



Psychological interventions for Gender Identity Disorder (GID) in childhood

A **CAMPBELL - COCHRANE** SYSTEMATIC REVIEW

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'My body is wrong'

'She was our first child' recalls Sarah (not her real name), a mother of two who lives in the south of England.

"But from the age of three we knew something was wrong. She was very introverted, isolated. When she started school at four she came home and said she was a freak. It seemed a strange word for a four-year old to use. She was always quite a sad little person."

Sarah's daughter was born and grew up as a boy. Now 19, she is far happier in a woman's body as a post-operative transsexual. It took two years for the family to get used to calling her "she". Her mother says her daughter experienced her childhood as mental torture, especially during puberty.

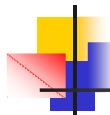
"Looking back, we could never find any tape in the house. It was because she was taping her genitals up every day. She said to us later that she thought it would all go right for her at puberty, that her willy would drop off and she would grow breasts. She said she was going completely crazy because she knew in her head that she was a girl."

(The Guardian, Thursday August 14, 2008)



Gender variant conditions

- Gender variance (gender dysphoria) ⇔ personal discomfort experienced by individuals whose psychological identification as men or as women (gender identity) is inconsistent with their phenotype and with the gender role typically associated with that phenotype.
- **Classification**
 - ICD-10:** five diagnoses in the field of gender identity disorders. Criteria differ between children and adults. Transsexualism is an extreme gender identity disorder (GID), which is still in the ICD, but has disappeared from the DSM.
 - DSM IV:** gender identity disorder is viewed as basically one disorder that could develop along different routes and could have various level of intensity (criteria have been criticised).



GID - children

Signs of a developing GID may be apparent **as early as 2 years**.

As soon as are able to talk, children

- show strong & persistent cross-gender identification
- express persistent discomfort with their biological sex and/or a sense of inappropriateness in the gender role of that sex.
 - state repeatedly that they are or will later become members of the opposite sex,
 - show cross-gender preferences and behaviour and
 - show unhappiness when they are not allowed to act on these preferences.



Gender variant conditions

- **Epidemiology**

No epidemiological studies exist that provide data on the prevalence of childhood GID.

- **Sex ratio**

-- The majority of prepubertal children attending gender clinics are **boys**. The boys to girl ratios are about 6:1 in Canada, 3:1 in the Netherlands and 4:1 in the UK.

-- The higher rates for boys seen in childhood in the UK and Canada may reflect a greater anxiety of parents about male effeminacy

- **Correspondence between childhood GID and transsexualism**

Not all children with GID will seek **SR** (sex reassignment surgery) after puberty (childhood GID is more strongly related to homosexuality than to transsexualism)



Aetiology

Complex condition but still largely in **the dark** and probably **multi-factorial** & will depend not only on individual circumstances but on cultural norms.

- **Psychological and psychobiological theories**

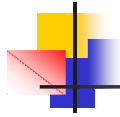
-- Many psychological factors have been declared responsible for GID development.

-- Recent theories include **multiple cumulative risk factors** (primarily developed to explain childhood GID; converge during a critical period of development)

- **Biological theories**

Brain studies support the paradigm that the neurobiology of the brain is an important element in the development of transsexualism

- Level of **pre-natal androgen levels**



Ethics of intervention

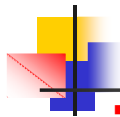
Short-term treatment goals depend on etiological theories of GID.

If GID is the result of

- **underlying developmental psychopathology** and/or defence to deal with stress (due to early life experiences) ⇒ modifying supposed causal and/or perpetuating factors ⇒ attain a gender identity change;
- **inappropriate learning experiences** ⇒ extinguish cross-gender behaviours and reinforce same-gendered behaviours and skills;
- **manifestation of later homosexuality** (and do not consider homosexuality a psychiatric disorder) ⇒ (a) focus on acceptance of the child's cross-genderedness by child and parents, (b) support in establishing a healthy self-esteem and adequate coping mechanisms.

GID associated with a range of psychological, emotional and behavioural difficulties ⇒ severe distress for parents and children.

The suffering should be alleviated under all circumstances.



Psychoanalytic therapies

- Wide range of treatment goals (dependent on theoretical orientation)
- Common denominator for the root cause of GID in children is the assumption of pathogenic early parenting.
- Rationale for treatment of gender-variant children rests on the assumption that gender-atypicality in children can be seen as evidence of a global developmental psychopathology. Focus on assumed underlying child or family pathology ⇒ influence cross-gender identity
- Boys with GID "behavioral difficulties, depressions, and separation anxiety are intrinsically associated with the gender confusion and may even be prerequisite to the development of effeminacy" (Susan Coates, 1987)



Behavioural & cognitive behavioural psychotherapies

Assumption that children **learn** sex-typed behaviours and that these behaviours can be shaped by reinforcing some and discouraging others.

“behaviour targets of intervention have included a variety of cross-gender behaviours, including toy and dress-up play, role playing, exclusive affiliation with the opposite sex, and mannerisms”
(Zucker, 1990).

- Primary target → cross-gender behaviour of boys
(virtually nothing published about behaviour therapy of girls with GID).



Family therapy

In younger children, FT primarily directed at the parents in order to

- facilitate understanding of their child’s sensitivity to conflict and concerns about self-value as a boy or a girl and
- at different ways they may be reinforcing their child’s concern about a same-gendered sense of self.

In other cases, more intensive marital, family or individual work may be necessary to deal

- with cross-gendered behaviours,
- familial and/or peer rejection
- stigma and isolation felt by many parents.



Objectives

Assess effects of

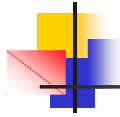
- psychoanalytic/psychodynamic therapy
 - Behavioural & cognitive behavioural psychotherapies
 - Family therapy
- for childhood Gender Identity Disorder (GID).



Type of studies

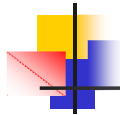
Study designs considered for this review but meta-analysed separately:

- **Randomised controlled trials (RCTs),**
- **controlled clinical trials (quasi-RCTs), where allocation is made for example by date of birth, alternate allocation, etc),**
- **controlled before and after studies (CBAs),**
- **interrupted time-series studies (ITSs), where there is a clearly defined point in time when the intervention occurred and at least three data point before and after the intervention.**
- no language restrictions



Type of participants

- Children aged 4-12 years who meet GID diagnostic criteria according to DSM-IV and/or ICD-10.
- GID Diagnosis based on extensive psychological assessment of the child and interviews with the child and the parents or caregivers, including details of the child's developmental history.
- Children with intersex conditions (e.g., ambiguous genitalia) will be excluded.
- For CBT+FT ⇄ intervention may or may not include separate parallel supportive work with parents/carers of children, but must not include therapy with both the child and parent(s) seen together.



Type of intervention

- **Psychoanalytic/psychodynamic psychotherapies**
- **Behavioural & Cognitive behavioural psychotherapies**
- **Family therapy**
aimed at addressing childhood GID which may include the child's parents or caregivers and is delivered in a one-to-one and/or group format.
Settings: community, primary care, and in-patient settings included.
- **Psychotherapeutic interventions combined with pharmacotherapy included only when explicitly stated that the medication is aimed at addressing GID aspects (e.g., depression) and not other primary co morbid psychiatric condition(s).**



Type of outcome measures

Primary outcomes (child)

- Psychological functioning
- Behavioural functioning

Secondary outcomes

- Social functioning (child)
- Parent/family outcomes

Validated scales (e.g. CBCL) and/or instruments for which the psychometric properties have been described in a peer-reviewed journal. Self-reports or completed by clinicians, parents, teachers and/or independent raters.



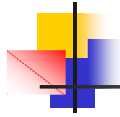
Search strategy

The following databases were searched:

- **CENTRAL** (The Cochrane Library Issue 1, 2009)
- **MEDLINE** (1950 to 27 March 2009)
- **PsycINFO** (1806 to 29 March 2009)

Total N= 829 records (ex duplicates)

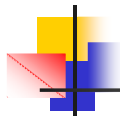
- **CENTRAL** (n=5)
- **MEDLINE** (n= 426)
- **PsycINFO** (n=437)



Search Results -cont

Relevant N= 65 records

- **Psychoanalytic/psychodynamic** (n=53)
- **Family Therapy** (n= 0)
- **Behavioural/CBT** (n=12)



Observations

- A large number of cases studies re. psychoanalytic/psychodynamic approaches
- Behavioural approaches ➡ single case designs
- No FT studies !
- So far, **no** outcome studies that meet inclusion criteria !

- So what now..... ?



Conclusions

- Is there a best practice?
 - At present, difficult to draw any conclusions
 - Any conclusion tentative (not all databases searched)
- uncommon conditions ➔ single case designs (SCEDs)
- New challenge(s)