Evidence needed to understand gender identity

DR.MANSOUREH.MIRZADEH

COMMENTARY ON SHERI A. BERENBAUM

JOURNAL OF CHILD PSYCHOLOGY AND PSYCHIATRY 59:12 (2018), PP 1244–1247

, Prevalence of Gender Dysphoria

Various studies have been conducted around the world to determine the prevalence of gender dysphoria.

According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, gender dysphoria prevalence accounts for 0.005–0.014% of the population for biological males and 0.002–0.003% for biological females.

In both Japan and Poland, the prevalence of gender dysphoria is higher in biological females.

important factor to consider regarding the prevalence of transgender people is the sociological risks associated with disclosure.

The fear of repercussion may prevent many gender dysphoric people from disclosing their status, which may mean that the prevalence of people with gender dysphoria is higher than currently reported.

According to DSM-5-TR, the prevalence of gender dysphoria is 0.005–0.014% for adult natal males and 0.002-0.003% for adult natal females.

In childhood, the sex ratio continues to favour birth-assigned males,

in adolescents, there has been a recent inversion in the sex ratio from one favouring birth-assigned males to one favouring birth-assigned females.

Recent studies suggest that the prevalence of a self-reported transgender identity in children, adolescents and adults ranges from:

0.5 to 1.3%, markedly higher than prevalence rates based on clinic-referred samples of adults.

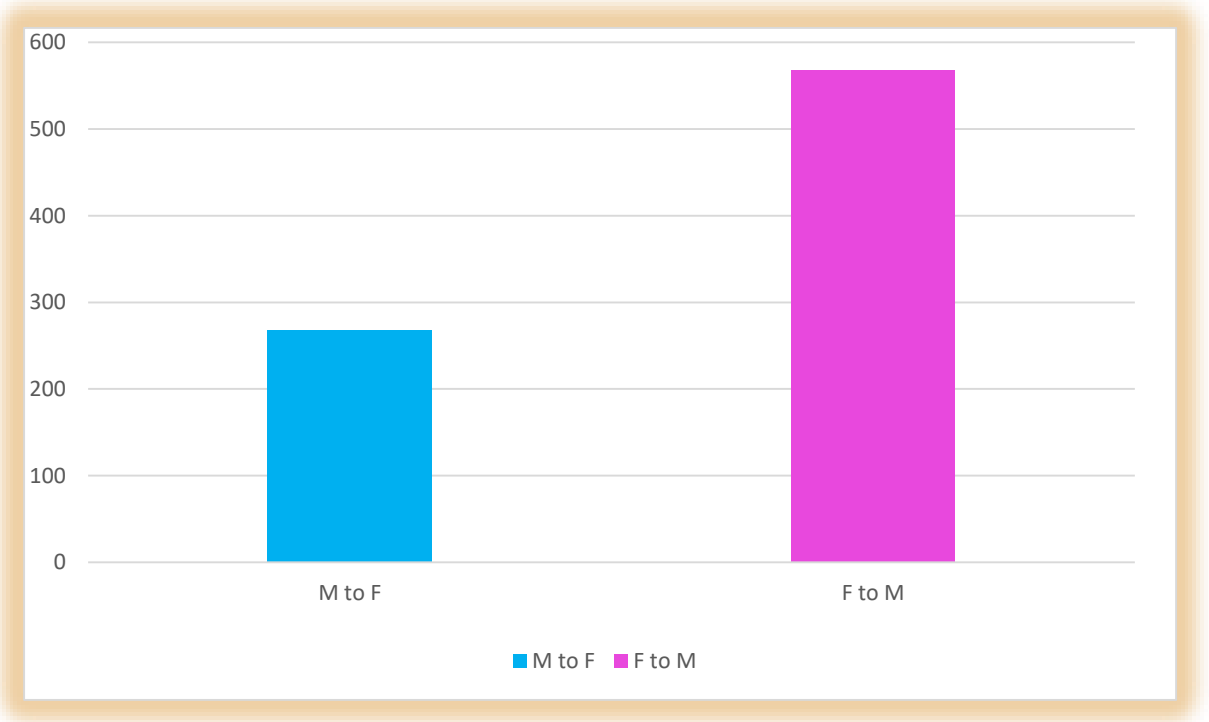
The stability of a self-reported transgender identity or a gender identity that departs from the traditional male–female binary among non-clinic-based populations remains unknown and requires further study.

در یک مطالعه از نوع گذشته نگر توصیفی از بازه ۱۳۹۱-۱۳۹۵ که با همکاری دانشگاه علوم پزشکی مشهد وسازمان پزشکی قانونی در سال ۱۳۹۷ انجام شده است .در این مطالعه ۸۳۹ پرونده در زمینه نارضایتی جنسی مورد بررسی قرار گرفت که فراوانی هر استان در این زمینه در مشخص شد.

فراوانی در کل کشور ۱/۱۰۰۰۰۰، در استان خراسان رضوی ۱/۱۰۰۰۰۰ و در استان های تهران و فارس ۱/۵۰۰۰۰ بوده است.

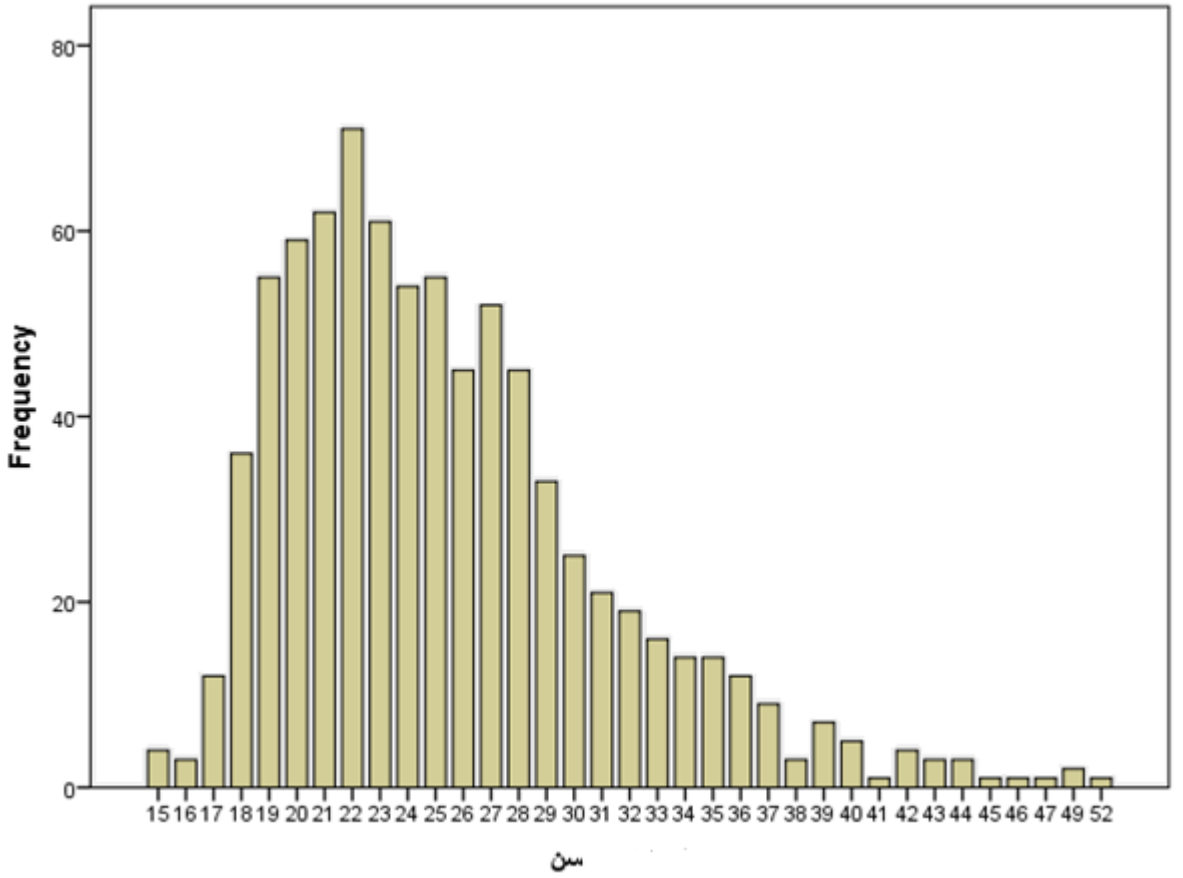
خصوصیات جنسیت اولیه در افراد سرکت کننده در مطالعه

خصوصیت	تعداد	درصد
مرد	۲۶۸	۳۲,۱٪
زن	۵۶۸	۶۷,۹٪



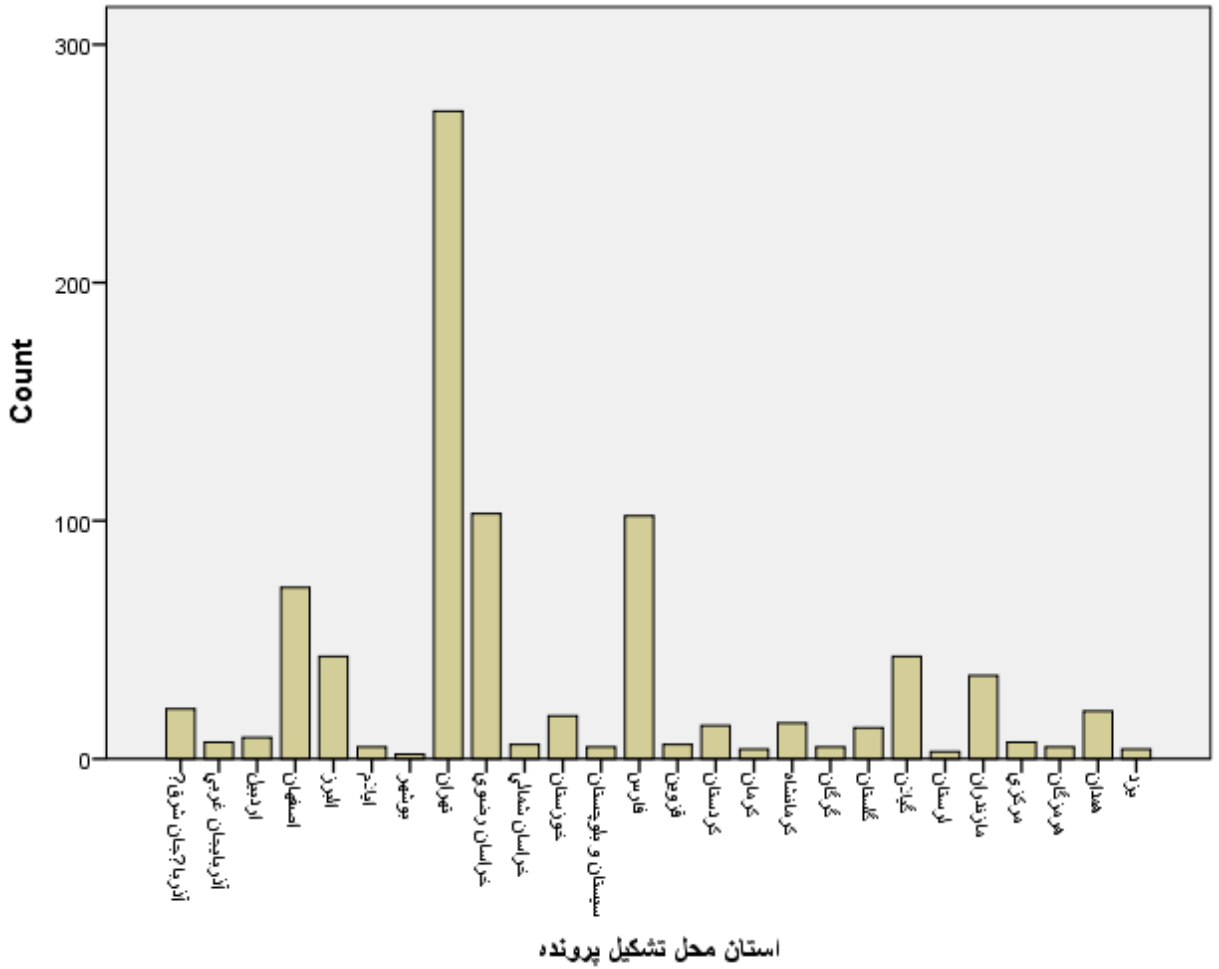
فراوانی افراد مراجعه کننده بر اساس جنسیت اولیه:

فراوانی افراد بر اساس سن زمان مراجعه

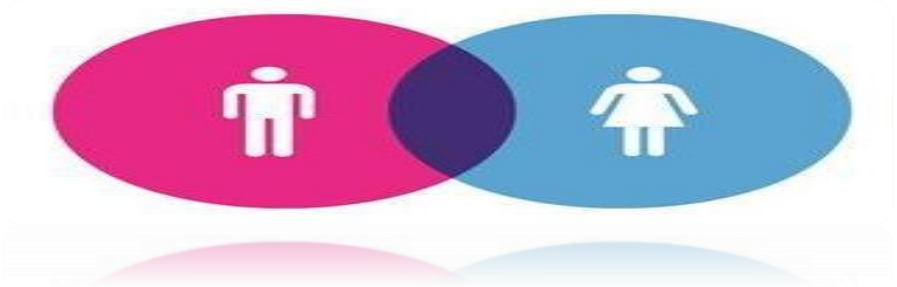


در زمینه سن زمان مراجعه ، میانگین سن زمان مراجعه ۲۵.۳۷±۵.۹۷ بود .
.در سن ۲۲ سالگی بیشترین تعداد مراجعه کننده وجود داشت

فراوانی افراد بر اساس استان محل تشکیل پرونده



بیشترین تعداد پرونده (۲۷۲) در استان تهران و سپس خراسان رضوی با تعداد ۱۰۳ پرونده بود.



- نتایج مطالعه حاضر نشان داد که از ۸۳۹ پرونده مراجعه کننده به مراکز پزشکی قانونی کل کشور ، استان تهران بیشترین مراجعه کننده بین سالهای ۹۱-۹۵ را داشته است (۲۷۲ پرونده) ، سپس خراسان رضوی (۱۰۳) و فارس (۱۰۲ پرونده) مراجعه کننده های بیشتری را به خود اختصاص داده بودند. نرخ کلی نارضایتی جنسی در کشور ۰.۰۰۰۰۱ بوده است بیشترین فراوانی در استان های تهران و فارس به میزان ۱در۵۰۰۰۰ بوده است . فراوانی در ۶ استان کشور صفر بوده است . در زمینه جنسیت اولیه افراد ، زنان بیشترین مراجعه را داشتند و نسبت FtM //MtF ۱به ۲ بوده است .
- در سال ۱۳۹۵ بیشترین مراجعه کننده به مراکز وجود داشته است که این می تواند به دلیل افزایش میزان اگاهی و شناخت افراد از این اختلال باشد.

Sheri Berenbaum is a Professor of Psychology and Pediatrics at the Pennsylvania State University, and a member of the Penn State Neuroscience Institute

Department of Psychology, The Pennsylvania State University, University Park, PA, USA

The Journal of Child Psychology and Psychiatry

Journal of Child Psychology and Psychiatry 59:12 (2018), pp 1244–1247 doi:10.1111/jcpp.12997

Evidence needed to understand gender identity: Commentary on Turban & Ehrensaft (2018)

Sheri A. Berenbaum

Department of Psychology, The Pennsylvania State University, University Park, PA, USA

Turban and Ehrensaft (2018) have provided a thoughtful review of transgender identity in children and adolescents.

They have discussed a number of issues about gender identity and have emphasized the benefits of the affirmative approach in maintaining positive psychological health in transgender individuals.

The review reveals gaps in our understanding of gender identity that require evidence before we can be confident that we are providing optimal treatment for children who are gender variant.

Development of gender identity

develop a sense of self

stability and plasticity of identity

the variations within a given identity

Experience of gender identity

developmental trajectory of knowledge about gender

the trajectory of feelings about gender

how gender knowledge is related to feelings

This gap likely reflects two factors:

the vast majority of children identify with their natal sex,

and gender identity has long been viewed as binary.

It is more useful – and scientifically credible – to conceptualize gender identity as continuous

and perhaps two-dimensional (male and female).

Measures of gender identity used in both typical and clinical samples allow for a spectrum of identification with the natal sex

A recent extension conceptualizes and measures gender identity on two (potentially independent) dimensions, allowing for a continuum of identification with the natal sex and a parallel continuum of identification with the other sex

Links between gender identity and other gendered characteristics

They consider gender expression (e.g. appearance, activities) to be 'an individual's outward presentation of . . . gender identity.'

In contrast, the American Psychological Association (2015) notes that 'gender expression may or may not conform to a person's gender identity.'

Furthermore, their definition of 'gender nonconforming/ gender variant/gender diverse' combines variations in gender-stereotypical behaviours with variations in gender identity.

- gender expression may or may not conform to a person's gender identity.
- gender development is multidimensional
- evidence shows a weak link between gender identity and other aspects of gender (gender expression, variations in gender-stereotypical behavior

- Although transgender children are gender-atypical in some behaviours, particularly appearance and interests, the converse is not true:

most children who have gender-atypical interests are cisgender.

For example, girls with early androgen exposure due to congenital adrenalhyperplasia(CAH) are interested in and engage with boys' toys, but identify as girls

variations in gender-typed behaviour are common among cisgender children.

In contrast, individuals whose transgender identification emerges during or after adolescence may have interests that are typical for their natal sex.

Compelling data make clear that an atypical gender expression is not an indication of either transgender identity or nonbinary gender identity(neither male nor female)

Gender identity change and plasticity

Rather than being immutable, gender identity is plastic – in both directions.

The majority of children with gender dysphoria desist in adolescence, although much remains to be learned about factors that differentiate children who will persist versus desist.

Interestingly, social transition contributes to persistence, and it is unclear whether it does so by allowing children to be who they really are, or instead pushes them to assume a binary identity when they would have been happy with a nuanced cisgender identity that does not involve medical interventions

Affirmation benefits and costs

Little is known about the long-term costs of affirmation or the ‘medicalization’ of gender identity.

Interventions to alter the body to accord with a transgender identity have significant long-term.

consequences, but decisions about those interventions are made when children are in distress and when **their cognitive capacities may not be fully developed**.

It is important to study, for example, effects of hormonal interventions on :

- Developing brain (particularly during the sensitive period of adolescence),
- fertility concerns (will people regret sacrificing their fertility?),
- health risks (e.g. hormonal effects on bone

- A caution about the affirmation approach arises from the tendency on the part of some people (both children and clinicians) to use gender expression or adherence to gender stereotypes as a marker of gender identity.

- This contrasts with the evidence that most children who are gender-atypical in their appearance and behaviours are not transgender

Oddly, increased tolerance for transgender identities might be associated with reduced tolerance for non-normative gendered presentation and activities.

It does not and should not require gender change to act in gender-atypical ways, nor does acting in gender-atypical ways signify a need for gender transition

The assumed (but scientifically unsupported) equivalence of gender-atypical expression and transgender identity has adverse consequences:

- it reduces the freedom of children to behave in ways that transcend gender roles,
- perpetuates the gender binary
- and reinforces gender stereotypes.

Conclusions

Optimal care for gender nonconforming children requires much more evidence than is currently available.

- First, we need to understand the nature of gender identity and how it develops
- Second, we need to understand what accounts for plasticity in gender identity.
- Third, we need to differentiate clearly gender identity from other aspects of gender, and understand when and how they might be related.
- Fourth, we need to examine carefully the long-term benefits and costs of affirmation and subsequent medical treatments – and determine when they are appropriate or not.

Gender expression and gender nonconformity are not isomorphic with gender identity, and it is a mistake to use them to mark a child's gender identity

We need to understand when gender nonconformity reflects transgender identity, and when it does not.

None of this is meant to deny affirmative protocols to children who undergo assessments and are confirmed to be gender dysphoric, but rather to be cautious in applying powerful and irreversible medical interventions