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TRANS CHILDHOOD AND ADOLESCENCE: REPORTS ABOUT A CHILD AND AN ADOLESCENT WITH GENDER VARIABILITY

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Abstract: Introduction: Transgender subjects have nonconformity between biological/ genital sex and self-classified gender. It is a variation of human sexuality that can be expressed since childhood and requires multidisciplinary care. **Objective:** To describe experiences and health follow-up of a transgender child and adolescent. **Method:** Documentary/longitudinal study, with data obtained from notes/information on clinical and psychotherapeutic follow-up between 2016-2022. Ethical research standards were followed. **Results/comments:** Transgender characteristics were perceived early at home, at school, in clinical consultations and psychotherapy. Individual follow-up was started, according to age, with a multidisciplinary team. The trans girl showed gender fluidity, a common fact in childhood, reinforced by the ban on expressing herself at school, using toys and clothing according to identification. The trans teenager adopted male hair and clothing, changed his name. At puberty, in Tanner's M2 stage, at age 12, he started pubertal block. At the age of 16, he started masculinizing hormones, according to current protocols. Both had dysphoria due to the unwanted body, suffered violence at school and by professionals, before receiving adequate care. Currently, they remain with a multidisciplinary team and the mothers, in a support group for transgender people. **Conclusion:** Health professionals must be empathetic and skilled in recognizing and managing protocols for transgender children and adolescents. Public policies must guarantee specific conduct. This theme must be included in undergraduate and graduate courses in Health and Humanities. People must be guaranteed human rights,

Keywords: Gender Dysphoria; Gender Identity; Transgender Person; human sexuality.

INTRODUCTION

Human sexuality has individual peculiarities or variability, which develop throughout existence and are perceived/ discovered in a unique way. Gender identity, one of these variables, refers to an individual's self-identification as female or male, or some category other than male or female, or none of these categories. (COLEMAN et al, 2022; CIASCA, HERCOWITZ, LOPES-JÚNIOR, 2021; SBP 2020).

All people develop their gender identity. An individual who has concordance between the biological sex assigned at birth, usually based on the observance of the external genitalia, and their gender identity is called cisgender. Transgender, transsexual or trans subjects demonstrate nonconformity between biological sex and self-perceived/felt gender, regardless of age. (CIASCA, HERCOWITZ, LOPES-JUNIOR, 2021; SBP 2020).

Transgender people are a heterogeneous group. Transgender male refers to individuals who identify as male, although they were assigned female biological sex at birth. The transgender woman was assigned male at birth, but identifies as female. Among transgender women, transvestites, a Brazilian feminine identity, with which the pronouns ela/dela must be used. There are also subjects who perceive themselves as having masculine and feminine characteristics at the same time, or in a fluid way, non-binary person, or who do not classify themselves in any of the categories - agender person. (ANTRA, 2022).

The feeling/self-perception of gender identity goes beyond biology and the body, not necessarily needing to be a desire to make bodily changes, and leaves the male-male / female-female binary. Each person is the one who announces their gender identity, a human right to exist and have access to health care, at any stage of life. (COLEMAN et al, 2022; CIASCA, HERCOWITZ, LOPES-JÚNIOR, 2021).

It is important to differentiate gender identity from affective-sexual orientation, both self-reported but independent. Orientation is the presence, or absence, of erotic/affective desire and to whom the desire is directed. Heterosexual people feel attraction/desire for subjects of gender other than their own. The other guidelines refer to lesbian, gay, bisexual, pansexual, asexual and other self-classifications. (HERCOWITZ, FERNANDES, CRENZEL, 2022).There are also Intersex People (IP) who have atypical genitalia, resulting from a biological plurality involving chromosomes, hormones and internal sexual organs. IP develop gender identity and affective-sexual orientation, regardless of interventions carried out on their bodies in childhood and, therefore, acts without the person's involvement. (ABRAI, 2022).

These human diversities are represented in the acronym LGBTQIA+, representative of gender identities and affective-sexual orientations: Lesbians, Gays, Bisexuals, Transgenders or transsexuals/transvestites, Queer (generic term for people who do not recognize themselves in cis-heteronormativity), Intersex, Agenders and Asexuals. The plus is a sign for people who don't feel represented in the acronym, such as pansexuals (attraction to people regardless of their gender) and non-binary people/ies - gender fluidity. (HERCOWITZ, FERNANDES, CRENZEL, 2022; CIASCA, HERCOWITZ, LOPES-JÚNIOR, 2021).

Gender incongruence (GI) is the term adopted to describe the nonconformity between biological sex and gender in the 11th International Statistical Classification of Diseases and Related Health Problems, ICD-11(WHO, 2019).It is important to emphasize that the GI moved from the chapter "Mental disorders" to "Conditions related to sexual

health", maintaining the classification in order to allow adequate follow-ups, never to pathologize(HERCOWITZ, FERNANDES, CRENZEL, 2021).

GA is an uncommon human trait. According to an international registry, the ratio between boys and girls is 2:1 to 4.5:1 in childhood, and 1:1 to 6.1:1 in adolescence. (AAP, DSM-5 2013).In Brazil, there are no official prevalence records for children and adolescents under 18 years of age. A recent publication referring to the Brazilian population registers 0.68% among adults identifying themselves as trans and about 1.2% of adults who recognize themselves as non-binary. (SPIZIRRI, EUFRASIO, ABDO et al., 2022).

The genesis of the GI is complex and always being updated. At the moment, research indicates a conjunction of elements, with no single factor. In the embryo, genital differentiation takes place in the first trimester of pregnancy, while the morphofunctionality of the brain - influenced by mutations in mitochondrial DNA, alterations in chromosomes, maternal hormonal influence, epigenetic factors - occurs in the second gestational trimester. Thus, genital sex and brain dimorphism are diverse, which allows the emergence of gender incongruence. This demonstrates why it goes beyond genital determinism and therefore gender binarity. (FERNÁNDEZ, RAMÍREZ, DELGADO-ZAYAS et al., 2022; BOUCHER, CHINNAH, 2020;).

The innate biological diversity of trans identities does not explain all cases, such as identical twins where only a minority are both transgender. This fact shows the importance ofarticulation with elements of psychological and social sciences (POLDERMAN, KREUKELS, IRWIG et al, 2018).

Winnicott's theory of maturational development (1945, 1957), a British psychoanalyst, introduces a unique perspective. In the Winnicottian subject, the development of sexuality is part of the creative potential with which every child is born and will be built from elements arising from experiences in the family and social environment. Psychic elements emerge in the form of welcoming and caring (by mother, father, relatives, society), through symbols and language, but far from the binary cultural structure. Thus, sexuality is constituted in the process of integration of the self. (WINNICOTT, 1945/2021, 1957/2021).

In this sense, sexuality is not something rigid, starting to occupy the space of playing, fantasy, dream and freedom. Integration gives the feeling of continuity of being and only exists when there is no submission to other people's desires, including culturally determined ones. (ALMEIDA, 2021).

In cis-heteronormative society, there is often repression due to transphobia, negative attitudes, beliefs and discrimination against the trans population, affecting children and adolescents equally. (COLEMAN et al., 2022). Its roots are in the social-psychic structure of cis-heteronormativity, which considers any other existence inappropriate.(BORTOLINI, VIANNA, 2022).

In the family, such violence is presented as denial and/or repression of the child's/adolescent's gender identification. (FAVERO, 2022; VAZ, 2021; SEPULVEDA et al, 2018).In the school environment, there is bullying and hostility from employees/teachers, including banning the social name, toys not considered appropriate and using the bathroom according to the gender of identification(ANTRA, 2022, NUNES, 2021).

As a result, various psychopathologies may arise, such as anxiety, depression, dysphoria (discomfort/suffering due to unwanted body characteristics), self-mutilation, introjected prejudice (assimilation of the structural

transphobia of cis-heteronormative society), school exclusion, in addition to homicide and even suicide. Much of this violence could be avoided with adequate family and social support.(ANTRA, 2022, OLSON et al. 2016).

The reality described above shows the importance of recognizing and caring for gender variability, both individually and in public health. However, there are still few works with this theme in Brazilian literature. The objective of this article is to describe the experiences of a trans girl and a transgender teenager, in addition to the management of multidisciplinary care.

METHOD

Documentary study, with data obtained from the clinical and psychotherapeutic follow-up notes of two patients in a private clinic, supervised by professionals from the public network, between 2016 and 2022. Ethical norms were strictly followed - agreement of the mothers and assent of the adolescent, guaranteed total anonymity and use of data only for scientific purposes. (BRAZIL, 2012). After a thorough reading, excerpts from the most significant speeches and attitudes were chosen, analyzed according to the criteria of the ICD-11 (WHO, 2013) and the rules of conduct in force in the Brazilian territory. (CFM, 2019; MINISTRY OF HEALTH, 2013).

REPORT - CASE 1

J., male assigned at birth, seven years old, resident of a Brazilian metropolis, healthy. Parents are divorced, both with higher education and professional/financial stability.

The mother reports that between two and three years old, J. showed admiration for makeup and feminine accessories and always preferred to play with girls. At the age of four, she asked for dolls, houses and kitchen sets as gifts. At the age of five, she began to suffer bullying and her mother chose to change her school. At the new school, J. was forbidden to take dolls "because of other parents" and to avoid new episodes of bullying. At the age of six, he began to regret having to "use the boys' bathroom", but expressed fear that "the little friends would know about his pitoca" (regional term for the penis). At the age of seven, J. showed sadness, mentioned hating himself, crying and stating: "I'm a girl! Why am I never going to be a real girl? I'm a girl!". At that time, she chose a feminine social name, not allowed at school. At home, in addition to using "girls'" toys, his mother allowed him to wear feminine clothing and lipstick, although his father did not agree. He wore men's clothing outdoors and, when permitted, took the dolls.

The mother resorted to several health professionals - mental and clinical - who refused to assist or gave opinions without scientific basis. In 2019, he began psychotherapeutic follow-up with a specialized professional. During the process, they stood out: "My name is J., I'm five years old, I like girls' toys!". She used to draw characters without arms and/or legs, with significant traces of the falus, in colorless strokes. She also drew characters with simultaneous girl/boy characteristics, always with phallic doodles. Throughout the sessions, J. presented fluid social experiences, sometimes socially attributed to the male gender, sometimes in the female field.

Currently eight years old, J. remains in the psychotherapeutic process, uses the social name and women's clothing in family environments. Her mother joined a support group and felt "more enlightened, it is a slow process and needs patience to have more understanding of society and school". Her daughter is now "happier, being respected in the transition and understanding gender fluidity. Acceptance is still an issue, but I love my child, whether he or she is."

REPORT - CASE 2

B. was born with female assigned biological sex; Born in a Brazilian metropolis, he has good socioeconomic conditions and excellent health. Her parents are divorced and B. lives with her mother, a university professor. According to the mother, at the age of three, B. began to ask: "Mother, when will I have a baby? I want to be a boy!" From the age of four, he had crying spells and exclaimed "Why did God do this to me? and started not accepting dresses or training ballet. Between five and seven years, he became aggressive and in a depressed mood, maintaining the assertion of "I'm a boy!". At the age of eight, he chose his male name and began to wear clothes associated with that gender. At age nine, he wore his hair short, refused to use the women's restrooms, and asked them to use male pronouns (he, his) in conversation.

She began psychotherapeutic follow-up at the age of nine, in 2016, due to the persistent demand for a dissonant gender identity. In the process, speeches such as: "I like to play with boys; we run and sometimes fight. I also practice futsal and I like to play with superheroes, dinosaurs and cars". His drawings always showed boys playing ball or a boy with his mother. Once, B. verbalized spontaneously: "I know why I'm here, I'm a boy... a different boy."

At age 10, he was referred to a broad multidisciplinary team. When presenting breast development in Tanner's M2 stage, aged 12, he started puberty blockade, with experimental protocol. Currently B. is 16 years old, persists with psychotherapy and multidisciplinary team. He has already rectified his name (civil documents) and started masculinizing hormones. His mother participates in a support group and has become an activist, welcoming other trans children and adolescents, and family members.

DISCUSSION

The article describes excerpts from the consultations of two people, a child and a teenager, over a period of six years, who presented evident characteristics of GA - persistent verbalization of being of a different gender than the one recognized at birth, rejection of genital and pubertal characteristics, use of clothing, toys, games or activities and prefer companies according to gender identification, among others.

Such characteristics and behaviors emerged from early childhood and persistently. Studies indicate that gender identity, whether cis or trans, can be expressed between two and three years of age. (SBP, 2020),although some authors record such identification even before two years(DIAMOND, 2020; PASCOTO, 2006).

The social manifestations and verbalizations found often pointed to the binary way of speaking and categorizing, especially in children. Thus, the trans girl showed fluidity, sometimes with feminine social expression, sometimes masculine. This can be justified by the assimilation of habits and language from cis-heteronormative, socially structured culture. (DIAMOND, 2020; RAFFERTY, 2018).

Several studies point to behavioral variation due to restraint in showing gender identity, exemplified in the non-use of clothes and bathroom according to the identified gender. (COLEMAN, 2022; CIASCA, HERCOWITZ, LOPES-JÚNIOR, 2021)corroborating this study. Otherwise, fluid expression can remain in non-binary gender people, a fact that will be confirmed over time, or not. (DIAMOND, 2020; RAFFERTY, 2018).

The girl and the adolescent presented dysphoria (anguish, sadness for the body or biological characteristics that are not accepted), even at early ages. This fact was perceived in the drawings, representative

of incomplete and uncolored bodies. In adolescents, dysphoria was redimensioned by the emergence of secondary sexual characteristics, which distance the real body from the idealized one.

In fact, a child realizes that his genitals do not change just because of desire around the age of seven, or earlier. (SBP, 2020).

International and national protocols. (COLEMAN, 2022, CFM, 2019; WIEPJES, NOTA, BLOK et al., 2018)define accompaniment in the process of gender affirmation, or transsexualization, through scientifically proven norms.

For the transgender girl, carrying out the psychotherapeutic process and consultations with the mother (the father refused), allowed social changes for the expression of her gender identity; reflected in better adaptation of family members and attitudes at school and in the extended family. It was recommended not to tolerate transphobia, including at school and with family members, through meetings for clarification or even distancing.

A national study reveals that structural transphobia, expressed in rejection by family members and at school, has important repercussions on mental health, anxiety, depression, self-mutilation and suicidal thoughts. (NUNES, 2021).In fact, the girl and the teenager suffered this violence and showed changes in mood, being carefully evaluated and their mothers guided, always.

In the trans adolescent, pubertal blockade and masculinizing hormone were performed following Brazilian protocols. It must be noted that all follow-up was based on the singular therapeutic program, PTS, and consisting of the mother's consent and the boy's assent, in specific documentation, as the norms govern.

Such measures ensure the active participation of the patient and family and clarify doubts, avoiding possible idealizations regarding the desired body. In addition to protecting professionals from future disagreements about management. (CFM, 2019).

International research is in line with the pubertal block, demonstrating that it can prevent the appearance of unwanted characteristics, which alleviates the suffering of dysphoria. In addition, it is a reversible intervention, if the person gives up following the transsexualization process later (COLEMAN, 2022, HORTON, 2022).

Research with English transgender adolescents, with an average age of 11 years and receiving pubertal block, revealed a decrease in prepubertal anxiety and relief for not being subjugated to unwanted body characteristics, results in agreement with those of the adolescent in this report. The authors also point out that health managers must seek to offer this management, as a way of protecting the mental health of trans adolescents. (HORTON, 2022).

It is worth mentioning that in the Unified Health System of Brazil, SUS, at the moment, the norm is to start cross-hormonization from 18 years of age, hormones are not supplied before that age. (MS, 2013).Clarifying this point is essential so that there are no more frustrations, if the family cannot afford this therapy, released since the age of 16 by the Federal Council of Medicine of the country (CFM, 2019).

The indication for psychotherapy was due to both dysphoria (suffering from unwanted body characteristics) and transphobia, especially the impediment of gender expression and little or no family support. These forms of transphobia may have contributed to the anxious and depressive symptoms of both patients.

Studies corroborate this fact, demonstrating that gender-dissident adolescents and young people have at least three times higher rates of depression and anxiety, self-injurious

behavior, substance use, eating disorders and suicide attempts, when compared to cisgender peers. (OLEZESKI, MEAD, 2022; OLSON et al. 2016).

Furthermore, the child, adolescent and their mothers were faced with professionals with a discriminatory attitude and lack of scientific knowledge, who expressed personal opinions and recriminated the mothers' attitude. This institutionalized violence generated more anxiety and guilt, leading to a tiresome pilgrimage by doctors and psychologists.

An international study corroborates this harmful reality. The stigma and discrimination of health professionals generate insecurity and fear in transgender people. As a result, there is a distancing from care in appropriate places and a tendency to perform interventions with high risk in an unsafe manner, in addition to overestimating dysphoria. (CHONG, KERKLAAN, CLARKE et al., 2021).

It is important to emphasize that the adolescent did not express his affective-sexual orientation. Research is in line with this silence in young people with gender dissidence, who postpone and/or avoid erotic-affective-sexual experiences due to dysphoria, multiple rejections and transphobia they go through. (COLEMAN, et al., 2022; ANTRA, 2022).

Brazilian research demonstrates that the existence of a transgender child or teenager in the family constitutes a state of vulnerability, due to the violence arising from society. The reception of family members works, then, as a support and strengthening of resilience, reverting to affirmative attitudes towards people with GI (NUNES, 2021).

Among the family members in this study, the distance from the father figure was highlighted in both cases, with denial and without adding support. On the other hand, the mothers sought specialized help and faced, together with their child, adversities both in the family and at school. It was also noticed the relief of anxious symptoms of the mothers, when engaged in the support group and with participation in activism.

The study in question had the limit of being based on the notes of professionals who, although specialized, are subject to failures. However, this does not detract from the work, which demonstrated a long period of follow-up, conducts with scientific basis and in accordance with national and international protocols.

CONCLUSION

The elements presented showed that transgender children and adolescents are highly vulnerable, due to the non-legitimization and restraint of their existence. The patients received adequate reception and protocol procedures, helping the transsexualization process. Their mothers benefited from engagement in a support group, empowering resilience for positive attitudes and greater confrontation with structural violence.

It is recommended that health professionals be trained on gender variability, without pathologizing, articulating with sectors of Education and Justice. Public policies need to guarantee comprehensive specialized care at all levels of care. Further studies are also recommended, of an epidemiological and in-depth nature, to expand knowledge in the Brazilian territory. Finally, a specialized and human look is necessary for a full existence of these children and adolescents.

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