CHALLENGING CASE: BEHAVIORAL CHANGES

Sammy: Gender Identity Concerns in a 6-Year-Old Boy*

CASE

Sammy, a 6-year-old new patient, came to his pediatrician for a health supervision visit. He had moved recently with his mother and two siblings, after a stormy marital separation. His mother felt that Sammy and his two younger siblings had weathered the events that led to the separation reasonably well. His birth and developmental history were uneventful. He had a good year in kindergarten, developed several friendships, and was responsive to early learning skills. His past medical history did not include any hospitalizations or chronic illness. The pediatrician recognized the potential importance of the parents’ separation. Focused questions to his mother revealed that the father remained in their old home, in a city 300 miles away; the children had not seen their father for 6 months, although he called them approximately once a month. The mother was living with a man with whom she had a close relationship. She stated that the children enjoyed the company of her friend, although Sammy seemed to play with him less than the younger children did. Marital discord had been ongoing for 2 years before the separation. Although heated verbal arguments had occurred frequently between the parents, Sammy’s mother denied either child abuse or spousal abuse. The pediatrician asked Sammy to draw a picture of his family doing an activity together. She used this opportunity to talk to his mother alone. In response to the question, “Is there anything else you would like to tell me about Sammy?”, Sammy’s mother said that she was concerned about his tendency “to do things like a girl.” He frequently asked his mother if he could dress in her clothes; on a few occasions, she found Sammy with one of her dresses on. He preferred to play with his sister’s girlfriends rather than with boyfriends. At one time, he put on his mother’s makeup. Sammy’s mother described him as “effeminate, with manners and body movements more like a girl than a boy his age.”

Index terms: gender development, gender identity, gender role.

Dr. Martin T. Stein

The hallmark of a finely tuned health supervision visit includes a set of opposites. On the one hand, focused questions and observations should be centered around a developmental theme appropriate to the child’s age. On the other hand, the pediatrician must be open to defining and exploring the parents’ agenda for the visit. At times, clarification of these “hidden concerns” might be more important to the child’s development than a checklist for specific milestones.

The case of Sammy is an example of active listening during a health supervision visit. The pediatrician recognized the potential significance of a conflictual divorce followed by a separation from his father, a move to a new city, and his mother’s new male friend. By shifting the structure of the visit to allow a few minutes alone with Sammy’s mother, the pediatrician asked an open-ended “Is there anything else you want to tell me?” question. I suspect that her response surprised the pediatrician. Questions concerning gender identification are not common in a general pediatric practice.

An approach to parental concerns about cross dressing, gender-related choices for friends, and behaviors that exemplify different sexual roles in school age children is developed in the following commentaries. Dr. Kenneth J. Zucker is a child and adolescent psychologist at the Clarke Institute of Psychiatry in Toronto. As the director of the Child and Adolescent Gender Identity Clinic, he has conducted extensive clinical research in the area of gender identification among children and adolescents. He has contributed to our understanding of the clinical spectrum of gender identity issues by contributing to the formulation of that section in the Diagnostic and Statistical Manual for Primary Care (DSM-PC). Dr. Suzanne D. Dixon is a developmental and behavioral pediatrician who is an active teacher, clinician, and researcher. Her interests range from the behavior of newborns exposed to drugs in utero to the implementation of breastfeeding programs in developing countries. Dr. Dixon has been active in the development of educational models for clinicians and parents in child development and behavior.

Dr. Kenneth J. Zucker

When she was given the opportunity to speak with her pediatrician in private, Sammy’s mother expressed some nascent concerns about his gender identity development. In my experience, the response of the office-based practitioner to this kind of question will go in one of two directions: (1) the parent’s concern will be minimized on the grounds that the behavior is only a “phase” that will be grown out of or the behavior will be “normalized” on the grounds that all children act in similar ways; or (2) the practitioner will explore in more detail the par-
ent’s concerns and, if appropriate, suggest a referral to a behavioral pediatrician, a child psychiatrist, or a child psychologist. In my view, the latter response is the more appropriate.

In Sammy’s case, the first step is to take a more thorough history concerning his gender identity development. Although cross-dressing and a preference to affiliate with girls as playmates are two symptoms of gender identity disorder (GID), as defined in the DSM-IV (Table 1), additional inquiry is required with respect to repeated verbal statements about wanting to be of the opposite sex, a preference for cross-sex roles in fantasy play, and a preference for cross-sex toys and games. In addition, information concerning avoidance and rejection of same-sex stereotypical games and activities and the presence of negative feelings concerning his sexual anatomy is important. The use of the DSM-IV diagnostic criteria or the DSM-PC can help the office-based practitioner gauge the extent to which a particular child is struggling with his or her gender identity development. Other assessment and diagnostic tools are available.

Let us assume that additional discussion with Sammy’s mother indicated that he did indeed meet the diagnostic criteria for GID. Parents of these youngsters typically have one or more concerns with respect to this behavior: (1) that their son is or will be at risk for social ostracism, particularly by other boys; (2) that life events within the family might have contributed to their son developing a sense of unease about being a boy; (3) that their son will grow up to be gay (homosexual); or (4) that their son will grow up to be transsexual, i.e., he will desire hormonal and surgical sex-reassignment. Parents might express both short-term and long-term concerns with respect to their child’s psychosexual development and differentiation.

The research literature on GID in boys confirms that social ostracism is, in fact, commonly experienced by these youngsters and partly accounts for other behavioral and emotional difficulties that are manifest. Retrospective and prospective data show that a homosexual sexual orientation and transsexualism are strongly associated with GID in childhood. Green found that 75 to 80% of boys in his study were bisexual or homosexual in fantasy and/or behavior when followed up in their late adolescence. Retrospective studies of both adolescent and adult patients with severe gender dysphoria (a subjective sense of unhappiness concerning one’s gender), particularly those who have a homosexual sexual orientation, typically recall the onset of cross-gender feelings and behaviors to be in early childhood.

Studies on the etiology of GID in children are limited. An interaction of biological and psychosocial variables has been postulated. One of the most underappreciated aspects of this disorder is its complexity—one cannot appraise it quickly, and there are no simple explanations of its origins. Therapeutic efforts to resolve gender identity conflict in children have been approached from several perspectives, including behavior therapy, psychodynamic therapy, and parental counseling. There is some evidence that resolution of gender identity conflict is easier to achieve with children than with adolescents or adults, suggesting a narrowing window of behavioral plasticity by puberty. The considerable pain and suffering that individuals with gender dysphoria can experience requires that the condition be

### TABLE 1. Gender Identity Issues: Diagnostic and Statistical Manual for Primary Care (DSM-PC) Child and Adolescent Version

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<tr>
<th>Child Manifestations</th>
<th>Common Developmental Presentations in Middle Childhood</th>
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<tr>
<td><strong>V65.49 Cross-Gender Behavior Variation</strong></td>
<td>The child may occasionally cross-dress, engage in cross-gender role play, toy play, and peer play.</td>
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<td>On average, boys and girls display gender-typical preferences and behaviors. Isolated or transient cross-gender behaviors are not uncommon, particularly during toddlerhood and early childhood. Thus, isolated or transient stereotypical cross-gender behavior is usually not of clinical concern.</td>
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<tr>
<td><strong>V40.3 Cross-Gender Behavior Problem</strong></td>
<td>The child occasionally cross-dresses, engages in cross-gender role play, toy play, and peer play that persists over a period of 6 months; periodically states that he or she would like to become a member of the opposite sex; does not show an interest in playing with same-sex peers or emulating same-sex fantasy models; and has toy and activity interests more typical of the other gender.</td>
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<tr>
<td>Usually, boys and girls display gender-typical preferences and behaviors. At the problem level, the display of periodic cross-gender behaviors is more persistent, and the child is notably different from same-sex peers, but the behaviors are not sufficiently intense to qualify for childhood or adolescent gender identity disorders.</td>
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<td><strong>302.6 Childhood Gender Identity Disorder</strong></td>
<td>The child engages in persistent and pervasive cross-dressing, cross-gender role play, toy play and peer play that persist over a period of 3 months; frequently states that he or she would like to become a member of the opposite sex; expresses the desire to have anatomic attributes of the opposite sex; strongly rejects any sex-typical behaviors associated with his or her own sex; is teased by peer groups, expresses overt distress that he or she cannot change sex.</td>
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<td>The display of a strong and persistent desire to be of the opposite sex and persistent discomfort with his or her sex resulting in such activities as cross-dressing and preoccupation with getting rid of secondary sex characteristics. The disturbance is not concurrent with a physical intersex condition.</td>
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taken seriously by behavioral pediatricians and others concerned with the well-being of children.

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Dr. Suzanne D. Dixon

Sammy’s pediatrician was confronted with an “OTD” (out-the-door) question that identified a very important concern, perhaps one that was more critical than any others discussed during the visit. Like many OTDs, this one needs much more exploration than a busy practice usually allows. Rather than being frustrated by the limited time available to deal with such a complex issue, the pediatrician should feel rewarded for really inspiring trust in a parent such that her deepest, perhaps scariest, concerns are brought forward. The best response should include an acknowledgment of the importance of this issue and a pledge to discuss it at another scheduled visit as soon as is possible. Sexual issues in general are some of the most difficult to evaluate in a practice setting, given the emotionally charged nature of the subject as well as the relative paucity of information we received in training concerning sexuality, particularly the processes of sexual maturation in children. A second appointment will give the pediatrician a chance to gather her thoughts and plan an approach. It would be inappropriate simply to provide assurance of normality without more information concerning this complaint.

Tremendous suppressed anger was found in these boys who had new onset of cross-gender behavior in the aftermath of a divorce, after a period of serious marital discord. These children seemed to lack a safe place psychologically to separate from their mothers. Tremendous suppressed anger was found in these temperamentally shy boys. These disturbances resolved with treatment during a period of several months to years, in what seemed to be a transient form of GID.

The new DSM-PC describes cross-gender behavior under two categories, in addition to GID described above: cross-gender behavior variation and cross-gender behavior problem. The descriptions of these are in Table 1. The variation form is the very transient cross-gender behavior that follows a stressful life event, e.g., in the case of a toddler, the birth of a sibling, or as part of a play. Gender-atypical, nonsexual interests in adolescents would fall under this variation designation. This level of complaint needs no intervention other than reassurance and support for the stressed toddler or young child or a temperamentally different adolescent. These behaviors come into the problem level when they persist for approximately 6 months, are pervasive across many domains of behavior, and involve moving away from sex-typical interests, peers, and activities. An expressed interest in being a member of the opposite gender might be seen at this level. Isolation from same-sex peers might be seen in older youngsters.
with a cross-gender behavior problem. It might be that these children are the ones who respond over time with therapy, family understanding, and support, whereas a much smaller group includes those with classic GID. These youngsters also need help but are less likely to change their cross-gender identity. Unfortunately, all of these groups have a higher-than-predicted prevalence of family turmoil in their backgrounds, so that the presence of marital turmoil in Sammy’s case does not rule out either the problem level or classic GID. The timing of his cross-gender behavior, however, relative to the family stress, might provide some help in our thinking. Children with true GID manifest cross-gender behavior before the age of 4 years; the descriptions of post-traumatic gender behavior problem have the onset of symptoms between 4 and 7 years, after the family upset or stress.

We also need to know how pervasive and persistent Sammy’s effeminate behaviors have been. His behavior in mixed gender groups would help us to understand the pervasiveness of this behavior. His teachers in kindergarten and 1st grade could offer valuable observations about his play and companions. By the age of 5 years, typical children will choose same-sex playmates if they have a choice. I would be more worried if Sammy’s friends, preferences, and play were feminine in all these settings over time. It would also be important to know whether this behavior in these settings was stigmatizing or generating negative responses. If so, there is an urgent need for intervention, no matter what the etiology or pervasiveness of the behavior. The teacher’s input is needed here.

Sammy’s wishes need to be explored. Has he said he wants to be a girl and, if so, has that been a persistent or recurrent wish? Has he denied that he has a penis or has he urinated sitting down? Has he said that he hates himself as a boy? Does his cross-dressing occur in private (I’d worry here), or is it part of fantasy play, shared with peers, or family?

More needs to be known concerning the divorce from Sammy’s perspective. How many changes has he experienced through it? Was he used as a wedge between his parents, making him feel that it was unsafe to express anger? Did he feel that it was dangerous to like Dad or want to be with him, fearing that he might lose Mom? Mom and Dad or a grandmother might be able to provide this insight, if guided by the pediatrician. Sammy’s drawings might also tell us a great deal concerning his feelings. Some reports suggest that boys with GID often draw female figures in Draw-a-Person assessments, whereas gender-typical boys most often choose to draw men or boys first. Although not diagnostic, Sammy’s drawings, particularly over time, might give some insight into how he thinks about himself, and they will certainly open up dialogue with this boy and with his family. Mental-health providers use a variety of these projective techniques to discover how a child views himself; that process can begin in the primary-care office. Office personnel could be directed to make focused observations of Sammy’s play in the waiting room, especially that with human figures or with toys that have a usual gender preference. This could occur while the pediatrician interviews the family. Clearly effeminate themes over a long period would add weight to consideration of true GID; masculine themes or feminine ones evident only since the onset of the marital discord would support the developmental arrest/normalization model.

My own guess is that Sammy has the transient form of GID that emerges after serious separation trauma. The pediatrician will need to identify a very sensitive mental health provider to work with Sammy and his family over time. From the information we have already, this concern is at least at the problem level and is unlikely to get better on its own; I don’t think he will “grow out of it”. Sammy might learn to hide his behavior but still will not embrace this sexual part of himself until he receives help to get around this. If he has true GID, he and his family will continue to need serious support for the longer term to avoid secondary consequences of gender dysphoria. The pediatrician should begin the work of discovery and continue to monitor and support the diagnostic and therapeutic processes. Her time will be compensated through engagement with this intriguing case and monetarily if she learns to accurately describe her work through the use of the appropriate diagnostic codes presented in the DSM-PC.

REFERENCES


Dr. Martin T. Stein

Almost every day, while driving home from my office, I reflect on “missed opportunities,” those fleeting moments when I neglected to follow through on a comment or inquiry from a parent, child, or adolescent. Some seem unimportant. Others suggest a new or alternative direction for exploring a problem, developing a hypothesis, or encouraging a parent/child insight. Although medical students and residents probably experience more of these missed opportunities, they are moments to learn from, even among the most experienced practitioners. Retrospective reflections on missed opportunities usually bring new insights and strategies.

The case of Sammy, fortunately, was not such a
missed opportunity. The pediatrician did not stumble and ignore what Dr. Dixon refers to as an “out-the-door” question. By providing an opening for exploration and by actively listening to parental concerns, Sammy’s pediatrician brought the mother’s agenda to the surface. This process can be a challenge in a primary-care practice, in which problems are quickly turned into a diagnosis and a remedial treatment. Neither the diagnosis nor the treatment was apparent from the mother’s stated concerns. As both commentators made clear, more contextual information and developmental history were needed.

Dr. Zucker pointed out short-term and long-term concerns of parents whose children show behaviors that suggest a gender identification problem. These concerns ranged from social ostracism, guilt, and future risks for homosexuality and transsexuality. Potentially, they engendered conflictual feelings in parent and clinician. A sensitive clinician who is unfamiliar with the subject should be motivated to review available literature or consult with a colleague. As with many problems in behavioral pediatrics, a diagnosis should not be a rushed process. If time for additional exploration is not available, the primary care clinician can arrange a 20-minute to 30-minute appointment to ask other questions and make additional observations.

Both commentaries referred to the new DSM-PC as a useful framework to clarify and expand on the concerns expressed by Sammy’s mother. The major contributions of the DSM-PC to behavioral and developmental pediatrics are explored in the commentaries in this issue of the Journal on pages 171 through 177. For primary care pediatricians and for those who specialize in behavioral pediatrics and pediatric psychology, the DSM-PC brings a substantial benefit when faced with perplexing symptoms. Because many pediatric clinicians have not had focused training in childhood sexual development, this benefit is apparent in the case of Sammy for experienced pediatricians as well. Drs. Dixon and Zucker demonstrated how the developmental variation problem disorder model can assist in the process of evaluating gender identity concerns in a school-age child.
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