

Characteristics of children and adolescents with gender dysphoria for their health care: scoping review

Características de crianças e adolescentes com disforia de gênero quanto ao cuidado à saúde: revisão de escopo
Características de niños y adolescentes con disforia de género para su atención en salud: revisión del alcance

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Abstract

Objective: To identify the demographic and psychosocial characteristics of children and adolescents with gender dysphoria and of the health professionals involved in their care. **Methods:** Scoping review according to PRISMA-ScR with the databases Web of Science, Science Direct, Scopus, Virtual Health Library and Pubmed, using the descriptors: children, adolescents, gender dysphoria, pediatrics and health professionals. Inclusion criteria: primary and secondary research on gender dysphoria and sexual diversity in health care, with students or health professionals. Exclusion criteria: adult population, other context of health care, treatments, comorbidities and gray publication. Fifteen articles were included. **Results:** Children present with dysphoria around 6 years of age, with late diagnosis and treatment. They have a greater tendency toward mental health problems such as anxiety, depression and eating disorders, and family support is crucial. Health professionals have low undergraduate training, scarce continuous training and multidisciplinary work. **Conclusion:** It is necessary to incorporate subjects on diversity, gender identity and dysphoria into the training of health professionals, as well as continuous training with tools that allow a comprehensive approach, increasing confidence and security in the provider-patient relationship, in order to improve the well-being of children.

Descriptors: Gender Dysphoria; Health Professionals; Child; Adolescent; Pediatrics.

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What is already known on this?

Children and adolescents who present with gender dysphoria are treated late by professionals who do not have knowledge of how to relate to them and how to conduct their treatment, which alters their development.

What this study adds?

The need to provide tools on gender diversity in primary health care professionals and educational centers, which support the detection of behaviors associated with gender dysphoria.



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Resumo

Objetivo: Identificar as características demográficas e psicossociais de crianças e adolescentes com disforia de gênero e dos profissionais de saúde envolvidos no seu cuidado. **Métodos:** Revisão de escopo segundo o PRISMA-ScR com as bases de dados Web of Science, Science Direct, Scopus, Biblioteca Virtual em Saúde e Pubmed, usando os descritores: crianças, adolescentes, disforia de gênero, pediatria e profissionais de saúde. Critérios de inclusão: pesquisas primárias e secundárias sobre disforia de gênero e diversidade sexual na assistência à saúde, com estudantes ou profissionais de saúde. Critérios de exclusão: população adulta, outro contexto de assistência à saúde, tratamentos, comorbidades e publicação cinza. Quinze artigos foram incluídos. **Resultados:** As crianças apresentam disforia por volta dos 6 anos de idade, com diagnóstico e tratamento tardios. Têm maior tendência a problemas de saúde mental como ansiedade, depressão e distúrbios alimentares, sendo fundamental o apoio familiar. Os profissionais de saúde possuem baixa formação de graduação, escassa formação permanente e atuação multidisciplinar. **Conclusão:** É necessário incorporar na formação dos profissionais de saúde temas sobre diversidade, identidade de gênero e disforia, bem como formação contínua com ferramentas que permitam uma abordagem abrangente, aumentem a confiança e a segurança na relação prestador-paciente, de forma a melhorar o bem-estar das crianças.

Descritores: Disforia de Gênero; Profissionais de Saúde; Crianças; Adolescente; Pediatria.

Resumen

Objetivo: Identificar las características demográficas y psicossociales de niños y adolescentes con disforia de género y de los profesionales de la salud involucrados en su atención. **Método:** Revisión de alcance según PRISMA-ScR con las bases de datos Web of Science, Science Direct, Scopus, Biblioteca Virtual en Salud y Pubmed, con los descriptores; niños, adolescentes, disforia de género, pediatría y profesionales de la salud. Los criterios de inclusión: investigaciones primarias y secundarias sobre disforia de género y diversidad sexual en la atención de salud, con estudiantes o profesionales de la salud. Los criterios de exclusión: población adulta, otro contexto de atención de salud, tratamientos, comorbidades y publicación gris. Se incluyeron quince artículos. **Resultados:** Los niños presentan disforia alrededor de los 6 años de edad, con diagnóstico y tratamiento tardío. Poseen mayor tendencia a sufrir problemas de salud mental como ansiedad, depresión y trastornos alimentarios, siendo crucial el apoyo familiar. Los profesionales de la salud cuentan con baja formación en pregrado, escasa capacitación continua y bajo trabajo multidisciplinario. **Conclusión:** Es necesario incorporar en la formación de los profesionales de la salud materias sobre diversidad, identidad de género y disforia, así como la capacitación continua con herramientas que permitan un abordaje integral, aumentar la confianza y seguridad en la relación proveedor-paciente, para mejorar el bienestar de los menores.

Descritores: Disforia de Género; Profesionales de Salud; Niño; Adolescente; Pediatría.

INTRODUCTION

Over the years, society has been confronted with various advances as a result of the change in human rights perspectives, generating movements whose objective is the depathologization of non-binary gender identities.⁽¹⁾

A rethinking and analysis of already established concepts have arisen, including “biological sex” and “gender identity”, which have made it necessary to reach a consensus on certain definitions and understandings. The first is the attribution of “sex,” which refers to the biological characteristics that define men and women.⁽²⁾ The second is gender identity, which, in turn, is understood as the personal and internal perception of what it means to be a man, a woman or another option, which does not always coincide with your biological sex. Therefore, it is a spectrum that is not necessarily limited to female and male identities, being able to approach the extremes, moving from one to the other, or not identifying with either. ⁽¹⁾

This should be taken into consideration the constant and evolutionary questioning of people about the need to comply with certain standards and stereotypes that are assigned to the biological sex with which they were born, which has been strongly influenced by culture, depending on the context and place where they are.⁽¹⁾

From the theory, gender identity is constructed by the continuous feedback generated between the environment and the biology one possesses, generating an internal self-categorization that is related to the learning of stereotypes, behaviors and roles. Therefore, it is considered a dynamic, multicausal phenomenon, of social and cultural construction.⁽³⁾

For Bem, once children are categorized, they will follow the personality characteristics, roles or behaviors associated with the group in which they identify themselves. From the social perspective, one should highlight the influence of stereotypes on behaviors and the construction of individual perception, learning through models and reinforcements, the demands associated with the socially established role and the categorization motivated by the valuation of a group or according to the integrating proposal, where individuals will have an identification product of the interactions they establish.⁽³⁾

The fact of considering that minors are active receptors of their environment helps to understand the appearance of Gender Dysphoria (GD) from infancy onwards, as they can express, from the age of 2 years, a persistent desire to be of another sex, discomfort with their primary sexual characteristics or prefer clothes, toys, activities, etc. that are socially attributed to the opposite sex.⁽⁴⁾

The DSM-5 American Psychiatric Guidelines defines GD as “incongruence between one’s felt or expressed sex and one’s assigned sex, lasting at least six months”,⁽⁵⁾ adding that gender incongruence corresponds to “a marked and persistent incongruence between an individual’s experienced gender and assigned sex”, where behavior and gender variants alone are not sufficient for a diagnosis.⁽⁶⁾

On the other hand, gender variability or identifying as transgender is not inherent to experiencing gender dysphoria,⁽⁷⁾ understanding the definition of trans as “those who do not meet the expectations of the sex assigned at birth and recognize themselves beyond the binary reference ‘boy’ or ‘girl’, based on the external interpretation of the physiological data used to demarcate a mandatory gender”.⁽⁸⁾ In turn, cisgendered is defined as identifying with the gender that is congruent with the natal sex.⁽⁹⁾

For decades, any gender expression that differed from cisgender was pathologized due to non-compliance with the stereotypes provided by society,⁽¹⁰⁾ whose non-compliance brings with it the appearance of dysphoria, a feeling that does not originate from gender non-conformity, but rather from subjective experiences associated with situations of discrimination and rejection in the different social spaces in which children and adolescents live.⁽¹⁾

It is therefore important to clarify that GD is not a mental pathology, as classified in the eleventh international version of diseases (ICD- 11), where a rethinking of these concepts was generated, aiming to eliminate stigmas and provide a “greater clinical utility and better response to the needs, experiences and rights of the populations involved”.⁽¹¹⁾

The concept of GD has been subjected to various criticisms and modifications over the years. In 1978, Dr. John Money, psychologist and sexologist, created the concept of “gender identity disorder” for people with “gender-crossed behavior”, that is, with behaviors that are socially attributed to the other gender.⁽¹²⁾

This idea was transformed into the current definition of GD, which defines it as anxiety and distress related to gender and sex conflict that are incongruent, which can lead to extreme anxiety, depression and suicidal tendencies that are exacerbated if family, friends, educators and health care providers are not supportive.⁽¹³⁾ The onset of dysphoria manifestations can occur between the ages of 3 and 7 years.⁽¹⁴⁾

Generally, GD increases as the child grows up, as a result of internal confusion, family concern and social stress generated by stigmatization in the school environment, religions, communities, etc. Therefore, they tend not to express their gender identity in order to fit in with social expectations, triggering mental disorders and alterations in the development and acceptance of their personality, self-esteem and identity, among others.⁽⁹⁾

Worldwide, data provided by the 2014 “Diagnostic and Statistical Manual of Mental Disorders” indicate a prevalence of between 0.005 and 0.014% of men and 0.002 to 0.003% of women meeting diagnostic criteria for gender dysphoria at birth.⁽¹⁴⁾ However, a study held in 2017 in Finland indicates that 1.3% of young people aged 16-19 years have gender dysphoria,⁽¹⁵⁾ while a study held in 2018 in Tokyo indicates a prevalence of 0.5% in boys and 1.6% of girls aged 3-12 years.⁽¹⁶⁾

On the other hand, in 2021, M. Di Grazia published that the prevalence of GD is influenced by the case definition and by the various methodologies applied by providers to evaluate cases, reporting a prevalence ranging from 1% to 4.7%, with predominance of male-to-female transition for children and from 1.2% to 16.1% in adolescents, among which female-to-male transition predominant.⁽¹⁷⁾

In Chile, despite the relevance of having specific data, there are no sources with concrete figures on the number of children with GD. However, support has been provided to advance steadily in the quality and breadth of care mechanisms for this group. One of the most significant advances has been the enactment of the Gender Identity Law in December 2018, which recognizes and gives protection to the right to identity in legal documents, both public and private, so that people are recognized and identified according to their gender identity.⁽¹⁸⁾

This accompanied by the first attempt to characterize a gender diverse population, through the T-survey, which included the transgender and gender non-conforming group, where it has not been possible so far to incorporate the participation of minors.^(1,19)

Health professionals have the opportunity to create direct contact with minors and adolescents in different contexts, such as regular health check-ups according to the life cycle, educational establishments, morbidity check-ups, etc. This is how the accompaniment performed at an early age in those who present with incongruence in their gender identity is directly linked to the functionality of the child in a healthy and comprehensive manner.⁽¹⁾

Although there has been progress in gender identity issues, there is still a lack of concrete information regarding prevalence and knowledge, considering that childhood and adolescence are crucial stages to address this issue, since they are amid physical, emotional and psychological problems and gender identity development.

Therefore, it is important to have the necessary skills to identify early gender incongruencies, dysphoria symptoms and to relate appropriately in different contexts of care, which would improve their approach and prevent possible present and future complications. It is important to recognize the manifestations of GD, understanding the importance of intervening in time so that these feelings of anguish and sadness do not interfere in the development of children and adolescents.

From the above, the research question that arises according to the PCC acronym is: What are the demographic and psychosocial characteristics of children and adolescents with gender dysphoria and that of the health professionals involved in their care? The general objective of this review is to identify the demographic and psychosocial characteristics of children and adolescents with gender dysphoria and of the health professionals involved in their care.

METHODS

In order to answer the research question, a scoping review⁽²⁰⁾ was conducted according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR).⁽²¹⁾ Databases with a focus related to health sciences were considered, namely: Web of Science (WoS), Science Direct, Scopus, Virtual Health Library (BVS) and PubMed.

The synthesis focused on a scope review was adopted, according to the approach proposed by Arksey H and O'Malley L, who identify four aspects to consider: review existing works and scientific information, including less related areas; perform a prior bibliographic search to determine the feasibility of the study; summarize the results of investigations; and identify the current gap.⁽²⁰⁾

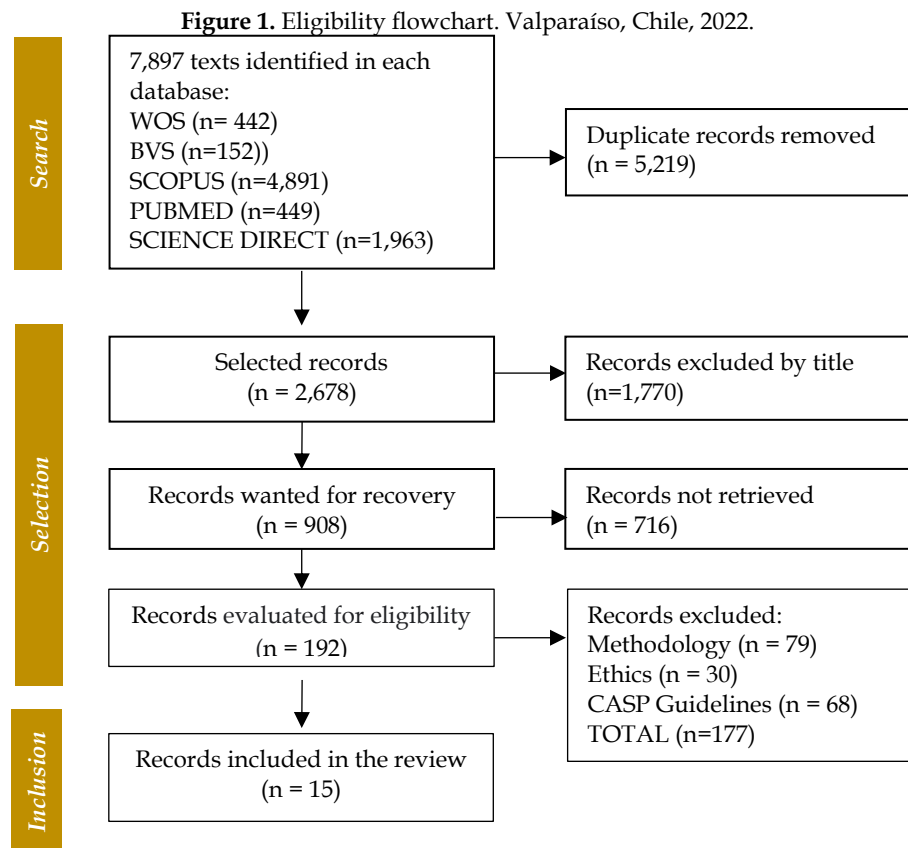
The standardized descriptors found in *Descritores em Ciências da Saúde* (Decs) and Medical Subject Headings (Mesh) were used, where Gender Dysphoria, Child, Adolescent, Health Professionals and Pediatrics were selected. These terms were combined with the Boolean operator AND, dispensing with any other operator or truncator, as this would shorten the search.

The search combinations, both in Spanish and English, were: Gender dysphoria AND health professionals, Gender dysphoria AND adolescent AND health professionals, Gender dysphoria AND children AND health professionals, Gender dysphoria AND Pediatrics. In addition, the filters used for this were the last 5 years, from 2017 to 2022, type of document; original articles and reviews, in order to answer with better evidence, and language: Spanish, English and Portuguese.

The described search generated a total of 7,897 texts, eliminating 5219 that were duplicates through the EndNote bibliographic manager, leaving 2678 texts.

The rescued texts were entered into an Excel. For the selection to be discerned according to the reading of the title and abstract, the following inclusion criteria were considered: primary and secondary research on gender dysphoria, or sensations associated with its definition (such as anguish, sadness, anxiety, etc.), gender dysphoria associated with sexual diversity in the context of health care and associated with students or health professionals. On the other hand, the exclusion criteria were: texts associated with adults and other contexts of health care, treatments, comorbidity recovery and gray publication. Based on the above, 2485 texts were eliminated and 192 were chosen.

Finally, critical analysis was performed through full text reading, where the quality of the articles was evaluated in terms of methodology, congruence and ethical aspects, with the support of CASP Guidelines.⁽²²⁾ By reviewing qualitative and quantitative articles, 117 texts were eliminated. For the selection and eligibility stages, the review was performed in duplicate, independently, with the support of a third author in case of doubts and with final consensus, resulting in 15 primary and secondary research articles for the review. The systematization is summarized in the eligibility flowchart (Figure 1) following PRISMA 2020 recommendations.⁽²³⁾



Source: Elaborated by the authors (2022).

RESULTS

Of the total number of texts obtained in the search, 7,882 texts were eliminated, and of the articles included for this review, the largest number of publications belong to the years 2018 (5) and 2021 (5), representing 33.3% each. In terms of language, 86.6% of the articles are in English, mostly from America, where 40% originated in the USA.

Considering the type of study, these articles were mainly qualitative and quantitative, 40% and 46.6%, respectively, where the majority consisted of nursing professionals, with 40%. What is described above is presented in Box 1, together with the characterization of the selected articles.

Box 1. Characteristics of the selected articles. Valparaíso, Chile, 2022.

Title /Year	Authors	Country/Language	Methodology / Sample
1.School-Based Nurse. Practitioners' Perceptions of the Health Care Needs of Transgender and Gender Nonconforming Adolescents. 2021 ⁽²⁴⁾	Davis J, Hequemburg A, Pamplum P.	United States/ English	Qualitative descriptive study. 6 female nurses, American, aged 42 to 65 years, with an average of 18.5 years of practice belonging to the New York School-Based Health Alliance (NYSBHA), which advocates for school-based health centers in New York State.
2.Descriptive Study of Transgender Youth Receiving Health Care in the Gender Identity Program in Southern Brazil. 2021 ⁽²⁵⁾	Machado B, Fontanar A, Brandelli A, Chinazz I, Cardoso D, Guadagnin F et al.	Brazil/ English	Quantitative descriptive study. 24 Brazilian youths aged 8 to 16 years with gender dysphoria and 34 of their caregivers: 21 mothers (aged 27 to 61 years) and 13 fathers (aged 30 to 64 years).
3.Gender Dysphoria in the Pediatric Population: Initial Experience of a	Moreno-Bencardino C, Zuluaga L, Pérez J, Céspedes-	Colombia/ English	Quantitative descriptive study. Four cases of adolescents with gender dysphoria aged 12, 14, 16 and 17

Transdisciplinary Group. 2021 ⁽²⁶⁾	Salazar C, Forero C & Fernández C.		years. Three of them with female gender identity and one male.
4.Negotiating Gender in Everyday Life: Toward a Conceptual Model of Gender Dysphoria in Adolescents. 2021 ⁽²⁷⁾	Jessen RS, Wæhre A, David L, Stänicke E.	Norway/ English	Qualitative phenomenological study. 15 patients aged 13-19 years, newly referred to the National Treatment Unit for Gender Incongruence at Oslo University Hospital.
5.Progression of Gender Dysphoria in Children and Adolescents: A Longitudinal Study. 2021 ⁽²⁸⁾	Wagner S, Panagiot L, Nash R, Bradlyn A, Getahun D, Lash T, et al.	United States/ English	Quantitative longitudinal study. 958 minors belonging to Kaiser Permanente (KP) integrated health care systems in Georgia, northern and southern California, with at least one follow-up appointment and evidence of gender dysphoria, without having received gender-affirming therapy.
6.Transsexuality: Transitions, detransitions and regrets in Spain. 2020 ⁽²⁹⁾	Pazos M, Gómez M, Gomes M, Hurtado F, Solá E & Morillas C.	Spain/ Spanish	Qualitative study. 4 cases of transition/regret; 3 adults and 1 adolescent who experienced gender dysphoria in adolescence and are beginning social transition.
7.Pediatric nurse practitioners' attitudes/beliefs and knowledge/perceived competence in caring for transgender and gender nonconforming youth. 2020 ⁽³⁰⁾	Collins CA.	United States/ English	Quantitative cross-sectional descriptive research. 93 nurses in the United States, aged 26 to 74 years. From 1 to 42 years of practice in 8 states: Arizona, Louisiana, New Jersey, New York, Oregon, Pennsylvania, Virginia and Washington.
8.LGBT youth in foster care and the critical advocacy role of Public Health Nurses. 2019 ⁽³¹⁾	Carabez R & Kim JE	United States/ English	Quantitative study. 39 US nurses working with LGBT minors in foster care in the San Francisco Bay Area (United States).
9.Perspectives From Nurses and Physicians on Training Needs and Comfort Working With Transgender and Gender-Diverse Youth. 2019 ⁽³²⁾	Rider N, McMorris BJ, Gower AL, Coleman L, Brown C & Eisenberg ME.	United States/ English	Qualitative study. 8 nurses and 6 physicians belonging to the multidisciplinary team at the University of Minnesota working with adolescents.
10.Supporting LGBTQ+ Students: A Focus Group Study with Junior High School Nurses. 2019 ⁽³³⁾	Laiti M, Pakarinen A, Parisod H, Hayter M, Sariola S & Salanterä S.	Finland/ English	Qualitative descriptive study. 15 nurses with work experience with LGBTQ+ high school students and who were native speakers of Swedish or Finnish, in 4 municipalities in southern Finland.
11.Moral challenges in transgender care: thematic analysis based on a focused ethnography. 2018 ⁽³⁴⁾	Gerritse K, Hartman L, Antonides MF, Wensing-Kruger A, de Vries ALC & Molewijk BC.	Netherlands/ English	Qualitative descriptive study. 10 observations of meetings between multidisciplinary teams at the Center for Expertise in Gender Dysphoria (CEGD) in Amsterdam, The Netherlands.
12.Mental Health Staff Perceptions and Practice Regarding Self-Harm, Suicidality and Help-Seeking in LGBTQ Youth: Findings from a Cross-Sectional Survey in the UK. 2018 ⁽³⁵⁾	Hughes E, Rawlings V & McDermott E.	United Kingdom/ English	Quantitative cross-sectional study. 113 health professionals working in different mental health settings in the National Health Services of England and Wales, North West regions, London and Yorkshire.

13. Disforia de Gênero em crianças: revisão integrativa da literatura e recomendações para o manejo na Atenção Primária à Saúde. 2018 ⁽¹⁶⁾	Oliveira-Mariano T & Moretti-Pires R.	Brazil/ Portuguese	Integrative review. 12 research articles found in PubMed, Medline, Lilacs, Scielo databases, published between 2008 and 2018, with the characteristics of comorbidities presented by minors with gender dysphoria.
14. Gender dysphoria in youth: An overview for primary care providers. 2018 ⁽³⁶⁾	Kameg B & Nativio D.	United States/ English	Literature review. Research articles spanning 2012 to 2018, using PubMed and Cinahl databases and references of selected articles.
15. Gender dysphoria assessment and action for youth: Review of health care services and experiences of trans youth in Manitoba 2018 ⁽³⁷⁾	Heard J, Morris A, Kirouac N, Ducharme J, Trepel S & Wicklow B.	Canada/ English	Quantitative descriptive study. File review of 174 patients under 18 years of age referred from the Gender Dysphoria Assessment and Action for Youth of Manitoba (GDAAY) program. In addition to 24 surveyed patients.

Source: Elaborated by the authors (2022).

In the results of the selected articles, as shown in Box 2, one can identify characteristics that can be grouped into those associated with children with GD, distributed in 3 dimensions: demographic, personal and social; while the second group is oriented toward providers, which is related to the training level and work areas where the results should be focused.

Box 2. Grouping of results of the selected articles. Valparaíso, Chile, 2022.

Characteristics of children and adolescents with gender dysphoria for health care.		
Demographic	Age	The age at which they begin to become aware of their gender identity is on average from 6 to 9 years of age ^(25,26,37) and GD begins at around 6 years of age, ⁽²⁶⁾ while its expression is between 12 and 14 years of age. ^(25,26) However, the age at which they receive attention for diagnosis and treatment occurs between 13 and 15 years. ^(28,37) On the other hand, the presence of anxiety or associated depression is frequent between 3 and 12 years of age, and suicidal ideation may occur before 13 years of age. ⁽³⁴⁾
	Sex	Although there is no difference in the recognition of gender incongruence by sex, those who are assigned female at birth and identify with the male gender are identified earlier by their parents ⁽²⁵⁾ , have a higher probability of receiving a diagnosis of dysphoria and initiate treatment, ^(28, 37) present with greater discomfort with their breasts and began their social transition later. ⁽²⁵⁾ In comparison with those who identified with the female gender, who began their social transition earlier ⁽²⁴⁾ and had greater discomfort with their sexual genitalia, they also presented with greater alcohol consumption, psychoactive substance abuse, depression, suicide attempts and psychiatric hospitalizations, while those who identified with the male gender had greater vulnerability to oppositional defiant disorder, anorexia and bulimia. ⁽²⁵⁾
Personal	Required needs	A study conducted in New York indicates that gender non-conforming adolescents with GD have unique mental needs, as there are important social risk factors such as bullying and discrimination, among others, that mainly influence gender-diverse minors. ⁽²⁵⁾ On the other hand, the concerns of children and adolescents are the use of bathrooms and locker rooms, treatment of puberty blockers and safety at school. ⁽³⁶⁾
	Mental health comorbidity	The study conducted in Manitoba reveals that 46.8% had some pre-existing mental health diagnosis, most frequently anxiety and depression. ⁽³⁷⁾ Another study in London shows that children under 12 years of age referred to the specialized center reported bullying, anxiety, self-harm and suicidal ideation. ⁽¹⁶⁾ A study in Brazil showed that children with GD are more prone to risk behaviors, depression, suicide attempts, psychiatric hospitalizations, oppositional defiant disorder, anorexia and bulimia. ⁽²⁵⁾
Social	Family	Parents for acceptance are concerned with the use of bathrooms, locker rooms, general resources, legal issues, and discussion of gender diversity with non-

		family members. ⁽¹⁶⁾ Nursing and medical professionals highlight family support as fundamental to the holistic well-being of minors and crucial to decision-making. ^(30,33,34) On the other hand, it is mentioned that caregiver/family can be a barrier for LGBTQ youth. ⁽³⁵⁾
	Schools/ teachers	While there are teachers who collaborate with nurses and accept dissidence, there are also conservative teachers who openly criticize and judge the LGBTQ+ community. ⁽³³⁾ There is a high percentage of minors presenting with GD who mention having felt rejection because of their gender incongruence and some decided to drop out of school. ^(25,27)
Characteristics of the Providers for the care of children with gender dysphoria		
Training Level	Undergraduate	Studies show that both students and health professionals indicate that there is brief, incomplete or no education on sexual diversity at the undergraduate level. ^(24,32,33) In addition, there is a need to update and add education on gender diversity in the curriculum of the programs, so that students are better prepared to provide adequate comprehensive care. ⁽³⁶⁾
	Continuous training	There is a lack of access to specialized gender-diverse services ⁽¹⁶⁾ because providers have little knowledge and experience. ^(26,34,37) This leads to late referrals to the multidisciplinary team ⁽²⁶⁾ and the patient is the one who must provide education to the provider. ⁽³⁷⁾ Although there are trainings on adolescent sexual health, these are very limited and address basic level topics, ⁽²⁴⁾ which is why health providers express the need for more advanced level trainings to work with gender-diverse children and adolescents, to address terminology, appropriate language to address gender, types of hormonal treatments, surgeries, etc. ^(24,32) A study in the United Kingdom states that better training would increase the degree of awareness, safety and management on the part of providers to discuss these issues with the users they serve. ⁽³⁴⁾ The Manitoba study reported that 65% of children and adolescents indicated that primary care providers did not know enough about transgender care. ⁽³⁷⁾
	Primary health care	Primary care providers are considered the first line of care for children with GD; therefore, they should be informed and available to answer questions from patients and their parents or caregivers. ^(16,36) A study from Brazil points out that the objective of this level of care is to promote the development of physical, emotional and social well-being of children with GD and their families. ⁽³⁵⁾
Work Areas	Provider-patient relationship	The study from Finland noted that nurses are willing to do everything possible to create a confidential and safe therapeutic relationship with minors, try to recognize their needs to assess whether they require information on sexual diversity and gender, ⁽³²⁾ which confirms another study in New York where the importance of being able to create a safe environment, where minors do not feel vulnerable, providing support and confidentiality in care, without discrimination, is recognized. ⁽²⁴⁾ However, the study in Manitoba observed that a high percentage of children with GD have experienced discrimination by providers. ⁽³⁷⁾
	Autonomy of children and adolescents	Physicians and nurses consider themselves to have a dual role: to be protectors of minors and promoters of their rights and autonomy. ⁽³³⁻³⁴⁾
	Working with a multidisciplinary team	The diagnosis of GD requires a multidisciplinary team experienced in the subject, ⁽¹⁶⁾ to create a balance and provide comprehensive care. ^(25,32,34) However, another study in Brazil shows that most children and young people were evaluated by a multidisciplinary team after the onset of puberty, i.e., late. In fact, 1 out of 4 young people had already begun to take hormonal drugs prior to the evaluation by the multidisciplinary team. ⁽²⁵⁾

Source: Elaborated by the authors (2022).

The children's perception of discomfort was associated with exclusion during the pubertal stage⁽²⁷⁾ as well as in the interaction with health professionals during their care⁽³²⁾, with up to 100% of negative interactions with health providers at some point during care.⁽³⁷⁾ As for the pathologization approach to GD, this was detected in the Spanish article where excessive medicalization was reported.⁽²⁹⁾

DISCUSSION

As in the presented results, the literature indicates that GD begins in childhood, from 5-6 years of age and persists without treatment for years, young people live between 22-27 years with dysphoria before they begin gender transition, whether it is hormonal treatment, surgery or social transition,⁽¹⁴⁾ although, in another study of 96 non-binary adolescents, some cases begin earlier, between 16-17 years of age,⁽³⁸⁾ considering that early diagnosis and management during childhood and adolescence can improve quality of life and survival.⁽¹⁴⁾

In relation to sex, there is literature with inverse results indicating that adolescents and young people with male gender identity have a higher level of gender dysphoria compared to those who identify with the female gender,⁽³⁸⁾ who also tend to seek some type of treatment, whether hormonal or surgical.⁽¹⁾ On the other hand, there is no significant difference with respect to risk behaviors and mental illnesses/disorders associated with male or female identity,⁽¹⁴⁾ which is relevant to clarify.

Minors with GD have unique needs, both physical and mental.⁽³⁹⁾ However, the reason why young people seek health system services is related to seeking information about sexual health. Thus, health personnel should address issues such as substance use and risky sexual behavior during any health-related visit with young people.^(40,41) Therefore, the lack of access to gender diversity units⁽¹⁶⁾ and the lack of staff experience^(26,34,37) makes it necessary to begin to give guidance related to any type of support or care based on the needs of children and adolescents.

It is important to understand that the presence of gender dysphoria does not necessarily imply psychopathology, but if any is present, it should be managed in parallel.⁽⁴²⁾ The most frequent psychopathological manifestations are depression, anxiety, oppositional behaviors, decreased academic performance, self-injurious behaviors, self-medication and suicidal behaviors,⁽⁴³⁾ which is consistent with a study in children with GD, where 37% reported disorders, with depression and anxiety standing out most frequently, and to a lesser extent eating disorders, borderline personality disorders and emotionally unstable personality disorders.⁽⁴⁴⁾

Furthermore, in the United States, of the 96 young transsexuals who sought care for their GD, 100% wanted to begin hormonal intervention to reduce dysphoria, of whom 35% reported symptoms of depression, 51% had suicidal thoughts and 30% had attempted suicide at least once. Regarding risk behaviors, approximately 65% of young people with GD reported having consumed alcohol, tobacco and cannabis one or more times, while 43% reported having used drugs such as cocaine, hallucinogens, opioids, tranquilizers and stimulants.⁽³⁸⁾

In the social sphere, the literature confirms that social support, especially from the family, has been identified as a determinant of mental health in transgender youth, in addition to influencing quality of life, well-being, self-esteem, depression, anxiety, stress, suicidal thoughts or attempts.⁽⁴⁵⁾

Parental support is associated with less personal burden of being transgender, fewer depressive symptoms and greater life satisfaction.⁽⁴²⁾ However, the emotional impact on families is a product of the lack of information and knowledge on how to deal with the situation,⁽⁴⁵⁾ which can lead to various reactions, from rapid acceptance to a sense of rejection,⁽⁴⁶⁾ which could foster the development of disorders associated with gender dysphoria in minors.⁽³⁸⁾

The fear experienced by parents due to misinformation about possible consequences of social transition and acceptance in society generates an apprehensive desire for their children to regret or reconsider the transition process.⁽⁴⁷⁾ In addition, denial of treatment by the family is a barrier experienced by children with GD, causing late or limited access to treatment,⁽⁴⁸⁾ considering that a requirement for GD treatment eligibility in the World Professional Association for Transgender Health (WPATH) Standards of Care (SC) is to have a good prior diagnosis.⁽⁴⁹⁾

The results in the school environment^(25,27,33) coincide with what has been reported by transgender youth, who have experienced harassment and discrimination in schools by their peers and even teachers, creating as a consequence that these spaces are seen as dangerous places, which, in turn, increases the risk of school absenteeism and low academic performance,⁽⁵⁰⁾ a situation confirmed in another study with adolescents who identified themselves as transgenders, who were 4.5 times more likely to have been bullied and almost twice as likely to have feared for their personal safety, to have been in a serious physical fight and to have been beaten, compared to their cisgender-identifying peers.⁽⁵¹⁾

The lack of training on gender diversity in undergraduate and work settings is consistent with a study conducted with health professionals and practitioners in the United States, where 90% of the students have no knowledge of gender-diverse populations with GD, while 80% of the professionals interviewed

had never received training on the subject, which makes them feel uncomfortable and insecure when providing care.⁽⁴²⁾

Likewise, a study in the United Kingdom indicated that there were multiple cases of gender-diverse young people who, when accessing the health system for counseling, were the ones who should provide information to professionals in any care setting.⁽⁴⁴⁾ Sometimes, it is the patients themselves who perceive the discomfort, inadequate treatment and insecurity on the part of the health care personnel, and finally it is the professional himself/herself who indicates that he/she does not have knowledge of the subject and cannot provide immediate attention,⁽⁵²⁾ even in primary care, and mentioned that many of the young people choose to keep their gender identity in silence for fear of discrimination by the service provider, and those who have managed to reveal themselves had to educate their own providers about their needs.⁽⁵³⁾ This translates into deficient comprehensive care, with poor counseling, guidance and difficulty in differentiating the type of treatment appropriate for each person.⁽⁴¹⁾

As can be seen in the results, a high percentage of children and adolescents with GD have experienced discrimination by providers, which can be associated with the assumptions of normalized heterosexuality, which makes the patient invisible or has no option for the provider, i.e., the professional assumes the heterosexuality of a person as if it were morally correct, making the population that differs from the assumption invisible.^(42,54)

Details as simple as the language used can mean a barrier to care or send the wrong message to the patient, where no space is given to gender identification, causing fear of exclusion from services or discrimination by health workers, making it less likely that they will reveal their sexual orientation or gender identity to the provider, resulting in poor communication and undermining the relationship.^(40,42)

Likewise, evidence has been found regarding providers making unethical comments and minimizing the consequences of delayed treatment, even mentioning that they would see them again in a while, if they were still alive. However, from a more positive perspective, language and correct communication can be used as tools that significantly improve the patient-provider relationship, which has been evidenced when professionals address adolescents by their chosen name or pronoun, who experience a sense of relief and even euphoria.⁽⁵⁵⁾

On the other hand, it is important to note that the stigmatization of minors is enhanced by having to have the approval of another person in order to develop on the basis of their gender identity, and those who present with a non-binary gender identity are excluded.⁽⁵⁶⁾ In Chile, after a long trajectory and discussion, the Gender Identity Law was enacted. However, those who can opt for this right autonomously are persons over 18 years of age, or between 14 and 17 years of age who have the authorization of their legal representative.⁽¹⁸⁾ Therefore, the theory suggests that the law should consider those under 18 years of age, since they are subjects of law and gender dysphoria occurs at an early age.⁽⁵⁷⁾

Limited or delayed access to hormonal therapies increases GD and, in many cases, young people begin to self-administer substances, such as testosterone, to diminish or accelerate the development of their sexual characteristics, without any type of follow-up and control.⁽⁵⁵⁾

It is important to prioritize the autonomy of children and adolescents, allowing them to make decisions according to their stage of growth, in actions such as a change of hairstyle, which make a great difference in their psychosexual and emotional development, which can reduce symptoms of dysphoria.⁽⁵⁵⁾

Regarding the results on the need to have a multidisciplinary team for the diagnosis of GD, it coincides with the available evidence, which states that it is important to seek a team for the management of children and their families to refer, when necessary, and offer the different types of treatments available, both reversible and irreversible, according to the situation.⁽⁵⁸⁾

Thus, children experiencing gender incongruence should receive an evaluation by a psychologist specializing in pediatric mental health, who can determine and clarify any gender incongruence, recognize limitation of sex reassignment and rule out the presence of an underlying pre-existing psychological health condition.⁽⁵⁹⁾ On the other hand, throughout the diagnostic evaluation, the child psychiatrist evaluates elements of the adolescent's psychosexual development (feelings of gender, sexual experiences, sexual attraction, sexual relationships, sexual fantasies and body image) and general aspects of psychological functioning, such as intellectual development, coping skills, psychopathology and self-esteem.⁽⁴³⁾

In addition, pediatric nurses can be key health care providers when parents question and seek guidance. School nurses, counselors, social service professionals, and psychiatric nurses should also be familiar with the characteristics of gender nonconformity for early identification, intervention and

support,⁽⁶⁰⁾ as delayed assessment by a multidisciplinary team may result in youths beginning to self-administer substances unsupervised.⁽⁵⁵⁾

The review identifies the characteristics necessary to address gender dysphoria and the special needs required by children and young people who go through a long period of time without adequate or sufficient support, providing the approach areas and existing deficits. In addition, it shows the lack of studies related to nursing support in primary care, as well as interventions that favor the process of gender identity in children and adolescents.

CONCLUSION

Even though gender identity has become more visible today, children must wait until adolescence for its expression and management, experiencing in the course of time alterations in their mental health and risk behaviors, which may be influenced by hostile environments in educational establishments or lack of family support. Each child or adolescent must be approached according to their own needs in order to achieve their wellbeing, respecting their autonomy and providing comfort and security in the spaces where he/she develops.

The literature review revealed the lack of undergraduate training in gender diversity; therefore, health sciences training institutions should reevaluate and integrate gender diversity and identity and dysphoria into their programs, addressing terminology, management, types of treatment and elements necessary to provide comprehensive and quality care, based on the needs of children, in order to prevent the onset of gender dysphoria.

Likewise, all health care providers should be trained, with emphasis on those who may have contact with minors, to demystify their attention and to be able to deliver education to their families about their needs and create a welcoming and non-judgmental environment at the time of care, to foster a relationship of trust between the professional and patient and have a better perception and approach.

It is necessary to provide tools on gender diversity to those working in primary care and schools, to detect behaviors associated with gender dysphoria, in order to have an early and continuous approach to avoid the alteration of physical, emotional and social well-being in childhood, which would favor gender identity, comprehensive development and prevention of mental health disorders and suicide attempts.

Although, in Chile, it is possible to perceive a change in the heteronormative view of health, by incorporating the gender approach in the technical standard for the supervision of children in Primary Health Care, more in-depth study of the subject is required globally, both to obtain epidemiological information and to address gender dysphoria in children and adolescents.

The study's limitations are related to the high duplication of articles in the databases, the delimitation of time and three languages in the search process, the lack of open access for some highly relevant articles and the insufficient exploration of dysphoria, associated with gender identity in children and adolescents, who, because they are still in the emotional, physical, psychological and sexual development phase, are sometimes unable to express and communicate their emotions or sensations. For this reason, researchers opt for the opinion of caregivers or when they are older.

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