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News review

Gender TROUBLES

"I HAVE a secret feeling," the five-year-old boy said on his first visit to Professor Louise Newman. He walked over and whispered into her ear: "I am a girl."

The boy's parents had brought him to see the child psychiatrist, concerned at his persistent desire to belong to the other gender.

"From age two-and-a-half to three, he had been playing with girls' toys and had wanted to dress in his mother's clothes," Professor Newman remembers. "He told his mother he had dreamt about turning into a girl. He was hiding his penis and saying he didn't like it. And he wished he could be like his younger sister."

When the child started primary school, the feelings intensified. He was afraid of the boys and was teased after telling other children he was a girl.

For clinicians working in paediatric gender identity disorder, such cases present unique challenges. Experts know the road ahead is likely to be rocky for these often very distressed children. They want to provide support, while avoiding premature

labelling of the child.

"We certainly don't know what the outcome will be at that age," says Professor Newman, who practises in Newcastle, NSW. "We would never tell the family, 'This means your child's going to be a transsexual', because things can change."

The earlier such feelings emerge, however, the more likely they are to be persistent, she says.

Although gender confusion can be a transitory part of a normal childhood or adolescence, clinicians working in the field say that true gender identity disorder is rare. But they do believe that for almost all transgender adults the struggle begins in childhood.

In May, the Family Court gave a 12-year-old girl, who cannot be named, permission to receive hormonal treatment to prevent her going through female puberty and allow her to enrol in secondary school as a boy (see box, page 24). The precedent that court approval should always be sought before initiating such treatment in a minor had been set by a similar case in 2004, in which a 13-year-old received the right to take hormones to prevent menstruation.

In the most recent case, the court said the child was fortunate to be able to start the treatment early, before the physical changes of puberty — "something which is not always open to young persons who have the same condition".

NOBODY knows what causes gender identity disorder — most experts talk of a "switch" being turned the wrong way, perhaps in utero or at a genetic level — although a study published this week may point to a specific genetic variation in some cases. There is also little reliable outcome data for most treatments. Nor does anybody really know how many people have the condition.

Each year, about 80 new patients present to Australia's only public clinic — the Melbourne Gender Dysphoria Clinic, which only accepts adults. One expert witness told the Family Court that all these patients would probably have presented during childhood if a clinic for young people existed, yet currently only a "trickle" of children was being seen. Asked what happened to the others, the endocrinologist replied: "They just suffer out there, I think."

That suffering is something clinicians working in the area would like to see addressed.

Former Melbourne GP Dr Darren Russell saw several adolescents with gender identity disorder at his inner-city practice and often feared for their future. He still wonders what happened to one teenage boy, who presented at age 15, suicidal and begging for female hormones. There is a note of sadness in the doctor's voice as he remembers his attempts "to do the best by this kid and stay within the law". Despite Dr Russell's best efforts, and those of the psychiatrist he referred the patient to, the boy ended up leaving home at 16 and was lost to follow-up.

"I have had some people in their late teens or early twenties who have just disappeared and I don't know if things have gone well or if things have gone really badly," says Dr Russell, who is now working in sexual health in Cairns. "We could definitely do more as a society — these kids are vulnerable and they are living in a society that doesn't have a place for them."

Although Dr Russell did not prescribe hormones before age 18, he found many of his young patients were "quite resourceful" and found ways to access them through friends or online. As a GP, he adopted a harm-minimisation approach, trying to maintain a rapport with the young person and providing advice on safer use of any agents they were taking. His advice to colleagues dealing with a transgender patient for the first time is to seek advice from a psychiatrist or another GP with experience in the area, as "doing this on your own can be very hard".

Ideally, all these young people would be managed by a multidisciplinary team in consultation with the child's family and school, the experts say. A more co-ordinated approach from childhood onwards might help to prevent many of the adverse outcomes known to be more common in transgender adults. A recent study at a Sydney sexual health clinic, for example, found sexually active transgender people had disproportionately high rates of risky behaviours, including injecting drug use, large numbers of sexual partners and sex work.[1]

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A court's decision to allow a 12-year-old girl to receive hormonal treatment to prevent puberty has focused attention on the plight of children who believe they have been born into the wrong gender.

> "We could definitely do more as a society — these kids are vulnerable and they are living in a society that doesn't have a place for them."

BY JANE MCCREDIE

ILLUSTRATION BY CHRISTOPHER NIELSON

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While half of the 40 transgender clients presenting to the clinic between 1990 and 2006 had not had sex at all in the previous 12 months, most of those who were sexually active had unprotected anal or vaginal sex in that time. Psychosocial morbidity was also common, the researchers said, with 22% of male-to-female clients seeking counselling from the clinic and 7.5% reporting a psychiatric diagnosis. Three clients said they had been sexually assaulted and two had experienced recurrent sexual abuse.

WHILE there is no evidence that persistent gender identity disorder can be "cured", clinicians believe that appropriate treatment during childhood and adolescence may give patients a better chance of avoiding such negative outcomes. Treatments range from psychotherapy to hormone treatment, with some surgical procedures, such as removal of breast tissue, considered after age 16.

Some, but not all, transgender people will go on to have more far-reaching surgery in adulthood. For male-to-female patients, that might include breast implants, removal of the male sexual organs, construction of a vagina and, in some cases, facial surgery. For female-to-male patients, the surgical options are more limited but generally include chest surgery to remove breast tissue and hysterectomy. Phalloplasty is yet to deliver a truly functional penis, but some patients opt for the less ambitious metoidioplasty, which enlarges the appearance of the clitoris and uses labial implants to simulate testes.

For very young children, however, such major decisions are a long way in the future. Professor Newman sees the major task at that early stage as working with the family "to help them hang in there". Children need to be given

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survival skills, including knowing who they can safely talk to about their feelings and that some cross-gender behaviours are best kept for home, rather than school.

The approach of puberty can be a nightmare for these children. Dr Russell observed a phenomenon he nicknamed "the ugly swan syndrome". Through childhood, many of the boys he saw had harboured a "magical belief" that they would eventually sprout breasts and turn into a woman. Instead, to their horror, they found their voice deepening, their penis increasing in size and their body becoming hairier. Suicide is a serious risk around this time.

Paediatric endocrinologist Professor Garry Warne, who has appeared as an expert witness in several court cases, has observed an increased risk of suicide and self-harm around the time of menstruation in children born girls but wanting to live as boys. In such cases, he has supported hormonal treatment to block puberty as the treatment is reversible and relatively safe — and the consequences of inaction could be far worse.

"The immediate risk is pretty obvious — a kid saying, 'I am going to throw myself under a tram unless you do this for me'," says Professor Warne, who has managed several children with gender identity disorder at Melbourne's Royal Children's Hospital in consultation with colleagues from other disciplines.

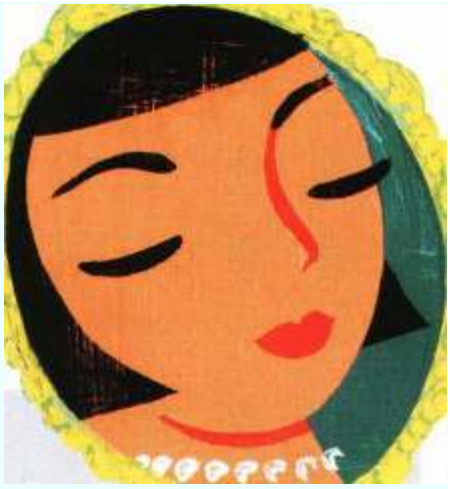
FOR transgender people themselves, the use of the word "disorder" to describe their situation can strike the wrong note, but they have no quibble with the clinicians' argument that more support is needed for children and adolescents grappling with the issue.

"Adolescence was just a really, really tough time," says Peta, a self-described "transgender lady", who has asked that her surname not be used because her father still does not know she became a woman 10 years ago (see box). Moved by the story of Professor Newman's five-year-old patient, she wishes there had been somebody she could have confided in during those lonely years.

"I just wish there was someone at school that I could have talked to, like a school counsellor ... because I certainly couldn't talk to the nuns," she says with a wistful laugh.

"I just hope they provide these services these days where a child can walk up and whisper in someone's ear: 'I've got a secret. I'm a girl.'" ●

1. *Sexual Health* 2007; 4:189-93.



Preventing puberty

"FROM a very early age, [my daughter] identified strongly as a boy and whilst she is a normal female in terms of her anatomy and physiology, I have observed that she really behaves and considers herself to be a boy in every practical sense."

The 12-year-old girl described in this manner by her mother in evidence to the Family Court is now on her way to becoming the boy she has always wanted to be. In May, the court gave the child, described as having "profound and persistent gender identity disorder", permission to start hormonal treatment to prevent her going through puberty.

A psychiatrist had assessed the child as having " clear, strong and persisting identification with the male gender, which was unchanged since at least the age of four, and seemed irreversible".

Both an endocrinologist and a psychiatrist supported the application, telling the court there was a risk of self-harm if the treatment was not allowed.

The approved treatment is reversible and involves the subcutaneous implant of a gonadotrophin-releasing hormone analogue every 2-3 months.

However, a further application is expected down the track (perhaps at about age 16) for the child to start treatment with testosterone, which would cause permanent physical changes.