

## More Than Two Developmental Pathways in Children With Gender Dysphoria?

To the Editor:

Current prospective studies on the development of children fulfilling diagnostic criteria of gender identity disorder according to the *DSM-III*, *DSM-III-R*, *DSM-IV*, and *DSM-IV-TR* have indicated that the most common psychosexual outcome is homosexuality or heterosexuality without gender dysphoria (GD).<sup>1</sup> Across all studies, the persistence rate of GD has been approximately 16%. What should be emphasized is that these studies did not use the fairly strict criteria of the *DSM-5*, and children could receive the diagnosis based only on gender-variant behavior. With *DSM-5* criteria, the persistence rate probably would have been higher. The design in nearly all follow-up studies was to have a first assessment in childhood (before puberty) and a second one in adolescence or young adulthood. The conclusion seemed to be that children with GD are “persisters” (children who remain gender dysphoric in adolescence and seek treatment) or “desisters” (children for whom the GD feelings desisted in adolescence and who do not reapply for treatment), and that the outcome becomes clear in the early stages of puberty.<sup>2</sup> If one considers retrospective accounts of adult applicants for treatment, many have claimed that they experienced GD in childhood.<sup>3</sup> Because in most countries treatment for adolescents was not available until very recently, this could be an important practical reason why treatment in these cases was not pursued until adulthood. The question arises as to whether these adults with childhood GD would have sought treatment with puberty blockers as young adolescents<sup>4</sup> had it been available, or whether there is a developmental route that is different from the often-described “desistence” and “persistence.”

Our gender identity clinic for children and adolescents started in 1987; since then, medical treatment in adolescence has become available. Currently, there is a fairly large group of individuals who were seen in childhood and are well into their 20s and 30s. We selected the first cohort of 150 children who are currently 19 to 38 years of age (mean 25.90, SD 4.03). At the time of first assessment, they were 5 to 12 years old (mean 8.31, SD 1.88). Of this group (111 natal males and 39 natal females), 40 (26.7%; 26 natal males and 14 natal females) appeared to be persisters.

They re-entered the clinic during adolescence (12–18 years of age). All other children were assumed to be desisters. However, after checking the files of our adult clinic (which sees nearly all adults with GD in the Netherlands), it appeared that 5 individuals (3.3%; 4 natal males and 1 natal female) applied for treatment only when they were older than 18 years, whereas 105 (70.0%; 81 natal males and 24 natal females) had not re-entered the clinic.

At the time of re-entrance, the mean age of the “straight persisters” was 13.14 years. Of this group, 75% came back

before 14 years of age and 25% at 14 to 18 years. The average age of the 5 individuals who re-entered the clinic in adulthood was 24 years (range 21–37). Despite their knowledge of the availability of treatment for adolescents and the fact that treatment is covered by insurance, they did not apply for treatment during adolescence. Four (3 natal males and 1 natal female) tried to live as gay or lesbian persons for a long time, and 1 natal male had autism spectrum disorder. He reported that he needed to solve other problems in his life before he could address his GD. The others reported not having any problems with being homosexual. Yet, after having intimate and sexual experiences with same (natal) sex partners, they came to realize that living as a homosexual person did not solve their feelings of GD, and they felt increasingly drawn toward transitioning. All also mentioned that they were somewhat hesitant to start invasive treatments, such as hormone therapy and surgeries.

From this information, this period of questioning sexual identity seems to be a phase that some children with GD have to go through as adolescents before they actually seek treatment for their GD. In the Netherlands, the attitude toward homosexuality and gender variance is relatively positive.<sup>5</sup> Therefore, it is likely that young people living in countries with less positive attitudes wait even longer, until they are socially settled and more certain about their GD, before they can deal with it. It would be worthwhile to know whether the GD of these “persisters-after-interruption” differs qualitatively or quantitatively from the GD of straight persisters and whether the groups differ in other respects. For instance, has the GD in the persisters-after-interruption group actually disappeared for some years or, as the reports of our young adults suggest, did they make a more or less conscious choice not to live according to their experienced gender? Knowing more about this developmental route would be clinically useful when counseling young people with GD.

The individuals with GD who were seen in childhood are still rather young. Studies encompassing much longer follow-up periods might show a prevalence higher than 16% if individuals with persistence-after-interruption are included. This might influence the discussion on medical treatment of youth with GD and the status of GD in childhood as a psychiatric diagnosis.

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