Parliament of NSW
ATTN: Portfolio Committee No. 3
Parliament House
Macquarie Street
Sydney NSW 2000
BY E-MAIL: portfoliocommittee3@parliament.nsw.gov.au

20 May 2021

Dear Committee

INQUIRY INTO THE EDUCATION LEGISLATION AMENDMENT (PARENTAL RIGHTS) BILL 2020 – RESPONSE TO SUPPLEMENTARY QUESTIONS TO MR ANDREW WALL, NATIONAL POLITICAL DIRECTOR, AUSTRALIAN CHRISTIAN LOBBY

Thank you for the opportunity extended to The Australian Christian Lobby to appear at the inquiry hearing on 20 April 2021 and for the opportunity to respond to further supplementary questions from the Committee.

The Committee has asked two supplementary questions regarding the NSW Department of Education, *Legal Issues Bulletin No. 55* (the **Bulletin**). I attach to this letter:

1. answers to the Committee's supplementary questions;

2. a copy of the Bulletin to assist the Committee; and

3. a copy of the working paper, *Gender Identity Discrimination and Vulnerable Adolescents: Reconciling Equality Goals with Child Protection* by Professor Patrick Parkinson.

4. a copy of *Psychosexual Outcome of Gender-Dysphoric Children* by Wallien et al;

5. a copy of *Clinical management of Gender dysphoria in Children and Adolescents: the Dutch Approach* by De Vries et al.

Please contact me if I can be of any further assistance to the Committee with its inquiry.

Yours faithfully,

Dan Flynn
Deputy Director
Australian Christian Lobby

ANSWERS TO SUPPLEMENTARY QUESTIONS

Question (a) – What are the Australian Christian Lobby's views on how the bulletin should be changed and updated?

The Australian Christian Lobby has reviewed the NSW Department of Education, *Legal Issues Bulletin No. 55* (the **Bulletin**). The Bulletin gives guidance to NSW schools on the legal rights of transgender students in schools. The ACL considers that the Bulletin is fundamentally flawed and needs to be completely rewritten so that it reflects the scientific reality about children suffering gender dysphoria and provides a nuanced and evidence-based approach to addressing gender dysphoria in accordance with the guidance of parents. The Bulletin should be retitled "Students with Gender Dysphoria in Schools."

The key failings that the ACL identifies with the Bulletin are as follows.

1. **Gender dysphoria should not be assumed to equal transgender identity.** The Bulletin assumes that all children who feel or display identity traits not traditionally associated with their sex are transgender. The Bulletin states:

   > *"Most people express the gender that corresponds with their biological sex. There are some people whose gender identity or expression is different from that traditionally associated with assigned sex at birth. This is known as being transgender. This can occur at any age."*

   This is incorrect. While gender dysphoria can be expressed from pre-puberty (not any age), around 90% of children will resolve this dysphoria before adulthood and are not transgender (see attached research). This is a fundamental flaw of the Bulletin which largely invalidates all policy advice and direction contained within the Bulletin. Because of this fundamental flaw, the Bulletin needs to be rewritten and cannot be fixed.

   The Bulletin uses language of sex that is "assigned" or "designated" at birth. This kind of language should be removed. It is an unequivocal medical fact that children are born either male or female, apart from very rare medical complications that involve chromosomal mutation. Official department policy should be ideologically neutral and not promote genderfluid ideology.

2. **Advice on rights needs to reflect best practice on gender dysphoria.** The Bulletin assumes that all gender dysphoric students are transgender. Its policy advice is therefore absolute and incomplete. It only gives advice about a school's legal obligations and the duty of care for the 10% of children suffering gender dysphoria who will identify as transgender upon reaching the age of majority. No advice is given about the 90% of children who will experience gender dysphoria and for whom this will resolve with acceptance of their natal sex by the time they reach adulthood.

   For children suffering gender dysphoria, the Bulletin should reflect that the best practice is watchful waiting – the neutral treatment of children that puts in place practices that will minimise distress, but which will not push a child down a pathway of transition.

3. **Parents are minimised and excluded.** The Bulletin does not recognise that parents (and not the school or the child) are by law primarily responsible for decisions about the moral and ethical guidance and formation of their child (including in relation to issues of their child's identity). Parents are an afterthought or are just excluded from the guidance (such as in relation to health care planning). Parents are given a tertiary position behind the school and the student themselves. Examples from the Bulletin include the following:

> *"…it is important wherever practicable to discuss how it is intended information will be used or disclosed with the student. This issue should also be discussed with the student's parent(s) or carer* ***unless the principal believes on reasonable grounds that it is not in the student's best interests to do this.****"*
>
> *"It is important to consult with the student and their parents or carers* ***where practicable*** *when planning for the student's support…"*
>
> *"Ongoing, open and transparent communication between the school, and the student and their parents or carers is an essential part of providing the student with a safe and successful education* ***unless the principal believes on reasonable grounds that it is not in the student's best interest to involve the parents or carers.****"*

4. **Fundamental rights of parents are not mentioned or recognised.** The Bulletin ignores international law that recognises the central responsibility of parents for their children's upbringing, education, and development. The Bulletin should recognise the importance of a parents' role if it purports to give policy advice. Such international laws include:

   (a) The Universal Declaration of Human Rights (Article 26(3));

   (b) The Convention on the Rights of the Child (Articles 5 and 14);

   (c) The Declaration on the Elimination of All Forms of Intolerance and Discrimination Based on religion or Belief (Article 5(2)); and

   (d) The International Covenant on Civil and Political Rights (Article 18.4).

5. **The rights of transgender students should be proportionately balanced with the rights of parents and other students.** The Bulletin preferences the rights of students with gender dysphoria above that of their fellow students and their parents. The wellbeing of every child should be prioritised, and no child should be compelled or forced to act against their conscience to use particular language and speech. Children should also not be placed in situations contrary to their best interests, like sharing changerooms with members of the opposite sex.

6. **Students should be allowed to question genderfluid ideology.** The Bulletin outlines that a teacher's response to student questions about fellow transgender students should promote acceptance. This statement needs clarification. Students should be encouraged to care for and act in the best interests of their fellow students, but this

7. does not mean that they should be compelled to endorse genderfluidity. Students should be able to engage critically with genderfluid theory in a respectful way.

8. **Schools should not be encouraged to report parents who question whether transition of their gender dysphoric child is suitable.** Parents know what is best for their children. As set out above, medical evidence clearly demonstrates that the vast majority of children who experience gender dysphoria grow out of their dysphoria after they reach adulthood. A parent should not be reported to any authority for adopting a watchful waiting approach or for questioning whether transition of a child is appropriate. Parents should always be the primary contact for issues concerning their child except in extreme circumstances where there is immediate threat of physical abuse.

Question (b) – What are the Australian Christian Lobby's views on the role of parents in relation to the changing and updating of the bulletin?

Parents are primarily responsible for the guidance and education of their children on issues of morality, ethics, sexuality and identity, not schools.

In ordinary circumstances, the ACL considers that the NSW Department of Education is responsible for drafting educational policy and guidance. The Bulletin does not relate to education. It relates to issues of sexuality and identity. These areas are the primary responsibility of parents and parents should have input into policy that concerns these areas of parental primacy.

Given the fundamental flaws in the Bulletin and the evidence before the Committee, the ACL considers that leaving such policy in the hands of academics, lawyers, and theorists alone while excluding parents leads to a Bulletin which is not in the best interests of gender dysphoric children.

Not all policies require parental involvement, however if a policy goes to the heart of child identity and matters of parental primacy, parents should be involved.

Wash your hands, cover your cough and stay home if you're sick. Get the latest COVID-19 advice (https://education.nsw.gov.au/covid-19).

NSW Department of Education

Transgender students in schools

Transgender students in schools, legal issues bulletin 55, LIB55

On this page

Sample support and risk management plan

The Department of Education is committed to providing safe and supportive learning environments that respect and value diversity and are free from violence, discrimination, harassment and vilification. Research shows the supportive environment schools provide can have a lasting impact on both the educational and lifelong outcomes for students.

Most people express the gender that corresponds with their biological sex. There are some people whose gender identity or expression is different from that traditionally associated with assigned sex at birth. This is known as being transgender. This can occur at any age.

All students, including those who identify as transgender, have a right to be treated equitably and with dignity. The department has a number of resources that support these rights including the **Student Welfare Policy** (/policy-library/policies/student-welfare-policy) and the Bullying: Preventing and Responding to **Student Bullying in Schools Policy** (/policy-library/policies/bullying-of-students-prevention-and-response-policy). These resources promote a proactive approach to the development of positive school environments in which every student is respected and valued. Additionally, schools have a legal duty to protect students from foreseeable risk of harm and to do what is reasonably practicable to ensure their safety.

The following information is general in nature. It is important, to structure any support specifically to the individual needs of the student within a particular school. Not all students who identify as transgender will require a plan to support them but it is necessary to assess the likelihood of any risk to each transgender student and where required plan for their support.

Legal rights for transgender students

A student who has identified as transgender enjoys the same legal rights or protections afforded to all students under the duty of care, education and work health and safety laws. Additional protections apply to such students under discrimination law. For example in NSW the Department of Education is prohibited from unlawfully discriminating against a student on transgender grounds:

- by refusing or failing to accept the person's application for admission as a student, or
- in the terms on which it is prepared to admit the person as a student.

The department is also prohibited from unlawfully discriminating against a student on transgender grounds:

- by denying the student access, or limiting the student's access, to any benefit provided by the educational authority, or
- by expelling the student or subjecting the student to any other detriment.

It does not follow that an application for enrolment from a transgender student can never be declined or that a transgender student can never be expelled. Rather, the law requires the student is not subjected to unlawful discrimination when such decisions are made. Further information about discrimination on transgender or gender identity grounds is found at Attachment A.

Privacy legislation and transgender students

Most, if not all, of the information collected about a transgender student will be personal or health information. This information is protected by privacy legislation.

While privacy legislation will not necessarily prevent school or other departmental staff from using or disclosing information for a lawful purpose (for example in the discharge of the duty of care or for child protection purposes), it is important wherever practicable to discuss how it is intended information will be used or disclosed with the student. This issue should also be discussed with the student's parent(s) or carer unless the principal believes on reasonable grounds that it is not in the student's best interests to do this (for example a court order has removed a parent's parental responsibility for that student).

School and other departmental staff should seek legal advice in circumstances where parents or carers and/or the student object to the proposed use or disclosure of a student's personal and/or health information.

Name and gender records

Generally, students are enrolled at school under the name and gender on their birth certificate. There are exceptions to this position, however, including where a student is transgender and seeks to change the way their first name is used and recorded by the school. Principals may wish to review **Legal issues bulletin 20** (/about-us/rights-and-accountability/legal-issues-bulletins/bulletin-20-changing-the-way-a-student-name-is-used-and-recorded-by-schools) for advice about the process to follow when this issue arises.

Students should then be referred to by the name they are enrolled under. The pronoun used to describe the student (he/she, him/her) should be consistent with the gender now recorded by the school. The department's **Code of Conduct** (/policy-library/policies/code-of-conduct-policy) and the individual school's discipline and welfare policy should be utilised where staff or students deliberately or repeatedly use names or pronouns other than the one identified by the student concerned.

Uniform for transgender students

The department's **School Uniform Policy** (/policy-library/policies/school-uniform-policy) encourages schools to consider individual student circumstances when considering the school's uniform. Many schools have developed unisex uniforms that are not gender specific.

Students who identify as transgender should be allowed to choose from the uniform options available at the school.

All students are required to wear items identified as necessary for particular activities, e.g. closed in shoes for practical food technology classes. A school uniform should meet requirements of work health and safety and anti-discrimination legislation.

Supporting a student who has identified as transgender

Support needs will vary from student to student. It is important to consult with the student and their parents or carers where practicable when planning for the student's support unless the principal believes on reasonable grounds that it is not in the student's best interests to do this (for example a court order has removed a parent's parental responsibility for that student).

Where reasonably practicable, the student should be treated on the same basis as other students of the same identified gender.

Consideration should be given to each activity the student is involved in at school. It is important to consider and as necessary plan ahead for any key transition points in the student's schooling.

Risks arising from these activities should be identified and assessed and strategies to eliminate or minimise the identified risks should be implemented so far as is reasonably practicable. Staff must be consulted where they are also potentially at risk. Activities to be considered may include:

- use of toilet and change room facilities
- excursions including overnight excursions
- school sport
- curriculum
- health care planning and
- gender transitioning while at school.

A sample plan for a high school student who has identified as transgender is found at Attachment B. This is a sample only – the strategies it contains will not apply in all circumstances. The actual strategies required to support a student will vary according to their individual circumstances and the school they attend.

Use of toilets and change room facilities

Toilets, showers and change rooms are specific to each school. An assessment of the risk posed to the student by using the toilets of their identified gender must be undertaken. If an identified risk to the student cannot be satisfactorily eliminated or minimised then other arrangements should be made. The need for the student to be safe is a paramount concern in these circumstances.

Students should not be required to use the toilets and change rooms used by persons of the sex they were assigned at birth if they identify as a different gender. Alternative arrangements may include using staff toilets or unisex toilets where possible. The exclusion of students who identify as transgender from the toilet or change rooms of their identified gender must be regularly reviewed to determine its continuing necessity.

If other students indicate discomfort with sharing single-sex facilities (toilets or change rooms for example) with a student who identifies as transgender, this should be addressed through the school learning and support team.

Excursion including overnight

An assessment of risk is normal procedure for all excursions. Ordinarily, a student who identifies as transgender should use the facilities of their identified gender or unisex facilities when available. In some circumstances, it may be appropriate to arrange private sleeping quarters.

School Sport

A student who identifies as transgender should be permitted to participate in most school-based sports as their identified gender. Where the sport is competitive and the student is under 12 they should compete as their identified gender. Most students will be able to continue to participate in competitive sport in their identified gender after they have turned 12.

It may be lawful to exclude students aged 12 and over from competing in certain sports at the elite level in certain circumstances. Confidential case-by-case evaluation should occur. More information is available at: **https://www.ausport.gov.au/supporting/integrity_in_sport/resources/national_member_protection_policy_template** (https://www.ausport.gov.au)

Curriculum

All teachers should be respectful and inclusive of all students' individual learning identity. Gender identity may be discussed in many curriculum areas including Personal Development, Health and Physical Education (PDHPE) classes following syllabus guidelines. Teachers should treat the topic in a manner that is respectful, inclusive and positive. Information for PDHPE teachers can be found at the department's **Curriculum Support Site** (/teaching-and-learning/curriculum).

Health care planning

Students undergoing a gender transitioning process will do so over time and in consultation with health care professionals. The process may or may not include medical treatment. The **Student Health in NSW** (/policy-library/policies/student-health-in-nsw-public-schools-a-summary-and-consolidation-of-policy)

Public Schools (/policy-library/policies/student-health-in-nsw-public-schools-a-summary-and-consolidation-of-policy) policy should be applied by schools in relation to medication or any other health care needs the student may have.

Gender transitioning while at school

When a student advises of their intention to gender transition, schools need to provide a safe and supportive environment. It is often useful to set a date of gender transition for the student (in consultation with the student and their parent/carer) at the point of return from holidays. This allows an immediately visible change even though the personal process of change will occur over a longer period of time.

The school counsellor is likely to have an important role to play in supporting the student and their family. This could include liaising with the school and health professionals, especially in cases where the student may be experiencing difficulties in their personal relationships with family and friends. Staff may need additional professional development to enable them to successfully support the student.

The welfare and educational needs of the student are of primary importance and should be the focus of all actions taken by the school.

Back to Index (#back_Legal_0)

Communication strategies

Communication strategies should potentially be developed and implemented for:

- the school and the student and his or her parents or carers
- the student and his or her friendship group
- other students and school staff
- the broader school community; and (potentially) the media.

The student and their parents or carers

Ongoing, open and transparent communication between the school, and the student and their parents or carers is an essential part of providing the student with a safe and successful education unless the principal believes on reasonable grounds that it is not in the student's best interest to involve the parents or carers (for example a court order has removed a parent's parental responsibility for that student). A point of contact should be established within the school and the parents/carers and student encouraged to provide the school with relevant information. Parents and the student should be encouraged to promptly advise the school of any new or changed information, issues or incidents that occur at the school.

It is also important to encourage parents and the student to advise the school of any relevant incidents that occur outside of school. For example, it is important for the school to be advised if there has been an incident involving the student and other students on the weekend or a public holiday in order to review any plans for supporting the student at school.

The student and friendship groups

A student who identifies as transgender may need to discuss issues with the school counsellor (or staff member nominated by that student) such as informing friendship groups and other peers if they choose to do so. Depending on the circumstances it may also be necessary to provide support to students in the friendship group.

Other students

Students may be curious or confused if one of their peers discloses that they identify as transgender. They should be reassured that the student deserves the same respect and courtesy that they would extend to any other person.

Other students may have questions about the student who has identified as transgender, particularly when the student has transitioned while they are at the same school. Staff should be provided with a suggested response to these questions. This response should promote acceptance but will vary according to the student's individual circumstances. The school counsellor and/or District Guidance Officer can assist in developing this response. Legal Services may be of assistance if legal issues arise.

Consideration should be given to how gender diversity is currently dealt with in the school and whether further action is necessary to reinforce the need for tolerance and respect for diversity.

Staff

It is important to identify the staff who need to have more detailed knowledge about the student in order to provide them with a safe and supportive learning environment. This is likely to include the principal, school counsellor and year advisor (where the student is in high school). Depending on the circumstances it may also include classroom teachers and other staff that need the information in order to safely provide the student with learning and support.

It is important to remind staff that a student who identifies as transgender has the same rights to learning in a safe and supportive environment as all other students and that additional support for the student may be necessary. It is also important to remind staff of their professional obligations in their dealings with all students and particularly with students who may be more vulnerable.

Staff may need additional professional development to support the student. Consideration should be given to what professional development staff may need while planning for the student's enrolment and/or transition. Assistance can be obtained from the Student Engagement and Interagency Partnership directorate in identifying possible sources of professional development.

The broader school community

On occasions, it is helpful if school staff are provided with a school-developed response to enquiries from the broader school community. The school should consult with the student who identifies as transgender and their parents to develop this response.

Media

The school should respond to any external enquiries about students who identify as transgender with respect for the student's privacy, as with enquiries about all students. Any media enquiries should be referred to the Media unit on (02) 9561 8501.

Support for the extended family of the student

Siblings and the student's extended family may find the student's transition challenging and be adversely affected by the impact of the student's transition on their family. Siblings and other family members can also experience bullying behaviour from peers and others as a consequence of the student's transition. Strategies to address this should be implemented across the schools in which the student who has identified as transgender or their affected family members are known to have enrolled.

When a sibling, or a member of the student's extended family, attends a non-government school it may be helpful to work with that school to coordinate support for the student and their family. Consent should ordinarily be sought from the student's parents or carers or to allow this information exchange and coordination to occur.

Where this consent is not able to be obtained and information related to the safety, welfare or wellbeing of the student or his/her siblings or extended family is needed to help with decision making, planning, assessment or service provision then the Children and Young Persons (Care and Protection) Act 1998 can be used to seek and/or provide information and also to coordinate services. The school counsellor may be able to assist in this regard. See **Legal issues bulletin 50** (/about-us/rights-and-accountability/legal-issues-bulletins/exchanging-information-with-other-organisations-the-care-and-protection-act) for more information about this process.

Back to Index (#back_Communication_10)

Reporting requirements

On rare occasions, a parent's or carer's response to a student identifying as being transgender could give rise to a reasonable suspicion that the student is at suspected risk of harm. This could relate to the parent's stated response to their child identifying as transgender but other risk factors may be present. School staff should inform their principal of any concerns about a student who may be at suspected risk of harm.

Principals need to consider whether a report to DCJ or contact with the department's Child Wellbeing unit or some other action is required. The **Mandatory Reporter Guide** (/student-wellbeing/child-protection/mandatory-reporting) can help with this decision. If in doubt or if assistance is required contact can be made with the department's Child Wellbeing unit. The department's **Child protection policy: responding to and reporting students at risk of harm and guidelines** (https://policies.education.nsw.gov.au/policy-library/policies/child-protection-policy-responding-to-and-reporting-students-at-risk-of-harm) also provides guidance about responding to child protection issues.

Enrolment in a single-sex school

If the student is seeking enrolment at a single-sex school, a decision about their eligibility to enrol should be made on the basis of his or her identified gender. If the student is already attending school advice should be sought from Legal Services.

Record keeping requirements

It is critically important to maintain appropriate official records when supporting a student who has identified as being transgender. These include records of:

- information provided by health care professionals or other professionals involved in providing support to the student
- meetings of the school learning and support team, copies of programs and where applicable units of work from year advisors or other staff used to raise awareness amongst students
- staff training and orientation (including briefing of casual staff)

- staff training and orientation (including briefing of casual staff)
- consultation with parents or carers, students, staff and others as appropriate during the development of learning and support plans for the student; and
- the development and implementation of plans to provide the student with learning and support (including any health care planning) and their later review. It is also important to keep a record of who has been provided with the current version of the plan.

Schools must observe any requirements imposed by privacy legislation with most records other than risk assessment and management strategies being kept secure and accessible only to those staff that need to see them. Staff should contact the Records Management Centre of Expertise (CoE) if they have specific records-related queries.

Back to Index (#back_Reporting_18)

Assistance available to schools within the department

The Principal Education Officer, Learning and Engagement Coordinator can be contacted to provide advice. Legal Services can also be contacted for legal advice.

Resources available to support schools

- An Anti-Discrimination Board Factsheet, Transgender Discrimination
- A Gender Centre factsheet, Gender Variant Students: For teachers dealing with transgender students
- A department **Student Engagement and Interagency Partnerships guide, Bias based bullying** (https://policies.education.nsw.gov.au/policy-library/policies/bullying-of-students-prevention-and-response-policy)
- **https://gendercentre.org.au/resources/kits-fact-sheets/general** (https://www.antidiscrimination.justice.nsw.gov.au/Pages/adb1_antidiscriminationlaw/adb1_types/adb1_transgender.aspx
<a_href=)

Back to Index (#back_Assistance_21)

Attachment A

Discrimination on the basis of gender identity

Commonwealth Sex Discrimination Act 1984

The Commonwealth Sex Discrimination Act 1984 (the Commonwealth Act) defines gender identity as meaning the gender-related identity, appearance or mannerisms or other gender-related characteristics of a person (whether by way of medical intervention or not) with or without regard to the person's designated sex at birth. It provides that a person is unlawfully discriminated against on the ground of their gender identity if by reason of:

- their gender identity; or
- a characteristic that appertains generally to persons who have the same gender identity; or
- a characteristic that is generally imputed to persons who have the same gender identity

the transgender person is treated less favourably than, in circumstances that are the same or are not materially different, a person who has a different gender identity would be treated.

A person may also be unlawfully discriminated against if a condition, requirement or practice that has, or is likely to have, the effect of disadvantaging persons who have the same gender identity as the aggrieved person is imposed (or proposed to be imposed) on that person unless the condition, requirement or practice is reasonable in the circumstances. The matters that are taken into account in deciding whether a condition, requirement or practice is reasonable in the circumstances include:

- the nature and extent of the disadvantage resulting from the imposition, or proposed imposition, of the condition, requirement or practice; and
- the feasibility of overcoming or mitigating the disadvantage; and

- whether the disadvantage is proportionate to the result sought by the person who imposes, or proposes to impose, the condition, requirement or practice.

NSW Anti-Discrimination Act 1977

The NSW Anti-Discrimination Act (the NSW Act) defines a transgender person as including persons who identify as a member of the opposite sex by living or seeking to live as a member of the opposite sex or who being of indeterminate sex identify as a member of a particular sex by living as a member of that sex.

The NSW Act provides that a person is unlawfully discriminated against on transgender grounds if, on the grounds that they are transgender:

- they are treated less favourably than in the same circumstances (or circumstances which are not materially different) than a person who is not transgender
- they are required to comply with a requirement or condition with which a substantially higher proportion of persons who are not transgender persons comply or are able to comply being a condition that is not reasonable having regard to the circumstances of the case and with which the transgender person does not or is not able to comply.

Back to Index (#back_Attachment_23)

Sample support and risk management plan

This is a sample plan for a **high school student (DOCX 55KB)** (/content/dam/main-education/about-us/rights-and-accountability/media/documents/legal-issues-bulletins/Transgender-student-sample-support-plan.docx). It should be modified to suit the needs of the individual student at the particular school.

Last updated: 10-Apr-2021

Gender Identity Discrimination and Vulnerable Adolescents: Reconciling Equality Goals with Child Protection

Prof. Patrick Parkinson

Professor of Law

University of Queensland, Australia

Law School
The University of Queensland
Brisbane Qld 4072 Australia

T +61 7 3365 1021
p.parkinson@law.uq.edu.au

Biographical note: Professor Parkinson is a specialist in family law, child protection and the law of equity and trusts. His books include *Australian Family Law in Context* (7th ed, 2019), *Tradition and Change in Australian Law* (5th ed, 2013), *Family Law and the Indissolubility of Parenthood* (2011), *The Voice of a Child in Family Law Disputes* (with Judy Cashmore, 2008), *Child Sexual Abuse and the Churches* (2nd ed, 2003) and *Principles of Equity* (editor, 2nd ed., 2003). Professor Parkinson served from 2004-2007 as Chairperson of the Family Law Council, an advisory body to the federal Attorney- General, and also chaired a review of the Child Support Scheme in 2004-05 which led to the enactment of major changes to the Child Support Scheme. He was President of the International Society of Family Law from 2011-14. Professor Parkinson has been a member of the NSW Child Protection Council, and was Chairperson of a major review of the state law concerning child protection which led to the enactment of the Children and Young Persons (Care and Protection) Act 1998. In 2018, Professor Parkinson was awarded a Doctor of Laws by the University of Sydney for his book, *Family Law and the Indissolubility of Parenthood* (Cambridge University Press, 2011).

Abstract

While gender dysphoria is a well-recognised medical issue, there are reasons to be concerned about the number of adolescents who are now claiming to be 'transgender' – especially natal females. Many of these children and young people have multiple mental health problems or are on the autism spectrum, and may have experienced abuse and other adverse life events. There is also some evidence for social contagion amongst friendship groups and through the influence of YouTube celebrities.

This article explores how the law should balance the right of adolescents who self-identify as transgender to be protected from discrimination, with the need to proceed cautiously before permitting them to transition socially to a different gender and to embark down the pathway of irreversible medical treatment which they may later regret. That balance is to be found in defining carefully what discrimination is, and is not. The law should protect children and young people against adverse action because they identify as transgender, for example, expulsion from school; but the law should not require schools or other organisations working with children and young people to accept the gender identity of a person that is different from his or her natal sex. The best way to respond in each case should be left as a matter of professional judgment.

Keywords: Adolescents – Transgender – Gender Diverse – Equality – Anti-discrimination – Child protection.

Gender Identity Discrimination and Vulnerable Adolescents: Reconciling Equality Goals with Child Protection

The rise and rise of the transgender movement

There have long been people who, while being anatomically either male or female, have so strongly identified as being of the opposite sex that they have eventually taken steps to identify publicly as having a different first name and gender.[1]

In the past, being transgender has been a relatively rare phenomenon. In version 5 of the *Diagnostic and Statistical Manual of Mental Disorders,* published by the American Psychiatric Association in 2013, rates of gender dysphoria for natal adult males are estimated at 0.005% to 0.014% of the population, and for natal females, from 0.002% to 0.003%.[2] Undoubtedly, for many who experience a disconnect between their unambiguous physical characteristics (male or female genitalia) and their feelings about what gender they are, this is a very distressing and enduring condition. It may be alleviated by engaging in hormonal and surgical treatments that have the effect of bringing a person's external appearance and genitalia more into concordance with his or her subjective gender identity.[3]

While identifying as transgender was once quite rare, it is so no longer. In many parts of the

[1] See e.g. Jan Morris, *Conundrum* (Faber & Faber, 1974).

[2] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders: DSM-5,* (5th ed, 2013) p. 454.

[3] See e.g. E. Castellano and others, 'Quality of Life and Hormones after Sex Reassignment Surgery'. (2015) 38(12) *Journal of Endocrinological Investigation* 1373.

.

world, the number of people presenting at specialist clinics with gender identity problems has increased exponentially over a short period of time. For example, the specialist services in England have experienced an average year-on-year increase of around 25% since 2014, with waiting times of up to three years for a first appointment.[4]

Gender assignation and fluidity

This growth in the number of those identifying as transgender has been accompanied by new ways of thinking about sex and gender. These inform both clinical practice in terms of assisting people to transition,[5] and advocacy for transgender people, including advocacy for law reform.

One central idea is that there can be a disconnect between body and brain from birth onwards which is only discovered as the child grows up. The popular understanding of this is that people can be 'born in the wrong body'.[6] Educational material for young children put out by the English charity, the Gender Identity Research & Education Society, seeks to communicate this idea through a penguin story. The penguin parent tells the infant: 'We can't always tell if you're a boy or a girl'. The parents encourages the infant penguin to tell them when the infant is ready.[7]

From this fundamental starting point comes the notion that sex is "assigned at birth" and that

[4] Sarah Marsh, 'Transgender People Face Years of Waiting with NHS under Strain' The Guardian, November 21st 2019 at https://www.theguardian.com/society/2019/nov/20/transgender-people-face-years-of-waiting-with-nhs-under-strain.

[5] Bernadette Wren, 'Ethical Issues Arising in the Provision of Medical Interventions for Gender Diverse Children and Adolescents' (2019) 24(2) *Clinical Child Psychology and Psychiatry*, 203.

[6] See e.g the British TV documentary series, *Born in the Wrong Body*, https://www.imdb.com/title/tt5101244/ (2015).

[7] Stephanie Davies-Arai & Susan Matthews, 'Queering the Curriculum: Creating Gendered Subjectivity in Resources for Schools' in Michele Moore and Heather Brunskell-Evans (eds) *Inventing Transgender Children and Young People* (Newcastle, UK: Cambridge Scholars Publishing, 2019), 199 at 201.

such an assignation, based upon observation of the genitalia, is at best provisional.[8] This idea has become mainstream in the academic literature on transgender issues,[9] as well as in the popular literature of the transgender movement.[10] The idea that sex is assigned by someone at birth assumes the exercise of a judgment, and one which is fallible.

This notion, that people can be 'born into the wrong body', has yet to be validated by science. Much research has been conducted to try to find a physiological basis for transgender identification, but it has provided little support for the view that brains can be wired differently to bodies. It may be that in course of time, a genetic or biological explanation will be found for at least some transgender identification,[11] but for now, this has eluded researchers.[12] A recent review of studies of the brain found that: "Despite intensive searching, no clear neurobiological marker or "cause" of being transgender has been identified".[13] Furthermore, there is no such thing as a quintessentially 'male' brain or a 'female' brain at birth. Our brains are shaped by our upbringing, and experiences throughout our lives.[14]

[8] Those whose gender identity is aligned with natal sex are now known as 'cisgender'.

[9] See e.g. Damien Riggs & Clemence Due, 'Mapping the Health Experiences of Australians Who Were Female Assigned at Birth but who now Identify with a Different Gender Identity' (2013) 18(3/4) *Lambda Nordica* 54.

[10] See for example, the popular "Gender Unicorn" available at http://transstudent.org/what-we-do/graphics/gender-unicorn/.

[11] There is some new evidence for possible genetic influences in male to female transsexuals: Madeleine Foreman and others, 'Genetic Link Between Gender Dysphoria and Sex Hormone Signaling' (2019) 104(2) *Journal of Clinical Endocrinology & Metabolism* 390.

[12] The research evidence is reviewed in S.C. Mueller, G. De Cuypere, & G. T'Sjoen, 'Transgender Research in the 21st Century: A Selective Critical Review from a Neurocognitive Perspective' (2017) 174 *American Journal of Psychiatry* 1155; Jack Turban & Diane Ehrensaft, Research Review: Gender Identity in Youth: Treatment Paradigms and Controversies' (2018) 59 *Journal of Child Psychology and Psychiatry* 1228; Lawrence Mayer and Paul McHugh, 'Sexuality and Gender: Findings from the Biological, Psychological and Social Sciences: Part Three' 50 *New Atlantis* (2016) available at https://www.thenewatlantis.com/publications/part-three-gender-identity-sexuality-and-gender.

[13] Mueller and others, ibid, at 1158.

[14] Gina Rippon, *The Gendered Brain* (2019).

Clinicians working with gender-dysphoric adolescents have quite a variety of opinions on the causes of gender dysphoria and about whether it matters that there is no clear biological or other explanation for it.[15] Even clinicians who find support in tentative indications from some studies to support a biological component to gender diversity, nonetheless acknowledge the need for "multiple-level explanations where the social and the biological intersect."[16]

Another fundamental premise of the transgender movement is that a sharp distinction should be drawn between sex and gender, with sex, in this usage, confined to genitalia and chromosomes, while gender is a matter of subjective identification. So for example, educational materials prepared for a Government-supported program in Australia provides instructions to teachers on how to explain this idea to 7th and 8th grade students:[17]

> Explain that sex is about the body you are born with (male, female or intersex), while gender is about your identity, or how you feel inside. Gender refers to the way that you feel on the inside. It might be expressed by how you dress or how you behave and for some people these things may change over time.

Gender, on this understanding, is a state of mind whereas 'sex' describes the physical, hormonal and chromosomal characteristics of the body.

Yet another new concept is that gender is fluid.[18] At one level, this is an empirical claim. So for example clinicians from four gender identity clinics write that "gender may be fluid, and is not binary, both at a particular time and if and when it changes within an individual across

---

[15] Lieke Vrouenraets and others, 'Early Medical Treatment of Children and Adolescents with Gender Dysphoria: An Empirical Ethical Study' (2015) 57(4) *Journal of Adolescent Health* 367.

[16] Gary Butler and others, 'Puberty Blocking in Gender Dysphoria – Suitable for All?' (2019) 104 *Archives of Disease in Childhood* 509.

[17] Safe Schools Coalition, *All of Us: Health and Physical Education Resource – Understanding Gender Diversity, Sexual Diversity and Intersex Topics for Years 7 and 8* (Melbourne: Safe Schools Coalition Australia, 2015) at 30.

[18] Lisa Diamond, 'Gender Fluidity and Nonbinary Gender Identities Among Children and Adolescents' (2020) 14 *Child Development Perspectives* 110.

time."[19] However it is not merely an empirical claim. It is also a philosophical premise, based upon the idea that gender is socially constructed, not innate. Leading gender theorist Judith Butler, for example, has written that:[20]

> "…gender is in no way a stable identity or locus of agency from which various acts proceed; rather, it is an identity tenuously constituted in time - an identity instituted through a stylized repetition of acts… Feminist theory has often been critical of naturalistic explanations of sex and sexuality that assume that the meaning of women's social existence can be derived from some fact of their physiology. In distinguishing sex from gender, feminist theorists have disputed causal explanations that assume that sex dictates or necessitates certain social meanings for women's experience."

Advocacy for law reform

There is a very active movement for different forms of legal recognition and protection for those who identify as transgender. This is the new frontier of law reform for many LGBT advocates who have seen victory after victory in terms of the rights of same-sex attracted people, culminating in recognition of same-sex marriage throughout much of the developed world.

However, some of the issues involved in legal recognition and protection of transgender people are far from straightforward. They are not reducible to the simple equality claims that have fuelled lesbian and gay advocacy. Several difficult questions arise: for example, if someone identifies as neither male nor female, what terminology should be used on official documents for which birth sex is relevant? Indeed, what, if anything, should follow from someone's legally recognised status as "non-binary" in a world which is organised in so many ways according to biological sex? To what extent does one person's desire to use certain pronouns as markers of

[19] M. Hidalgo and others, 'The Gender Affirmative Model: What we Know and What We Aim to Learn' (2013) 56 *Human Development* 285.

[20] Judith Butler, 'Performative Acts and Gender Constitution: An Essay in Phenomenology and Feminist Theory' (1988) 40 *Theatre Journal* 519 at 519-520.

identity require others to use those pronouns in relation to them, and does it matter if those preferred pronouns are not hitherto recognised words in the English language?[21] Should it be enough to change a birth certificate that a person identifies as transgender, or should they have had to take steps towards gender reassignment involving hormone treatment and surgery? What about sex-segregated sports? Does faith make a difference? Is a Catholic bishop, faced with an application from a natal female who identifies as male and has undergone testosterone treatment, in breach of anti-discrimination laws if he refuses to accept the person as a trainee for the priesthood?

Many of the most difficult issues arise when a person who does not share the beliefs of the person claiming a different gender identity to their natal sex is asked to treat that other person as the gender with which they now identify. In many cases, the person seeking to be treated in this way may not have undergone any form of medical transition. It is one thing to ask me to respect your self-identity. It is another to ask me to act towards you as if I share your self-understanding about yourself. What is the school principal to do, for example, if a girl in her co-educational school wants to transition to adopt a male identity and name, and from thenceforth be treated as male for the purposes of all gender-segregated activities? The principal might readily accept that change of identity; but if she has reason to be concerned about it, for example because this new identification is quite sudden and the girl has a lot of other problems, what place should there be for her to exercise professional judgment or to act in accordance with her conscience?

Adolescents who identify as transgender

These issues are now arising with increasing frequency in schools and other organisations

[21] Robin Zembroff and Daniel Wodak, 'He/She/They/Ze' (2018) 5 *Ergo* 371.

working with children and young people. That is, perhaps, not surprising. Gender identity issues are often talked about, given the attention paid more widely to the concerns of the LGBTQIA+ movement. Being transgender is normalised in the media and entertainment industries. A new generation of transgender actors are demanding that only 'trans' people perform in the burgeoning number of transgender roles in film and on television.[22] There is a particular awareness about transgender issues in youth culture.

It would seem that these influences are having an impact. Far more adolescents than adults now identify in surveys as transgender or gender diverse. While the highest reputable estimate of adults who identify as transgender is 0.52% of the American population as at 2016,[23] school-based surveys yield much higher figures. A study of 9th-12th grade students in Boston schools conducted as long ago as 2006 found that 17 out of 1032 students reported being transgender (1.6%).[24] A survey of 2730 Californian students in years 6-8 conducted in 2011 found 1.3% identified as transgender.[25] A survey of nearly 82,000 students in Minnesota in 2016 found that 2.68% of students answered affirmatively to the question: "Do you consider yourself transgender, genderqueer, genderfluid, or unsure about your gender identity?" [26] This was more than double the number who identified as gay or lesbian.[27] New Zealand data is comparable.

---

[22] Christopher Rosa 'Should Cisgender Actors Be Allowed to Play Transgender Characters?' *Glamour*, July 6 2018 at https://www.glamour.com/story/should-cisgender-actors-be-allowed-to-play-transgender-characters.

[23] A Flores and others, *How Many Adults Identify as Transgender in the United States?* (Williams Institute, UCLA, 2016) p.7 at http://williamsinstitute.law.ucla.edu/wp-content/uploads/How-Many-Adults-Identify-as-Transgender-in-the-United-States.pdf (survey of people in 19 States).

[24] Joanna Almeida and others, 'Emotional Distress among LGBT Youth: The Influence of Perceived Discrimination Based on Sexual Orientation' (2009) 38 *Journal of Youth and Adolescence* 1001.

[25] JP Shields and others, 'Estimating Population Size and Demographic Characteristics of Lesbian, Gay, Bisexual, and Transgender Youth in Middle School' (2013) 52 *Journal of Adolescent Health* 248.

[26] Laura Baams, 'Disparities for LGBTQ and Gender Nonconforming Adolescents' (2018) 141(5) *Pediatrics* e20173004. For another analysis of the same dataset, see Nicole Rider and others, 'Health and Care Utilization of Transgender and Gender Nonconforming Youth: A Population-Based Study' (2018) 141(3) *Pediatrics* e20171683.

[27] Baams, ibid, Table 1 (1.27% identified as gay or lesbian and 4.98% as bisexual).

A study of 8,166 high school students in New Zealand in 2012 found that 96 (1.2%) identified themselves as transgender while a further 3% described themselves as unsure.[28]

The number of children and adolescents who self-identify as transgender is reflected in a massive increase in referrals to youth gender identity clinics that offer sex reassignment treatments such as cross-sex hormones. For example, at a specialist clinic in the Royal Children's Hospital, Melbourne (Australia), referrals increased from one child or adolescent patient every 2 years after the clinic was established in 2003, to 104 new patients in 2014.[29] By 2018, the number of new patients had increased to 268, and that number had been exceeded in the first ten months of 2019.[30]

Among adults, the consistent evidence has been that gender identity issues are most commonly experienced by natal males. Studies in the past suggest that at least three times as many men identify as transgender as do females,[31] and, the ratio may be as high as 6-1,[32] although there appears to be variation between countries.[33] Similar ratios have been found for children and young people who have been referred to gender identity clinics in the past.[34]

---

[28] Terryann Clark and others, 'The Health and Well-being of Transgender High School Students: Results from the New Zealand Adolescent Health Survey (Youth'12)', (2014) 55 *Journal of Adolescent Health* 93. The question was: "Do you think you are transgender? This is a girl who feels like she should have been a boy, or a boy who feels like he should have been a girl."

[29] M. Telfer, M. Tollit, & D. Feldman, 'Transformation of Health-care and Legal Systems for the Transgender Population: The Need for Change' (2015) 51 *Journal of Paediatrics and Child Health* 1051.

[30] Bernard Lane, Gender Fix Locks Future Identity, say Senior Psychiatrists' *The Australian*, Jan 14th 2020 at https://www.theaustralian.com.au/nation/gender-fix-locks-sexual-identity-say-senior-psychiatrists/news-story/a6881f04c9f617a7ad46d26046423ef5.

[31] International statistics are found in G. De Cuypere and others, 'Prevalence and Demography of Transsexualism in Belgium' (2007) 22 *European Psychiatry* 137.

[32] See e.g. J. Veale, 'Prevalence of Transsexualism among New Zealand Passport Holders' (2008) 42 *Australia and NZ Journal of Psychiatry* 887; M. Ross and others, 'Cross-cultural Approaches to Transsexualism: a Comparison between Sweden and Australia' (1981) 63 *Acta Psychiatrica Scandinavica* 75.

[33] De Cuypere and others, above n.31.

[34] H. Wood and others, 'Patterns of Referral to a Gender Identity Service for Children and Adolescents (1976–2011): Age, Sex Ratio, and Sexual Orientation' (2013) 39 *Journal of Sex & Marital Therapy* 1; Kenneth Zucker,

However, the gender ratio has now inverted amongst adolescents. For example, in the 2016 Minnesota study of nearly 82,000 adolescents, 68% who identified as transgender, genderfluid or similar, were female.[35] This is reflected in the proportions of natal female and male adolescents being seen in clinics around the world. The Royal Children's Hospital in Melbourne indicated in 2019 that the number of referrals of natal females to its gender clinic had risen at more than four times the rate of biological males since 2012,[36] and now natal females comprise two-thirds of patients. The equivalent Brisbane clinic indicated in February 2020 that 79 adolescents were receiving testosterone treatment from the hospital pharmacy, while only around 5 were receiving oestrogen,[37] indicating that the vast majority of patients progressing to take cross-sex hormones are natal females.

A study in Finland of all the young people presenting at one of two clinics in the country over a two year period reported that 41 were natal girls and 6 were natal boys. In the other clinic in Finland the gender ratio was similar.[38] An inversion in the gender ratio in adolescent clinics since 2006 has also been observed in clinics in Toronto and Amsterdam,[39] and at the Tavistock and Portman clinic in London.[40] Clinicians and researchers associated with the Tavistock and

'Epidemiology of Gender Dysphoria and Transgender Identity' (2017) 14 *Sexual Health* 404. The gender ratio is lower for adolescents than for children.

[35] Baams, above n.26.

[36] See Lane, above n.30.

[37] Data provided to the Hon Greg Donelly MLC, Feb. 6th 2020, on file with the author.

[38] Riittakerttu Kaltiala-Heino and others, 'Two Years of Gender Identity Service for Minors: Overrepresentation of Natal Girls with Severe Problems in Adolescent Development' (2015) 9 *Child and Adolescent Psychiatry and Mental Health* 9.

[39] M. Aitken and others, 'Evidence for an Altered Sex Ratio in Clinic-Referred Adolescents with Gender Dysphoria' (2015) 12(3) *Journal of Sexual Medicine* 756.

[40] N.M. de Graaf and others, 'Sex Ratio in Children and Adolescents Referred to the Gender Identity Development Service in the UK (2009–2016)' (2018) 47(5) *Archives of Sexual Behavior* 1301.

Portman clinic have no research-based explanation for why this inversion has occurred.[41] Even if under-diagnosis or severe reticence to disclose in the past explains the rise in the number of people now identifying as transgender, it is hard to see why there should be such a dramatic change in gender ratios.

The number of school students now identifying as transgender and seeking to transition to another gender identity gives rise to particular dilemmas about how schools, and other organisations working with children, should respond to a young person's newly declared gender identity when he or she wants particular accommodations in the light of it. In the United States, these issues seem to be playing out in the 'bathroom wars' as part of a broader culture war between conservative and progressive advocates.[42] These are often fruitless arguments, when practical accommodations can typically be found in schools and other such institutions with a little goodwill. Typically every toilet in a private home is a gender-neutral one.

However, there are more fundamental questions, especially for schools. Is it, or should it be, discrimination on the grounds of gender identity to refuse admission to a boys' school of a natal female who now identifies as male and has adopted a male first name? Should schools be obliged in other respects to treat a young person as the gender with which he or she now identifies, when determining issues about school uniforms and sex-segregated sports? What if the parents object to a young person's desire to be known by a different name and gender? If the law were to move in the direction of requiring schools to accept the self-identified gender

[41] Gary Butler and others, 'Assessment and Support of Children and Adolescents with Gender Dysphoria' (2018) 103 *Archives of Disease in Childhood* 631.

[42] Robin Wilson, 'The Nonsense about Bathrooms: How Purported Concerns Over Safety Block LGBT Nondiscrimination Laws and Obscure Real Religious Liberty Concerns', (2017) 20 *Lewis & Clark L. Rev*. 1373. See also Robin Wilson, 'Bakers and Bathrooms: How Sharing the Public Square is the Key to a Truce in the Culture Wars' in William Eskridge, Jr. & Robin Wilson, eds., *Religious Freedom, LGBT Rights, and the Prospects for Common Ground* (Cambridge University Press, 2018) 402.

of an adolescent, with or without parental consent, should there be exemptions for faith-based educational institutions?

There are particular difficulties in developing hard and fast rules on such matters. Children and adolescents may initially indicate that they consider themselves to be transgender at a range of ages and at greatly varying stages of psycho-sexual and emotional development. Adolescence, in particular, is a time of exploration of the young person's identity, as well as a time when major changes are occurring physically. Part of that journey of self-exploration may involve identifying for a time as transgender, gender diverse, agender or non-binary without this becoming a settled or lasting view of themselves. This is because there are so many influences on gender identity. As psychologist Prof. Dianna Kenny observes:[43]

> Gender development is a complex process, the outcome of which is a complex interplay of genes, gonadal hormones, cognitive, language, and socioemotional development, the child's socialization history, and culture.

Vulnerable young people and transgender identification

The issues about how to respond to young people who identify as transgender are particularly complex because there is now extensive evidence that many of them are profoundly troubled young people whose situations could be made much worse by attempting gender transition. Adolescents who identify as transgender, and who seek help from specialist clinics, are much more likely than adolescents in the general population to come from troubled family backgrounds, to have histories of abuse and other mental health issues.

Family background

[43] Dianna Kenny, 'Gender Development and the Transgendering of Children' in Moore and Brunskell-Evans (eds), above n.7, 93 at 94.

In the Minnesota study, those who identified as transgender, "genderqueer" or similar were about 75% more likely to have a parent or guardian in prison, nearly twice as likely to live with a problem drinker, over twice as likely to live with a drug abuser, and also reported much higher levels of physical abuse, psychological abuse and of witnessing domestic violence. They were about four times as likely as those who did not identify as transgender to have experienced childhood sexual abuse.[44] In the New Zealand study, adolescents identifying as transgender were substantially more likely to come from households that had experienced high levels of deprivation (43% compared with 30% of those who did not identify as transgender). [45] If the explanation for gender dysphoria is primarily or entirely physiological ('being born into the wrong body') then one would expect a demographic profile and range of family histories for transgender-identifying young people to be similar to the population as a whole.

Autism

Numerous studies have found that children and young people who identify as transgender are many times more likely than the general population to be diagnosed as on the autism spectrum. A leading study of 204 children or adolescents seen at the Gender Identity Clinic in Amsterdam indicated that the rate of autism diagnoses among those with gender dysphoria were about ten times as high as the general population.[46] A study in Finland of children and young people presenting at a gender identity clinic found that over 25% were diagnosed as being on the autism spectrum.

[44] Baams, above n.26.

[45] Clark and others, above n.28 at 96.

[46] A. de Vries and others, 'Autism Spectrum Disorders in Gender Dysphoric Children and Adolescents' (2010) 40(8) *Journal of Autism and Developmental Disorders* 930. See also A. van der Miesen and others, 'Autistic Symptoms in Children and Adolescents with Gender Dysphoria' (2018) 48(5) *Journal of Autism and Developmental Disorders* 1537. The data is summarized in John Whitehall, 'Gender Dysphoria and the Fashion in Child Surgical Abuse' (2016) 60(12) *Quadrant* 23.

Mental health issues

These children and young people are also much more likely to have depression and anxiety disorders and to experience suicidal ideation – in some cases leading to suicide attempts.[47] This is often explained in terms of the struggle they experience with the discordance between natal sex and gender identity, because of discrimination and parental disapproval or rejection on account of their gender identity.[48] While these may be factors, other causes of depression, anxiety and suicidal ideation need to be considered – including a history of sexual abuse[49] and family dysfunction, as so many of them have.

Anxiety and depression are not the only mental health issues for children with gender identity issues. In one study of children aged 3-9 years old identified as gender non-conforming, there was a much higher rate of attention deficit disorders than the control group.[50] Gender dysphoria may also co-exist with eating disorders.[51]

For some expert clinicians at least, the presence of other psychiatric disorders leads to caution about offering hormonal treatments and other interventions to children and adolescents that lead them on the pathway to full transition. One German team that includes experts in

[47] TA Becerra-Culqui and others, 'Mental Health of Transgender and Gender Nonconforming Youth Compared With Their Peers' (2018) 141(5) *Pediatrics* e20173845; Johanna Olson and others, 'Baseline Physiologic and Psychosocial Characteristics of Transgender Youth Seeking Care for Gender Dysphoria' (2015) 57(4) *Journal of Adolescent Health*, 374.

[48] Hidalgo and others, above n. 19.

[49] A. Plunkett and others, 'Suicide Risk Following Child Sexual Abuse' (2001) 1 *Ambulatory Pediatrics* 262; M. Cutajar and others, 'Suicide and Fatal Drug Overdose in Child Sexual Abuse Victims: A Historical Cohort Study' (2010) 192(4) *Medical Journal of Australia* 184.

[50] Becerra-Culqui and others, above n. 47.

[51] G.L. Witcomb and others, 'Body Image Dissatisfaction and Eating-Related Psychopathology in Trans Individuals: A Matched Control Study, (2015) 23(4) *European Eating Disorders Review* 287.

adolescent psychiatry, sexual medicine, and pediatric endocrinology described its research findings as follows:[52]

> All of the 21 patients who received a new diagnosis of GID in our clinic up to mid-2008 (aged 5 to 17; 12 boys, 9 girls) had psychopathological abnormalities that, in many cases, led to the diagnosis of additional psychiatric disorders. As a rule, there were also major psychopathological abnormalities in their parents. The "motive for switching" among the 15 adolescents in the group was mainly a rejected (egodystonic) homosexual orientation, the development of which would have been arrested by puberty-blocking treatments.

If not only the adolescents, but also their parents, suffer from 'major psychopathological abnormalities', there is reason for great caution in assuming that their gender dysphoria is entirely unrelated to these other problems. Indeed, earlier research on gender identity issues identified problems in the family of origin as important in understanding the aetiology of gender identity disorders.[53]

Peer and social influences

There is also evidence of peer and social media influences which help explain the rapid growth in the number of teenagers identifying as transgender.[54] Popular figures on YouTube promote a somewhat rosy view of the transition journey, and to be transgender can be a basis for celebrity status. [55]

---

[52] A. Korte and others, 'Gender Identity Disorders in Childhood and Adolescence: Currently Debated Concepts and Treatment Strategies', (2008) 105 *Deutsches Ärzteblatt International,* 834 at 838.

[53] John Whitehall, 'Conversion Therapy and Gender Dysphoric Children' (2019) 63(3) *Quadrant* 26.

[54] Lisa Marchiano, 'Outbreak: On Transgender Teens and Psychic Epidemics', (2017) 60(3) *Psychological Perspective,* 345.

[55] Elin Lewis, 'Transmission of Transition via YouTube' in Moore and Brunskell-Evans (eds), above n.7, 180.

Lisa Littman, in a landmark study,[56] provided a 90 question survey to parents who reported that their child had a sudden or rapid onset of gender dysphoria, occurring during or after puberty. This would seem to be a new phenomenon, for hitherto, children and young people with gender identity issues seen at clinics have all had symptoms of gender dysphoria since early childhood. Particularly new is the phenomenon of adolescent onset gender dysphoria in young women.[57]

There were responses from 256 parents. Nearly 83% of the young people concerned were female and on average were 15 years old at the time they announced a new gender identification. The majority had been diagnosed with at least one mental health disorder or neuro-developmental disability prior to the onset of their gender dysphoria. None of them, based on parents' reports, would have met diagnostic criteria for gender dysphoria in childhood. Nearly half had been formally assessed as academically gifted. Over 40% expressed a non-heterosexual sexual orientation prior to identifying as transgender. Nearly half had experienced a traumatic or stressful life event prior to the onset of their gender dysphoria such as parental divorce, sexual assault or hospitalisation for a psychiatric condition.

For 45% of these young people, parents reported that at least one of the members of their friendship group came to identify as transgender. The average number of individuals who became transgender-identified was 3.5 per group; for 37% of the young people, the majority

[56] Lisa Littman, 'Parent Reports of Adolescents and Young Adults Perceived to Show Signs of a Rapid Onset of Gender Dysphoria' (2018) 13(8) *Plos One* e0202330. The article was heavily amended post-publication following complaints that Littman was spreading misconceptions about transgender people and employing biased methods. This is despite having gone through a conventional peer-review process prior to initial publication. The amendments were required by the editor following reviews by senior members of the journal's editorial team, two Academic Editors, a statistics reviewer, and an external expert reviewer. See further Jonathan Kay, 'An Interview With Lisa Littman, Who Coined the Term 'Rapid Onset Gender Dysphoria'' March 19, 2019 at https://quillette.com/2019/03/19/an-interview-with-lisa-littman-who-coined-the-term-rapid-onset-gender-dysphoria/

[57] Littman, ibid at p.3.

of friends in the group had come to identify as transgender. Parents reported that about 60% of the young people experienced increased popularity within their friendship group when they announced that they now identified as transgender. A similar proportion of the parents reported that the friendship groups were known to mock people who did not identify as lesbian, gay, bisexual, transgender, intersex, or asexual.

The majority of parents reported that when the young person disclosed the belief that he or she was transgender, the language came word for word from online sites. Two-thirds indicated, at the time of disclosing an identification as transgender, that they wanted to take hormones and over 50% wanted gender reassignment surgery. More than half had very high expectations that transitioning would solve their social, academic, occupational or mental health problems.

Sudden, post-pubertal identification as transgender helps to explain the very high rates at which adolescents, particularly teenage girls, identify as transgender compared to the adult population. In the New Zealand study, among whom a majority of those who identified as transgender were female, 54% of the respondents first wondered about being transgender when they were at least 12 years old.[58] 65% had not disclosed to someone else their belief in being transgender.

The importance of therapeutic support

For these reasons, counselling and psychotherapy to assist a child or young person to understand what may be leading them to believe that their problems will be resolved by changing gender is a frontline treatment. As Finnish experts have advised:[59]

[58] Clark and others, above n.28 at 96.

[59] R. Kaltiala-Heino and others, 'Gender Dysphoria in Adolescence: Current Perspectives' (2018) 9 *Adolescent Health, Medicine and Therapeutics*, 31 at 38.

> [F]or the majority of adolescent-onset cases, [gender dysphoria] presented in the context of severe mental disorders and general identity confusion. In such situations, appropriate treatment for psychiatric comorbidities may be warranted before conclusions regarding gender identity can be drawn. Gender-referred adolescents actually display psychopathology to the same extent as mental health–referred youth.

A study conducted by two clinicians from the Tavistock and Portman Gender Identity Development Service in London reported on 12 cases of adolescents seen at the clinic who initially sought medical transition. All met the criteria for a diagnosis of gender dysphoria, but did not proceed to hormonal treatment. They arrived at a different understanding of their distress through counselling.[60]

The risks of transitioning

It matters to understand how these different factors may be affecting a presentation of gender dysphoria, for there are serious risks, as well as potential benefits, to transitioning from natal sex to another gender presentation. Many adolescents who insist that they are transgender want to have cross-sex hormone treatment and, for girls, a double mastectomy, to accord with their new gender identity. The medical treatments that may now be now offered to children and young people to facilitate transition carry serious health risks that need to be weighed against potential benefits. A first step in treatment for children is the use of puberty blockers, which have been presented as harmless and fully reversible,[61] but which have some permanent

[60] Anna Churcher Clarke & Anastassis Spiliadis, ''Taking the Lid Off the Box': The Value of Extended Clinical Assessment for Adolescents Presenting with Gender Identity Difficulties'. (2019) 24(2) *Clinical Child Psychology and Psychiatry* 338.

[61] See eg. the case law in the Family Court of Australia discussed by Felicity Bell in 'Children with Gender Dysphoria and the Jurisdiction of the Family Court' (2015) 38(2) *UNSW Law Journal* 426.

consequences, particularly on bone density.[62] Other long-term effects of early suppression of puberty are unknown.[63] The next stage of the transition process is cross-hormone treatment. In order to maintain the appearance of the preferred gender, people need to take these hormones for the rest of their lives. This carries significant health risks.[64] The medical treatment may also render a patient sterile.[65] The final stage is surgery to remove breasts, for natal females, and to transform genitalia.

Given the extreme seriousness of the decisions involved, there is properly a concern that people who undergo processes of transition from one gender to another do so only when this represents the optimal treatment plan for a medically diagnosed problem. Research to date has concluded that the evidence-base for such treatment is of low quality (due mainly to the lack of control groups and long-term follow-up) and that the psychosocial and cognitive impact of this treatment regime is largely unknown.[66] Consequently, clinicians are making decisions about whether facilitating transition through medical interventions is in the long-term best interests of a child or young person in the absence of reliable evidence that allows for a proper balancing of the risks and benefits.[67]

[62] Gary Butler and others, above n.16.

[63] Wren, above n.5 at 208.

[64] See e.g. Darios Getahun and others, 'Cross-sex Hormones and Acute Cardiovascular Events in Transgender Persons: A Cohort Study' (2018) 169(4) *Annals of Internal Medicine* 205 (effects of oestrogen treatment in natal males).

[65] See generally, Michelle Telfer and others, *Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents* Version 1.1. (Melbourne: The Royal Children's Hospital; 2018) at 14.

[66] D Chew and others, 'Hormonal Treatment in Young People with Gender Dysphoria: A Systematic Review' (2018) 141(4) *Pediatrics* e20173742.

[67] Mike O'Connor and Bill Madden, 'In the Footsteps of Teiresias: Treatment for Gender Dysphoria in Children and the Role of the Courts' (2019) 27 *Journal of Law and Medicine* 149.

There are also problems with the notion of facilitating gender transition if indeed, gender is fluid and socially constructed; for if gender is fluid, identification with 'really' being of the opposite sex may both be a state of mind and transient. Bernadette Wren, a leading clinician at the Tavistock and Portman Gender Identity Development Service in London, has written of the struggle she experiences between her belief that gender is socially constructed and the strongly held beliefs of her young clients that they have been 'born in the wrong body'.[68] She asks how we "justify supporting trans youngsters to move towards treatment involving irreversible physical change, while ascribing to a highly tentative and provisional account of how we come to identify and live as gendered?"[69] Her conclusion is that the decision to recommend physical treatment for young people rests on "no foundation of truth". That does not mean at all that hormonal treatment or surgery are contra-indicated. In her view, the therapist does not need to be right or certain, but to "offer a reflexive and thoughtful space to help clients explore the architecture and borders of their gendered world view".[70]

Canadian transgender theorist, Florence Ashley, resolves the dilemma in a different way by arguing that "gender is tentative: it is always provisional and improvisational. If that is so, then transitioning, both socially and medically, is an integral part of exploring ourselves as autonomous gendered beings."[71] The difficulty, of course, is that medical transition is a one-way street with irreversible effects, particularly for natal females who stay long enough on testosterone.

There appears to be a growing number of young people and adults who are now deeply

[68] Bernadette Wren, 'Thinking Postmodern and Practising in the Enlightenment: Managing Uncertainty in the Treatment of Children and Adolescents' (2014) 24 *Feminism & Psychology* 271.

[69] Ibid at 271.

[70] Ibid at 287.

[71] Florence Ashley, 'Thinking an Ethics of Gender Exploration: Against Delaying Transition for Transgender and Gender Creative Youth' (2019) 24(2) *Clinical Child Psychology and Psychiatry*, 223 at 224.

regretting their decision to transition with hormonal or medical interventions. What is not known is the percentage this represents of all the adolescents and young adults who have received hormonal treatment or surgery in the last ten or fifteen years. There is a paucity of research on this area. A Swedish study from 1960–2010 found 2.2% had sought to reverse the process surgically.[72] However, the research team found high rates of suicide among post-operative transsexuals compared with a general population control group, even after controlling for prior psychiatric morbidity.[73] The authors concluded that: "Even though surgery and hormonal therapy alleviates gender dysphoria, it is apparently not sufficient to remedy the high rates of morbidity and mortality found among transsexual persons."[74] A recent study of a cohort of patients referred to a gender identity clinic in Amsterdam over a period of over 40 years found that rather less than 1% experienced regret about their sex reassignment surgery. However, for the most part this study covers a period when the numbers attending such clinics were very much smaller, and before the current trend to have substantial numbers of teenage females with other mental health issues seeking treatment.[75] Clinic data on regrets may also understate the real incidence as the clinic may not be informed that the patient has had regrets.

What we know about regretful transitioners comes mainly from social media[76] and the growing number of people who have been prepared to give interviews on television[77] or to other

[72] Cecilia Dhejne and others, 'An Analysis of All Applications for Sex Reassignment Surgery in Sweden, 1960–2010: Prevalence, Incidence, and Regrets' (2014) 43(8) *Archives of Sexual Behavior* 1535. For results of a follow-up on satisfaction with the effects of the surgery, see Dmitry Zavlin and others, 'Male-to-Female Sex Reassignment Surgery using the Combined Vaginoplasty Technique: Satisfaction of Transgender Patients with Aesthetic, Functional, and Sexual Outcomes' (2018) 42(1) *Aesthetic Plastic Surgery* 178.

[73] Cecilia Dhejne and others, 'Long-term Follow-up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden'. (2011) 6(2) *Plos One*, e16885.

[74] Ibid at 7.

[75] CM Wiepjes and others, 'The Amsterdam Cohort of Gender Dysphoria Study (1972-2015): Trends in Prevalence, Treatment, and Regrets' (2018) 15(4) *Journal of Sexual Medicine* 582.

[76] https://www.reddit.com/r/detrans/. See also https://sexchangeregret.com/.

[77] BBC Newsnight, 'Detransitioning: Reversing a Gender Transition' (Nov. 2019) at https://www.youtube.com/watch?v=fDi-jFVBLA8; 60 Minutes (Australia), 'Transgender boy transitioning to life

media.[78] This evidence, while anecdotal, is sufficiently voluminous to warrant attention. One study was conducted through Tumblr, Facebook groups, and on the Wordpress blog 4thWaveNow. The author of the survey invited responses from females who had formerly identified as transgender. The survey was posted for a two-week period and received 203 responses that met the criteria. On average they had transitioned for four years before detransitioning. Over 75% reported that detransitioning had helped them to cope better with their gender dysphoria – indeed 11% reported that it had completely gone. Disturbingly, of the 117 individuals who had medically transitioned, only 41 had received counselling beforehand. That is, 65% had received no therapy prior to receiving medical support to transition. The two most common reasons for detransition were shifting political/ideological beliefs (63%), and finding alternative coping mechanisms for dysphoria (59%). Over two-thirds indicated that they had been given inadequate counselling and information about transition.[79]

The risks of social transition

Medical decisions must of course be made by clinicians; but the first step along the journey to transition is typically to transition 'socially' – that is to adopt a new name and gender identification. Guidelines from the World Professional Association for Transgender Health indicate that genital surgery should not be contemplated before the age of 18 and only after the person has spent at least 12 months living as the other gender. A double mastectomy in female to male patients may be considered earlier, but only after ample time of living in the desired

as girl changes his mind' (Oct. 2019); at https://www.youtube.com/watch?v=27qjn0v4Av4. BBC News, 'I used gender transition as a form of escape' (Jan 21 2020) at https://www.bbc.com/news/av/health-51193849/i-used-gender-transition-as-a-form-of-escape; The Atlantic, 'Reversing a gender transition' (June 2018 at https://www.youtube.com/watch?v=V6V0p3_bd6w.

[78] YouTube videos include: 'Detransitioning — Stories Behind Reversing a Gender Transition' (2019); Pique Resilence Project 'Detransition Q & A' (2019).

[79] Cari Stella, 'Female Detransition and Reidentification: Survey Results and Interpretation' (September 2016). At http://guideonragingstars.tumblr.com/post/149877706175/female-detransitionand-reidentification-survey.

gender role and after one year of testosterone treatment.[80]

The Association counsels strongly that parents should be very cautious about letting younger children transition socially. The Association notes the evidence that very few children who experience childhood gender dysphoria persist in this through puberty, [81] and that a "change back to the original gender role can be highly distressing" and difficult for the child to do.[82] In the same vein, Ristori and Steensma argue: [83]

> The rationale for supporting social transition before puberty is that children can revert to their originally assigned gender if necessary since the transition is solely at a social level and without medical intervention. Critics of this approach believe that …a child may 'forget' how to live in the original gender role and therefore will no longer be able to feel the desire to change back; or that transitioned children may repress doubts about the transition out of fear that they have to go through the process of making their desire to socially (re)transition public for a second time.

[80] World Professional Association for Transgender Health (2012). *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* (version 7), available at: www.wpath.org pp. 21, 60.

[81] A large body of research evidence has shown that childhood gender dysphoria may well be a transitory stage on a child's journey towards a sexually and mentally healthy – or at least more healthy – adulthood. Gender dysphoria in childhood is strongly associated with a lesbian, gay, or bisexual outcome. For a substantial majority of the children the gender dysphoric feelings remitted around or after puberty. See eg M. Wallien, & P. Cohen-Kettenis, 'Psychosexual Outcome of Gender-dysphoric Children' (2008) 47 *Journal of the American Academy of Child and Adolescent Psychiatry* 1413. Gender dysphoria that is not resolved once the child or young person goes through puberty is typically much more enduring: S. Leibowitz and A. de Vries, 'Gender Dysphoria in Adolescence' (2016) 28 *International Review of Psychiatry* 21. The research on children's desistance is contested. See Julia Temple Newhook and others, 'A Critical Commentary on Follow-Up Studies and "Desistance" Theories About Transgender and Gender-Nonconforming Children' (2018) 19 *International Journal of Transgenderism* 212; and the responses to that critique from Kenneth Zucker, Thomas Steensma & Peggy Cohen-Kettenis in the same issue.

[82] Above, n.80 at 17.

[83] J. Ristori and T. Steensma, 'Gender Dysphoria in Childhood' (2016) 28 *International Review of Psychiatry* 17.

Affirming a new gender identity, particularly for a child who has not yet gone through puberty, may diminish the chances that a child will resolve his or her gender confusion with the effluxion of time and the onset of puberty – particularly if puberty blockers are prescribed.

It follows that the decisions of parents, school principals and others who have responsibility for the pastoral care of children and young people are of great importance in deciding whether to permit a child or adolescent to transition socially – that is, to adopt a different name and gender identity whether or not this is accompanied by any medical interventions. It may not be at all helpful to many children with gender dysphoria to encourage them to embrace an identity of being 'transgender'. The issue is one of child protection – ensuring so far as possible that young people do not make decisions that they will later deeply regret and which could cause them lasting harm.

The law's role in supporting equality and preventing harm

What then of the legal position? The law may influence decision-making about how to respond to a young person who seeks to transition to a different gender in a variety of ways. If the law is drafted, or interpreted, to mean that it constitutes discrimination not to accept a young person's newly declared gender identity, then that will greatly influence the practice of health professionals, schools and others who are asked to act in various ways in response to that young person's self-identification. If there are not carve-outs for schools, health professionals and others that provide support to a troubled adolescent whose gender dysphoria may prove transient with appropriate therapeutic interventions, then the young person may well be encouraged to pursue a less than optimal path in terms of his or her health and wellbeing.

What constitutes discrimination?

In considering this issue, a fundamental question arises. What does it mean to discriminate

against someone who identifies as transgender or non-binary? Put differently, what obligations fall upon an individual not to discriminate on the basis of gender identity? Does the law require a person who is making an employment decision or supplying a service of some kind to affirm the transgender or non-binary person's gender identity?

All State and federal laws make it unlawful to discriminate against someone on the basis of their gender identity in circumstances where their gender identity is irrelevant.[84]

Federal law

In federal law, the relevant statute is the *Sex Discrimination Act 1984* (Cth). It prohibits discrimination, inter alia, on the basis of sex, relationship status, pregnancy, sexual orientation and gender identity. It defines gender identity as "the gender-related identity, appearance or mannerisms or other gender-related characteristics of a person (whether by way of medical intervention or not), with or without regard to the person's designated sex at birth." The application of the law is reasonably clear in relation to at least some forms of conduct. For example, discrimination against a transgender person by refusing service in a shop or a restaurant, or refusing to rent out a hotel room, is clearly unlawful.[85] In such contexts, his or her gender identity is not materially relevant to the provision of the service.

What though, if the alleged discrimination is in refusing to recognise the person as the gender with which he or she now identifies, where that gender identity is different from natal sex? At least in Commonwealth law, the fact that the law prohibits discrimination on the basis of gender identity does not necessarily mean that others must accept a person as the sex with which they identify for all intents and purposes. So for example, s.21(3) of the *Sex Discrimination Act*

[84] See e.g. *Sex Discrimination Act* 1984 (Cth), *Equal Opportunity Act* 2010 (Vic.).

[85] See further, Neil Foster, 'Transgender discrimination law in Australia- uncertainties' at https://lawandreligionaustralia.blog/2019/07/21/transgender-discrimination-law-in-australia-uncertainties/

1984 (Cth) makes clear that it is not unlawful to discriminate on the basis of either sex or gender identity in determining an application for admission to an educational institution that is conducted solely for students of a different natal sex from that of the applicant. Other exemptions apply where accommodation is provided solely for persons of one sex who are students at an educational institution.[86] There are also special provisions governing sex-segregated sports.[87]

State and Territory laws

In addition to federal laws, there are also state and territory laws that prohibit discrimination. These vary considerably. Most simply prohibit discrimination on the basis of gender identity in a manner similar to federal law. However, as a result of legislative changes in 2019, two States have now gone further, allowing birth certificates to be changed on the basis of self-identification as a different sex or gender (the laws vary in their terminology). This has ramifications for that person's identity under other State laws. The first to enact such a change was Tasmania. The *Births, Deaths and Marriages Registration Act 1999 (Tas.)*[88] allows a person 16 years or older to register "another gender" and for parents to do so for a child under 16. The choices of gender identification are not limited to male and female. The registered gender could be an "indeterminate gender"; or "non-binary"; or "a word, or a phrase, that is used to indicate a person's perception of the person's self as being neither entirely male nor entirely female".[89] The same law provides that if there is a registered gender in relation to a

[86] *Sex Discrimination Act 1984* (Cth) s.34(2).

[87] Section 42 of the *Sex Discrimination Act 1984* (Cth) states that it is lawful "to discriminate on the ground of sex, gender identity or intersex status by excluding persons from participation in any competitive sporting activity in which the strength, stamina or physique of competitors is relevant." See also s.38P of the *Anti-Discrimination Act* 1977 (NSW).

[88] As amended by the *Justice and Related Legislation (Marriage And Gender Amendments) Act 2019* (Tas.).

[89] Section 3A, *Births, Deaths And Marriages Registration Act 1999* (Tas.).

person, the person is, for the purposes of, but subject to, any law in force in this State, a person of that gender.[90] This includes the *Anti-Discrimination Act* 1998 in Tasmania. It follows that it would seem to be discrimination on the basis of gender to treat a person as a gender other than as registered. What that means for gender identities that are other than male or female is unclear.

Victoria passed similar legislation in 2019 by amendment to the *Births, Deaths and Marriages Registration Act 1996*.[91] Section 30G allows for changes to birth certificates on the basis of self-identification as another sex. This section provides that after an alteration to the birth certificate is made "the person is a person of the sex as altered" and a similar provision applies to children whose sex is changed as a result of parental application. Like in Tasmania, the choices are not confined to male and female. A person could use any sex descriptor that is not obscene, offensive, or that could not practically be established by repute or usage.

By way of contrast, in New South Wales, to have a change of gender recorded in official documents, it is necessary to go through a medical sex reassignment process. Part 3A of the *Anti-Discrimination Act* 1977 (NSW) makes it unlawful to discriminate on the grounds of transgender status; but a distinction is drawn between 'recognised' transgender status and unrecognised status. Recognition is where the birth certificate has been formally changed. This requires an application by someone over 18, supported by two doctors who certify that the person has undergone a sex affirmation procedure.[92] It is unlawful to treat an aggrieved person, being a recognised transgender person, as being of the person's former sex.[93] There is no right

[90] Ibid, s. 28D.

[91] *Births, Deaths and Marriages Registration Amendment Act 2019.*

[92] *Births, Deaths and Marriages Registration Act* 1995 (NSW) s.32C.

[93] *Anti-Discrimination Act* 1977 (NSW), s.38B(1)(c).

for an ‘unrecognised’ transgender person to be treated as being of the opposite sex, but they are otherwise protected from discrimination against them.

Religious exemptions

In Commonwealth law, and in the laws of the States and Territories, there are exemptions that apply to faith-based organisations in relation to discrimination on the basis of sex, sexual orientation, gender identity and other attributes. These vary in detail from one jurisdiction to another. In the *Sex Discrimination Act 1984* (Cth) s.37(1), there are exemptions in relation to the selection and training of ministers of religion and any “act or practice of a body established for religious purposes, being an act or practice that conforms to the doctrines, tenets or beliefs of that religion or is necessary to avoid injury to the religious susceptibilities of adherents of that religion.” Section 38 makes it lawful for faith-based educational institutions to discriminate on a number of grounds, including gender identity, if the institution is “conducted in accordance with the doctrines, tenets, beliefs or teachings of a particular religion or creed” and the discrimination is “in good faith in order to avoid injury to the religious susceptibilities of adherents of that religion or creed”. This exemption applies both to employment of staff and issues concerning students.

In New South Wales, a similar exemption applies to all private schools, whether or not religious.[94] Furthermore, religious bodies have a broadly-based exemption from anti-discrimination laws in relation to appointments of people “in any capacity by a body established to propagate religion” and in relation to “any other act or practice of a body established to propagate religion that conforms to the doctrines of that religion or is necessary to avoid injury to the religious susceptibilities of the adherents of that religion.”[95] In Victoria,

[94] *Anti-Discrimination Act* 1977 (NSW), s.38K(3).

[95] *Anti-Discrimination Act* 1977 (NSW), s.56.

the *Equal Opportunity Act* 2010, s.83 provides a similar exemption for educational institutions where the discrimination conforms with the doctrines, beliefs or principles of the religion; or is reasonably necessary to avoid injury to the religious sensitivities of adherents of the religion. Other sections of the Act provide exemptions in other contexts where the discrimination is on the basis of religious belief.[96]

In all these statutory provisions, the exemption is not based on the fact that the person discriminating happens to hold religious beliefs; rather, the exemption applies where the discrimination is based upon those religious beliefs or done in good faith to avoid upsetting other adherents of the religion. In application to gender identity, this raises a question, as a matter of law, whether discrimination on the basis of gender identity can be said to be based upon religious beliefs or otherwise justified in terms of offence to adherents. A policy put out by one large diocese of the Anglican Church in Australia, [97] as well as a policy document issued by the Vatican,[98] provide a theological basis for non-recognition of a self-identifying transgender person as being the gender with which they now identify if this is different from natal sex,[99] while seeking to adopt an empathetic pastoral response to people who identify as transgender.

The notion that people of faith should have a 'right to discriminate' is inherently controversial. In recent years there has been a growing chorus of opposition to such religious exemptions,

[96] *Equal Opportunity Act 2010* (Vic.) ss. 82, 84.

[97] Social Issues Committee, Anglican Diocese of Sydney, *Gender Identity* (2017).

[98] Congregation for Catholic Education, "*Male And Female He Created Them": Towards a Path of Dialogue on the Question of Gender Theory in Education* (2019) available at http://www.vatican.va/roman_curia/congregations/ccatheduc/index.htm

[99] Both documents begin with the biblical conviction that there are only two sexes, male and female, for 'male and female He created them': Genesis 1:27 (see also Genesis 5:2). Such a view presupposes that sex is binary, and based on reproductive function. On this view, gender, as distinct from sex, is a completely alien concept within the Christian tradition and results from a different use of the term 'gender' linguistically. See Anglican Diocese of Sydney, above n.97 at 5ff and 13.

particularly from organisations purporting to be concerned with human rights.[100] The Australian Law Reform Commission has been tasked by the Government to conduct an inquiry into the religious exemptions in anti-discrimination laws.[101] It is unavoidable that, as part of this review, the Commission will need to provide clarification about whether, and in what circumstances, it constitutes discrimination to decline to treat someone as the gender with which they now identify, for this is central to the issue of whether religious exemptions, in relation to gender identity, should remain. The Commission will also need to consider the application of the law to include people who identify as a gender other than male or female, or as 'agender' or 'non-binary', at least in Victoria and Tasmania where such descriptors can be accepted as the person's official gender for legal purposes.

Government policies for state schools

The law is not the only factor in determining how schools in particular, might respond to young people who identify as transgender. Another important factor is what government policies in relation to schools provide. Because of government policy within a particular jurisdiction, a school principal in a State school may consider he or she has no choice but to affirm the parent's decision that a child be known henceforth by a different name and gender – in other words to engage in social transition.[102] In NSW, the relevant policy is said to be *required by* anti-

[100] See further, Patrick Parkinson, 'Christian Concerns about an Australian Charter of Rights' (2010) 15 *Australian Journal of Human Rights* 83.

[101] Australian Law Reform Commission, 'Review into the Framework of Religious Exemptions in Anti-discrimination Legislation' (April 2019). The terms of reference are at www.alrc.gov.au.

[102] See e.g. 'Gender Identity', Education and Training, Victorian Government, (undated) at http://www.education.vic.gov.au/school/principals/spag/health/Pages/genderidentity.aspx; Department for Education (South Australia), 'Gender diverse and intersex children and young people support' at education.sa.gov.au. Contrast Queensland, which gives school principals freedom to exercise professional judgment on a case by case basis: 'Diversity in Queensland Schools – information for principals', Queensland Department of Education, (undated) at education.qld.gov.au'.

discrimination laws,[103] although this is almost certainly a misreading of the relevant legislation. These government policies do not apply to schools that are not run by state education departments.

What should the law be?

As I have argued above, given so many of the young people who identify as transgender are vulnerable youth with psychiatric comorbidities, histories of trauma or autism diagnoses, there are compelling reasons why the law should not require that a professional such as a school principal has to accept a child or young person's self-identified gender identity where this is inconsistent with natal sex. The issue should be left to the principal's professional judgment in each case to do what he or she considers best for the child and to make such accommodations to the child as seem appropriate in the circumstances. Responding to young people who are convinced that they have been 'born in the wrong body' is a pastoral and ethical minefield - and navigating that minefield is not helped by laws that prohibit discrimination on the basis of gender identity without clarifying the nature of the obligation in this context.

A school principal may, after due consideration, decide that the most compassionate response to a young person who seeks to change gender is not to embrace his or her newly found gender identity. That may be for many reasons, including concerns about the rapid onset of gender dysphoria, observable influences in the young person's friendship group, awareness of other mental health disorders and concern that those other mental health issues may not receive the attention they warrant if transitioning is seen as the answer to all the young person's difficulties.

[103] See eg. 'Transgender students in schools – legal rights and responsibilities', *Legal Issues Bulletin No 55, December 2014* at education.nsw.gov.au. 'Transgender and intersex student support', SA Department for Education and Child Development at .https://www.decd.sa.gov.au/sites/g/files/net691/f/transgender-and-intersex-support-procedure.pdf

There needs to be clarification about what the obligation 'not to discriminate' requires, particularly for school students. It should be made clear that nothing in anti-discrimination legislation prevents educational institutions and other service providers, organising or offering their services on the basis of biological sex rather than gender identity. Sex, or what it means to be male or female, needs to be defined in terms of reproductive function while gender identity can be defined in terms of subjective belief. The distinction between sex and gender is already implicit, if not explicit, in the *Sex Discrimination Act* 1984 (Cth) which distinguishes at various points between them. However, the law could be more clearly stated so that people realise that gender identity is not to be equated with biological sex when it comes to the use of sex-segregated facilities or sex-segregated activities, except insofar as the law specifically provides. Such clarification in the law would go a long way to resolving the dilemmas now being created by laws which base changes to gender identity on nothing more than self-declaration.

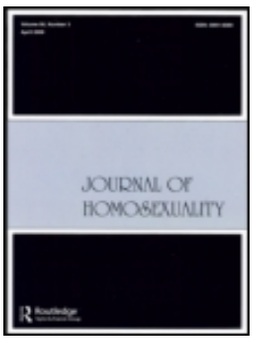
The need for clarification is particularly important now that Victoria and Tasmania allow birth certificates to record a self-designated gender identity that is neither male, female nor even non-binary. That creates new challenges for understanding what the law requires of others who must engage with them in circumstances where natal sex is prima facie relevant.

All schools ought to have an absolute defence to a claim of discrimination against a young person under the age of 18 that they acted in good faith on the basis of what they considered at the time to be in the best interests of the child. Without such a provision, an educational professional may be unable to reconcile his or her duty of care towards the child with the requirements of anti-discrimination law. It would be contrary to fundamental principles of child protection if the law compelled, or was understood to compel, a professional with a duty of care towards a child to make decisions that are contrary to what he or she considers are the

child's best interests and which could cause them harm. The most the law can do in this respect is to accept good faith determinations by professionals.

This does not mean that there is no place for laws prohibiting discrimination on the basis of their gender identity that apply to children and young people. If the law provides only that people who have a gender identity different to their natal sex should not suffer ill-treatment or discrimination as a consequence, then no problems arise. There is no justification for discriminating against a person in the delivery of goods and services on the basis of their gender identity, for example, nor for expelling a child from school on the basis only that they identify as transgender.

By clarifying, in the context of gender identity, what it means to 'discriminate', a proper balance between support for equality, and protection of children and young people, may most readily be found.



Journal of Homosexuality

ISSN: 0091-8369 (Print) 1540-3602 (Online) Journal homepage: http://www.tandfonline.com/loi/wjhm20

Clinical Management of Gender Dysphoria in Children and Adolescents: The Dutch Approach

Annelou L. C. de Vries MD PhD & Peggy T. Cohen-Kettenis PhD

To cite this article: Annelou L. C. de Vries MD PhD & Peggy T. Cohen-Kettenis PhD (2012) Clinical Management of Gender Dysphoria in Children and Adolescents: The Dutch Approach, Journal of Homosexuality, 59:3, 301-320, DOI: 10.1080/00918369.2012.653300

To link to this article: http://dx.doi.org/10.1080/00918369.2012.653300

Journal of Homosexuality, 59:301–320, 2012

ISSN: 0091-8369 print/1540-3602 online
DOI: 10.1080/00918369.2012.653300

Routledge
Taylor & Francis Group

Clinical Management of Gender Dysphoria in Children and Adolescents: The Dutch Approach

ANNELOU L. C. DE VRIES, MD, PhD and
PEGGY T. COHEN-KETTENIS, PhD
VU University Medical Center, Amsterdam, the Netherlands

The Dutch approach on clinical management of both prepubertal children under the age of 12 and adolescents starting at age 12 with gender dysphoria, starts with a thorough assessment of any vulnerable aspects of the youth's functioning or circumstances and, when necessary, appropriate intervention. In children with gender dysphoria only, the general recommendation is watchful waiting and carefully observing how gender dysphoria develops in the first stages of puberty. Gender dysphoric adolescents can be considered eligible for puberty suppression and subsequent cross-sex hormones when they reach the age of 16 years. Currently, withholding physical medical interventions in these cases seems more harmful to wellbeing in both adolescence and adulthood when compared to cases where physical medical interventions were provided.

KEYWORDS gender, gender identity, gender identity disorder, gender identity disorder of childhood, gender identity disorder of adolescence, gender variance, pubertal suspension, transgender, transsexual, treatment

The first specialized gender identity clinic for children and adolescents in the Netherlands opened its doors at the Utrecht University Medical Center in 1987. The number of applicants was initially low: No more than a few children and adolescents were referred to the clinic annually. In 2002, the clinic moved to the VU University Medical Center in Amsterdam and is now

Address correspondence to Annelou L. C. de Vries, VU University Medical Center, PO Box 7057, Amsterdam, 1007 MB, the Netherlands. E-mail: alc.devries@vumc.nl

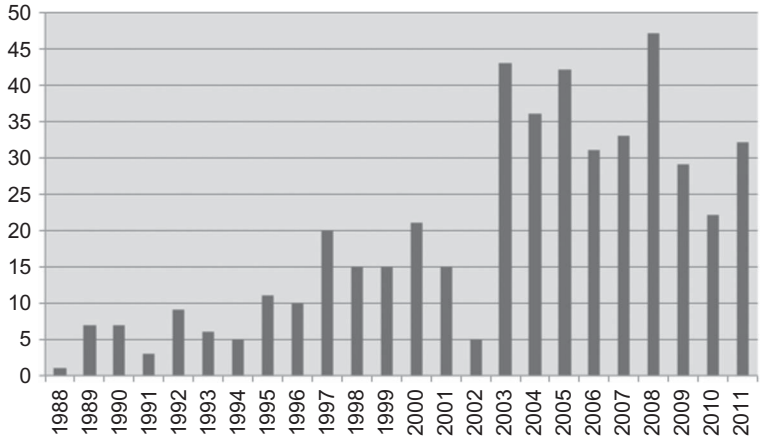


FIGURE 1 Referred children, Dutch Gender Identity Clinic, 1987–2011.

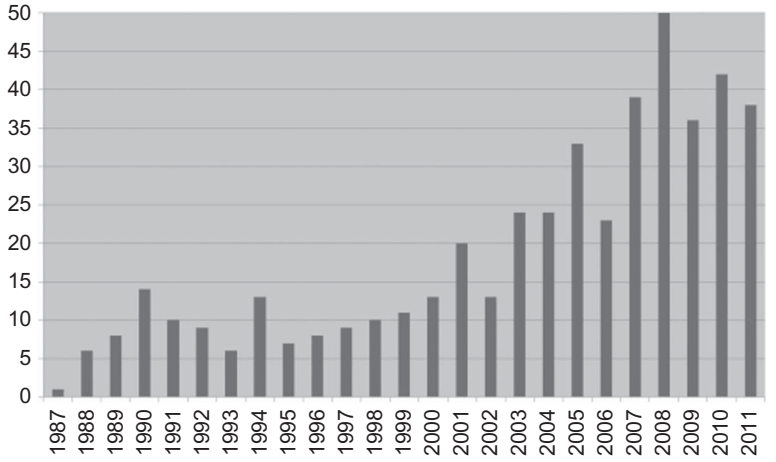


FIGURE 2 Referred adolescents, Dutch Gender Identity Clinic, 1987–2011.

part of the Center of Expertise on Gender Dysphoria. Compared to the early years, the number of referrals increased considerably. To date, more than 400 children and an almost equal number of adolescents have attended the gender identity clinic (see Figures 1 and 2).

Between 2004 and 2009, an average of 40 children and 40 adolescents registered per year for the first time at the clinic with a mean age of 8.0 and 14.3 years, respectively. In the past decade, 12- to 18-year-old adolescents have been attending the clinic in ever greater numbers and at ever younger ages (see Figures 2 and 3).

When the gender identity clinic for children and adolescents first opened, there were no diagnostic guidelines, no Dutch language screening instruments, and no guideline or protocol for dealing with gender

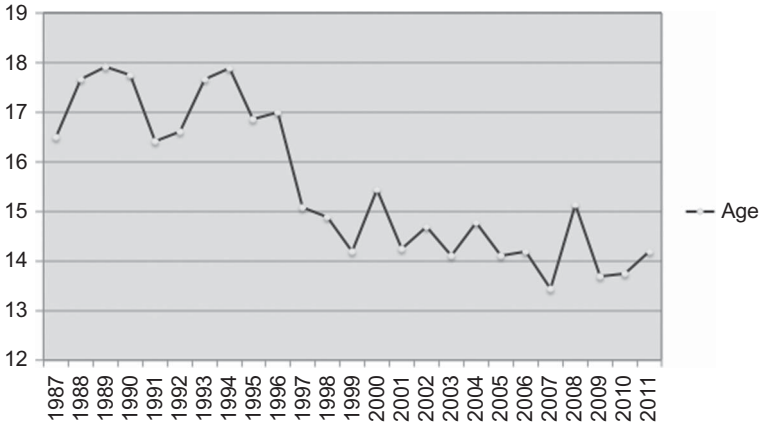


FIGURE 3 Mean age of referred adolescents, 1987–2011.

dysphoria at an early age. A great deal has been accomplished in this field in the past three decades. In addition to the increasing numbers of referrals, the care for these gender dysphoric children and adolescents has also experienced growth. Over the course of years, diagnostic protocols for children under 12 years, as well as adolescents from 12 to 18 years, of age have been constructed (Cohen-Kettenis & Pfäfflin, 2003; Delemarre-van de Waal & Cohen-Kettenis, 2006), screening and diagnostic instruments have been developed, and there are now specific approaches for both age groups.

These are not isolated developments: Outside of the Netherlands, even more experience has been gained and knowledge has expanded in the field of juvenile gender dysphoria. Various international treatment guidelines have been developed (de Vries, Cohen-Kettenis, & Delemarre-van de Waal, 2007; Di Ceglie, Sturge, & Sutton, 1998; Hembree et al., 2009; World Professional Association of Transgender Health, WPATH, 2011).

Especially with regard to the clinical management of gender dysphoria in adolescents, the Netherlands has pioneered and played a leading role internationally. The "Dutch protocol" has become proverbial in this field. Various publications have demonstrated the efficacy of parts of this approach (Cohen-Kettenis & van Goozen, 1997; de Vries, 2010; de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2010; Smith, van Goozen, & Cohen-Kettenis, 2001), although the protocol has also been subject to criticism (Korte et al., 2008).

As a likely result of the professional and media attention to the Dutch approach, there is an increasing clinical interest in the rationale and description of the ways gender dysphoria in children and adolescents is managed in the Netherlands (Kreukels & Cohen-Kettenis, 2011). However, to date such a description did not exist. In this article, we will, therefore, give an account of our diagnostic and treatment protocols, which differ for children

and adolescents. Before proceeding, we will dwell shortly on the context of views on etiology and gender development that have contributed to developing the Dutch approach. This discussion of the context is by no means complete.

CONTEXT

Etiology

No unequivocal etiological factor determining atypical gender development has been found to date. The most extreme form of gender dysphoria, Gender Identity Disorder (GID) in the current *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2000) is most likely a multifactorial condition in which psychosocial as well as biological aspects play some role. In recent years, a great deal of attention has been paid to biological theories (for an overview, see Meyer-Bahlburg, 2010), whereas psychosocial factors used to be considered of primary importance in the past. For instance, it was once theorized that GID was a symptom of certain psychiatric disorders such as borderline personality (Lothstein, 1984) or psychosis (a Campo, Nijman, Merckelbach, & Evers, 2003). Current studies on psychopathology among adults with GID do not support either of these conclusions (e.g., Gomez-Gil, Vidal-Hagemeijer, & Salamero, 2008; Haraldsen & Dahl, 2000; Smith, van Goozen, Kuiper, & Cohen-Kettenis, 2005).

However, the relationship between certain forms of psychopathology and GID is still not entirely clear (Meyer-Bahlburg, 2010). In adults, elevated psychopathology has been found in some studies (e.g., Bodlund, Kullgren, Sundbom, & Hojerback, 1993; De Cuypere, Janes, & Rubens, 1995; Hepp, Kraemer, Schnyder, Miller, & Delsignore, 2005). Research among children and adolescents referred to gender identity clinics has demonstrated more frequent (internalizing) psychopathology than observed in their peers from the general population (Cohen-Kettenis, Owen, Kaijser, Bradley, & Zucker, 2003; de Vries, Doreleijers, Steensma, & Cohen-Kettenis, 2011; Di Ceglie, Freedman, McPherson, & Richardson, 2002; Wallien, Swaab, & Cohen-Kettenis, 2007; Zucker & Bradley, 1995; Zucker, Bradley, Owen-Anderson, et al., 2010; Zucker, Owen, Bradley, & Ameeriar, 2002). One theory about this relationship is that a predisposition to anxiety combined with parental psychopathology in gender variant children can lead to full-blown GID (Zucker & Bradley, 1995). Zucker and colleagues (Zucker, Bradley, Ben-Dat, et al., 2003; Zucker, Bradley, & Lowry Sullivan, 1996) have found among children referred to the Toronto gender identity clinic more separation anxiety in the boys and more psychopathology in their mothers than in the general population. At the Dutch gender identity clinic, some indications were found for a predisposition to anxiety among the referred children (Wallien, Swaab, et al., 2007; Wallien, van Goozen, & Cohen-Kettenis, 2007). However, parental psychopathology was not demonstrated (Wallien, 2008).

The increasing quantity of research on typical gender development demonstrates that a number of psychological and social factors play a role (for a review, see Ruble, Martin, & Berenbaum, 2006), in addition to biological factors. It remains to be seen whether and to what degree these same influences also influence gender dysphoric development. Biological factors do seem to be involved in the etiology of GID. For example, brain anatomy and brain activation patterns are reported to be different in adult transsexuals in comparison to non-gender dysphoric controls (Carrillo et al., 2010; Garcia-Falgueras & Swaab, 2008; Kruijver et al., 2000; Luders et al., 2009; Zhou, Hofman, Gooren, & Swaab, 1995; Berglund, Lindstrom, Dhejne-Helmy, & Savic, 2008; Gizewski et al., 2009; Schoning et al., 2010). Genetic factors are also likely to be important in the development of gender dysphoria (e.g., Coolidge, Thede, & Young, 2002; van Beijsterveldt, Hudziak, & Boomsma, 2006). However, this research is still very limited and the findings are sometimes inconsistent. It is unclear whether these findings are also applicable to less extreme forms of gender dysphoria.

With the current state of knowledge, it remains most plausible that a complex interaction between a biological predisposition in combination with intra- and interpersonal factors (Crouter, Whiteman, McHale, & Osgood, 2007; Maccoby, 1998; Zucker & Bradley, 1995) contribute to a development of gender dysphoria, which may come in different forms and intensities. Assuming, therefore, that gender dysphoria is most likely determined multifactorially, in clinical practice an extensive work-up weighing various symptoms and evaluating all kinds of potentially relevant factors seems indicated.

Perspective of Developmental Trajectories

In the diagnosis and treatment of gender dysphoric children and adolescents, one must take the perspective of development into account. Gender variant behavior and even the wish to be of the other gender can be either a phase or a normal developmental variant without any adverse consequences for a child's current functioning (e.g., Bartlett, Vasey, & Bukowski, 2000). Follow-up studies have demonstrated that only a small proportion of gender dysphoric children become transsexual at a later age, that a much larger proportion have a homosexual sexual orientation without any gender dysphoria, and that a small proportion of these children develop into heterosexual adults. The proportions of persistence found in the initial studies were below 10% (for a review of the literature, see Zucker & Bradley, 1995). More recent studies show a variation from 12 to 27% (Cohen-Kettenis, 2001; Drummond, Bradley, Peterson-Badali, & Zucker, 2008; Wallien & Cohen-Kettenis, 2008). It is important to note that these figures are for children attending a gender identity clinic; in a study on children from the general population, these numbers were different. Adults, whose parents had indicated that their children either showed gender variant behavior or expressed the wish to

be of the other gender during childhood, more frequently indicated that they were either homosexual or bisexual, but none of them was transsexual (Steensma, van der Ende, Verhulst, & Cohen-Kettenis, in press). This implies that gender variant children, even those who meet the criteria for GID prior to puberty, for the most part are not gender dysphoric at a later age. To date, we do not yet know exactly when and how gender dysphoria disappears or desists. Clinical experience has shown that this most often takes place right before or right after the onset of puberty. This is also confirmed by youths in a qualitative study in whom the gender dysphoria disappeared after puberty (Steensma, Biemond, de Boer, & Cohen-Kettenis, 2011).

In contrast to what happens in children, gender dysphoria rarely changes or desists in adolescents who had been gender dysphoric since childhood and remained so after puberty (Cohen-Kettenis & Pfäfflin, 2003; Zucker, 2006). Youths who began the reversible treatment with puberty suppression at an average age of 14.75 years, to enable them to explore their gender dysphoria and treatment wish, were still gender dysphoric nearly two years later. All started with the first steps of their actual gender reassignment trajectory, the cross-sex hormones (de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2011).

CHILDREN

Diagnosis

In the Amsterdam gender identity clinic, several sessions spread out over a longer period of time are allotted to prepubertal children below age 12 for diagnosis. This is done to gain insight into how the gender dysphoria develops over time. The children and their parents are seen at least once together, each of the parents is interviewed individually, and the child is observed a number of times and subjected to an extensive psychodiagnostic assessment. The procedure is concluded with an advisory consultation.

One aim of the examination is to determine whether the criteria for a GID diagnosis have been met. This can be rather simple with children demonstrating an extreme degree of gender dysphoria or who are very explicit in their desire for gender reassignment. However, the clinical picture is not always that clear. Gender dysphoria is a dimensional phenomenon and can exist to a greater or lesser degree. This is something to be taken into greater account in *DSM-5* (APA, for proposed revision see www.dsm5.org) than is presently the case (Zucker, 2010). In addition, it can also manifest itself in various ways. One child with a strong gender dysphoric feeling may be very sensitive to his or her surroundings and only dares to come out at certain times and under certain circumstances. In another child, we can see very openly expressed gender dysphoria (Meyer-Bahlburg, 2002). In other cases, a child can show gender variant behavior without suffering from

actual gender dysphoria. In those cases, the reason for referral usually lies more in the environment (e.g., parents struggling with their child's behavior) than in the child.

All kinds of aspects of the children's functioning are subsequently evaluated, such as their cognitive level, psychosocial functioning, and scholastic performance. For example, a boy may like playing with girls, not because he is unhappy being a boy, but because he has difficulty joining in with other boys of his age due to limited cognitive faculties and immaturity. Any other possible psychopathology is dealt with extensively (Wallien, Swaab, & Cohen-Kettenis, 2007). If any is found, the possible relationship between the gender dysphoria and other diagnoses is investigated. In this way, for example, one can investigate whether an autistic boy's fascination for fancy dresses and long hair is more part of his autism or whether his autism reinforces certain aspects of his gender dysphoria (de Vries, Noens, Cohen-Kettenis, van Berckelaer-Onnes, & Doreleijers, 2010). Some psychiatric diagnoses may be unrelated to the gender presentation but still need attention (e.g., tic disorders). There are also problems or psychiatric disorders that can arise as a consequence of the gender dysphoria (social anxiety, depression, oppositional defiant disorders).

Furthermore, a good assessment of family functioning as well as the role of the child's gender variant behavior on family functioning is useful in order to gain a complete clinical picture.

Treatment

The Dutch approach to clinical management of children with GID contains elements of a therapeutic approach but is not directed at the gender dysphoria itself. Instead, it focuses on its concomitant emotional and behavioral and family problems that may or may not have an impact on the child's gender dysphoria.

Parent counseling

After the evaluation described above, the results of the assessment and diagnostic procedure are discussed with the parents (and partially with the child) and an ensuing individual recommendation is given. For children in whom no concomitant problems have been observed, who have sensitive parents with an appropriate style of child rearing, advice aimed at dealing with the gender dysphoria is sufficient. This sometimes results in more counseling at a later point in time when the family again needs support or advice or finds it increasingly difficult to deal with the uncertainties with regard to the child's psychosexual outcome. Because most gender dysphoric children will not remain gender dysphoric through adolescence (Wallien & Cohen-Kettenis, 2008), we recommend that young children not yet make a complete social

transition (different clothing, a different given name, referring to a boy as "her" instead of "him") before the very early stages of puberty. In making this recommendation, we aim to prevent youths with nonpersisting gender dysphoria from having to make a complex change back to the role of their natal gender (Steensma & Cohen-Kettenis, 2011). In a qualitative follow-up study, several youths indicated how difficult it was for them to realize that they no longer wanted to live in the role of the other gender and to make this clear to the people around them (Steensma, Biemond, et al., 2011). These children never even officially transitioned but just were considered by everyone around them as belonging to the other (non-natal) gender. One may wonder how difficult it would be for children living already for years in an environment where no one (except for the family) is aware of the child's natal sex to make a change back. Another reason we recommend against early transitions is that some children who have done so (sometimes as preschoolers) barely realize that they are of the other natal sex. They develop a sense of reality so different from their physical reality that acceptance of the multiple and protracted treatments they will later need is made unnecessarily difficult. Parents, too, who go along with this, often do not realize that they contribute to their child's lack of awareness of these consequences.

Parents are furthermore advised to encourage their child, if possible, to stay in contact with children and adult role models of their natal sex as well. Moreover, we advise them to encourage a wider range of interests in objects and activities that go with the natal sex. Gender variant behavior, however, is not prohibited. By informing parents about the various psychosexual trajectories, we want them to succeed in finding a sensible middle of the road approach between an accepting and supportive attitude toward their child's gender dysphoria, while at the same time protecting their child against any negative reactions from others and remaining realistic about the actual situation. If they speak about their natal son as being a girl with a penis, we stress that they have a male child who very much wants to be a girl, but will need an invasive treatment to align his body with his identity if this desire does not remit. Finding the right balance is essential for parents and clinicians because gender variant children are highly vulnerable to developing a negative sense of self (Yunger, Carver, & Perry, 2004). This goes especially for situations of social exclusion or teasing and bullying (Cohen-Kettenis, Owen, et al., 2003). Fortunately, social exclusion does not invariably take place, as can be seen from a recent study of gender dysphoric Dutch children (Wallien, Veenstra, Kreukels, & Cohen-Kettenis, 2010).

Parents can play a significant role in creating an environment in which their child can grow up safely and develop optimally. In this regard, it is also important that appropriate limit setting is part of the parent's style of raising their child. For example, if a young boy likes to wear dresses in a neighborhood in which aggression can be expected, they could come to an

understanding with their son that he only wears dresses at home. In such a case, it is crucial that the parents give their child a clear explanation of why they have made their choices and that this does not mean that they themselves do not accept the cross-dressing. The child will, thus, sometimes be frustrated and learn that not all of one's desires will be met. The latter is an important lesson for any child, but even more so for children who will have a gender reassignment later in life. Although hormones and surgery effectively make the gender dysphoria disappear (Murad et al., 2010), someone's deepest desire or fantasy to have been born in the body of the other gender will never be completely fulfilled.

Treatment of non-gender dysphoria related problems

If concomitant problems are observed (e.g., substantial problems with peers, psychiatric problems, or conflicts with parents or siblings), the child may be referred to a local mental health agency. The primary aim is for the child and, if necessary, the family to function better. If these problems have contributed to causing or keeping up some gender dysphoria, the dysphoria will likely disappear by tackling these other problems. Although there is little evidence that psychotherapeutic interventions can eliminate gender dysphoria in general, it is conceivable that in some cases gender variant behavior can change as a result of therapy. In our own practice, a reduction or disappearance of gender variant behavior seems to take place particularly when this behavior appeared to be a clear reaction to certain events or situations which in themselves are amenable to therapy (e.g., a boy suddenly dressing up and saying he wants to be a girl as an expression of extreme jealousy after the birth of a younger sister). There are, however, no controlled studies that have investigated psychological interventions aimed at influencing certain types of gender dysphoria. It remains for the most part unclear if "treated" children have been "cured" through interventions or just "grew out of" their gender variance. Yet, even if there is no change in the gender dysphoria, many children with gender dysphoria can benefit from psychotherapy or counseling aimed at securing a positive self-image or dealing with negative reactions from others. Without such support, these children run the risk of developing social relationship problems, emotional problems such as anxiety and depression, behavioral problems, or problems at school due to difficulties with concentration, or a low self-esteem.

Physical medical interventions

The Amsterdam gender identity clinic does not provide any physical medical interventions before puberty. Parents are advised to adopt an attitude of watchful waiting. Not until the child arrives at puberty and is still gender

dysphoric will he or she be seen again in our gender identity clinic. Parents and child are informed about this possibility.

ADOLESCENTS

Diagnosis

In nearly all cases seen, adolescents age 12 and up come to the Amsterdam gender identity clinic with a desire for gender reassignment. While gender dysphoric feelings in younger children will usually remit, in adolescents this is rarely the case. Similar to the children, a diagnostic trajectory is initiated that is spread out over a longer period of time. Here, too, there is an intake session with the adolescents and their parents, followed by individual talks with the parents and the youths and a psychodiagnostic assessment. Shortly before the start of any physical medical treatment, adolescents will also have a child psychiatric examination by a member of the team other than the diagnostician and a medical screening by the pediatric endocrinologist. Finally, a recommendation concludes the procedure. When an adolescent is considered eligible for puberty suppression, the diagnostic trajectory is extended, as the puberty suppression phase is still considered diagnostic. This medical intervention puts a halt to the development of secondary sex characteristics. It has been used for over 20 years now in the treatment of precocious puberty and there is evidence that gonadal function is reactivated soon after cessation of treatment (Mul & Hughes, 2008).

The Amsterdam gender identity clinic follows the international Standards of Care of the World Professional Association for Transgender Health (WPATH, 2011), which advises that the decision to undergo gender reassignment be taken in several steps. In the *Standards of Care*, the diagnostic phase is followed by the real-life experience stage in which cross-sex hormones are prescribed and, eventually, the subject can undergo gender reassignment surgery.

In developing a rapport with adolescents and their parents, particular attention is paid to obtaining open and nonjudgmental contact with the youths and their parents. Many elements of this are recognizable as the developmental approach described by Di Ceglie (2009). In a number of sessions, the diagnostician tries to gain a picture of the youth's general and psychosexual development. Information is gathered about current functioning, individually, with peers and in the family. As to sexuality, the subjective meaning of dressing up or the type of clothing, sexual experience, sexual behavior and fantasies, sexual orientation and body perception are discussed.

Adolescents are considered eligible for puberty suppression when they are diagnosed with GID, live in a supportive environment and have no serious psychosocial problems interfering with the diagnostic assessment

or treatment (Cohen-Kettenis, Delemarre-van de Waal, & Gooren, 2008; Delemarre-van de Waal & Cohen-Kettenis, 2006). During the diagnostic trajectory, information is obtained from both the adolescents and their parents to assess whether the adolescents meet the eligibility criteria. Therefore, first it is ascertained whether adolescents are suffering from a very early onset gender dysphoria that has increased around puberty, or whether something else brought them to the clinic (e.g., confusion about homosexuality or transvestic fetishism). About one quarter of the referrals in Amsterdam do not fulfill diagnostic criteria for GID and most of them drop out early in the diagnostic procedure for this reason or because other problems are prominent (de Vries, et al., 2011). Second, the youth's further general and psychological functioning is assessed. Are there psychiatric problems or other issues that could hinder a correct assessment or future treatment compliance? Third, an assessment is made of the adolescent's social support. As puberty suppression and subsequent hormone treatment and surgery have far-reaching implications, an adolescent needs adequate support.

The diagnostic stage does not only focus on obtaining information. To prevent unrealistically high expectations from gender reassignment in the future, all the possibilities and impossibilities of the treatment are discussed extensively with the adolescent and the family. Giving such information starts early in the trajectory. Sometimes, the way in which the youth responds to this information is also diagnostically informative.

If the eligibility criteria are met, gonadotropin releasing hormone analogues (GnRHa) to suppress puberty are prescribed when the youth has reached Tanner stage 2–3 of puberty (Delemarre-van de Waal & Cohen-Kettenis, 2006); this means that puberty has just begun. The reason for this is that we assume that experiencing one's own puberty is diagnostically useful because right at the onset of puberty it becomes clear whether the gender dysphoria will desist or persist. Starting around Tanner stages 2–3, the very first physical changes are still reversible (Delemarre-van de Waal & Cohen-Kettenis, 2006). Because the protocol for young adolescents had started in a period when there were no studies on the effects of puberty suppression, the age limit was set at 12 years because some cognitive and emotional maturation is desirable when starting these physical medical interventions. Further, Dutch adolescents are legally partly competent to make a medical decision together with their parent´s consent at age 12. It is, however, conceivable that when more information about the safety of early hormone treatment becomes available, the age limit may be further adjusted (de Vries, 2010).

Treatment

When it appears from the advisory consultation that there are concomitant psychiatric or family problems, some form of psychological treatment will be sought. This treatment is usually given close to the youth's home rather

than at our clinic. Certainly, when the problems are destabilizing and there is an insufficient guarantee that the youth is committed to the therapeutic relationship necessary for a physical medical intervention, the treatment will be postponed. In a study investigating the extent of psychiatric problems in gender dysphoric adolescents, it appeared that the diagnostic stage in some cases may take more than one and a half years before physical medical intervention actually can begin (de Vries, Doreleijers, et al., 2011). This was the case in about one third of the youths with a GID diagnosis. These youths more frequently suffered from an oppositional defiant behavioral disorder or more than three psychiatric diagnoses (in addition to the GID diagnosis) compared with adolescents who were considered immediately eligible. They also were less likely to live with both biological parents and on average had a lower intelligence. Furthermore, they were, on average, older at the time of referral (de Vries, Doreleijers, et al., 2011). Clearly, psychiatric problems were not the only factor influencing the delay in starting puberty suppression.

However, for many of the gender dysphoric youths, there are no psychological problems other than the gender dysphoria. Yet, these adolescents do need good counseling. Some themes need repeatedly to be touched upon, because they gain a new dimension as the adolescents grow older, for example, dating when you have a body that has not yet been operated on, or infertility. Regular contact with the psychologist is also necessary for adequate preparation for the next treatment steps. An increasing problem is that many adolescents do not realize that an unhealthy lifestyle (smoking, obesity) has a negative influence on the treatment, surgery in particular. In addition to a preparation for the future, some profit from a form of psychotherapy. This may be because they are anxious, need to become more assertive or feel insecure. For those who do not easily verbalize their concerns, psychomotor therapy can be helpful to let them feel more at ease with their bodies and to learn to talk more easily about their problems.

Transitioning

Many gender dysphoric youths choose to begin living in the desired gender role simultaneously with the beginning of puberty suppression. The adolescents and their families are then supported in this process so that it can be achieved successfully. Many youths also obtain help from Transvisie, the only self-help organization working with trans youth in the Netherlands. It is, however, not a requirement to begin with the real life experience as long as cross-sex hormones are not taken.

Physical medical interventions

Physical medical interventions can be divided into completely reversible interventions (puberty suppressors such as GnRHa), partially reversible

interventions (cross-sex hormones) and completely irreversible gender reassignment surgery (WPATH, 2011).

Completely reversible interventions. Puberty suppression has two aims. First and foremost, they offer the adolescent time to smoothly explore his or her gender identity and to find out if a gender reassignment trajectory is really what the youth wants. Moreover, the knowledge that their bodies in this stage will not continue to develop in the undesired direction often results in a vast reduction of the distress they have been suffering from since the onset of puberty. Second, stopping the development of secondary sex characteristics makes passing in the desired gender role easier than delaying treatment until adulthood. This entails advantages for functioning throughout one's life (Ross & Need, 1989). The team's view that puberty suppression does not automatically have to lead to actual treatment (gender reassignment) is explicitly discussed with the youths and their parents. While with some adolescents it is clear early on that there is only a very small chance that they will abandon this trajectory, they still have to see their psychologist or psychiatrist regularly in the years that they are on GnRHa or cross-sex hormones. Each adolescent is also regularly given consideration in the weekly multidisciplinary conferences in which the pediatric endocrinologist also participates. As soon as necessary, extra help is deployed or the trajectory is adjusted.

Youths with psychiatric or family problems can also become eligible for puberty suppression if the mental health treatment they receive is adequate enough to ensure that the diagnostic or treatment process is not unduly disturbed. To achieve this, good, regular contact with their external therapists or counselors is necessary. Special attention is given to gender dysphoric adolescents with an autism spectrum disorder. It is certainly the case for them that the treatment has to be introduced calmly and each step must take place in close consultation with the other mental health clinicians (de Vries, Noens, et al., 2010).

Partially irreversible interventions. Gender dysphoric adolescents are eligible for the first step of the actual gender reassignment when they have reached the age of 16. This age has been chosen because in the Netherlands (as well as in many other countries), young people are then considered to be able to make independent medical decisions. While their parents do not have to approve, the Amsterdam clinic prefers their approval, as most adolescents are still very much dependent on their caretakers. Furthermore, adolescents have to meet the same criteria as at the onset of puberty suppression (except for the Tanner stage criterion). Although most of the youths will have already made a social transition, this is now a requirement because sex characteristics of the desired gender will become visible to others.

Cross-sex hormones will result in a start of puberty of the desired gender. Male-to-females (MTF) or trans girls receive estrogens which result in breast growth and female fat distribution. Female-to-males (FTM) or trans boys receive androgens, and will become more muscular and develop

a low voice and facial-and body hair growth (Delemarre-van de Waal & Cohen-Kettenis, 2006).

In addition, new themes will be brought up in sessions. In this stage, some of the youths will start going out with someone for the first time and they will be more consciously dealing with dating, romantic relationships, partner choice, careers, and having children. Because the operations suddenly seem to be close at hand, the possibilities and limitations of the gender reassignment surgery, about which they will gradually have to make choices (e.g., various types of metaidoioplasty or phalloplasty, or no genital surgery for trans boys), are once again discussed (Cohen-Kettenis, 2006).

Completely irreversible interventions. When the adolescent has come of age at 18 and still meets all the eligibility criteria, he or she can be eligible for the last step of the gender reassignment treatment trajectory, the gender reassignment surgeries. Trans boys may undergo several operations: (if they came relatively late to the clinic and already had some breast development) mastectomy, hysterectomy or oovariectomy, and, if desired, genital operations (metaidoioplasty or phalloplasty). Trans girls usually undergo vaginoplasty and, if necessary, at their own financial expense, augmentation mammoplasty. Trans girls who began puberty suppression at a young age often have insufficient penile skin for a classical vaginoplasty and need an adjusted surgical procedure using colon tissue.

Treatment evaluation

While there are still reservations about physical medical interventions in youths under the age of 18 (e.g., Korte et al., 2008; Meyenburg, 1999; Viner, Brain, Carmichael, & Di Ceglie, 2005), many clinicians are changing their views on this (Cohen-Kettenis, Delemarre-van de Waal, & Gooren, 2008). There are indications that starting cross-sex hormones early (under 18 but over 16 years of age) followed by gender reassignment surgery at 18 can be effective and positive for general and mental functioning (Cohen-Kettenis & van Goozen, 1997; Smith, van Goozen, & Cohen-Kettenis, 2001; Smith, van Goozen, Kuiper, & Cohen-Kettenis, 2005).

By now, two studies have been performed evaluating the effects of puberty suppression. Psychological functioning of the first 70 gender dysphoric adolescents eligible for puberty suppression was measured twice: at their attendance at the clinic and shortly before the start of cross-sex hormones. Their behavioral and emotional problems and depressive symptoms decreased, while general functioning as measured by the Global Assessment Scale (Shaffer et al., 1983) improved significantly during puberty suppression. No adolescent withdrew from puberty suppression and all started cross-sex hormone treatment, the first step of the actual gender reassignment (de Vries, Steensma, Doreleijers, et al., 2010). A second group, assessed postoperatively, appeared to be satisfied with their lives and no longer

gender dysphoric (de Vries, 2010). Many studies in gender dysphoric adults have demonstrated that gender reassignment treatment is effective. These initial results demonstrate that this is also the case in young people who have received GnRHa to suppress puberty at an early age, followed by the actual gender reassignment (de Vries, 2010).

The concern that early physical medical intervention has unfavorable physical effects has to this date not been confirmed (Delemarre-van de Waal & Cohen-Kettenis, 2006). Initial studies on, for example, bone development and insulin sensitivity demonstrate favorable results (Schagen et al., in press; Vance, et al., in press).

SUMMARY AND CONCLUSIONS

At the Amsterdam gender identity clinic the clinical approach to prepubertal children under the age of 12 is different from the approach to adolescents starting at age 12. In children, the diagnosis is focused on elucidating all possible factors that could play a role in gender dysphoria, but the gender dysphoria itself is not actively dealt with in treatment. A general recommendation is given not to have transitioning take place too early, but to carefully observe how the gender dysphoria develops in the first stages of puberty. Parents and child are supported in tolerating the uncertainty about the outcome. Of special concern are concomitant problems and, whenever present, necessary help is actively sought so that the child can develop in an optimal way.

Gender dysphoric adolescents who have reached puberty also undergo meticulous diagnosis, but, in contrast to prepubertal children, they can be considered eligible for physical medical interventions under strict conditions. This does not, however, rule out parallel psychotherapy or other psychological interventions. Any vulnerable aspects of the youth's functioning or circumstances deserve thorough concern. These need not be contraindications to physical medical interventions, but they do need due attention. Using an approach that cares for every aspect of the adolescent´s psychosocial functioning and not only aims at eliminating the gender dysphoria, we try to provide the future young adult with the necessary resources for an optimal psychological development and a good quality of life. Despite the understandable concern about potential harm that could be done by early physical medical interventions, it seems currently that withholding intervention is even more harmful for the adolescents' wellbeing during adolescence and in adulthood. It is fortunate that nearly all diagnostic and treatment aspects, except for breast enlargement, are covered by insurance. Transgender individuals in the Netherlands do not need to suffer from incomplete or inadequate treatment because of financial problems.

REFERENCES

a Campo, J., Nijman, H., Merckelbach, H., & Evers, C. (2003). Psychiatric comorbidity of gender identity disorders: a survey among Dutch psychiatrists. *American Journal of Psychiatry*, *160*, 1332–1336.

American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*. Washington, DC: Author. www.dsm5.org

American Psychiatric Association. (in press). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Bartlett, N. H., Vasey, P. L., & Bukowski, W. M. (2000). Is gender identity disorder in children a mental disorder? *Sex Roles*, *43*, 753–785.

Berglund, H., Lindstrom, P., Dhejne-Helmy, C., & Savic, I. (2008). Male-to-female transsexuals show sex-atypical hypothalamus activation when smelling odorous steroids. *Cerebral Cortex*, *18*, 1900–1908.

Bodlund, O., Kullgren, G., Sundbom, E., & Hojerback, T. (1993). Personality traits and disorders among transsexuals. *Acta Psychiatrica Scandinavica*, *88*(5), 322–327.

Carrillo, B., Gomez-Gil, E., Rametti, G., Junque, C., Gomez, A., Karadi, K., et al. (2010) Cortical activation during mental rotation in male-to-female and female-to-male transsexuals under hormonal treatment. *Psychoneuroendocrinology*, *35*, 1213–1222.

Cohen-Kettenis, P. T. (2001). Gender identity disorder in DSM? *Journal of the American Academy of Child and Adolescent Psychiatry*, *40*, 391.

Cohen-Kettenis, P. T. (2006). Gender identity disorders. In C. Gillberg, R. Harrington, & H.-C. Steinhausen (Eds.), *A clinician's handbook of child and adolescent psychiatry* (pp. 695–725). New York, NY: Cambridge University Press.

Cohen-Kettenis, P. T., Delemarre-van de Waal, H. A., & Gooren, L. J. (2008). The treatment of adolescent transsexuals: changing insights. *Journal of Sexual Medicine*, *5*, 1892–1897.

Cohen-Kettenis, P. T., Owen, A., Kaijser, V. G., Bradley, S. J., & Zucker, K. J. (2003). Demographic characteristics, social competence, and behavior problems in children with gender identity disorder: a cross-national, cross-clinic comparative analysis. *Journal of Abnormal Child Psychology*, *31*, 41–53.

Cohen-Kettenis, P. T., & Pfäfflin, F. (2003). *Transgenderism and Intersexuality in Childhood and Adolescence* (Vol. 46). Thousand Oaks, CA: Sage.

Cohen-Kettenis, P. T., & van Goozen, S. H. (1997). Sex reassignment of adolescent transsexuals: a follow-up study. *Journal of the American Academy of Child and Adolescent Psychiatry*, *36*, 263–271.

Coolidge, F. L., Thede, L. L., & Young, S. E. (2002). The heritability of gender identity disorder in a child and adolescent twin sample. *Behavior Genetics*, *32*, 251–257.

Crouter, A. C., Whiteman, S. D., McHale, S. M., & Osgood, D. W. (2007). Development of gender attitude traditionality across middle childhood and adolescence. *Child Development*, *78*, 911–926.

De Cuypere, G., Janes, C., & Rubens, R. (1995). Psychosocial functioning of transsexuals in Belgium. *Acta Psychiatrica Scandinavica*, *91*, 180–184.

Delemarre-van de Waal, H. A., & Cohen-Kettenis, P. T. (2006). Clinical management of gender identity disorder in adolescents: a protocol on psychological and paediatric endocrinology aspects. *European Journal of Endocrinology/European Federation of Endocrine Societies*, *155*(Suppl. 1), 131–137.

de Vries, A. L. (2010). *Gender dysphoria in adolescents: Mental health and treatment evaluation*. Published PhD Dissertation. VU University Amsterdam.

de Vries, A. L., Cohen-Kettenis, P. T., & Delemarre-van de Waal, H. A. (2007). Clinical management of gender dysphoria in adolescents. *International Journal of Transgenderism*, *9*(3–4), 83–94.

de Vries, A. L., Doreleijers, T. A., Steensma, T. D., & Cohen-Kettenis, P. T. (2011). Psychiatric comorbidity in gender dysphoric adolescents. *Journal of Child Psychology and Psychiatry*, *52*(11), 1195–1202.

de Vries, A. L., Noens, I. L., Cohen-Kettenis, P. T., van Berckelaer-Onnes, I. A., & Doreleijers, T. A. (2010). Autism spectrum disorders in gender dysphoric children and adolescents. *Journal of Autism and Developmental Disorders*, *40*(8), 930–936.

de Vries, A. L., Steensma, T. D., Doreleijers, T. A., & Cohen-Kettenis, P. T. (2011). Puberty suppression in adolescents with gender identity disorder: A Prospective Follow-Up Study. *Journal of Sexual Medicine*, *8*(8), 2276–2283.

Di Ceglie, D. (2009). Engaging young people with atypical gender identity development in therapeutic work: A developmental approach. *Journal of Child Psychotherapy*, *35*, 3–12.

Di Ceglie, D., Freedman, D., McPherson, S., & Richardson, P. (2002). Children and adolescents referred to a specialist gender identity development service: Clinical features and demographic characteristics. *International Journal of Transgenderism*. Retrieved from www.symposion.com/ijt/ijtvo06no01_01.htm

Di Ceglie, D., Sturge, C., & Sutton, A. (1998). The Royal College of Psychiatrists: Gender identity disorders in children and adolescents: Guidance for management. *International Journal of Transgenderism*, *2*(2).

Drummond, K. D., Bradley, S. J., Peterson-Badali, M., & Zucker, K. J. (2008). A follow-up study of girls with gender identity disorder. *Developmental Psychology*, *44*, 34–45.

Garcia-Falgueras, A., & Swaab, D. F. (2008). A sex difference in the hypothalamic uncinate nucleus: relationship to gender identity. *Brain*, *131*(Pt. 12), 3132–3146.

Gizewski, E. R., Krause, E., Schlamann, M., Happich, F., Ladd, M. E., Forsting, M., et al. (2009). Specific cerebral activation due to visual erotic stimuli in male-to-female transsexuals compared with male and female controls: an fMRI study. *Journal of Sexual Medicine*, *6*, 440–448.

Gomez-Gil, E., Vidal-Hagemeijer, A., & Salamero, M. (2008). MMPI-2 characteristics of transsexuals requesting sex reassignment: comparison of patients in prehormonal and presurgical phases. *Journal of Personality Assessment*, *90*, 368–374.

Haraldsen, I. R., & Dahl, A. A. (2000). Symptom profiles of gender dysphoric patients of transsexual type compared to patients with personality disorders and healthy adults. *Acta Psychiatrica Scandinavica*, *102*, 276–281.

Hembree, W. C., Cohen-Kettenis, P., Delemarre-van de Waal, H. A., Gooren, L. J., Meyer, W. J., III, Spack, N. P., et al.. (2009). Endocrine treatment of transsexual

persons: an Endocrine Society clinical practice guideline. *Journal of Clinical Endocrinology and Metabolism*, *94*, 3132–3154.

Hepp, U., Kraemer, B., Schnyder, U., Miller, N., & Delsignore, A. (2005). Psychiatric comorbidity in gender identity disorder. *Journal of Psychosomatic Research*, *58*, 259–261.

Korte, A., Lehmkuhl, U., Goecker, D., Beier, K. M., Krude, H., & Gruters-Kieslich, A. (2008). Gender identity disorders in childhood and adolescence: currently debated concepts and treatment strategies. *Deutsches Aerzteblatt International*, *105*(48), 834–841.

Kreukels, B. P., & Cohen-Kettenis, P. T. (2011). Puberty suppression in gender identity disorder: The Amsterdam experience. *Nature Reviews Endocrinology*, *7*(8), 466–472.

Kruijver, F. P., Zhou, J. N., Pool, C. W., Hofman, M. A., Gooren, L. J., & Swaab, D. F. (2000). Male-to-female transsexuals have female neuron numbers in a limbic nucleus. *Journal of Clinical Endocrinology and Metabolism*, *85*, 2034–2041.

Lothstein, L. M. (1984). Psychological testing with transsexuals: a 30-year review. *Journal of Personality Assessment*, *48*, 500–507.

Luders, E., Sanchez, F. J., Gaser, C., Toga, A. W., Narr, K. L., Hamilton, L. S., et al. (2009). Regional gray matter variation in male-to-female transsexualism. *Neuroimage*, *46*, 904–907.

Maccoby, E. E. (1998). *The two sexes: Growing up apart, coming together. Family and public policy*. Cambridge, MA: Belknap Press/Harvard University Press.

Meyenburg, B. (1999). Gender identity disorder in adolescence: outcomes of psychotherapy. *Adolescence*, *34*(134), 305–313.

Meyer-Bahlburg, H. F. (2010). From mental disorder to iatrogenic hypogonadism: dilemmas in conceptualizing gender identity variants as psychiatric conditions. *Archives of Sexual Behavior*, *39*, 461–476.

Meyer-Bahlburg, H. F. L. (2002). Gender identity disorder in young boys: A parent- and peer-based treatment protocol. *Clinical Child Psychology and Psychiatry*, *7*, 360–376.

Murad, M. H., Elamin, M. B., Garcia, M. Z., Mullan, R. J., Murad, A., Erwin, P. J., et al. (2010). Hormonal therapy and sex reassignment: A systematic review and meta-analysis of quality of life and psychosocial outcomes. *Clinical Endocrinology*, *72*(2), 214–231.

Mul, D., & Hughes, I. A. (2008). The use of GnRH agonists in precocious puberty. *European Journal of Endocrinology/European Federation of Endocrine Societies*, *159*(Suppl. 1), 3–8.

Ross, M. W., & Need, J. A. (1989). Effects of adequacy of gender reassignment surgery on psychological adjustment: a follow-up of fourteen male-to-female patients. *Archives of Sexual Behavior*, *18*, 145–153.

Ruble, D. N., Martin, C. L., & Berenbaum, S. A. (2006). Gender development. In N. Eisenberg, W. Damon & R. M. Lerner (Eds.), *Handbook of child psychology: Vol. 3, Social, emotional, and personality development* (6th ed., pp. 858–932). Hoboken, NJ: Wiley.

Schagen, S. E. E., Cohen-Kettenis, P. T., van Coeverden-van den Heijkant, S. C. C. M., Knol, D. L., Gooren, L. J., & Delemarre-van de Waal, H. A. (in press). Bone mass development in transsexual adolescents receiving treatment with

gonadotropin-releasing hormone analogues in combination with cross-sex hormones to induce cross-sex puberty. *Journal of Clinical Endocrinology and Metabolism*.

Schoning, S., Engelien, A., Bauer, C., Kugel, H., Kersting, A., Roestel, C., et al. (2010) Neuroimaging differences in spatial cognition between men and male-to-female transsexuals before and during hormone therapy. *Journal of Sexual Medicine*, *7*, 1858–1867.

Shaffer, D., Gould, M. S., Brasic, J., Ambrosini, P., Fisher, P., Bird, H., et al. (1983). A children's global assessment scale (CGAS). *Archives of General Psychiatry*, *40*, 1228–1231.

Smith, Y. L., van Goozen, S. H., & Cohen-Kettenis, P. T. (2001). Adolescents with gender identity disorder who were accepted or rejected for sex reassignment surgery: a prospective follow-up study. *Journal of the American Academy of Child and Adolescent Psychiatry*, *40*, 472–481.

Smith, Y. L., van Goozen, S. H., Kuiper, A. J., & Cohen-Kettenis, P. T. (2005). Sex reassignment: outcomes and predictors of treatment for adolescent and adult transsexuals. *Psychological Medicine*, *35*, 89–99.

Steensma, T. D., Biemond, R., de Boer, F., & Cohen-Kettenis, P. T. (2011). Desisting and persisting gender dysphoria after childhood: A qualitative follow-up study. *Clinical Child Psychology and Psychiatry*, *16*(4), 499–516.

Steensma, T. D., & Cohen-Kettenis, P. T. (2011). Gender transitioning before puberty? *Archives of Sexual Behavior*, *40*(4), 649–650.

Steensma, T. D., van der Ende, J., Verhulst, F. C., & Cohen-Kettenis, P. T. (in press). Childhood gender variance and adult sexual orientation: A 24-year prospective study. *Journal of Sexual Medicine*.

van Beijsterveldt, C. E., Hudziak, J. J., & Boomsma, D. I. (2006). Genetic and environmental influences on cross-gender behavior and relation to behavior problems: a study of Dutch twins at ages 7 and 10 years. *Archives of Sexual Behavior*, *35*, 647–658.

Vance, S. R., Jr,, Schagen, S. E. E., Gooren, L. J., Wouters, F. M., Knol, D. L., Cohen-Kettenis, P. T., et al. (in press). Insulin sensitivity in adolescents with gender identity disorder during puberty suppression with GnRH analogues.

Viner, R. M., Brain, C., Carmichael, P., & Di Ceglie, D. (2005). Sex on the brain: dillemmas in the endocrine management of children and adolescents with gender identity disorder. *Archives of Disease in Childhood*, *90* (Suppl. 2), A78.

Wallien, M. S. (2008). *Gender dysphoria in children; Causes and consequences*. PhD Dissertation. VU University, Amsterdam.

Wallien, M. S., & Cohen-Kettenis, P. T. (2008). Psychosexual outcome of gender-dysphoric children. *Journal of the American Academy of Child and Adolescent Psychiatry*, *47*, 1413–1423.

Wallien, M. S., Swaab, H., & Cohen-Kettenis, P. T. (2007). Psychiatric comorbidity among children with gender identity disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*, *46*, 1307–1314.

Wallien, M. S., van Goozen, S. H., & Cohen-Kettenis, P. T. (2007). Physiological correlates of anxiety in children with gender identity disorder. *European Child and Adolescent Psychiatry*, *16*, 309–315.

Wallien, M. S., Veenstra, R., Kreukels, B. P., & Cohen-Kettenis, P. T. (2010). Peer group status of gender dysphoric children: a sociometric study. *Archives of Sexual Behavior*, *39*, 553–560.

World Professional Association of Transgender Health (WPATH). (2011). *Standards of care*. Seventh edition. Retrieved from http//www.wpath.org/

Yunger, J. L., Carver, P. R., & Perry, D. G. (2004). Does gender identity influence children's psychological well-being? *Developmental Psychology*, *40*, 572–582.

Zhou, J. N., Hofman, M. A., Gooren, L. J., & Swaab, D. F. (1995). A sex difference in the human brain and its relation to transsexuality. *Nature*, *378*(6552), 68–70.

Zucker, K. J. (2006). Gender Identity Disorder. In D. A. Wolfe & E. J. Mash (Eds.), *Behavioral and emotional disorders in adolescents: Nature, assessment, and treatment* (pp. 535–562). New York, NY: Guilford.

Zucker, K. J. (2010). The *DSM* diagnostic criteria for gender identity disorder in children. *Archives of Sexual Behavior*, *39*, 477–498.

Zucker, K. J., & Bradley, S. (1995). *Gender identity disorder and psychosexual problems in children and adolescents*. New York, NY: Guilford.

Zucker, K. J., Bradley, S. J., Ben-Dat, D. N., Ho, C., Johnson, L., & Owen, A. (2003). Psychopathology in the parents of boys with gender identity disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*, *42*, 2–4.

Zucker, K. J., Bradley, S. J., & Lowry Sullivan, C. B. (1996). Traits of separation anxiety in boys with gender identity disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*, *35*, 791–798.

Zucker, K., Bradley, S., Owen-Anderson, A., Singh, D., Blanchard, R., & Bain, J. (2010). Puberty-blocking hormonal therapy for adolescents with gender identity disorder: A descriptive clinical study. *Journal of Gay & Lesbian Mental Health*, *15*(1), 58–82.

Zucker, K. J., Owen, A., Bradley, S. J., & Ameeriar, L. (2002). Gender-dysphoric children and adolescents: A comparative analysis of demographic characteristics and behavioral problems. *Clinical Child Psychology and Psychiatry*. 7, 398–411.

Psychosexual Outcome of Gender-Dysphoric Children

MADELEINE S.C. WALLIEN, PH.D., AND PEGGY T. COHEN-KETTENIS, PH.D.

ABSTRACT

Objective: To establish the psychosexual outcome of gender-dysphoric children at 16 years or older and to examine childhood characteristics related to psychosexual outcome. **Method:** We studied 77 children who had been referred in childhood to our clinic because of gender dysphoria (59 boys, 18 girls; mean age 8.4 years, age range 5–12 years). In childhood, we measured the children's cross-gender identification and discomfort with their own sex and gender roles. At follow-up 10.4 ± 3.4 years later, 54 children (mean age 18.9 years, age range 16–28 years) agreed to participate. In this group, we assessed gender dysphoria and sexual orientation. **Results:** At follow-up, 30% of the 77 participants (19 boys and 4 girls) did not respond to our recruiting letter or were not traceable; 27% (12 boys and 9 girls) were still gender dysphoric (persistence group), and 43% (desistance group: 28 boys and 5 girls) were no longer gender dysphoric. Both boys and girls in the persistence group were more extremely cross-gendered in behavior and feelings and were more likely to fulfill gender identity disorder (GID) criteria in childhood than the children in the other two groups. At follow-up, nearly all male and female participants in the persistence group reported having a homosexual or bisexual sexual orientation. In the desistance group, all of the girls and half of the boys reported having a heterosexual orientation. The other half of the boys in the desistance group had a homosexual or bisexual sexual orientation. **Conclusions:** Most children with gender dysphoria will not remain gender dysphoric after puberty. Children with persistent GID are characterized by more extreme gender dysphoria in childhood than children with desisting gender dysphoria. With regard to sexual orientation, the most likely outcome of childhood GID is homosexuality or bisexuality. *J. Am. Acad. Child and Adolesc. Psychiatry,* 2008;47(12):1413–1423. **Key Words:** gender identity disorder, gender dysphoria, pubertal outcome, psychosexual differentiation, sexual orientation.

Children diagnosed with gender identity disorder (GID) have a strong cross-gender identification and a persistent discomfort with their biological sex or gender role associated with that sex (gender dysphoria). Initial studies have shown that most children with GID will no longer be gender dysphoric later in life.[1–7] However, a few more recent articles[8,9] indicated that the psychosexual differentiation of children with GID is more variable than what the early studies suggested and that, in a substantial proportion of the children (20%), the gender-dysphoric feelings persist into adolescence.

With *DSM-V* on the horizon, an important diagnostic issue concerns the relation between childhood and adolescent/adult GID. Some critics have expressed concerns that the *DSM*[10,11] criteria do not adequately differentiate the children with "true" (and probably persistent) GID from those who show merely gender-nonconforming behavior[12] and that, as a consequence, children who should not be classified as having a psychiatric disorder would be treated with various psychological interventions. Clinically, it is also important to be able to discriminate between persisters and desisters before the start of puberty. If one was certain that a child belongs to the persisting group, interventions with gonadotropin-releasing hormone (GnRH) analogs to delay puberty could even start before puberty

Accepted June 23, 2008.

Dr. Wallien is with the Department of Medical Psychology and Institute for Clinical and Experimental Neurosciences, Graduate School of Neurosciences, VU University Medical Center. Dr. Cohen-Kettenis is a clinical psychologist and the head of the Department of Medical Psychology, VU University Medical Center.

This article is the subject of an editorial by Dr. Kenneth Zucker in this issue.

Correspondence to Dr. Madeleine S.C. Wallien, VU University Medical Center, Department of Medical Psychology, PO Box 7057, 1007 MB Amsterdam, The Netherlands; e-mail: m.wallien@vumc.nl/ pt.cohen-kettenis@vumc.nl.

Supplemental digital content is available for this article. Direct URL citations appear in the printed text and are provided in the HTML and PDF versions of this article on the *Journal's* Web site *(www.jaacap.com).*

DOI: 10.1097/CHI.0b013e31818956b9

rather than after the first pubertal stages, as now often happens.[13] The possibility of identifying the persisters in childhood would also be helpful, if treatments would be available to prevent the intensive and drastic hormonal and surgical treatments these children face in adolescence or adulthood.

Another issue regarding the psychosexual outcome of children with GID is the relation between the child's gender atypicality and sexual orientation in adulthood. Early prospective follow-up studies indicated that a high rate (60%–100%) of children (mostly boys) with gender dysphoria had a homosexual or bisexual sexual orientation in adolescence or adulthood and no longer experienced gender-dysphoric feelings.[1–8] In a prospective follow-up study by Green,[3] sexual orientation and gender identity in adulthood were assessed in 44 feminine boys and 30 control boys. Of these 44 feminine boys, only one youth was gender dysphoric at the age of 18, whereas none of the control boys reported gender dysphoria at follow-up. Sexual orientation in fantasy and behavior was assessed by means of a semi-structured interview. Green found that, on the behavior dimension, 80% of the feminine boys were either homosexual or bisexual, and, on the fantasy dimension, 75% of the feminine boys had a homosexual or a bisexual sexual orientation at follow-up. Among the control boys, the ratings were 4% for behavior and 0% for fantasy. Green and colleagues[14] also found that sexual orientation was associated with childhood doll play and female role playing. The results of Green and others[1–7] are in accordance with retrospective studies among adult homosexuals, who recalled more childhood cross-gender behavior than heterosexuals.[15]

The earlier follow-up studies[1–9] indicated that the percentages of gender-dysphoric boys and girls who had a later bisexual/homosexual orientation were much higher than the base rates of bisexuality or homosexuality in general surveys and in epidemiological studies of adolescents and young adults. The reported percentages are lower in the study by Zucker and Bradley[8] on (mostly) gender-dysphoric boys (31% of the 41 participants who had sexual fantasies had either a bisexual or homosexual sexual orientation in fantasy; for 58%, no data on sexual behavior were available) and in a study by Drummond et al.[16] among 25 gender-dysphoric girls (32% of the girls reported having bisexual or homosexual fantasies; there were no data on sexual behavior for 32% of the girls), but in both studies, the proportion of participants with a homosexual and bisexual sexual orientation was still substantially higher than the base rates in the general population.

Because a gender-dysphoric outcome was not common in the above studies, the studies[1–9] focused more on the sexual orientation outcome of the gender-dysphoric children than on the relation between childhood gender dysphoria and later GID. Therefore, these reports do not give information on whether participants with distinct gender identity outcomes differ from each other in childhood. It has been argued that there is plasticity in gender identity differentiation that occurs in early development and narrows considerably by adolescence,[16] but the precise factor or set of factors influencing psychosexual development is still unknown. It is likely that only the children with extreme gender dysphoria are future sex reassignment applicants, whereas the children with less persistent and intense gender dysphoria are future homosexuals or heterosexuals without GID. However, none of the follow-up studies have as yet provided evidence for this supposition.

In this study, we first assessed the psychosexual outcome of gender-dysphoric boys and girls in terms of gender identity and sexual orientation. Second, we investigated which childhood measures of gender behavior and feelings were related to GID persistence or desistance. Based on our clinical experience, we expected the more extreme gender-dysphoric children to be persisters.

METHOD

Participants

Between 1989 and 2005, 200 children (144 boys and 56 girls) were referred to the Gender Identity Clinic of the Department of Child and Adolescent Psychiatry at the University Medical Center Utrecht (which moved to the Department of Medical Psychology of the VU University Medical Center in Amsterdam in 2002). To be included in the follow-up study, participants had to be at least 16 years of age. Using this cutoff, we identified 77 children (59 boys and 18 girls, who were between 5 and 12 years of age at first assessment). All 77 children were contacted for participation.

Table 1 provides participant characteristics at childhood assessment (T_0) and follow-up assessment (T_1). At T_0, 75% of the 77 potential participants who were contacted had met complete diagnostic criteria for GID, according to the *DSM-III-R*,[20] whereas 25% were subthreshold for the diagnosis (GID not otherwise specified [NOS]).[20]

At T_1, 23 of the 77 potential participants (30%; 19 boys and 4 girls) did not respond or were not traceable (nonresponder group); the other 54 (40 boys and 14 girls) were included in our study.

TABLE 1

Demographic Characteristics, IQ, and *DSM* Diagnosis of GID at T_0 and T_1

	All (*N* = 77)		Persistence (*n* = 21)		Desistance (*n* = 23)		Parent (*n* = 10)		Nonresponders (*n* = 23)	
Variables	Boys (*n* = 59)	Girls (*n* = 18)	Boys (*n* = 12)	Girls (*n* = 9)	Boys (*n* = 19)	Girls (*n* = 4)	Boys (*n* = 9)	Girls (*n* = 1)	Boys (*n* = 19)	Girls (*n* = 4)
Age at childhood assessment										
Mean	8.3	8.6	8.6	8.8	8.7	8.3	8.1	9	7.9	8.5
SD	2.0	1.5	1.4	1.8	2.4	1.9	2.3	0	1.8	1.8
Range	5–12	6–11	6–11	6–11	5–12	7–11	5–12	0	5–11	7–9
Age at follow-up assessment										
Mean	19.4	18.7	19.1	17.8	19.8	18.3	17.8	25	19.8	19.8
SD	3.4	2.7	2.9	2.5	3.3	1.3	1.4	0	4.3	2.2
Range	16–28	16–25	16–24	16–24	16–28	17–2	16–20	0	16–24	17–22
Interval, y[a]										
Mean	10.4	10.1	10.5	9.0	9.9	10.0	8.8	16	11.6	11.3
SD	3.4	3.8	3.7	4.3	3.2	4.3	3.1	0	3.4	2.8
Marital status[b]										
Two parents, *n*	42	11	9	8	15	2	7	0	11	1
Other family/institution, *n*	12	5	3	1	4	2	0	0	5	2
Total IQ[c]										
Mean	96.7	103.2	92.2	101	101.8	107.3	99.3	122	92.5	91.7
SD	16.1	23.4	14.2	20.2	13.4	31.4	20.3	0	17.1	28.0
Range	67–131	61–129	67–114	74–128	79–129	61–129	70–131	0	68–129	74–124
Nationality										
Dutch, *n*	50	16	10	8	15	4	9	1	16	3
Other, *n*	9	2	2	1	4	0	0	0	3	1
Childhood GID diagnosis, *n*	44	14	12	9	12	3	5	1	15	1
Childhood GID NOS diagnosis, *n*	15	4	0	0	7	1	4	0	4	3

Note: GID = gender identity disorder; NOS = not otherwise specified.

[a] Interval denotes the time between childhood assessment and follow-up assessment.

[b] For marital status, we asked whether the children were living with two parents or had another family composition. For seven children, there were no data on marital status.

[c] IQ was assessed with Dutch versions of the Wechsler Preschool and Primary Scale of Intelligence[17] or the WISC.[18,19] For five boys and two girls, there were no IQ data.

Twenty-one participants (27%; 9 girls and 12 boys) were still gender dysphoric at follow-up (persistence group). All of these persisters had met the complete diagnostic criteria for GID according to the *DSM-IV*[10] or the *DSM-IV-TR*[11] at follow-up and had applied for sex reassignment at the Gender Identity Clinic before the age of 16. They had subsequently followed a standardized diagnostic protocol. This implies that information is obtained from the adolescents and their parents or caretakers on various aspects of their general and psychosexual development since the last contact with the clinic and on their current functioning. The procedure also includes a psychodiagnostic assessment, a child psychiatric evaluation (by a different clinician than the diagnostician), and often a family evaluation (for more information on the clinical procedure, see Reference 21). In this group, we found a significant sex difference ($\chi^2_1 = 5.129$, $p < .05$): 50% of the girls and 20% of the boys had persisting gender dysphoria (Table 1). Because of this significant sex difference, we analyzed our data separately by sex.

Twenty-three participants (30%; 19 boys, 4 girls) were visited at home because they had no longer been seen at the clinic after childhood (desistance group). Ten participants (13%) did not want to participate themselves, but they allowed their parents to fill out a questionnaire. This parent group consisted of 9 boys and 1 girl. Because there were no significant differences between the desistance group and the parent group for all background variables (marital status: $\chi^2_3 = 4.41$, $p > .05$); diagnoses in childhood ($\chi^2_1 = 0.676$, $p > .05$); nationality: ($\chi^2_4 = 2.56$, $p > .05$); full-scale IQ ($z = -0.27$, $p = .80$); and psychological functioning, as measured by the Child Behavior Checklist (CBCL; total *T* scores [$z = -0.88$, $p > .05$], internalizing *T* scores [$z = -0.84$, $p > .05$], or externalizing *T* scores [$z = -1.17$, $p > .05$]), the participants in the parent group were included in the desistance group. Therefore, the desistance group consisted of 33 participants (28 boys and 5 girls).

Table 1 shows the background data and age for the children at T_0 and for the four different groups at T_1. There were no data on marital status for 7 participants because three parents of adolescents (parent group) did not provide this information, and for four children from the nonresponder group, we had no childhood data on marital status. Furthermore, we had no total IQ scores for 5 boys and 2 girls because their intelligence had not been assessed in childhood. Three of these boys belonged to the nonresponder group, one boy to the persistence group, and one boy belonged to the desistance group. One of the two girls belonged to the persistence group, and the other to the desistance group. No significant age differences were found between the groups.

Because there were no differences between the nonresponder and the desistance group, or between the nonresponder and the parent group on all scales of the CBCL and on background variables, the desistance group seems to be representative of all subjects who did not seek sex reassignment after puberty.

Measures

Background Measures and DSM Diagnosis. Diagnoses and five background measures were obtained from the medical charts at childhood assessment: age at assessment, sex, parents' marital status, total IQ, and nationality. Information provided by the parents (clinical interviews on gender development and current gender role behavior, Gender Identity Questionnaire for Children [GIQC; for a description of the GIQC, see below]), the child (clinical interviews on current and past peer and play preferences, gender role behavior and identity status, Gender Identity Interview for Children [GIIC; for a description, see below], a standardized play observation, and the Draw-a-Person test), and teachers (by means of a self-developed teacher questionnaire and the Teacher's Report Form, a teacher version of the CBCL[22]), during a standardized clinical assessment procedure, was used to determine whether a child met the *DSM* criteria for GID[10,11] (for a detailed description of the clinical procedure and instruments, see Reference 21). The diagnosis was made by either a clinical child psychologist or a child and adolescent psychiatrist. IQ was assessed with Dutch versions of the Wechsler Preschool and Primary Scales of Intelligence[17] or one of two versions of WISC.[18,19]

Gender Identity/Gender Dysphoria. Table 2 provides the study design. At T_0, a Dutch translation of the semistructured GIIC of Zucker et al.[23] was used. This child informant instrument consists of 12 items and measures two factors: affective gender confusion and cognitive gender confusion. Higher scores reflect more gender-atypical responses. Each question is scored on a three-point scale ranging from 0 to 2. A score of 0 is assigned if the child answers a factual question correctly (e.g., "Are you a boy or a girl?") or gives a putatively normal or stereotypic response (e.g., "no" to the question, "In your mind, do you ever think that you would like to be a [opposite sex]?"). A score of 1 is assigned if the child provides an ambiguous or intermediate response (e.g., "I don't know" to the question, "Do you think it is better to be a boy or a girl?"; "sometimes" to the question, "In your mind, do you ever think that you would like to be a [opposite sex]?"). A score of 2 is assigned to responses that are putatively atypical and without ambiguity (e.g., "yes" to the question, "In your mind, do you ever think that you would like to be a [opposite sex]?"). The GIIC strongly discriminated gender-referred children from controls, with a large effect size, using Cohen *d* of 1.72 for Canadian probands and of 2.98 for Dutch probands (M.S.C. Wallien, unpublished data, 2007).

At T_1, a Dutch translation of the semistructured Gender Identity Interview for Adolescents and Adults (GIIAA) was used.[24] This interview has 27 items measuring gender identity and gender

TABLE 2
Study Design

Time	Group	Age, y	Instruments	Variable
T_0	All ($N = 77$)	5–12	GIIC	Gender
			GIQC	Gender
			CBCL	Psychological functioning
T_1	Persistence group ($n = 21$)	16–24	UGS	Gender
			BIS	Body satisfaction
T_1	Desistance group ($n = 23$)	16–28	Sexual orientation questionnaire	Sexual orientation
			GIIAA	Gender
			UGS	Gender
			BIS	Body satisfaction
T_1	Parent group ($n = 10$)	16–25	Parent questionnaire	Gender and sexual orientation

Note: GIIC = Gender Identity Interview for Children; GIQC = Gender Identity Questionnaire for Children; CBCL = Child Behavior Checklist; UGS = Utrecht Gender Dysphoria Scale; BIS = Body Image Scale; GIIAA = Gender Identity Interview for Adolescents and Adults.

dysphoria in adolescents and adults. Responses, rated on a five-point scale, are based on a time frame of the past 12 months. Lower scores reflect more gender-atypical responses. The GIIAA score is calculated by summing scores on the completed items and dividing by the number of marked responses. Deogracias et al.[24] reported a Cronbach α of .97 and found that people with GID reported significantly more gender dysphoria than both heterosexual and nonheterosexual non–gender-dysphoric individuals, indicating good discriminant validity. Using a cutoff score of 3.00, they found that the sensitivity was 90.4% for the gender-dysphoric group and the specificity was 99.7% for the controls.

Gender Identity Questionnaire for Children. The GIQC is a one-factor, 14-item parent-report questionnaire covering a range of sex-typed behaviors that correspond to various features of the core phenomenology of the GID diagnosis. Each item is rated on a five-point scale for frequency of occurrence, with lower scores reflecting more cross-gendered behavior.[25] A GIQC score is calculated by summing the 14 items and then dividing the sum by 14. Johnson et al.[25] reported that a one-factor solution best fit the data, accounting for 43% of the variance, and that 14 of the 16 items have factor loadings 0.30 or greater. The GIQC strongly discriminated gender-referred children from controls, with a large effect size, using Cohen *d* of 3.70. With a specificity set at 95% for the controls, the sensitivity for the probands was 86.8%.

Utrecht Gender Dysphoria Scale (UGS). The UGS measures the degree of gender dysphoria in adolescents or adults.[26] Reported Cronbach α's are .61 and .81 for male and female controls, .80 and .92 for males with gender dysphoria, and .78 and .80 for females with gender dysphoria. The scale showed good discriminant validity in a sample of individuals with and without GID and in gender-dysphoric individuals who were accepted and rejected for sex reassignment.[27] The scale consists of 12 items; scores range from 1 to 5, with higher scores reflecting more gender dysphoria.

Body Image Scale (BIS). The BIS,[28] used in a Dutch translation,[29] measures body satisfaction. On a five-point scale, one has to indicate satisfaction on 30 body parts and features (e.g., "neutral" body parts, such as hands or nose, and various primary and secondary sex characteristics). A score of 1 indicates the highest satisfaction regarding the specific body part; a score of 5 indicates the highest dissatisfaction.

Sexual Orientation. To assess sexual orientation, we used a questionnaire with nine items. The Sexual Orientation Questionnaire can be found in the supplemental digital content (online-only) materials at *http://links.lww.com/A569*. We assessed sexual orientation in four domains: sexual identity, sexual behavior (experience), sexual fantasy, and sexual attraction. In each of the domains, the questions were rated on a seven-point scale ranging from exclusively heterosexual (0) to exclusively homosexual (6).[30] Items 1 and 2 were used to rate sexual attraction, items 3 and 4 were used for the assessment of sexual fantasy, items 5 to 8 assessed sexual behavior, and item 9 pertained to sexual identity.

Psychological Functioning. To assess whether the desistance group was representative of all children who do not seek sex reassignment, and to check whether the parent group and desistance group were comparable with regard to psychological functioning, we used the Dutch translation of the CBCL.[31,32] This instrument measures behavioral and emotional problems. Parents (or other caregivers) have to rate the child/young adult using a three-point scale: 0 = not true, 1 = somewhat or sometimes true, and 2 = very true or often true. Depending on age group and sex, Cronbach α's for the internalizing, externalizing, and total score scales range from .78 to .93.

Psychosexual Outcome (Parent Report). This questionnaire consists of nine questions covering gender identity and sexual orientation of the participant, as observed by the parent. This instrument was used only if participants were not available for assessment at follow-up.

Procedure

Childhood Assessment (T_0). Childhood measures were collected as part of the child's clinical assessment at the Gender Identity Clinic. Four of the obtained measures were used: the CBCL, total IQ, the GIQC, and the GIIC. Background information was also collected during clinical assessment.

Follow-up (T_1). All children in the persistence group had applied for sex reassignment at the Gender Identity Clinic before the age of 16 and had followed the clinic's standardized diagnostic procedure.[21] The assessment of the persisters took place during this procedure. All had subsequently been treated with GnRH analogs to suppress puberty and with cross-sex hormones after the age of 16 years. At our clinic, GnRH analogs are used as an aide in the diagnostic procedure (for a description of the eligibility criteria, see Reference 13).

The other adolescents received a letter in which the purpose of the study was explained. Although many participants were older than 18 years, we contacted the parents first and asked their permission to contact their child. We did so because the last clinical contact had been with them rather than with the child, and we did not want to approach their children without their consent. If the parents gave their permission, and the adolescent wanted to participate, we visited the participants at home. If the adolescent did not want to participate, we asked if they would allow their parents to fill out a questionnaire, the Parent Questionnaire on Psychosexual Outcome.

Two measures, UGS and BIS, were obtained from both the adolescents who were visited at home and the adolescents who were seen at the clinic because of their persistent gender dysphoria. In addition, the GIIAA and the sexual orientation questionnaire were administered to the participants who were seen at home. Information on sexual orientation of the participants who applied for sex reassignment was gathered during the clinical procedure. Questions were part of a semistructured clinical interview.

The ethical committees of the University Medical Center Utrecht and VU University Medical Center approved the study.

RESULTS

T_0: Childhood Gender Dysphoria

The percentages of *DSM* GID or GID NOS diagnoses were significantly different between the persistence and the desistance groups ($\chi^2_2 = 10.90$, $p = .004$) and between the persistence and the nonresponder groups ($\chi^2_1 = 7.6$, $p = .006$). All participants in the persistence group were given a diagnosis of GID. This was not the case in the other two groups (Table 1). When all nonpersisting groups were taken together, 69% had a GID diagnosis.

For the boys, the percentages of *DSM* GID or GID NOS diagnoses were also significantly different between the persistence and the desistance groups ($\chi^2_2 = 6.50$, $p = .011$). There were no significant differences between

TABLE 3
Mean Scores on the Gender Identity Interview for Children and the Gender Identity Questionnaire at T_0

	Persistence, Mean (SD)		Desistance, Mean (SD)		Nonresponders, Mean (SD)		Desistance-Persistence, *p*		Desistance-Nonresponders, *p*		Nonresponders-Persistence, *p*	
Scale	Boys (*n* = 12)	Girls (*n* = 9)	Boys (*n* = 19)	Girls (*n* = 4)	Boys (*n* = 19)	Girls (*n* = 4)	Boys	Girls	Boys	Girls	Boys	Girls
GIIC	*n* = 9	*n* = 8	*n* = 19	*n* = 3	*n* = 18	*n* = 3	.02	NS	NS	NS	NS	.02
	11.6 (4.6)	12.9 (1.8)	7.2 (4.7)	11.3 (5.5)	9.3 (5.4)	6.7 (4.5)						
GIQC	*n* = 11	*n* = 7	*n* = 19	*n* = 4	*n* = 16	*n* = 3	.008	NS	NS	NS	0.02	.03
	2.1 (0.4)	2.2 (0.6)	2.6 (0.6)	2.9 (0.4)	2.6 (0.7)	3.2 (0.4)						

Note: GIIC = Gender Identity Interview for Children; GIQC = Gender Identity Questionnaire for Children; NS = not statistically significant.

the desistance and the nonresponder groups, or between the persistence and the nonresponder groups. Among the girls, the percentages of *DSM* diagnoses of GID or GID NOS were significantly different between the persisting and the nonresponding girls ($\chi^2_1 = 8.775$, $p = .003$), but not between the persisting and desisting girls (Table 1).

With regard to the scores on the GIIC and GIQC, persisters generally showed more cross-gender behavior than the other groups. The persistence group had a significantly higher mean GIIC score (mean 12.2) than the desistance group (mean 7.6; $z = -2.35$, $p = .02$) and the nonresponder group (mean 8.9; $z = -2.01$, $p = .04$). This indicates more cross-gender identification in the total persistence group than in the desistance group (Table 3). The persisters had a significantly lower mean GIQC score than the desisters ($z = -2.782$, $p = .005$) and the nonresponders ($z = -2.82$, $p = .005$), again reflecting more cross-gender identification in childhood in the persistence group than in the desistance and the nonresponder groups.

Among the boys, the scores on both the GIIC and the GIQC indicated that the persisting subgroup had a more cross-gender identification and that the persisters showed a more cross-gender behavior in childhood than the desisting boys. Among the girls, the scores on both the GIIC and the GIQC indicated that the persisting girls had a more cross-gender identification and showed more cross-gender behavior than the nonresponding girls but not the desisting girls (Table 3).

T_1: Gender Dysphoria

At T_1, all participants in the persistence group had been given a *DSM* diagnosis of GID. The desistance group did not have a second clinical assessment, but their mean GIIAA scores (1.1) and their UGS scores indicated that they no longer had gender-dysphoric

TABLE 4
Mean Scores on the Gender Identity Interview for Adolescents and Adults and on the Utrecht Gender Dysphoria Scale and the Body Image Scale at T_1

	Persistence			Desistance			Persistence-Desistance, *p*		
Scale	All	Boys	Girls	All	Boys	Girls	All	Boys	Girls
GIIAA					*n* = 17	*n* = 3			
Divided score, mean (SD)					1.2 (0.2)	1.1 (0.2)			
Total score, mean (SD)					31.8 (4.8)	30.1 (6.4)			
UGS	*n* = 12	*n = 5*	*n = 7*	*n* = 1	*n = 19*	*n = 2*			
Total score, mean (SD)	53.5 (7.4)	*50.6 (10.6)*	55.6 (3.8)	13.6 (3.0)	13.6 (3.1)	13.0 (1.4)	.001	.001	.004
BIS	*n* = 16	*n* = 9	*n* = 7	*n* = 17	*n* = 14	*n* = 3			
Total score, mean (SD)	3.1 (0.4)	3.1 (0.4)	3.1 (0.5)	2.5 (0.5)	2.4 (0.3)	2.5 (1.0)	.001	.001	NS

Note: Desistance group consists of children who had not applied for sex reassignment when approached by us at 16 years or older. Persistence group consists of children who were still gender dysphoric at 16 years or older. Values are cited in italics. GIIAA = Gender Identity Interview for Adolescents and Adults; UGS = Utrecht Gender Dysphoria Scale; BIS = Body Image Scale; NS = not statistically significant.

feelings at follow-up (Table 4). With regard to the UGS, it was found that the persistence group had significantly more gender dysphoria than the desistance group ($z = -4.81$, $p = .001$; Table 4). This was also found when separately analyzed for boys and girls (boys: $z = -3.51$, $p = .001$; girls: $z = -2.06$, $p = .004$).

As expected, the persistence group also reported significantly more body dissatisfaction on the BIS ($z = -3.62$, $p = .001$; Table 4) than the participants in the desistance group. The desistance group reported, on average, dissatisfaction with four body parts, and the participants in the persistence group reported, on average, dissatisfaction with nine body parts. Most participants in the persistence group were dissatisfied with their primary and secondary sex characteristics and height. Most of the subjects in the desistance group were dissatisfied with "sex neutral" body characteristics such as nose, shoulders, or feet, and they were satisfied with their primary sex characteristics. Analyzed separately for the sexes, the persisting boys reported more body dissatisfaction than the desisting boys ($z = -3.5$, $p = .001$), whereas this was not found for the girls.

T_1: Sexual Orientation

Table 5 shows the data on sexual orientation at follow-up. Participants were classified in the following way, according to their scores on sexual fantasy, sexual attraction, and sexual behavior: heterosexual (Kinsey rating 0–1), bisexual (Kinsey rating 2–4), and homosexual (Kinsey rating 5–6).[30] The participants also rated their sexual identity as heterosexual, bisexual, or homosexual. In the parent group, only the parents' ideas about their children's sexual attraction feelings could be asked for. We therefore have more participants who are rated on the sexual attraction dimension than on the other sexual orientation dimensions.

On the sexual attraction dimension, about half of the boys ($n = 25$) in the desistance group were attracted to men ($n = 14$), and the others ($n = 11$) were attracted to women. Almost all natal boys in the persistence group ($n = 11$) were attracted to men; only one natal boy reported to be attracted to women. All persisting girls were attracted to women, and all desisting girls were attracted to men.

On the sexual identity dimension, half of the boys in the desistance group reported having a homosexual identity, three boys reported a bisexual identity, and one-third reported a heterosexual identity. All desisting girls reported having a heterosexual identity. Because we classified sexual orientation in relation to birth sex, all natal boys and almost all natal girls in the persistence group reported a homosexual identity. Only one natal girl in the persistence group classified herself as bisexual, although she reported that she was attracted to girls.

TABLE 5
Percentage Participants Who Rated Themselves on Three Dimensions of Sexual Orientation and on Sexual Identity

	Attraction		Behavior		Fantasy		Sexual Identity	
Group	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls
Desistance	$n = 25$	$n = 3$	$n = 13$	$n = 2$	$n = 16$	$n = 1$	$n = 18$	$n = 3$
Heterosexual	44	100	23	100	19	100	27	100
Bisexual	0	0	23	0	25	0	17	0
Homosexual	56	0	54	0	56	0	56	0
Persistence	$n = 12$	$n = 7$	$n = 6$	$n = 3$	$n = 5$	$n = 2$	$n = 9$	$n = 8$
Heterosexual	8	0	17	0	17	0	0	0
Bisexual	0	0	0	0	0	0	0	12
Homosexual	92	100	83	100	83	100	100	88
Combined group of gender-dysphoric children	$n = 37$	$n = 10$	$n = 19$	$n = 5$	$n = 21$	$n = 3$	$n = 27$	$n = 11$
Heterosexual	32	30	21	40	19	0	19	18
Bisexual	0	0	16	0	19	33	19	9
Homosexual	68	70	63	60	62	66	62	73
Normative study	$n = 1{,}628$	$n = 1{,}676$	$n = 1{,}618$	$n = 1{,}670$	$n = 1{,}624$	$n = 1{,}674$		
Heterosexual	96	98	94	83	91	76		
Homosexual	3	1	6	17	9	24		

Note: The percentages are in relation to birth sex. In the combined group, the percentages of children in the Persistence and the Desistance groups are combined. The normative data are from a study by de Graaf et al.[33]

We also compared our sexual orientation findings with prevalence estimates from a large Dutch study among 3,304 adolescents and young adults (age range 12–25 years).[33] Table 5 shows that, in all our groups, there were considerably more adolescents with a nonheterosexual sexual orientation than in the non-referred Dutch adolescents. In our study group, the overall odds of reporting same-sex or bisexual attraction was 2.1 (32 of the 47 children reported same-sex attraction, and 15 were attracted to the opposite sex: 32/15 = 2.1; for the natal males, it was 2.1; for the natal females, 2.3). This percentage would even be higher if one assumes that most nonresponders may also have a homosexual sexual orientation. Adult individuals with childhood gender dysphoria are thus much more likely to have a nonheterosexual sexual orientation than a heterosexual sexual orientation. In the normative study, the odds of same-sex or bisexual attraction was 0.02 (68 of the 3,268 children reported same-sex or bisexual attraction; for the males, it was 0.03; for the females, 0.04). This implies that it is about 100 times more likely that someone with childhood gender dysphoria is attracted to partners of the same sex or to both sexes than someone without a gender-dysphoric history.

Participants (both persisters and desisters) who were rated differently on the Kinsey dimensions did not differ in age at T_0 or at T_1. There was one significant difference between the GIQC score of the participants with same-sex or bisexual attraction and the participants with a heterosexual attraction ($z = -2.53$, $p = .01$). The participants with same-sex or bisexual attraction had a lower score (mean 2.26) than the participants with a heterosexual attraction (mean 2.78). This indicates more parent-reported gender atypicality in childhood in participants with same-sex or bisexual attraction than in participants with a heterosexual attraction. However, when we analyzed the GIQC scores of participants in the desistance group only, we found no significant differences between the participants with same-sex or bisexual attraction and the participants with heterosexual attraction. Therefore, the more extreme scores of the persisters were responsible for the total group difference on the GIQC.

DISCUSSION

This study investigated the psychosexual outcome among gender-dysphoric children and determined whether childhood characteristics gave an indication of later GID. We found that 27% of our total group of gender-dysphoric children was still gender dysphoric in adolescence. In the Netherlands, treatment is covered by insurance and easily available, but only in the Amsterdam clinic. It therefore seems unlikely that some nonresponders are, in fact, persisters, and that the observed persistence rate of 27% differs much from the actual persistence rate.

For boys, our percentage of persisting gender dysphoria was similar to what Zucker and Bradley[8] reported: one of five boys was still gender dysphoric in adolescence/young adulthood. For girls, we found a much higher percentage of persisters than was found in the only follow-up study on girls by Drummond et al.[16] In our study, 50% of the gender-dysphoric girls seemed to be persisters, whereas Drummond et al.[16] found that only 12% of gender-dysphoric girls seemed to have persistent gender dysphoria. Our higher rate of persisting girls could perhaps be explained by differences in childhood cross-gender behavior between the Canadian and Dutch referred children. Although no direct comparison between the girls in the Drummond et al.[16] study and our follow-up study could be made with respect to their scores on the GIIC, a study comparing 376 Canadian and 228 Dutch gender-referred children from both centers reported that the Dutch girls scored significantly higher on the GIIC than the Canadian girls (M.S.C. Wallien, unpublished data, 2007). However, the percentages of girls fulfilling the childhood GID criteria in the study of Drummond et al. (64%) and our study (77%) were not significantly different. In another study, it was found that Dutch children are, on average, referred for gender problems at an older age than Canadian children.[34] It may thus be that a combination of a relatively late age at referral and severity of gender-dysphoria accounts for the differences between the rates of female persisters in the two studies. Because these are reports from only two studies with relatively small numbers of female participants, it is, of course, possible that the percentages of females with persisting gender dysphoria will change when larger samples are studied.

We also found that both boys and girls with more extreme gender dysphoria were more likely to develop adolescent/adult GID, whereas children with less extreme gender dysphoria seemed to have overcome their gender dysphoria. For example, all participants in

the persistence group were given a complete GID diagnosis in childhood, whereas half of the group of desisting children was subthreshold for the diagnosis (Table 1). The diagnoses were partly based on a number of parent and child measures (GIIC and GIQC scores), and scores on these instruments also fairly consistently indicated that the persisters showed more childhood gender atypicality than the desisters. Comparing the scores separately for the sexes, similar results were found, although not all comparisons were significant. However, this may have been due to the sometimes small numbers in the various subgroups. Taking all results together, it seems that certain childhood gender identity and gender role measures may give an indication of gender dysphoria persistence after puberty. Clinicians should therefore take child and parent reports of cross-gender identification and behavior seriously, to address them in a timely manner when the subjects enter adolescence. It is conceivable that, in the future, persisting children will be identified and treated with GnRH analogs, even before the actual beginning of puberty. However, at the moment, their reaction to the first physical signs of puberty is still used diagnostically. Clearly, many more studies are needed before one can make any evidence-based recommendations about hormonal interventions in prepubertal children.

With regard to sexual orientation, almost all persisters seemed to be attracted to someone of the same biological sex at follow-up, whereas in the desistance group, this was found for only about half of the participants. In total (persistence and desistance groups together), two-thirds of the participants reported having a same-sex or bisexual attraction. This high percentage of nonheterosexuality is similar to what has been reported in other follow-up studies.[1–8] Compared with sexual orientation rates from a Dutch normative study, both our boys and girls were far more likely to have a bisexual or homosexual sexual orientation. Childhood gender dysphoria thus seems to be associated with a high rate of later same-sex or bisexual sexual orientation. In clinical practice, gender-dysphoric children and their parents should be made aware of such an outcome and, if this would create problems, be adequately counseled.

Because almost all persisters reported having same-sex sexual attractions, there were no sex differences in this group. However, in the desistance group, half of the boys reported a homosexual or bisexual sexual orientation, whereas none of the desisting girls did. In contrast to our findings, Drummond et al.[16] found much higher rates of desisting girls with either a homosexual or bisexual sexual orientation. Their rates for either a homosexual or bisexual sexual orientation in fantasy and behavior were 30% (6 of 20) and 26% (4 of 15). This difference can probably be attributed to the fact that our sample size of desisting girls was small (n = 3) and that two of our desisting girls (16 years of age) mentioned that they were still questioning their sexuality. If one of the two would, at an older age, seem to be homosexual, the numbers would be much more comparable. All of the desisting homosexual/bisexual girls in the study of Drummond et al.[16] were older than 23. Thus, it is possible that these girls were more "crystallized" with respect to their sexual identities. A study by Diamond[35] showed that it is not uncommon for nonheterosexual adolescent girls to change their sexual orientation over time. In her 2-year follow-up study of 80 lesbian, bisexual, and "unlabeled" women, first interviewed at 16 to 23 years of age, half of the women seemed to change their sexual identities more than once, and one-third changed their sexual identity since the first interview. Changes in sexual attraction were small but were larger among bisexuals and "unlabeled" females. Considering this, it is possible that the apparent differences between our results and those of Drummond et al.[16] are, in fact, nonexistent.

Research on the sexual identity development of lesbian, gay, and bisexual youths has shown that the sexual orientation, especially for bisexual youths, may change over time.[36,37] Our results on sexual orientation also suggest that some male participants were still in an experimentation phase, as the percentage of participants reporting a heterosexual or bisexual orientation differs between the three dimensions of sexual orientation. Furthermore, social desirability is a key validity issue in the assessment of sexual orientation during the adolescent years. One limitation of this study is that we did not measure the participants' propensity to give socially desirable responses, because we did not want to lose cooperation by making the follow-up session unnecessarily long and tedious. Therefore, it is possible that some of our "heterosexual" adolescents were, in fact, attracted to people of the same sex. Even if this were not true, the prevalence rates of same-sex attraction in our study are still substantially higher than in the general population.

Carver et al.[38] assumed that gender atypicality may precede the development of a homosexual identity as such. Drummond et al.[16] indeed found that the participants with a bisexual or homosexual orientation recalled more cross-gender behavior during childhood than the participants with a heterosexual or asexual sexual orientation. Although our persisting and desisting participants taken together with a homosexual or bisexual sexual orientation were more cross-gendered in childhood than the participants with a heterosexual sexual orientation, we did not find any significant differences on the childhood measurements between the desisting participants with different sexual orientation outcomes. It is, however, possible that our results did not reach statistical significance because of the small sample sizes. Conversely, in retrospective reports, there is always a risk of memory distortion. It is clear that long-term prospective follow-up studies, in which gender nonconformity is measured in large normative samples of young children, and psychosexual outcome in adolescence or adulthood, are needed to gain more insight in the relationship between childhood gender nonconformity and sexual orientation.

In response to our question at what point in time the desisting participants noticed that their cross-gender preferences and feelings had decreased or disappeared, most answered that the change took place upon entry into secondary school. Only few answered that it took place during the first stages of puberty. It is understandable that an intensification or moderation of the gender dysphoria is closely related to the development of the physical markers of maleness and femaleness. Why most participants reported entrance into secondary school as a "turning point" is less clear. It may be that secondary school entrance is better remembered than the start of puberty because puberty concerns a more gradual transition. More systematic follow-up every few years, especially around critical developmental time points (i.e., school entry, pubescent milestones such as menarche or first ejaculation), is needed to know better exactly when and how GID persistence or desistance takes place.[39]

Disclosure: The authors report no conflicts of interest.

REFERENCES

1. Bakwin H. Deviant gender-role behavior in children: relation to homosexuality. *Pediatrics*. 1968;41:620–629.
2. Davenport CW. A follow-up study of 10 feminine boys. *Arch Sex Behav*. 1986;15:511–517.
3. Green R. *The "Sissy Boy Syndrome" and the Development of Homosexuality*. New Haven, CT: Yale University Press; 1987.
4. Kosky RJ. Gender-disordered children: does inpatient treatment help? *Med J Aust*. 1987;146:565–569.
5. Lebovitz PS. Feminine behavior in boys: aspects of its outcome. *Am J Psychiatry*. 1972;128:1283–1289.
6. Money J, Russo AJ. Homosexual outcome of discordant gender identity/role in childhood: longitudinal follow-up. *J Pediatr Psychol*. 1979;4:29–41.
7. Zuger B. Early effeminate behavior in boys: outcome and significance for homosexuality. *J Nerv Ment Dis*. 1984;172:90–97.
8. Zucker KJ, Bradley SJ. *Gender Identity Disorder and Psychosexual Problems in Children and Adolescents*. New York: Guilford Press; 1995.
9. Cohen-Kettenis PT. Letter to the editor: gender identity disorder in the *DSM*? *J Am Acad Child Adolesc Psychiatry*. 2001;40:391.
10. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, 4th ed*. Washington, DC: American Psychiatric Association; 1994.
11. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, 4th ed, Revised Text*. Washington, DC: American Psychiatric Association; 2001.
12. Hill DB, Rozanski C, Carfagnini J, et al. Gender identity disorders in childhood and adolescence: a critical inquiry. *Int J Sex Health*. 2007;19:57–75.
13. Delemarre-van de Waal HA, Cohen-Kettenis PT. Clinical management of gender identity disorder in adolescents: a protocol on psychological and pediatric endocrinology aspects. *Eur J Endocrinol*. 2006;155:S131–S137.
14. Green R, Roberts CW, Williams K, Goodman M, Mixon A. Specific cross-gender behaviour in boyhood and later homosexual orientation. *Br J Psychiatry*. 1987;15:84–88.
15. Bailey JM, Zucker KJ. Childhood sex-typed behavior and sexual orientation: a conceptual analysis and quantitative review. *Dev Psychol*. 1995;31:43–55.
16. Drummond KD, Bradley SJ, Peterson-Badali M, Zucker KJ. A follow-up study of girls with gender identity disorder. *Dev Psychol*. 2008;44:34–45.
17. Wechsler D. *Wechsler Preschool and Primary Scales of Intelligence (WPSSI-R)*. 1997. Flemish-Dutch translation by G. Vandersteene and A. Bos.
18. Wechsler D. *Wechsler Intelligence Scale for Children: Manual*, 3rd ed. San Antonio, TX: The Psychological Corporation; 1991.
19. Wechsler D. *Wechsler Intelligence Scale for Children: Manual*, 3rd ed. Dutch translation by W. Kort, M. Schittekatte, P.H. Dekker, P. Verhaeghe, E.L. Compaan, lic. M. Bosmans, lic. G. Vermeir; 2005.
20. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Revised Third Edition*. Washington, DC: American Psychiatric Association; 1987.
21. Cohen-Kettenis PT. Gender identity disorder. In: Gillberg C, Harrington R, Steinhausen HC, eds. *A Clinician's Handbook of Child and Adolescent Psychiatry*. Cambridge: Cambridge University Press; 2006:695–725.
22. Verhulst FC, Van der Ende J, Koot HM. *Manual for the Teacher's Report Form (TRF)*. Rotterdam: Erasmus University/Department of Child and Adolescent Psychiatry, Sophia Children's Hospital; 1997.
23. Zucker KJ, Bradley SJ, Lowry Sullivan CB, Kuksis M, Birkenfeld-Adams A, Mitchell JN. A gender identity interview for children. *J Pers Assess*. 1993;61:443–456.
24. Deogracias JJ, Johnson LL, Meyer-Bahlburg HFL, Kessler SJ, Schober JM, Zucker KJ. The gender identity/gender dysphoria questionnaire for adolescents and adults. *J Sex Res*. 2007;4:370–379.
25. Johnson LL, Bradley SJ, Birkenfeld-Adams AS, et al. A parent-report gender identity questionnaire for children. *Arch Sex Behav*. 2004;33:105–116.
26. Doorn CD, Kuiper AL, Verschoor AM, Cohen-Kettenis PT. Het verloop van de geslachtsaanpassing: een 5-jarige prospective studie [The course of sex reassignment: a 5- year prospective study]. Report for the Dutch National Health Council; 1996.
27. Cohen-Kettenis PT, van Goozen SHM. Sex reassignment of adolescent

transsexuals: a follow-up study. *J Am Acad Child Adolesc Psychiatry*. 1997;36:263–271.
28. Lindgren TW, Pauly IB. A Body Image Scale for evaluating transsexuals. *Arch Sex Behav*. 1975;4:639–656.
29. Kuiper AJ. *Transseksualiteit: Evaluatie van de Geslachtsaanpassende Behandeling [Transsexuality; Evaluation of Sex-Reassignment]*. Amsterdam: VU University Press; 1991.
30. Kinsey AC, Pomeroy WB, Martin CE. *Sexual Behavior in the Human Male*. Philadelphia: WB Saunders; 1948.
31. Achenbach TM. *Manual for the Child Behavior Checklist and 1991 Profile*. Burlington: University of Vermont Department of Psychiatry; 1991.
32. Verhulst FC, van der Ende J, Koot H. *Handleiding voor de CBCL/4-18*. Rotterdam: University Press; 1996.
33. de Graaf H, Meijer S, Poelman J, Vanwesenbeeck I. *Seks onder je 25e: Seksuele gezondheid van jongeren in Nederland anno 2005 [Sex Under 25: Sexual Health of Youth in the Netherlands Anno 2005]*. Delft: Eburon; 2005.
34. Cohen-Kettenis PT, Owen A, Kaijser VG, Bradley SJ, Zucker KJ. 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;31:41–53.
35. Diamond LM. Sexual identity, attraction, and behavior among young sexual-minority women over a 2-year period. *Dev Psychol*. 2000;36: 241–250.
36. Rosario M, Schrimshaw EW, Hunter J, Braun L. Sexual identity development among lesbian, gay, and bisexual youths: consistency and change over time. *J Sex Res*. 2006;43:46–58.
37. Stokes JP, Damon W, McKirnan DJ. Predictors of movement towards homosexuality: a longitudinal study of bisexual men. *J Sex Res*. 1997; 34:304–312.
38. Carver PR, Egan SK, Perry DG. Children who question their heterosexuality. *Dev Psychol*. 2004;40:43–53.
39. Wallien MSC, Cohen-Kettenis PT, Lambert SL, Owen-Anderson A, Bradley SJ, Zucker KJ. Cross-National Replication of the Gender Identity Interview for Children, submitted.

Prospective Effects of Attention-Deficit/Hyperactivity Disorder, Conduct Disorder, and Sex on Adolescent Substance Use and Abuse Elkins IJ, McGue M, Iacono WG

Context: Attention-deficit/hyperactivity disorder (ADHD), an early manifestation of externalizing behavior, may identify children at high risk for later substance abuse. However, the ADHD-substance abuse relationship often disappears when co-occurring conduct disorder (CD) is considered. *Objective:* To determine whether there is a prospective relationship between ADHD and the initiation of substance use and disorders, and whether this relationship depends on the ADHD subtype (hyperactive/impulsive or inattentive), CD, or sex. *Design, Setting, and Participants:* Dimensional and categorical measures of ADHD and CD were examined via logistic regression analyses in relation to subsequent initiation of tobacco, alcohol, and illicit drug use by 14 years of age and onset of substance use disorders by 18 years of age in a population-based sample of 11-year-old twins (760 female and 752 male twins) from the Minnesota Twin Family Study. *Main Outcome Measures:* Structured interviews were administered to adolescents and their mothers regarding substance use and to generate diagnoses. *Results:* For boys and girls, hyperactivity/impulsivity predicted initiation of all types of substance use, nicotine dependence, and cannabis abuse/dependence (for all, p G .05), even when controlling for CD at 2 time points. By contrast, relationships between inattention and substance outcomes disappeared when hyperactivity/impulsivity and CD were controlled for, with the possible exception of nicotine dependence. A categorical diagnosis of ADHD significantly predicted tobacco and illicit drug use only (adjusted odds ratios, 2.01 and 2.82, respectively). A diagnosis of CD between 11 and 14 years of age was a powerful predictor of substance disorders by 18 years of age (all odds ratios, 94.27). *Conclusions:* Hyperactivity/impulsivity predicts later substance problems, even after growth in later-emerging CD is considered, whereas inattention alone poses less risk. Even a single symptom of ADHD or CD is associated with increased risk. Failure in previous research to consistently observe relationships between ADHD and substance use and abuse outcomes could be due to reliance on less-sensitive categorical diagnoses.