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Contributions of the health sector to the construction of gender identity in children and adolescents with diverse gender identities

Yesenia Castro-Cely[1], **Olga Patricia Melo Barbosa**[1]

ABSTRACT

Introduction: Childhood and adolescence constitute the period of greatest exploration and consolidation of gender identity, as gender expression is linked to the physical, emotional, and cognitive development of the individual. It is common during this stage for signs of gender incongruence to manifest and for medical and psychosocial care to begin addressing the physical and mental discomfort symptoms of children and adolescents with diverse gender identities.

Objective: To identify the contribution of the health sector in the construction of gender identity in children and adolescents with diverse gender identities.

Methods: Integrative literature review including original articles and reviews published between 2008 and 2023.

Results: Five associated themes were identified: different diagnostic labels, access to healthcare services, treatments and their side effects, mental health, and autonomy for healthcare decision-making.

Conclusions: It must be understood that gender variations are part of human diversity and do not have an inherently pathological nature, meaning they are not disorders or illnesses.

Keywords: gender identity; health; children; adolescents; transsexuality.

Corresponding author: Olga Patricia Melo Barbosa. Emails: patrymelobar@uan.edu.co; patrymelobar@yahoo.es

[1] Facultad de Enfermería, Universidad Antonio Nariño (Bogotá, Colombia).

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Aportes del área de la salud a la construcción del género de niños, niñas y adolescentes con género diverso

RESUMEN

Introducción: La infancia y la adolescencia constituyen el periodo de mayor exploración y de consolidación de la identidad de género, debido a que la expresión de género está ligada al desarrollo físico, emocional y cognitivo del individuo, y es común que en esta etapa se manifiesten las señales de incongruencia de género y se inicie la atención médica y psicosocial para abordar los síntomas de malestar físico y mental de los niños, niñas y adolescentes con identidades de género diversas.

Objetivo: Identificar el aporte del área de la salud en la construcción del género de niños, niñas y adolescentes con género diverso.

Métodos: Revisión integrativa de la literatura de artículos originales y revisiones publicados en el periodo 2008-2023.

Resultados: Se identificaron cinco temáticas asociadas, así: diferentes etiquetas diagnósticas utilizadas, acceso a servicios en salud, tratamientos y sus efectos secundarios, salud mental y la autonomía para toma de decisiones en salud.

Conclusiones: Se debe comprender que las variaciones de género son parte de la diversidad humana y no tienen naturaleza inherentemente patológica, es decir, no son trastornos o enfermedades.

Palabras clave: identidad de género; salud; niños; adolescentes; transexualidad.

Contribuições da área da saúde na construção de gênero de crianças e adolescentes com gênero diverso

Resumo

Introdução: A infância e a adolescência constituem o período de maior exploração e consolidação da integridade de gênero, pois a expressão de gênero está ligada ao desenvolvimento físico, emocional e cognitivo do indivíduo, sendo comum que nessa fase se manifestem os sinais de incongruência de gênero e se inicie o cuidado médico e psicossocial para abordar os sintomas de desconforto físico e mental de crianças e adolescentes com identidade de gênero diversas.

Objetivo: Identificar a contribuição da área da saúde na construção de gênero de crianças e adolescentes com gênero diverso.

Métodos: Revisão integrativa da literatura de artigos originais e revisões publicados no período de 2008 a 2023.

Resultados: Foram identificados cinco temas associados, a saber: diferentes etiquetas diagnosticas utilizadas, acesso a serviços de saúde, tratamentos e seus efeitos colaterais, saúde mental e autonomia para tomada de decisões em saúde.

Conclusões: Deve-se compreender que as variações de gênero são parte da diversidade humana e não têm natureza inherentemente patológica, ou seja, não são transtornos ou doenças.

Palavras-chave: identidade de gênero; saúde; crianças; adolescentes; transexualidade.

INTRODUCTION

The terms *transgender or trans* are used to refer to individuals whose gender identity does not conform to the cultural norms associated with the sex assigned at birth, meaning they are general terms that describe identities that fall between male and female or outside of these binary categories (1). Non-heteronormative gender has received different designations from healthcare professionals: gender incongruence, gender variability, gender dysphoria, or gender discordance. Likewise, individuals use various self-descriptions, including terms like gender nonconformity, gender noncongruence, gender fluid, transgender, non-binary gender, neutral gender, among others.

The use of the term *transgender* has its origins in the works of Magnus Hirschfeld (1923), who established the distinction between homosexuality (having same-sex partners) and the individual's desire to live as the other sex (transsexualism) (2), initiating questioning of the conservative and practical view of sexuality oriented towards reproduction and the dichotomous approach to gender-based on sexual differences. In medical discourse, non-heteronormative gender has been addressed as pathologies and disorders requiring treatment.

The pathologization of gender and sexual diversity originates in the work on homosexuality by Richard von Krafft-Ebing, who in 1886 published Psychopathia Sexualis (2), where unconventional sexual behaviors without procreative purposes are identified as a form of psychopathology. Although Krafft-Ebing's proposal is not accepted today, it has wide dissemination among the medical and scientific community, leading to non-normative sexualities and gender diversity being erroneously associated with psychiatric disorders and harmful effects that persist to this day (3). Michael Foucault also reflected on the regime of power, knowledge, and pleasure, which gave rise to discourses on sexuality, and how this new regime changed the free and spontaneous meaning of sexuality (4).

The reductionist and binary view of gender has been widely criticized, as gender encompasses individuals' experiences on a continuum of possibilities beyond being male or female. Gender identity is constructed based on congruence or incongruence with the sex assigned at birth; however, identity can be fluid, thus impacting the gender experience (5). It is known that the period of greatest exploration and consolidation of gender identity occurs during childhood and adolescence, as gender expression is linked to the physical, emotional, and cognitive development of the individual. It is common for signs of incongruence to manifest during this stage, leading to the diagnosis of gender dysphoria and the initiation of medical and psychosocial care to address the physical and mental distress symptoms of children and adolescents with diverse gender identities. However,

there is limited statistical data available on this matter (6). Hence, it is necessary to identify the contribution of the healthcare field in the construction of gender for children and adolescents with diverse gender identities.

METHODOLOGY

An integrative literature review was conducted, guided by the question: How has the healthcare field contributed to the construction of gender for children and adolescents with diverse gender identities? Original articles and review articles published between 2008 and 2023 were systematically searched and organized in the *Biblioteca Virtual de Salud, Medline*, Science Direct, Proquest, and SciELO, using search terms such as *gender, health, children, and adolescents*, along with their equivalents in Spanish, English, and Portuguese, combined with the Boolean connector AND.

As inclusion criteria, documents conceptualizing gender as a social construct were considered, along with articles available in full text published within the specified period and languages. Exclusion criteria included articles not addressing the guiding question, publications equating the gender variable with sex, dissertation-type documents, theses, book chapters, editorials, letters to the editor, or similar types.

A total of 1192 publications related to the search terms were identified. The records were organized using the Mendeley reference manager. Initially, titles and abstracts were read to identify documents that addressed the guiding question. Subsequently, 30 publications were selected for in-depth reading and critical analysis to extract information on objectives, subjects, context, theoretical frameworks, methodology used, relevant findings, and conclusions.

Following a systematic analysis of the studies, five thematic areas were identified. This review describes the different diagnostic forms used, access to healthcare services, treatments and their side effects, mental health, and autonomy in healthcare decision-making for children and adolescents with diverse gender identities.

RESULTS

Different Diagnostic Forms

The diagnostic categories used in addressing gender incongruence or dysphoria in childhood have been evolving across various versions of the International Classification of Diseases (ICD) and the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). Initially categorized under "neurotic disorders, personality disorders, and other non-psychotic mental disorders," they are now classified as "conditions related to sexual health," (7,8) as summarized in Table 1.

Table 1. Evolution of diagnostic labels for sexual diversity in childhood

Year	ICD	DSM	Parent Entity	Diagnosis Name
1965	CIE-8	-	Sexual Deviations	Transvestism
1968	-	DSM-II	Sexual Deviations	Transvestism
1975	CIE-9	-	Sexual Deviations	Sexual and Gender Identity Disorders (Transsexualism, Transvestism, and Sexual Identity Disorder in Children)
1980	-	DSM-III	Psychosexual Disorders	Transsexualism Sexual Identity Disorder in Children
1987	-	DSM-IIIR	Sexual Identity Disorders	Transsexualism Sexual Identity Disorder in Children Sexual Identity Disorder in Adolescents and Adults (Non-Transsexual)
1990	CIE-10	-	Gender Identity Disorders	Transsexualism Dual Role Transvestism Gender Identity Disorder in Childhood Other Gender Identity Disorders Unspecified Gender Identity Disorder
1994	-	DSM-IV	Sexual and Gender Identity Disorders	Sexual Identity Disorder in Children Sexual Identity Disorder in Adolescents or Adults
2000	-	DSM-IV-TR	Sexual and Gender Identity Disorders	Sexual Identity Disorder in Children Sexual Identity Disorder in Adolescents or Adults
2013	-	DSM-V	Gender Dysphoria	Gender Dysphoria in Children [302.6-F64.2] Gender Dysphoria in Adolescents and Adults [302.85- F64.1] Other Specified Gender Dysphoria [302.6-F64.8] Unspecified Gender Dysphoria [302.6-F64.9]
2018	CIE-11	-	Conditions related to sexual health/ gender discordance	Gender Discordance in Adolescence or Adulthood [HA60] Gender Discordance in Childhood [HA61] Gender Discordance, Unspecified [HA6Z]

Source: based on Drescher J. Queer diagnoses revisited: The past and future of homosexuality and gender diagnoses in DSM and ICD. Int Rev Psychiatry. 2015;27(5):390.

In 1975, with the publication of the ninth version of the ICD-9, a specific category related to gender variation or incongruence in childhood was included for the first time, called *Sexual Identity Disorders in Children*, linked within the main category of sexual deviations and disorders, and defined as "behavior occurring in preadolescents with immature psychosexual development that is similar to that shown in sexual deviations described in transvestism [...] and transsexualism" (7).

With the implementation of the third version of the DSM-III (1980), Gender Identity Disorders became part of the category of "psychosexual identity disorders", with specific diagnostic criteria for each age group (childhood, adolescence, and adulthood) and a clear differentiation from paraphilias and sexual dysfunctions. In the DSM-III and DSM-III Revised versions (1987), essential features of Sexual Identity Disorders in childhood included the persistent sense in children regarding anatomical sex and the desire or affirmation of being the other sex, not just the rejection of stereotypical feminine or masculine behaviors. Both versions of the manual agree that these essential features may appear before the age of four; therefore, confirmation of the diagnosis should not be delayed until puberty (8).

In the tenth version of the ICD (1990), the parent category was modified, now called *Gender Identity Disorders*, which includes diagnoses applicable to adolescents and adults such as transsexualism, dual role transvestism, and other gender identity disorders. The diagnosis for children changed to *Gender Identity Disorder of Childhood*, consistent with the DSM-III designation; however, ICD-10 conditions the use of the diagnostic label on the existence of a profound alteration of *normal* gender identity, thus the masculine or feminine habits and behaviors of girls and boys respectively are insufficient (9).

In the DSM-IV (1994) and DSM-IV-TR (2000) versions, significant changes were incorporated. The category name remained gender identity disorder of Childhood; however, it was moved to a new parent category called *Sexual and Gender Identity Disorders*, which also included sexual dysfunctions and paraphilias. Additionally, the diagnosis of transsexualism was replaced by gender identity disorder, and diagnostic criteria for children, adolescents, and adults were grouped; however, the *Manual* assigns specific indicators for diagnosis during childhood and requires coding according to the individual's age and long-term monitoring of the child or adolescent to confirm the diagnosis.

In the DSM-V (2013), gender diagnoses were grouped into their parent category called *Gender Dysphoria*, which includes diagnoses of gender dysphoria in children, gender dysphoria in Adolescents or Adults, unspecified gender dysphoria,

or other kinds. In DSM-V, Gender Dysphoria in children highlights the recognition of incongruence between the felt gender (desire or affirmation of being the opposite gender) and the assigned gender (2,8).

In the eleventh version of the ICD (2018), the diagnostic label *Gender Incongruence* was adopted to group gender identity disorders and replace the previous denomination of Gender Dysphoria. The diagnosis in prepubescent children is referred to as *gender incongruence in childhood*, indicating the discordance between the experienced or expressed gender and the assigned sex; the intense desire to be of a gender different from the assigned sex; the marked aversion to their sexual anatomy or secondary sexual characteristics, or a strong desire to have sexual characteristics that match the experienced gender; as well as preferences for company, activities, or games that are not typical of the assigned sex (10).

ICD-11 includes some clarifications for diagnosis, including that discordance may or may not be accompanied by distress and significant functional impairment; it also establishes that the required observation period to establish the diagnosis is approximately two years (9). While the observation period allows for monitoring of the individual's behaviors and interests, it can also impact the opportunity for access to healthcare services and potential risks and effects on the individual's physical and mental health.

The evolution of diagnostic categories has not been without controversy. According to some studies, the label of mental disorder increases stigma and discrimination towards people with diverse gender identities (11). However, the advances made in DSM-V and ICD-11 are at an intermediate point that contributes to the depathologization of gender diversity and the elimination of stigma related to mental disorders experienced by transgender individuals or those belonging to sexual or gender minorities, while ensuring access to healthcare services to address perceived distress or dysfunction and choose available options to explore gender diversity and transition to desired roles; options that can be extremely costly and inaccessible outside of healthcare systems or insurance schemes.

Parallel to the evolution of diagnostic forms, a significant number of psychological and diagnostic tests were developed and validated. Currently, there is a wide variety of instruments and psychological tests used in the psychosocial assessment of children and adolescents with gender diversity and the psychosocial effects experienced by their families or caregivers (Table 2).

Table 2. Instruments used in the assessment and diagnosis of children and adolescents with diverse gender

Instrument or Test	Children and Adolescents			
	11 years old or younger	12 to 18 years old	Over 19 years old	Parents or caregivers
Child Symptom Inventory (CSI-4) (12)	x			
Early Childhood Inventory (ECI-4) (13)	x			
Gender Identity Questionnaire for Children (GIQC) (14)	x			
Youth Symptom Inventory (YI-4) (15)		x	x	
Child Behavior Checklist (CBCL) (16)	x	x		
Gender Dysphoria Degree - Utrecht Test (17)		x	x	
Body Image Scale (18)		x	x	
Transgender Congruence Scale (19)		x	x	
Gender Minority Stress and Resilience Scale (GMSR) (20)		x	x	
Parenting Stress Questionnaire, Short Form (PSI-SF) (21)				x

Source: based on Chen D, Hidalgo MA, Leibowitz S, Leininger J, Simons L, Finlayson C, et al. Multidisciplinary care for gender-diverse youth: a narrative review and unique model of gender-affirming care. Transgender Heal. 2016;1(1):117-23.

Among the available diagnostic instruments are inventories of anxiety symptoms, discomfort or dysphoria, and behaviors, as well as inventories of protective or risk factors (see Table 2), which have been validated in different contexts; however, many of these instruments were constructed based on diagnostic criteria from previous editions of DSM-V, ICD-11, or theoretical constructs that have been re-evaluated today, thus they may present psychometric or practical limitations (22).

Access to healthcare services

In parallel with advances in research and understanding of gender diversity, the need for access to medical and mental health services for children with gender diversity and their families during the process of developing their identities, social transition, and gender affirmation has become evident. These needs led to the creation of multidisciplinary institutions specialized in gender diagnostics. Some of them follow the "gender affirmation model," created at the Hospital Infantil Ann & Robert H. Lurie in Chicago, United States. The model focuses on the healthy psychosocial development of children of diverse genders and the promotion of support from their families or caregivers (23).

The gender affirmation model is based on the premises that: a) gender variations are part of human diversity and do not have inherently

pathological nature, that is, they are not disorders or diseases; b) gender representations vary according to cultural context; c) gender involves aspects of biology, development, socialization, culture, and context; d) gender can be fluid or changing, and it is not binary; and e) often, expressions of physical and mental pathology in a gender-diverse individual stem from negative cultural reactions such as transphobia, homophobia, sexism, rather than from the individual's identity or behavior (24). Based on these premises, children and their families receive individualized and flexible care, with a multidisciplinary and comprehensive approach (23).

Comprehensive care for children and adolescents diagnosed with gender dysphoria is important so that they and their families or caregivers have specialized information about this condition; moreover, timely access to physical and mental health services helps prevent and reduce risks associated with negative experiences and provides an opportunity for gender-diverse children to live according to their identity, feel comfortable, and express themselves without restrictions, stigma, or rejection (25).

There is consensus that to obtain suitable environments and treatment options, the support of the State is needed, represented in an inclusive healthcare system that eradicates prejudices and discrimination towards gender and sexual diversity (23,26) and strengthens the capacities and skills of healthcare professionals to address individuals with diverse families. This results in positive effects for healthcare professionals, as it eliminates their behavioral and emotional barriers, leading to an improvement in the relationship between the professional and the patient (27).

Treatment options and their side effects

Initially, medical treatments for non-conforming individuals with gender dysphoria focused on identifying the need for sexual reassignment procedures or interventions aimed at obtaining changes in physical appearance; however, as advances were made in understanding the variability and diversity of sexual and gender identity, treatments shifted towards relieving distress or dysphoric symptoms (28). Currently, healthcare for gender-diverse children and adolescents includes the use of clinical protocols based on recommendations from the World Professional Association for Transgender Health (WPATH) and scientific societies of psychology and endocrinology (28-31).

The recommended treatments aim to assist individuals of diverse genders in exploring their gender identity and expression. This process may or may not include body modifications, taking into consideration the fluid nature of gender itself and the individuality of the gender experience. Availa-

ble treatments help individuals feel comfortable with their body and identity and reaffirm their gender, encompassing psychotherapy, changes in gender expression and role, hormone therapy for feminization or masculinization of the body, surgical procedures to modify primary or secondary sexual characteristics, such as external or internal genitals, breasts, facial or bodily features, among others (23,28).

According to the recommendations of the World Professional Association for Transgender Health (28), recommended interventions for children and adolescents with gender variability and dysphoria include psychotherapeutic support in the process of exploring gender identity and expression, the potential social transition to the identity gender role, as well as decision-making regarding puberty-related changes and available physical intervention options. Treatment with physical interventions in adolescents is a gradual process aimed at providing more time for adolescents with gender dysphoria to explore their gender variability and prevent the development of puberty-induced sexual characteristics. Physical interventions involve three stages:

The first stage, which is reversible, aims to delay puberty-related physical changes through the use of gonadotropin-releasing hormone (GnRH) analogs (such as goserelin, buserelin, and triptorelin) and progestins (*medroxyprogesterone*). In this stage, medication can be discontinued, resulting in the reactivation of the hypothalamic-pituitary-gonadal axis, leading to the continuation of pubertal development in line with gonadal sex. The second stage, partially reversible, seeks feminization or masculinization of the body's appearance. Meanwhile, the third stage, considered irreversible, involves surgical gender affirmation procedures (28).

Currently, there is intense debate on the ethical dilemmas of early genital confirmation and the appropriate timing for surgical interventions considered in stage three. In this regard, the *World Professional Association for Transgender Health* recommends that they should be performed when the adolescent reaches the legal age of majority and their maximum psychological development (28), although some countries have their regulations regarding the age criterion. For example, 18 years in the United States and 16 years in Germany (32).

It has been documented that gender affirmation treatments (mastectomy, sexual affirmation surgery in genitals, and facial feminization and masculinization procedures) report positive benefits associated with a substantial reduction in psychological stress and body dysphoria, and with a remarkable improvement in the quality of life of individuals (28,33). Some studies indicate that genital surgery reduces the psychological stress

and shame caused by the absence of congruent genitals (32). Likewise, it is accepted that hormonal treatment in the early stages of puberty (Tanner I and II) helps adolescents with gender dysphoria avoid invasive surgical procedures because it prevents the complete development of secondary sexual characteristics, leading to a reduction in body dissatisfaction and an increase in perceived well-being and social functioning (34).

The potential adverse effects of hormonal therapy have also been studied. Evidence suggests that this type of therapy can affect brain structure and circuits, ventricular volume and thickness, hypothalamic neuroplasticity, and functional connectivity in adults, while in adolescents, there is an alteration of cognitive processes, mainly visual-spatial working memory. Likewise, physiological effects are documented, such as increased hemoglobin and hematocrit values and decreased high-density lipoprotein levels in transgender adults and adolescents receiving testosterone treatment, decreased alkaline phosphatase levels in adolescent females receiving estradiol (second or third year of treatment), reduced bone density in the spinal area in hormonal replacement therapy during puberty, and changes in body fat distribution and musculature in transgender women and transgender men due to estrogen and testosterone effects, respectively (33,35).

Likewise, hormonal therapy may favor the onset of venous thromboembolic disease, hypertriglyceridemia, hypertension, type 2 diabetes mellitus with the administration of feminizing hormones, and polycythemia, hyperlipidemia, cardiovascular disease, hypertension, and type 2 diabetes mellitus with masculinizing hormones (28). However, the available evidence is inconclusive, especially regarding some types of cancer (breast, cervix, ovary, and uterus), hence longitudinal studies are needed to provide new and better evidence (28,36-38).

As stated, gender affirmation interventions offered to children and adolescents are not limited to hormonal therapy or surgical procedures; they also provide alternatives to individuals who report dissatisfaction with the pitch or characteristics of their voice with therapeutic accompaniment of speech therapy and support in aspects related to communication, especially nonverbal, such as facial expressions, gestures, and postures; as well as voice feminization surgery. It has been demonstrated that these interventions reduce the anxiety that social interaction can generate (28).

On the other hand, some prolonged hormonal treatments and surgical procedures have effects on fertility; hence the need for, before initiating physical interventions, the healthcare provider to inform the patient about the consequences of treatment on reproductive health and include

counseling about the options available for fertility preservation, including sperm cryopreservation for post-pubertal males, egg and embryo cryopreservation for post-menarchal females, and testicular and ovarian tissue cryopreservation, in both cases (28,39).

The mental health of children and adolescents with diverse gender identities

Often, children and adolescents with diverse gender identities perceive puberty as a painful and unbearable stage, a result of the persistent incongruence between their identity and their appearance (1). Moreover, they may experience microaggressions (19), discriminatory behaviors (40), and physical and sexual violence in the family, social, or school context (41,42), with short, medium, and long-term consequences that affect individual coping mechanisms, academic performance, social interaction, and may be risk factors for mental health disorders (43). Various studies suggest that young people with gender diversity are at higher risk of experiencing anxiety and depression disorders (1,32), self-harm and suicide attempts (1,44-46), eating disorders (1), alcohol consumption or substance abuse (47), and social isolation (1,32,44,45) when compared to cisgender youth.

Regularly, the behaviors of children and adolescents with diverse genders challenge socially and culturally accepted norms of behavior; for this reason, in the school context, they may be victims of homophobic and transphobic bullying, especially in institutions that do not have programs for information or education about sexual diversity and gender identities (48). Therefore, interventions aimed at improving mental health should include the school environment, as they reduce the possibility of discrimination or marginalization by their peers or teachers (5,42).

Behaviors and gender role nonconformity are risk factors for increased rates of physical, emotional, and sexual abuse in family systems (42). It has also been identified that parents, caregivers, or extended family members increase surveillance or control in an attempt to modify or suppress atypical gender behavior through negotiation, imposition, or physical and verbal violence (49).

Gender diversity in childhood and adolescence seems to involve some stressful and distressing experiences; however, it does not mean that children and adolescents with diverse gender identities have mental pathologies. In fact, perceived psychological distress is often not related to the existence of an organic and functional disorder but rather a result of stigma, social rejection, and violence they experience (50,51). In any case, psychosocial support is essential, as mental health professionals accompany them in the process of exploration and confirmation of their gender

identity, reinforce their autonomy in decision-making, promote proper emotional management, encourage the development of coping mechanisms and resilience, and help the family understand and accept gender diversity (1,44). Psychotherapeutic treatments focus on the nonjudgmental recognition and acceptance of gender identity and improving associated behavioral, emotional, and relational difficulties (28).

Whenever possible, family interventions should be accompanied by group support work, as they promote interaction with peers and the creation of social support networks, as well as reduce the sense of isolation (27). Some authors report positive effects for children and adolescents with diverse gender identities and their families when attending therapy or psychological support groups, as it allows them to resolve doubts about hormonal and surgical treatment options, the processes of exploration, expression, and "coming out" regarding gender, and how to strengthen family relationships and coping skills (1,23).

To ensure the mental health of children and adolescents with gender diversity, access to psychotherapy must be facilitated, but it is also essential for mental health professionals to have the clinical competencies, ethical behavior, and sensitivity required to address the care needs of this population group (28,44), moving away from the idea of "treating" or achieving congruence between the body and identity (52), as this would ignore the great diversity of human gender experience and limit the individual's opportunities to explore the possibilities, benefits, advantages, and risks presented by gender-related treatments.

Autonomy for decision-making in health

Children and adolescents have the right to receive confidential and comprehensive sexual and reproductive health services. However, in most countries, there are legal provisions that limit minors' autonomy to make decisions about their health and treatment options, based on age and the presumption that minors do not have the capacity or necessary maturity to make decisions, thus transferring this responsibility to their parents (53,54). This situation can be an obstacle to accessing and providing sexual and reproductive health services for adolescents with non-binary gender identities when legal authority or parental rights are not regulated or are limited (55). Rickett et al. (56) suggest that this decision should be left to adolescents.

The presumption of legal incapacity of minors to make decisions about their health restricts the autonomy of the child and may violate their rights to health and self-determination in family environments with presence of transphobic, homophobic, or psychological, sexual, or physical abuse (51,57). To protect the rights of minors,

some countries have adopted measures to facilitate the legal emancipation of young people and limit parental authority in matters related to gender identity and surgical procedures for sex reassignment in intersex minors, aiming to balance the rights of parents and their children and offer minors the opportunity to understand the implications of treatments and evaluate their potential benefits, risks, or harms in recognition of their capacity and autonomy.

This is the case of Colombia, which through its jurisprudence protects the rights to health, social security, equality, human dignity, the free development of personality, and the self-determination of minors, and restricts parental authority to consent to invasive or risky procedures where the benefits are not completely clear, such as genital surgeries for intersex children. Colombian legislation requires obtaining "qualified and persistent informed consent" from the minor, obtained through a process of detailed information by the treating medical team, allowing the underage patient to understand the risks of treatment and other available options (57).

To promote autonomy in health decision-making for individuals with gender diversity, the "Informed Consent Model" has been promoted in the United States in recent years. This model omits the assessment or diagnosis by a psychiatrist or mental health specialist to access health services and physical gender affirmation interventions. This alternative approach to transgender medical care promotes a distancing from the use of the diagnostic label of gender dysphoria and grants individuals the possibility to decide if they are ready to access health services and give their informed consent based on their knowledge of the risks, side effects, benefits, and potential consequences of undergoing gender confirmation treatments. With this model, the individual does not need to demonstrate the existence of "distress" or dysphoria, but rather the cognitive capacity to make informed decisions about their health (52). It is necessary to note that with this approach, the healthcare provider offering counseling on treatment options may refer the patient to mental health services if they identify symptoms or risk factors (28).

DISCUSSION

This review on the contribution of the health sector to gender construction in diverse gender children and adolescents revealed the existence of a clinical and healthcare research agenda restricted to the Global North; consequently, there is very limited academic literature production in the Global South, especially in Latin America, which hinders understanding the needs, characteristics, realities, and bodily constructions in these contexts.

In this regard, a knowledge gap is identified that can be explored through research in the clinical and healthcare fields and through the exploration of family, social, economic, and political environments, such as the social movement for the fight for their rights. Therefore, healthcare professionals must free themselves from pathologizing positions and analyze this object of study with an open and flexible mind toward gender and sexual health transformations. Likewise, it must be understood that gender variations are part of human diversity and do not have an inherently pathological nature, meaning they are not disorders or diseases.

Regarding diagnostic classifications (DSM and ICD), significant progress has been made in the latest versions to avoid the stigmatization of individuals with diverse genders. The classification emphasizes that gender incongruence is not a mental illness but a symptom associated with identity. However, diagnosing gender dysphoria as a mental pathology reinforces stigma and discrimination, leading to emotional suffering for those who experience it. An example of this is the expulsion from biological families *and/or* the educational and healthcare systems of children with diverse genders.

On the other hand, although the diagnostic labels related to transgenderism used in the tenth and eleventh versions of the ICD (gender identity disorder and gender incongruence, respectively) denote the existence of a gender identity disorder, these labels cannot be assumed as a mental disorder. However, children and adolescents of diverse genders may suffer from problems such as anxiety and depression due to the stigma that these labels generate. As a consequence of stigma, these individuals could end up on the streets and in the world of prostitution as an option that not only represents a way to solve their economic problems but also a space for socialization and construction of their identity. Involvement in the prostitution milieu leads to many mental health problems and initiates risky bodily transformation processes for their health, such as the use of liquid silicone and indiscriminate consumption of hormones and other medications for transition.

Although transgenderism is no longer part of the list of mental disorders of the World Health Organization, it remains in a new heading titled "Conditions related to sexual health" and to be called *gender incongruence*, alongside other concepts such as *sexual dysfunctions or disorders related to sexual ailments*, whereby gender diversity remains linked to a diagnosis and, therefore, may suggest the existence of an illness. In other words, changes in diagnostic labels aim to depathologize gender diversity, but in practice, the term gender incongruence continues to be pathologizing.

On the other hand, in Colombia and some countries in Latin America, for children and adolescents with diverse genders to be attended to by healthcare systems with specialists in sexual health, endocrinology, and mental health, among others, they must have the diagnosis of gender dysphoria issued by a psychiatrist. In that sense, the purpose of medical and mental health diagnostic nomenclature is to offer safe and effective treatments to each person. The medical interventions that these individuals require are not included in the Health Benefits Plan, in the case of Colombia. Therefore, their identity must be pathologized with the diagnosis and through the tutelage (3) to embark on a long path to access healthcare services. This, in many cases, is frustrating for families and leads them to seek interventions outside the healthcare system, with procedures that are not entirely safe and at low prices. This type of makeshift procedure and its consequences have only been traced in Latin America; there is no evidence of its use in developed countries with individualized, flexible, and comprehensive care (58).

As has been discussed, the different discourses about people with diverse genders stem from pathologization. The diagnosis of gender dysphoria ensures an interpretative framework in which *trans* subjectivities are only considered in medical discourses that seek to normalize different bodies and intervene in them according to the logic of heteronormativity. This pathologizing discourse has brought negative consequences for transgender communities, as having the label of mental illness of the trans condition, discrimination has caused multiple issues, such as transphobia, and extreme violence, among others. Moreover, these discourses turn out to be totalizing, which is why these individuals are excluded from spaces that think, reflect, and create theories about their realities. In response to this, it is proposed to use trans epistemologies in Latin America, as they allow recognition of the voice of the trans population through horizontal dialogues that promote knowledge construction.

Within the framework of trans epistemologies, the political and transformative value of knowledge resulting from research is recognized (59). This theoretical framework aims to contribute to the reconstruction of trans realities through the lived experience of having transitioned from various social positions and, thereby, strengthen activism from within the community, that is, through trans epistemologies, the trans population must be given a voice to acknowledge their knowledge and thus open up an academized dialogue, without placing themselves in a position of subordination. From trans epistemologies, it is conceived that knowledge production transcends university academic spaces and is consolidated through direct work in the field, through narratives, and the reading of bodily, political, and social expressions.

An important point in these final considerations relates to the mental health effects on children and adolescents of diverse genders and is related to the disparities they face in accessing healthcare services. The acts of discrimination they are subjected to when seeking healthcare services. Transgender individuals avoid or delay medical attention to avoid discrimination (60,61). All this provides an opportunity for healthcare providers to open up to cultural competencies and understand the lived experiences and priorities of the transgender population (62).

While it is true that there has been progress in the contribution of the healthcare sector to individuals with diverse gender, it has been within the discourse of pathologization and, in many cases, from ignorance or knowledge of heteronormativity. An example of this is that healthcare professionals do not differentiate between sex and gender in research instruments, considering these two variables as synonymous. Healthcare professionals must educate themselves about sex and gender and be able to provide more effective responses to the issues faced by this human group.

Finally, it is important to note that this document presents a rigorous and exhaustive review of the publications identified in the consulted databases. However, a limitation of the study is considered to be the possible existence of additional publications in academic databases, languages, and year ranges not considered in the present review.

CONCLUSIONS

The identified publications agree that gender identity is fluid, rather than binary and that childhood and adolescence involve the exploration of personal experiences and roles, without implying the existence of mental disorders or psychological distress. This new narrative helps overcome unnecessary pathologization and, therefore, the medicalization of sexual diversity.

Publications suggest that children and adolescents with diverse genders have complex and fluid experiences that can increase their vulnerability to various rejection and discrimination behaviors, the consequences of which affect their health, social interaction, and academic performance.

The complexity of gender diversity requires a comprehensive and holistic approach that allows children and adolescents the freedom to explore and express their gender identity; facilitates psychosocial adaptation, and reduces vulnerability and the risk of experiencing negative effects on their health and the well-being of their families. To achieve this, it is necessary to advance in the updating of healthcare professionals and the elimination of outdated knowledge, language, and practices that restrict gender to a binary element and pathologize non-normative experiences.

CONFLICT OF INTEREST

The authors declare no conflicts of interest.

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