

Understanding Transgender Identity Development in Childhood and Adolescence

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Many sexuality educators and professionals, even those involved in program development and planning, are not aware of the biological and social factors involved in gender identity development in youth. As such, this topic is often not as well addressed in whole life educational curricula as better understood topics, such as reproductive anatomy, puberty, and contraception. This review article is intended to provide an overview of gender identity development in childhood and adolescence, in order to encourage better integration of comprehensive understandings of gender identity into new sexuality education curricula through the inclusion of specific information about transgender and other gender nonconforming identities.

KEYWORDS *Gender identity, transgender, child development, sex education*

There is a growing understanding of the importance of comprehensive, age-appropriate sexuality education, even though it has not been uniformly implemented in the United States (Centers for Disease Control and Prevention, 2012). Such comprehensive sexuality education is more effective, and can have a greater impact, on important outcome factors such as adolescent pregnancy and sexually transmitted disease rates than when sexuality education is implemented in a more restrictive way, such as through abstinence-only programs (Chin et al., 2012). However, comprehensive sexuality education is defined and evaluated primarily on its inclusion of safer sex and contraception information. It is not necessarily as comprehensive in the discussion of other aspects of human sexuality.

Research has shown that teachers of even theoretically comprehensive sexuality education curricula often face barriers in teaching about more

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controversial topics such as abortion and sexual orientation and are forced to stint on coverage of such subject matter (Eisenberg, Madsen, Oliphant, & Sieving, 2013; Shindel & Parish, 2013). This is primarily due to political and administrative objections, or concerns about parental objections, to “controversial” topics being discussed in the classroom (Dailard, 2001; Wilson, 2000). Discussions of sexual orientation are often perceived as particularly problematic, although studies have found they are supported by the majority of parents (Eisenberg, Bernat, Bearinger, & Resnick, 2008; Kirby & Michaelson, 2008; SIECUS, 2010), and sexuality education curricula are only required to include discussion of sexual orientation in a few states (Guttmacher Institute, 2014).

Furthermore, even sexuality education programs that manage to do a good job of integrating diverse view points on sexual orientation generally fail to include more than a brief mention of gender diversity and related topics (Green, 2010). Some of this may be due to a perception that cross-gender behaviors, behaviors more commonly associated with the other sex, and identities are rare. However, cross-gender behaviors are apparent in up to 6% of young boys and 12% of young girls, and a small fraction of the young people exhibiting such behaviors will eventually develop a cross-gender identity (Moller, Schreier, Li, & Romer, 2009; Shechner, 2010), also known as a *transgender* identity.

When people are transgender, they usually identify as a gender other than the one corresponding to the sex they were assigned at birth. Individuals who are gender nonconforming may identify as transgender, *genderqueer*, or off the gender binary entirely. Looking at older adolescents, in a recent, national study of New Zealand high school students, 1.2% reported being transgender and another 2.5% reported being uncertain of their gender, and all such youth were at an increased risk of peer bullying and other school socialization problems (Clark et al., 2014). Unfortunately, to date gender identity has not been included as an item on large, national surveys in the United States, although it has been pilot tested for inclusion in the Youth Risk Behavior Survey, a national survey of middle and high school students performed by the Centers for Disease Control on an annual basis. The pilot test, which was performed in San Francisco middle schools, found that 1.3% of the middle school students surveyed identified as transgender. This number is quite similar to the New Zealand estimate and also similar to estimates from other research (Shields et al., 2013). Other regional studies have estimated the percentage of the population that identifies as transgender as ranging from 0.1% to 0.5%, with 0.3% being the current standard approximation (Gates, 2011). However, these differences may also relate to how people report their identity in surveys. One study that examined the issue in detail found that while between 0.5% and 2% of the population said that they felt a strong transgender identity, only approximately 0.1%–0.5% chose to undertake some level of social or medical transition, and some surveys

have been designed in ways that principally assess the second group (Conway, 2002). Unfortunately, restricting analyses of the gender nonconforming population to those who have socially or medically transitioned ignores both the group of people who have no desire to surgically or medically transition and the group who do wish to engage in such a transition but lack the financial, social, or other resources to do so. Therefore, when making estimates of the gender nonconforming population, a broader understanding of their identities is warranted. Given a population size of 316 million (Census, 2013), such estimates suggest that between 1.5 and 6 million Americans identify as transgender. As such, gender identity development is an important issue to address in sexuality and relationship education across a wide range of grade levels and for the broader population.

It is important to note that the prevalence of actual *transsexualism*, defined as the desire to live full-time as a member of the opposite sex,¹ is far lower than the proportion of individuals who exhibit cross-gender behaviors and identities. Estimates of the prevalence of transsexualism range from 1:3,000 to 1:60,000 depending on the gender and population examined (Moller et al., 2009; Selvaggi & Bellringer, 2011). Part of the wide variability in this estimate can be attributed to the fact that there is not yet a consistent, accepted definition for what it means to be either transgender or transsexual. For this and other reasons, the factors that lead to a *persistent* cross-gender identity remain poorly understood. However, whether or not gender identity will persist throughout the lifespan is often less relevant to sexuality educators than the experience of gender nonconforming youth in the classroom. Research has shown that young people with cross-gender and other nonconforming gender identities are frequently subject to bullying and harassment in the school environment (Bradford, Reisner, Honnold, & Xavier, 2013; Clark et al., 2014; Hong & Espelage, 2012; McGuire, Anderson, Toomey, & Russell, 2010), which could potentially be addressed through better education about gender identity and encouragement of more accepting social norms around gender expression for both conforming and non-conforming youth.

A BRIEF HISTORY

Mainstream cultural awareness of cross-gender and non-conforming gender identities has increased enormously over the past few years; however, such identities are still not universally, or even necessarily broadly, accepted. Additionally, even though their visibility has increased at a population level, it

¹ The use of these terms vary considerably in the scientific literature. In this article, I am using a set of definitions commonly used by professionals engaged in gender and sexual orientation affirming work (Fenway Health, 2010).

is important to note that cross-gender identities are not new constructs. There is an extensive historical record of individuals whose sex does not match their gender identity (Ramet, 1996). Such individuals have been identified in a number of cultures, from the Native American two-spirit people (Epple, 1998) to the Indonesian *waria* (Blackwood, 2005).

What has been changing is the notion that a cross-gender identity is inherently dysfunctional. Socio-cultural and professional views of gender incongruity are evolving in ways similar to how opinions about homosexuality changed through the 1960s and 1970s (Drescher, 2010). For example, the updated definition of Gender Dysphoria that replaced Gender Identity Disorders in the *Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5)* was constructed, at least in part, to depathologize gender incongruity by identifying the discomfort, or dysphoria, associated with gender incongruence as the clinical problem rather than the incongruence itself (American Psychiatric Association, 2013). In addition, the explicit discussion of the use of gender-confirmation surgery to reduce dysphoria, helps to address the concerns of those individuals who were concerned that the removal of Gender Identity Disorder from the DSM could affect the ability of transsexuals to receive medical coverage for such surgeries and related procedures (Meyer-Bahlburg, 2010).

GENDER IDENTITY VERSUS GENDER DYSPHORIA

Not all gender nonconforming youth identify as the other gender, or even as male or female, and in recent years the notions that gender identity is neither inherently binary nor fully linked to biological sex have both gained traction (Drescher, 2010). However, wherever an individual's gender identity falls, whether it is on or off the gender binary it is well established that having a gender identity that does not conform to one's physical sex increases an individual's risk of experiencing emotional disorders and trauma, including physical, psychological, and sexual abuse (Roberts, Rosario, Corliss, Koenen, & Austin, 2012). Transgender youth have an elevated rate of emotional problems and disorders associated with trauma, including posttraumatic stress disorder, depression, anxiety, and suicide (Gomez-Gil et al., 2012; Liu & Mustanski, 2012; Roberts et al., 2012; Weinrich, Atkinson, McCutchan, & Grant, 1995). Furthermore, much of the psychological stress associated with transgender identities is thought to be attributable to familial and societal reactions to gender non-conformity rather than to the identity itself (Egan & Perry, 2001; Golub, Walker, Longmire-Avital, Bimbi, & Parsons, 2010; Yunger, Carver, & Perry, 2004). Therefore, encouraging tolerance through education about gender diversity could have profound effects on young people's emotional health (Stieglitz, 2010).

One way for sex and relationship education programs to begin to explore issues of gender diversity, particularly for younger children, is through exposure to the growing number of books and videos that present gender as a flexible construct and gender non-conforming youth in a positive light. Options range from Marlo Thomas's classic book and record compilation, *Free to Be You and Me* to newer works such as *10,000 Dresses* by Marcus Ewert and Rex Ray or *My Princess Boy* by Cheryl Kilodavis and Suzanne DeSimone. Lists of books and other resources suitable for young people at different reading levels can be found online at places such as Transgender-Child.net and GayYA.org (Young Adult).

Sexuality education programs can also explore persistent gender-related social inequities that exist and affect even gender-normative youth. Social issues, such as differential tolerance for cross-gendered behaviors in young men and women, reflect broad social concerns. They also partially explain the seemingly contradictory fact that girls exhibit more cross-gendered behaviors but boys are more often referred to medical providers for concerns about gender dysphoria (discomfort with their gender) (Moller et al., 2009). Discussions about gender diversity also offer opportunities to explore problems with the construction of masculinity in our culture, and how what is commonly constructed as "male privilege" can also have negative effect on young men (Biddulph, 2007). Men, in general, have more cultural and professional opportunities and privileges than women, but they are simultaneously restricted to more rigidly defined gender roles. This can be seen in the fact that while females are more likely to be allowed, and are sometimes even encouraged, to engage in masculine activities and make masculine clothing choices, acting out feminine behaviors and wearing female garments are generally discouraged and sometimes even dangerous for males (Ewing Lee & Troop-Gordon, 2011; Levant, 2011; Thomas & Blakemore, 2012). The fact that male roles are generally seen as aspirational for women, while female roles are often conceptualized as subordinate to men (Munsch & Willer, 2012), also contributes to the increased victimization experienced by cisgender² and transgender girls and women (Gershon, Minor, & Hayward, 2008; Roberts et al., 2012).

In contrast, men clearly benefit from fewer norms and expectations about their appearance. Another factor that may contribute to the increased social difficulties experienced by transgender girls and women, and their higher number of medical referrals when compared to transgender boys and men, is the fact that it may be easier for post-pubertal transgender men to pass as male both with and without medical intervention (Smith, van Goozen, & Cohen-Kettenis, 2001). Conversely, the ability to live more easily

² Cisgender individuals are those whose gender identity matches, or is congruent with, expectations based upon their assigned sex at birth.

and convincingly as male may contribute to the lower prevalence of dysphoria in transgender boys and men. Acceptance and validation of one's gender by others is correlated to decreased stress (Dubois, 2012; Ross & Need, 1989), and feelings of attractiveness are associated with improved emotional well-being (Dijkstra & Barelds, 2011; Kraemer, Delsignore, Snyder, & Hepp, 2008). Including a discussion of variations in appearance and cultural constructions of attractiveness in relationship education programs can be valuable for not just gender nonconforming students but also other students who fall outside conventional notions of beauty and normalcy and therefore are at risk of bullying over various aspects of their appearance (Hong & Espelage, 2012; Janssen, Craig, Boyce, & Picket, 2004). Curricula currently being used to discuss race and gender privilege in the classroom can be adapted to encourage discussion of the privileges associated with gender conformity as well.

CHILDREN'S PERCEPTION OF GENDER AND DEVELOPMENT OF GENDER IDENTITIES

One of the issues in integrating gender diversity information into health education programs may be determining when it is appropriate for such instruction to begin. Children develop an awareness of gender, and gender role, quite early (Martin, Ruble, & Szkrybalo, 2002). Individual notions of what attributes and behaviors are defined as masculine and feminine vary across cohorts and cultures, but by 8 months of age, children have been shown to have some ability to categorize adults by gender, and they generally begin to spontaneously label their own gender by age 2 (Zosuls et al., 2009). By age 3 or 4, most children spontaneously assign behaviors and traits differently to males and females, although these assignments do not necessarily reflect culture-wide gender expectations (Campbell, Shirley, & Candy, 2004; Tenenbaum, Hill, Joseph, & Roche, 2010).

Because children become cognizant of their own gender so early, it should not be surprising that children with gender dysphoria often begin to express their cross-gender identity between the ages of 3 and 4 years. Some even begin to make statements about their gender not matching their biological sex as early as age 2 (Diamond, Pardo, & Butterworth, 2011), the same age range when children generally begin to self label as boys or girls (Zosuls et al., 2009). Early cross-gender identity formation can also be observed indirectly through gender-linked behaviors such as the choice of playmates and preferred play styles. For example, while young cisgender children generally prefer to play with other children of their own sex, the opposite is true for transgender youth (Fridell, Owen-Anderson, Johnson, Bradley, & Zucker, 2006). Therefore, age-appropriate lessons about of gender diversity and gender expectations could conceivably be developed

for students in elementary school or even kindergarten, and overlap well with discussions of gender roles and equality of opportunity.

THE ROLE OF BIOLOGY IN GENDER IDENTITY FORMATION

Although detailed discussion of the biology of gender identities may not be appropriate in a classroom setting until the high school or college level, it is important for sexuality educators to be aware of, particularly when confronting students or others who consider gender identities a choice. As such, it is important to understand that while cross-gender identities may first become recognizable in early childhood, the actual formation of gender identities appears to begin even earlier in development. Prenatal androgen exposure has been linked to the formation of both gender identity and sexual orientation (Byne, 2006). There are likely genetic influences as well (Coolidge, Thede, & Young, 2002; Gomez-Gil et al., 2010; Lippa & Hershberger, 1999).

Much of the research on the role of prenatal hormone exposure in gender identity formation comes from the study of intersex individuals with genetic conditions affecting hormone levels both *in utero* and after birth. Intersex individuals are different from transgender individuals, whose gender identities have no clear genetic or hormonal basis. However, intersex individuals have historically been easier to study, and the clear genetic and hormonal differences they experience provide a useful model for the study of gender identity formation in transgender and gender non-conforming individuals.

One group of intersex individuals consists of XX females born with congenital adrenal hyperplasia, a disorder that increases prenatal testosterone levels. This condition can cause masculinization of the genitalia, including enlargement of the clitoris so that it resembles a small penis (Speiser, 2007). It is also associated with an increased risk of developing masculine behaviors and male gender identities (Frisen et al., 2009; Servin, Nordenstrom, Larsson, & Bohlin, 2003), although cross-gender identification does not always appear to be associated with somatic masculinization (Berenbaum & Bailey, 2003), and many masculinized children with congenital adrenal hyperplasia identify as tomboy females rather than as males.

Another group of intersex individuals whose gender identity formation has been well studied is XY females with conditions that cause resistance to testosterone, such as complete androgen insensitivity syndrome (CAIS). Children with CAIS typically appear to be female, identify as female, and are raised as female, although they are chromosomally male (Hughes et al., 2012). Their insensitivity to androgens appears to drive both physiological and psychological femininity, and many do not discover their chromosomal sex until they fail to menstruate (Jorgensen, Kjartansdottir, & Fedder, 2010).

Only in extremely rare cases do these children develop masculine gender identities (T'Sjoen et al., 2011).

One subset of androgen-resistant children is individuals born with 5 α -reductase deficiency. These children can not make dihydrotestosterone, a potent testosterone derivative that causes early virilization of the genitalia, and so they are often assigned and raised as girls (Cohen-Kettenis, 2005). However, if the disorder goes undetected, they begin to produce large amounts of testosterone during puberty, which causes them to suddenly become masculinized both physically and behaviorally. At this time, their gender identities often abruptly switch from female to male (Cohen-Kettenis; Imperato-McGinley, Peterson, Gautier, & Sturla, 1979). In one Dominican community where this genetic disorder is particularly common, affected children are known as *guevedoces*, which is usually translated as “penis at 12,” although the literal translation is “eggs (testicles) at 12” (Imperato-McGinley et al.). The behavioral switch these children undergo at puberty is considered one of the most potent pieces of evidence for the role of androgen in gender identity formation.

A final, if inconclusive, piece of evidence pointing to a potential role of prenatal androgen exposure on gender identity formation is the fact that the ratio of second to fourth finger length varies from gender typical expectations in male individuals with Gender Identity Disorder (Kraemer et al., 2009) and in nonheterosexual females (Kraemer et al., 2006). Finger length ratio is a marker for prenatal androgen exposure. However, to date, the research on the topic has both been methodologically problematic and somewhat inconsistent (Grimbos, Dawood, Burriss, Zucker, & Puts, 2010).

In addition to genetics factors and the hormonal environment during pregnancy, there are a number of other factors that could conceivably affect gender identity development during infancy and childhood. These include environmental hormone exposure, upbringing, and changes in the internal hormone milieu. To date, there has been minimal research on the role of environmental hormone exposure on gender identity formation, and what research has been performed does not support a clear association (Cicchetti, 2003; Sandberg et al., 2003; Vreugdenhil, Slijper, Mulder, & Weisglas-Kuperus, 2002). However, both postnatal hormone levels and upbringing clearly play a role in the formation of gender identity. Research on these two areas frequently overlaps. This is because while hormone research consistently suggests a role for androgens in gender identity formation, it also consistently shows that androgen exposure does not fully determine gender, either before or after puberty.

In the end, the sex of rearing is highly predictive of gender identity in most individuals, even those who might be expected to be gender dysphoric because of their genetic or medical background (Berenbaum & Bailey, 2003; Byne, 2006; Meyer-Bahlburg, 2005). In part, this is because cross-gender identities are rare. However, parents also constantly reinforce their children's

assigned gender through toy, clothing, and activity choices (Caldera, Huston, & O'Brien, 1989; Lobue & Deloache, 2011; McHale, Crouter, & Tucker, 1999), something which most children endorse as both appropriate and welcome (Conry-Murray & Turiel, 2012). An individual must have strong, consistent feelings about their cross-gender identity in order to maintain that identity in the face of the myriad social and familial cues that are constantly acting to undermine it. Additionally, in a world that categorizes everything from socks to bathrooms by gender, identity formation and maintenance may be particularly difficult for those individuals whose self conception falls outside the gender binary (Diamond et al., 2011).

CONSISTENCY IN GENDER IDENTITY THROUGH THE LIFE COURSE

One question that often comes up in the discussion of gender non-conforming children and adolescents is whether their gender diversity is just a phase. The vast majority of transsexuals who have chosen to surgically transition are extremely happy with their choice (Johansson, Sundbom, Højerback, & Bodlund, 2010; Lobato et al., 2006; Weyers et al., 2009; Wierckx et al., 2011); however, that should not be taken as evidence that all individuals with a cross-gender identities maintain those identities throughout their lives. Instead, it may well reflect the extensive screening that individuals must go through before they can access sex-confirmation surgery, screening which selects for those people who have had a strong and consistent cross-gender identification and who do not suffer from severe, unrelated psychopathology (Selvaggi & Bellringer, 2011; Smith et al., 2001). When consistency of gender identities are examined in wider cross-sections of the population, scientists have found that cross-gender identities expressed at an early age do not always last through adolescence and into adulthood (Zucker, 2008).

One study, which followed 25 girls who were diagnosed with varying degrees of cross-gender identities over an average of 14 years, found that very few of the girls had a persistent diagnosis of Gender Identity Disorder. When they entered the study between the ages of 3 and 12, 60% of the girls fit the DSM criteria for Gender Identity Disorder, and the other 40% had subthreshold diagnoses. However, only three girls (12%) still maintained a Gender Identity Disorder diagnosis when followed up in young adulthood. Also, 56% of the girls were homosexual or bisexual in either fantasy or practice (Drummond, Bradley, Peterson-Badali, & Zucker, 2008). These rates are significantly higher than the rates of gender dysphoria, bisexuality, and homosexuality in the general population. Nonetheless, it is notable that only a fraction of the gender-variant girls retained their cross-gender identities into adulthood.

A more recent study looked at the persistence of gender dysphoria in 77 prepubescent children referred to a Dutch gender identity clinic. The researchers found that 20% of boys and 50% of girls who were gender dysphoric before puberty remained gender dysphoric after puberty (Wallien & Cohen-Kettenis, 2008). Like Drummond et al. (2008), they found that many of the children who did not maintain their gender dysphoria after puberty developed homosexual or bisexual fantasies and behaviors (Wallien & Cohen-Kettenis). Importantly, they also discovered that the children who remained dysphoric were a strict subset of the children whose prepubertal identities reached the diagnostic threshold for Gender Identity Disorder. No children with subthreshold diagnoses remained dysphoric after puberty (Wallien & Cohen-Kettenis).

This research, along with research on the continuity of gender variant behaviors in youth who do not suffer from gender dysphoria (Golombok, Rust, Zervoulis, Golding, & Hines, 2012), supports the notion that gender identities are both fluid and fixed. A reasonable fraction of children will display gender variant behaviors and cross-gender identities, and some level of difference is likely to persist throughout their life. However, not all gender variance is so strong, so consistent, and so persistent as to reach the threshold of a cross-gender identity or to inspire a social or medical transition. Instead, many gender-variant youth will age into queer, rather than transgender, identified adolescents, where their queerness either reflects a place on the gender spectrum outside the gender binary or a nonheterosexual sexual orientation (Drescher, 2010). Such queer identities are being increasingly endorsed by youth as the notion of nonbinary gender identities and sexual orientations becomes more acceptable in Western society (Kuper, Nussbaum, & Mustanski, 2012; Stein, 2012; Welle, Fuller, Mauk, & Clatts, 2006). These identities should, therefore, ideally be discussed as part of education on sexual orientation on gender diversity. Additionally, sex and relationship education should try and reinforce the notion that a person's gender identity reflects how they see themselves, not how others perceive them. The ways in which behaviors and appearance are perceived as gendered have as much or more to do with the expectations of the observer as they do with the gender identity of the person being observed.

ADDRESSING THE TOPIC OF PUBERTY

Puberty is a major component of sexuality education, as it is a time when young people have a great deal to learn about their bodies in the context of sexual maturation (Goldman, 2011). It is also a time that can be enormously stressful, even more so for gender nonconforming youth than for their cisgender counterparts (Edwards-Leeper & Spack, 2012). Although before puberty the gendered appearance of young people is determined far

more by hairstyles and clothing than by facial structure or other physical features, that ceases to be the case once puberty has begun and hormonally driven sex differences in facial structure begin to develop (Weston, Friday, & Liò, 2007). In addition, the fear of developing, or actual development of, secondary sexual characteristics that do not match a child's gender identity can be intense and even destabilizing (de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2011).

Because of this, educators should be aware that discussions of puberty are potentially a source of significant stress for gender nonconforming youth. Furthermore, although it is less likely to be relevant to their educational practices, they should also be aware that medications are occasionally used to block or postpone puberty in these populations. When this is done, cross-gender hormones are often postponed until later adolescence (de Vries & Cohen-Kettenis, 2012). The resulting delays in development may affect youth perception of and comfort with reproductive health and sexuality topics in the classroom. This may be particularly problematic when certain biological functions are linked strongly with gendered adulthood—*“when you get your period, you know you're really a woman”*—as youth experiencing a delayed puberty will neither necessarily have those specific signs of adulthood nor experience other visible signs that are linked to growing up among their peers.

Blocking puberty has several potential benefits for transgender youth. Natural puberty causes detectable, sexualized changes in the body that can make transitioning more difficult, as these changes need to be “undone” through medical or surgical care. Individuals who can transition before puberty, or after a delayed puberty, need less extensive surgery, and they also have improved outcomes across a number of domains, including both appearance and psychological function (Kreukels & Cohen-Kettenis, 2011).

However, although puberty blockers have the potential to ease the process of gender transitions, these drugs also have their detractors. The long term health effects of these drugs are not yet known. In addition, hormones play a role in the maturation of the brain, and so some scientists question whether delaying puberty in gender dysphoric adolescents affects their ability to make informed decisions about transitioning (Sisk & Zehr, 2005). There are also concerns that, in some individuals, gender dysphoria resolves after puberty, and halting puberty denies gender-variant youth the opportunity for such a natural resolution to occur (Steensma, Biemond, de Boer, & Cohen-Kettenis, 2011).

An expert review on the subject concluded that, in youth whose gender dysphoria is worsened by the onset of puberty, the use of puberty suppressors is probably a safer choice than allowing natural puberty to continue (Kreukels & Cohen-Kettenis, 2011). There are some health risks associated with puberty suppression; however, many of them, such as growth restriction (Delemarre-van de Wall & Cohen-Kettenis, 2006), will be mitigated by

the eventual use of hormone treatments. The rest are likely outweighed by the reduction in risky behaviors, such as illicit hormone use, that often results from failing to address adolescents' gender dysphoria in a prompt and sufficient manner (Baltieri, Prado Cortez, & de Andrade, 2009). The potential dangers of such behaviors, including HIV risk, may be an appropriate topic of discussion for sexuality classes directly addressed towards transgender and gender non-conforming teens. They might also be brought up in the context of discussions of injection drug use, where needle sharing could be discussed as a risk factor separate from the dangers of illicit drugs.

CONCLUSION

An improved understanding of gender identity development can help add nuance to sexuality and gender education programs offered across the lifespan. Although gender identity development is a complex issue that is of particular importance to transgender and gender nonconforming teens, it is one which does not only affect them. Issues of gender expectation, conformity, and gender roles are highly relevant to cisgender, transgender, and genderqueer teens alike. Therefore discussions of these topics should not be limited to transgender and gender nonconforming youth.

Learning to think about and question gender norms and stereotypes can be beneficial to all children and young adults, as doing so encourages them to consider where and when gender based assumptions should and should not have a role in their lives. Several existing sexuality education curricula already encourage young people to question sexual behavior norms (Crane, Towne, & Crane-Seeber, 2013; Sclafane et al., 2005), and such topics and curricula provide another possible entry point for improving gender inclusiveness in sexuality education.

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