE. Unique Needs of the Adolescent. Pediatrics 2019; 144.
103. Korpaisarn S, Safer JD. Gaps in transgender medical education among healthcare providers: A major barrier to care for transgender persons. Rev Endocr Metab Disord 2018; 19:271.
104. Fraser L, Knudson G. Education Needs of Providers of Transgender Population. Endocrinol Metab Clin North Am 2019; 48:465.

105. Möller B, Schreier H, Li A, Romer G. Gender identity disorder in children and adolescents. Curr Probl Pediatr Adolesc Health Care 2009; 39:117.

106. Feldman J, Goldberg J. Transgender Primary Medical Care: Suggested Guidelines for Clinicians in British Columbia. 2006. Available at: transhealth.vch.ca/resources/library/tcpdocs/guidelines-primcare.pdf (Accessed on October 05, 2012).

107. de Vries AL, Cohen-Kettenis PT, Delemarre-Van de Waal H. Caring for transgender adolescents in BC: Suggested guidelines. Available at: transhealth.vch.ca/resources/library/tcpdocs/guidelines-adolescent.pdf (Accessed on October 05, 2012).

108. Kreiss JL, Patterson DL. Psychosocial issues in primary care of lesbian, gay, bisexual, and transgender youth. J Pediatr Health Care 1997; 11:266.

109. American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, and Society for Adolescent Medicine. Protecting adolescents: Ensuring access to care and reporting sexual activity and abuse. J Adolesc Health 2004; 35:420.

110. Ford C, English A, Sigman G. Confidential Health Care for Adolescents: position paper for the society for adolescent medicine. J Adolesc Health 2004; 35:160.

111. Association of Women's Health, Obstetric & Neonatal Nursing. Confidentiality in adolescent health care. J Obstet Gynecol Neonatal Nurs 2010; 39:127.

112. Edwards-Leeper L, Spack NP. Gender identity disorder. In: The Zuckerman Parker Handbook of Developmental and Behavioral Pediatrics for Primary Care, 3rd ed, Augustyn M, Zuckerman B, Caronna EB (Eds), 2011. p.229.

113. Bonifacio JH, Maser C, Stadelman K, Palmert M. Management of gender dysphoria in adolescents in primary care. CMAJ 2019; 191:E69.

114. Olson J. Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Youth and the Internet: A Virtual Closet or Cornucopia? California Pediatrician 2011; :6.

115. Perrin E, Smith N, Davis C, et al. Gender variant and gender dysphoria in two young children. J Dev Behav Pediatr 2010; 31:161.

116. Bockting W, Knudson G, Goldberg JM. Counseling and mental health care for transgender adults and loved ones. Int J Transgend 2006; 9:35.

117. Anton BS. Proceedings of the American Psychological Association for the legislative year 2008: Minutes of the annual meeting of the Council of Representatives, February 22-24, 2008, Washington, DC, and August 13 and 17, 2008, Boston, MA, and minutes of the February, June, August, and December 2008 meetings of the Board of Directors. Am Psychol 2008; 64:372.

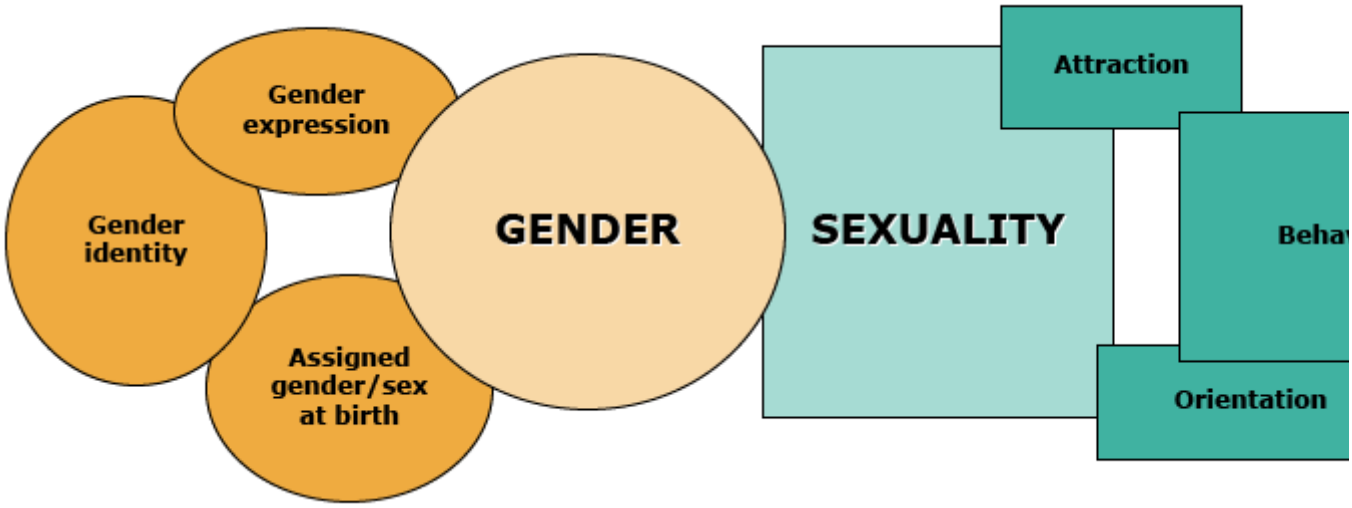
118. Menvielle E, Gomez-Lobo V. Management of children and adolescents with gender dysphoria. J Pediatr Adolesc Gynecol 2011; 24:183.

119. Rood BA, Reisner SL, Surace FI, et al. Expecting Rejection: Understanding the Minority Stress Experiences of Transgender and Gender-Nonconforming Individuals. Transgend Health 2016; 1:151.

Topic 83665 Version 54.0

GRAPHICS

Intersections of gender and sexuality



Developing sexuality encompasses complex intersections between gender (gender expression, gender i
assigned gender/sex at birth) and sexuality (attraction, behaviors, orientation).

Courtesy of Michelle Forcier, MD, MPH and Johanna Olson-Kennedy, MD.

Graphic 50053 Version 8.0

Terms used to describe various aspects of gender and sexuality*

Gender identity	An individual's innate sense of feeling male, female, neither, or some combination of both.
Natal or birth-assigned/birth-designated sex	Typically assigned/designated according to external genitalia or chromosomes.
Gender expression	How gender is presented to the outside world (eg, feminine, masculine, androgynous); gender expression does not necessarily correlate with birth-designated sex or gender identity.
Gender diversity	Variation from the cultural norm in gender identity, expression, or gender role behavior (eg, in choices of toys, playmates); "gender diversity" acknowledges the spectrum of gender identities and replaces "gender nonconformity," which has negative and exclusionary connotations.
"Transgender" ("trans" as an abbreviation)	Umbrella term that is used to describe individuals with gender diversity; it includes individuals whose gender identity is different from their birth-designated sex and/or whose gender expression does not fall within stereotypical definitions of masculinity and femininity; "transgender" is used as an adjective ("transgender people"), not a noun ("transgenders").
Gender dysphoria or incongruence	Distress or discomfort that may occur when gender identity and birth-designated sex are not completely congruent.
Transsexual	Older, clinical term that has fallen out of favor; historically, it was used to refer to transgender people who sought medical or surgical interventions for gender affirmation.
Sexual orientation	An individual's pattern of physical and emotional arousal (including fantasies, activities, and behaviors) and the gender(s) of persons to whom an individual is physically or sexually attracted (gay/lesbian, straight, bisexual); sexual orientation is an entirely different construct than gender identity, but is often confused with it; the sexual orientation of transgender people is based upon their identified gender (eg, a transgender man who is attracted to other men might identify as a gay man; a transgender woman who is attracted to other women might identify as a lesbian).
Sexual behaviors	Specific behaviors involving sexual activities that are useful for screening and risk assessment; many youth reject traditional labeling (homosexual, heterosexual, bisexual) but still have same-sex partners.

Transgender man/transman/transmasculine person	Person with a masculine gender identity who was designated a female sex at birth.
Transgender woman/transwoman/transfeminine person	Person with a feminine gender identity who was designated a male sex at birth.
Nonbinary gender identity	Person of any birth-designated sex who has a gender identity that is neither masculine nor feminine, is some combination of the two, or is fluid. Other terms that may be used for nonbinary gender identity include genderqueer, gender creative, gender independent, bigender, noncisgender, agender, two-spirit, third sex, and gender blender.

* These are cultural and descriptive terms, not diagnostic terms, which are specific to medical and pathology-based paradigms.

References:

1. *Perrin EC. Sexual Orientation in Child and Adolescent Health Care, Springer, New York 2002.*
2. *Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society* Clinical Practice Guideline. J Clin Endocrinol Metab 2017.*
3. *Adelson SL, American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). Practice parameter on gay, lesbian, or bisexual sexual orientation, gender nonconformity, and gender discordance in children and adolescents. J Am Acad Child Adolesc Psychiatry 2012; 51:957.*
4. *Frankowski BL, American Academy of Pediatrics Committee on Adolescence. Sexual orientation and adolescents. Pediatrics 2004; 113:1827.*
5. *Edwards-Leeper L, Spack NP. Psychological evaluation and medical treatment of transgender youth in an interdisciplinary "Gender Management Service" (GeMS) in a major pediatric center. J Homosex 2012; 59:321.*
6. *Rafferty J, Committee on Psychosocial Aspects of Child and Family Health, Committee on Adolescence, Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness. Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents. Pediatrics 2018; 142:e20182162.*

Graphic 86993 Version 12.0

Examples of ways that youth, providers, and caretakers can assist gender diverse youth create a transition plan according to youth, family/parent, and provider priorities

Goal (examples)	Specific action(s)		
	Youth	**Family/parent**	**Therapist/other child health professionals**
Youth priorities			
Be allowed to dress in the gender they assert	▪ Pick out clothes that express asserted gender and are school and age appropriate	▪ Assist the youth with in-store, online shopping ▪ Allow the youth to cut hair in style they want	▪ Reassure parents that allowing a youth to express their asserted gender is generally desirable for self-esteem and identity development
Be called by asserted name and pronouns	▪ Tell friends that you would like them to use your asserted name and desired pronouns	▪ Make using asserted name a priority for self and family members; apologize and try again when mistakes are made ▪ Engage with school, peers and parents, and other family and social settings to introduce and find ways to maintain change in name and pronouns	▪ Impress upon parents and others that use of the asserted name and pronouns is very important to the youth; it sends the youth a message that their identity is acknowledged and that their needs are important
Family/parent priorities			
Help the youth disclose at a time and in a manner that allows parents to prepare important support persons	▪ May need to delay full social transition until parents have talked to and prepared other support persons	▪ Work with teachers, guidance office, and principal to create plan for disclosure to peers	▪ Work with schools to increase their knowledge of gender-diverse youth and needs specific to this youth and family

	▪ Can fully social transition at home with support of parents ▪ Consider and tell parent if there are any persons who might make transition unsafe	▪ Have plan for supporting the youth when there are negative reactions to disclosure	▪ Engage agencies that may help parents by taking the role of advocate so that parents can maintain role of caregiver
Maintain plans for safety with potential for bullying and assault	▪ Be alert to persons or situations that present as negative or threatening regarding their gender expression ▪ Immediately report to teacher and parent(s) if persons are bullying or threatening	▪ Discuss with principal and school zero tolerance policies on bullying and assault ▪ Consider which past and present persons and settings may be negative or harmful to the youth's transition goals	▪ Work with youth and parents regarding healthy ways to express self, react to negative social interactions, and maintain safety with persons who are not supportive or intolerant
Mental health provider priorities			
Prevent self-harm and suicide	▪ Agree to safety plan with therapist	▪ Know safety plan and be one of the responsible adults to whom the youth can report suicidal or self-harm thoughts	▪ Encourage total honesty and disclosure when discussing self-harm, suicidality, and suicide attempts; review and revise safety plan as needed
Family/parent acceptance	▪ Understand that parents and other families may "transition" and accept their identity in a somewhat different time frame than theirs	▪ Be open to individual, couples, or family therapy to learn how to adapt to the youth's asserted identity and cope with their own feelings	▪ Assist parents, siblings, and additional significant caregivers with their own thoughts and feelings with the transition plan

Courtesy of Michelle Forcier, MD, MPH, and Johanna Olson-Kennedy, MD.

Graphic 87390 Version 7.0

Examples of responses to caregiver concerns about gender diversity

Example of question	Poor response	Supportive response
I am worried about how often my son plays with his sister's dolls. What do you think? Do you think my son may be gay?	Playing with dolls is not typical of boys. He may be gay. Maybe I should refer you to a psychiatrist.	Tell me more about what sort of play and activities your child enjoys? How do you and the family support and encourage the range of his play? All children experiment with and explore toys and play that are more stereotypical of the opposite gender. What is most important is for you to help your child explore their interests.
My school-age daughter refuses to wear a dress. She is always playing with the neighborhood boys. I think she may be a lesbian. I am worried.	Lots of girls hate dresses. But you as the parent can make her wear what you think is appropriate. You need to set better limits on her clothing choices.	Tell me more about the conversations you and your child have had around wearing dresses and other types of clothes. Why does your child refuse to wear a dress? Has your child talked about other aspects of being a girl or gender? What would your child wear if it was all up to them?
We found out that my daughter thinks she is a boy trapped in a girl's body from a Facebook post. Can we help her not be a lesbian?	Being gay is not so bad anymore. Being gay is more accepted and cool for kids.	Let's talk some more about and try to understand about your child's identity and feelings about their birth-assigned gender versus their feelings, attractions, and possible sexual orientation. Gender and sexual orientation get confusing but they are very different aspects of each person.
My son is driving his father crazy with the feminine clothes he wears, his long hair, etc. My son and his father fight all the time. I am so worried. What should I do?	You should tell your son to get a haircut and wear normal clothing. Being effeminate is only going to get him beat up at school.	Why do you think this upsets your child's dad? Does it upset you? Have you talked to your child about their preference for feminine clothes? Have you asked your child how they feel about their dad's reactions and the fighting?

Courtesy of Michelle Forcier, MD, MPH and Johanna Olson-Kennedy, MD.

Graphic 86987 Version 5.0

Contributor Disclosures

Michelle Forcier, MD, MPH Consultant/Advisory Boards: Folx Health[Protocols, library articles, training];OutCare[LGBTQ+ health care];Planned Parenthood[Clinical services]. Other Financial Interest: Springer [Pediatric gender care (book royalties)]. All of the relevant financial relationships listed have been mitigated. **Johanna Olson-Kennedy, MD** Consultant/Advisory Boards: Novartis [Transgender adolescents and young adults]. All of the relevant financial relationships listed have been mitigated. **Diane Blake, MD** No relevant financial relationship(s) with ineligible companies to disclose. **David Brent, MD** Grant/Research/Clinical Trial Support: AFSP [Suicide prevention]; NIMH [Child and adolescent psychiatry]; Once Upon a Time Foundation [Suicide prevention]; The Beckwith Institute [Healthcare grants for patient care]. Consultant/Advisory Boards: AFSP [Suicide prevention]; Healthwise [Consumer health education]; Klingenstein Third Generation Foundation [Child and adolescent mental health]. Other Financial Interest: eRT Inc [Clinical assessment, electronic self-rated version of the C-SSRS]; Guilford Press [Royalties, Depression and suicidality]. All of the relevant financial relationships listed have been mitigated. **Mitchell E Geffner, MD** Grant/Research/Clinical Trial Support: Adrenas [Congenital adrenal hyperplasia]; Diurnal [Congenital adrenal hyperplasia]; Neurocrine Biosciences [Congenital adrenal hyperplasia]; Novo Nordisk [Growth]; Spruce Biosciences [Congenital adrenal hyperplasia]. Consultant/Advisory Boards: Adrenas [Congenital adrenal hyperplasia]; Aeterna Zentaris [Growth]; Eton [Congenital adrenal hyperplasia]; Neurocrine Biosciences [Congenital adrenal hyperplasia]; Novo Nordisk [Growth]; Nutritional Growth Solutions [Growth]; Pfizer [Growth]; Spruce Biosciences [Congenital adrenal hyperplasia]. Other Financial Interest: McGraw-Hill textbook royalties [Pediatric endocrinology]. All of the relevant financial relationships listed have been mitigated. **Mary M Torchia, MD** No relevant financial relationship(s) with ineligible companies to disclose.

Contributor disclosures are reviewed for conflicts of interest by the editorial group. When found, these are addressed by vetting through a multi-level review process, and through requirements for references to be provided to support the content. Appropriately referenced content is required of all authors and must conform to UpToDate standards of evidence.

Conflict of interest policy

→