Still More to Understand in the Intersection Between Gender Diversity and Sexual Development

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The intersection between gender identity and sexuality is complicated. In gender affirmative treatment (GAT), care is approached by listening to the youth, with the input of their parents and caregivers, to best understand how to affirm and validate their gender identity and expression in the context of their health and development.[1] It may include any of the following: social interventions (eg, by using asserted name and pronouns), pubertal suppression, hormone treatment, or gender affirming surgery (GAS), with psychosocial support provided throughout.[2] Although empirical support of GAT is growing, the literature often minimizes the fundamental, dynamic connection between intimate relationships and one's sense of self. For example, intimate activities may be adapted to overcome or avoid gender dysphoria associated with certain sexual parts. Traditional labels (gay, straight, bisexual, etc) may be seen as inadequate and too restrictive given evolving identities. One's gender label may influence power dynamics and roles in the relationship. Developmentally, young people are navigating these challenges with gender identity and sexuality simultaneously in a process that is not well understood or supported by medical providers.

In this month's issue of *Pediatrics,* Bungener et al[2] examined sexual behaviors among transgender and gender diverse (TGD) youth during and after GAT. They reviewed previous research suggesting that at the time of referral, before any intervention, TGD youth had fallen in love, formed relationships, and engaged in sexual contact at lower rates than their cisgender peers. By adulthood, trends in sexual activity and satisfaction are less clear.[2] Bungener et al[2] specifically assessed sexual experiences among young adults, from 18 to 26 years old, who had all undergone puberty suppression, affirming hormones (estrogen or testosterone), and GAS.

Bungener et al[2] found an increase in nearly all sexual experiences from those recalled during GAT (presurgery) to those reported postsurgery. Transwomen demonstrated the largest increases in experiences that involved their own genitals (intercourse, receptive oral intercourse, receptive manual intercourse, and masturbation), whereas transmen had the strongest increases in sexual behaviors that involved them touching their own genitals (receptive oral intercourse and receptive manual intercourse). This is in contrast to the finding that, before GAS, the majority of TGD youth only touched their partner's genitals. Despite these increases in experiences, TGD youth were generally underexperienced sexually when compared with a representative sample of Dutch youth.[2] Overall, this supports the necessity of GAT not only in validating one's sense of self but also in fostering interpersonal and intimate relationships.

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TGD youth and their parents commonly fear a future of loneliness, victimization, and difficulty in romantic relationships.[3] However, ad hoc analysis revealed all TGD youth in the study value sex, love, and relationships and, with GAT, can be moderately to very satisfied with their sexual behaviors. Most reported having had a partner and high levels of sexual competency and assertiveness.[2]

There are a number of important considerations from their work that could help expand future research on the sexual lives of TGD youth. Attribution bias is possible from the sizeable drop-out rate, reducing the sample size from 113 (38 transwomen and 75 transmen) to 91 (unclear differentiation) youth, largely because of unreturned questionnaires or refusal to participate. It is unclear why some were reluctant to respond or participate.

Bungener et al[2] grouped TGD youth into transmale and transfemale categories, presumably on the basis of rejection of gender assigned at birth and/or their specific GAT. Therefore, these are researcher prescribed labels that carry important assumptions. These labels fail to recognize the complexity of gender diversity beyond a male and female binary, particularly the unique contributions of less represented and understood groups, such as nonbinary, agender, and genderqueer populations. Such groups are likely to struggle considerably against stereotypical assumptions about relationships and sex. It is also important to recognize that gender identity also cannot be determined by using specific GAT interventions.[4–6] For example, a person assigned as male at birth may choose to go on estradiol and have a mastectomy but may still assert as a feminine male or something other than transfemale. A self-asserted label would be more accurate and inclusive and is likely to be a better indicator of patterns in relationships and sexual behaviors.

There is no prescribed path or sequence of interventions that constitutes appropriate GAT. Bungener et al[2] included participants who, like many TGD youth, start with pubertal suppression and hormones and progress to a "final step" of GAS. Although that path may be true of many TGD youth, there are important exceptions, including many individuals who are nonbinary,[4,5] who need to be identified and included to truly understand gender diversity and relationships.

Bungener et al[2] referred to the participants as having received "early" GAT, but puberty suppression and hormones can be started much earlier at the onset of puberty, when indicated.[7,8] The mean age at referral was nearly 15 years old, ranging from 10 to nearly 18 years old. In general, pubertal onset in children is 8 to 10 years old, with completion usually within 3 to 5 years.[9] This means that a majority of youth referred to start GAT in this study had full or nearly complete development of secondary sex characteristics before the onset of GAT, which may have influenced the need for GAS and increased sexual experiences postoperatively. TGD youth who start pubertal suppression at pubertal onset and later pursue affirming hormones develop a physical appearance more in line with their asserted gender, often without the need for certain GAS.[10] They also have improved mental health outcomes.[8] Expanding on this study, it will be important to assess whether the increase in sexual experiences is truly related to GAS or if the experience is any different for youth who start earlier and may not need certain GAS.

Bungener et al[2] provide an important contribution to TGD health care, emphasizing the importance of GAT on the sexual health and development of TGD youth, while also dispelling myths. It is a necessity to expand on these findings by including TGD youth who present earlier and increasingly with nonbinary identities to not only further understand gender diversity but also challenge conventional conceptions of sexual attraction and relationships.

ABBREVIATIONS

GAS: gender affirming surgery
GAT: gender affirmative treatment
TGD: transgender and gender diverse

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