The Holistic Management of Children with Gender Identity Development Issues
16 May 2025

Question and Answer

Q1. How young is the youngest that you have seen with features of gender dysphoria?	**A/Prof Ong Say How**: Based on our child guidance clinic's (CGC) recent retrospective study of 107 patients over a 5-year period from 2017-2021, 71 (67%) first experienced gender-related issues before they turned 13 years old. The median age for the onset of these issues was 11 years. The average age at which participants sought help for their GD concerns was 15.6 years. **A/Prof Oh Jean Yin**: The youngest I have seen is 12 years old. Note that the Adolescent Medicine service sees kids in the adolescent age group mainly
Q2: Do you see young children (all speakers) who want to have sex change due to incongruence with their gender identity/orientation? Or that caregivers insist on sex change as they sympathise with child/adolescent?	**A/Prof Ong Say How**: In Child Guidance Clinic, we have not seen young children (referring to children age 6 - 12 years old) who want sex change or that their caregivers insist on sex change. As elucidated in the talk, there are a lot of diagnostic challenges, ethical considerations and health implications when considering medical transitioning in young children with GD. **A/Prof Oh Jean Yin**: No, the service has not seen this trend.
Q3: The Healthcare Services Act 2021 has added gender reassignment surgery into the list of surgical procedures requiring ethical approval, similar procedures include separation of conjoint twins and organ transplantation. What should the guiding principles be in reviewing such cases for ethical approval, in contrast with organ transplants/separation of conjoint twins?	**A/Prof Chan Mei Yoke**: The guiding principles are not that different and make use of frameworks like the 4 Principles of Beauchamp and Childress to identify which principles are involved and which are in conflict; the Jonson 4-box method to find out what information is important and what is missing; and the ABC toolkit to help with consistent decision-making. There are of course other frameworks out there that can be used as well. Every case is different and ultimately, we have to balance the pros and cons of all ethically reasonable options, taking into account individual and societal factors.
Q4: How common is gender dysphoria in children/adolescent locally vs elsewhere? compared with adults	**A/Prof Ong Say How**: Based on a local 2024 retrospective study of 107 patients diagnosed with GD in a tertiary child psychiatric clinic, the incidence rate of GD in Singapore residents aged 6 -19 yrs old has increased from 2.17 per

	10,000 population in 2017 to 5.85 per 10,000 population in 2021. The prevalence (2017–2021) of GD in the study was 1:5434 (0.019%). Western studies estimate the prevalence of GD to range from 0.002% to 0.7%, while Asian studies report a range from 0.0015% to 0.92%. These studies are predominantly on adult populations.
Q5: Gender dysphoria is now almost synonymous with transgenderism. However, the literal interpretation of gender dysphoria relates to the anxiety and distress experienced by a person with gender identity incongruence. Can a person with gender identity incongruence NOT have dysphoria if they do not suffer anxiety, distress etc from it?	**A/Prof Ong Say How**: Not all individuals with transgenderism or gender incongruence would experience anxiety, depressive symptoms or emotional distress. Without distress or impairment to academic, occupational or social functioning, it would categorically not be considered as an illness. Hence the term transgenderism has been removed from DSM-5 and replaced by gender dysphoria which connotes a disorder that should be approached from a bio-psychosocial and medical perspective.
Q6: Does co-morbidity include ADHD? Noted that it is not listed here	**A/Prof Ong Say How**: The link between GD and ADHD is not strong and there is no known underlying mechanism for the association between the two. However, we have seen children presenting first as having ADHD and a few years later when they become adolescents express having GD experiences.
Q7: From a psychiatric assessment perspective, can we assume that upon establishing mental capacity in the absence of other psychiatric illness be considered the same as condoning / approving gender-related treatment such as hormonal treatment, gonadectomy (oophorectomy, orchidectomy) or even gender reassignment surgery?	**A/Prof Ong Say How**: Having the mental capacity does not connote a straight path to medical transitioning including surgical gender reassignment. The medical indication must be clear and strong before such a recommendation is made. Local age of consent for surgical procedure must be met as well. In adolescents, it is recommended that the consent of two parents be obtained for hormonal treatment if medically indicated and if the patient is under 21 years of age
Q8: How do healthcare providers - doctors, psychologists, counsellors, MSWs - provide for transition of care for patients with GD? Will it be better for a doctor to refer a child presenting with possible GD direclty to a doctor / healthcare resources who can continue care of this child into adulthood?	**A/Prof Ong Say How**: A multidisciplinary approach to assessment and management is an essential part of the biopsychosocial approach a doctor should take in all his/her patients with GD. Typically in a mental health clinic, a young person with GD would be referred to a psychologist to explore his/her gender identity, to assess coping skills/styles and to manage any emotional distress arising from unhelpful or negative thought processes or beliefs. Parents and caregivers can be referred to a medical

social worker for assessment of parental attitudes and their belief systems, how they could support their child during the medical review process and whether they need any support of their own. The medical review process could take years and if necessary, a handover should be conducted from the child mental health team to the adult team.

A/Prof Oh Jean Yin: Agree that the approach is to ensure all biopsychosocial health aspects is considered. The medical review is to understand if there are any physical health conditions e.g. ambiguous genitalia/ disorders of sex development (DSD), and to assess the pubertal and growth development and nutritional status. A multidisciplinary team who provides developmentally appropriate management should be involved in the care of a patient with GD and their family with the consideration of transitioning to adult care when the young person (and family) is ready.

Q9: Would you agree that sexual and gender identity consolidation is still developing during adolescence, and that making decisions regarding gender reassignment or hormonal treatment during this stage may be premature? Given the relatively high percentage of individuals of individuals who eventually desist, what considerations might clinicians take into consideration when contemplating a delay in such interventions which are mostly irreversible?

A/Prof Ong Say How: Agree. Experience tells us that young patients can and do change their mind with the passage of time, after being provided with more information and more time to think about their situations or gender experiences. Any medical interventions come with significant risks, and it is paramount that patients and their caregivers fully understand the implications of going through the medical treatment and procedures, and whether if they could live with the side effects or if they were to be dissatisfied with the treatment outcomes. Clinicians must be guided by scientific evidence of any medical treatments and procedures. Given the paucity of long-term outcome studies on hormonal treatment in young children, certain treatments are not recommended, for example the use of pubertal blockers for pre-pubertal children with GD.

A/Prof Oh Jean Yin: This is the approach that we take with many medical conditions in needing to balance the risks with the benefits of treatment. Even with conditions like severe obesity in adolescents, where there is evidence that Bariatric Surgery is effective in managing the chronic condition – clinicians should be guided by recommendations based on more robust long-term studies which in recent years show significant treatment effectiveness of sleeve gastrectomy in improving metabolic outcomes in young people. And for this surgical intervention which is mostly irreversible, we need to help

	the adolescent and their family in their consideration of options which are right for them, in the best interest of their biopsychosocial health.
Q10: To Singapore-based panelist: Is it true that hormonal treatments (as opposed to psychological and psychiatric intervention) for gender dysphoria in Singapore are not government subsidised and that patients have to self-fund?	**A/Prof Chan Mei Yoke**: At this point in time, that is true.
Q11: What are the actual/potential implications of the recent executive and court orders regarding recognition of biological sexes in the US and UK have on medical care?	**A/Prof Oh Jean Yin:** We can't comment on other countries' legal framework. For adolescents, we just need to be aware of what material they may be exposed to on social media and help them to understand context and encourage perspective taking.
Q12: I keep hearing nonjudgment as the approach but how else can we help the child and parents / family that is supportive and yet enlighten them that this could be possibly a transient struggle and address the other stressors that could have triggered this? How much do you think social media has influenced and made this trend so rampant as compared to the past	**A/Prof Ong Say How**: It is unclear how much of an influence social media has on the development of GD. Studies regarding this is still ongoing. However, there have been anecdotal reports of individuals with GD citing social media as playing a part in their coming out as transgender because they identified with other transgender members online, discovered that they are not alone and then decided to talk about their own experiences. Some sought connections online as they felt lonely or were social isolated while still exploring their gender identity. This can lead to them drawing erroneous conclusions about their own gender identity. It is believed that social media would likely influence those who are already questioning their gender identity but have yet articulated about it or sought professional help. **A/Prof Oh Jean Yin**: Even in populations with limited access to social media, their youth have experienced gender identity questioning. For parents and families, it can be hard to know if struggles are going to be transient – so we often need to also support parents and families in still taking their child/ adolescent's concerns seriously and ensure safety/ function especially if there is distress. The quest of finding root causes/ other triggers can be done over time.
Q13: Why would purchasing cosmetics be viewed as problematic for a YP for themselves, unless there are binary norms	**A/Prof Ong Say How**: A lot of older teenage or young adult males nowadays use skin care products or cosmetics. Hence in itself, it is not a problem. It becomes a problem

and negative social expectations being imposed on the child themselves by parents?	only if they adult caregivers disprove of their use. This may cause parent-child conflict.
Q14: This can be life threatening - GD can cause such distress that it leads to suicidal ideation and completion (not caused by depression alone. Especially with onset of puberty where the GD increases untenably for the child, this harm is often dismissed and not quantified and aggregated sufficiently. The precautionary principle is useful but sometimes you need to make a decision to support the child and ethically assess their capacity to benefit more broadly.	**A/Prof Chan Mei Yoke**: Yes, indeed, that is one of the main reasons why the distress caused by GD in children (or by any condition!) needs to be acknowledged and addressed appropriately. **A/Prof Ong Say How**: Indeed, very often, a balance has to be struck regarding potential side effects of medical transitioning versus harm reduction (due to suicide attempts arising from GD).
Q15: It is often very helpful to have 1-1 time with an adolescent patient. Different parents will view such interactions differently. How would you balance between respecting the adolescent patient's right to privacy and our legal responsibility towards the parents / guardians of the legal minor? Are there situations where we can safely withhold information from the parents to protect the rights of adolescent patient?	**A/Prof Oh Jean Yin**: Having solo interactions with adolescent patient's is a priviledge and parents are usually open to this when the purpose is clearly explained and a discussion around confidentiality around patient disclosure is done before the 1-1 time. Patient and parents are told that all information shared to doctor is kept confidential unless there are concerns around safety (self-harm, suicidality, abuse or exposure to violence, involvement in illegal behaviour e.g. substance use etc.). Most of the time, parents are open and majority are glad to leave the consult room.
Q16: What also would the approach be if the young child is highly cognizant of the assessment for his gender preference/orientation and denies all deviation or atypicalities but parents are pushing for evaluation in front of him - my patient was 7 years old	**A/Prof Oh Jean Yin**: This sounds challenging. I would question the parent's motivation in pushing for evaluation. If a 7 year old is not ready for any conversation around a sensitive topic be it gender identity, or being bullied in school etc. etc - I wonder if conversations at home have sufficient empathy and trust that their views will be taken seriously. I would try to frame that some incongruent behaviours related to gender expression, can be normal. Important to screen for abuse/ trauma/ learning disorders/ Autism Spectrum Disorder. Most of time, can wait and see while rapport builds over time.
Q17: Given that sexual orientation and gender identity are different and separate, is it usual for an individual who goes through with the whole gender switch process, to still maintain a 'deviant' gender preference - eg a biological male	**A/Prof Ong Say How**: This is possible though much less common. Through my interactions with my counterparts, I have heard of such cases.

undergoes sex change to a female but still has a sexual preference for females?	
Q18: How do institutions of learning in Singapore deal with youths with gender issues and the use of toilets? Thank you	**A/Prof Oh Jean Yin**: MOE has guidance that schools should consult and work with different stakeholders including the relevant medical professionals, student concerned and their parents for any school arrangements needed. They emphasise that each situation is unique and to manage with dignity and respect.
Q19: Is GD a mental illness in itself as historically homosexuality was a mental illness	**A/Prof Ong Say How**: For now, yes. GD is a mental health diagnosis. However, this might change with time as what we have seen with homosexuality when there is more research findings and greater consensus about how it should be approached.
Q20: Since gender dysphoria is still considered a mental disorder, MOH accepts that gender reassignment surgery can be considered medically necessary procedures, provided that "full psychological and psychiatric assessment and treatment has been rendered but failed". However, many psychiatrists do not feel that there is a "treatment" for gender identity disorder. Should we then refer cases of well-adjusted patients with gender identity disorder without any anxiety or depression?	**A/Prof Ong Say How**: If there are no mental health symptoms such as anxiety or depression, a referral to a psychiatrist would not be necessary. The roles of psychiatrists are also to establish the GD diagnosis, determine whether there are other psychiatric co-morbidities (and treat accordingly) and to establish mental capacity should the patients decide to undergo medical transitioning including gender reassignment surgery.
Q21: If an adolescent (let's say 17-20yo) came on their own, to seek an assessment for GD on their own. Assuming no risks and no intention to pursue medical transition at the moment, would it be appropriate to respect their confidentiality and not inform their parents of the visit? What about if the adolescent was keen for allied health support (eg MSW/psychologist), would we need to inform parents then?	**A/Prof Oh Jean Yin**: Confidentiality should balance ethical obligation to keep patient information secure (duty to protect), patient autonomy (right to control disclosure), and exceptions (imminent risk from active suicidal ideation). But adolescent is help-seeking and breaking confidentiality can impact trust and continued help seeking decisions.
Q22: Just a comment on gathering evidence and trying to tap on international resources. Unfortunately, the perception and acceptance of GD will be	**A/Prof Chan Mei Yoke**: Yes, that is largely true, so these resources and evidence can act as a guide to help us develop our own local guidelines.

very much colored by our societal norms / culture. Not sure how much we can really tap on the resources developed elsewhere?	
Q23: Would psychotherapy be the first line treatment for someone with GD?	**A/Prof Ong Say How**: Yes. Cognitive behavioural therapy (CBT) is typically used to assess the patient's cognitive processes, identify whether there are any cognitive biases or distortions regarding one's gender identity and belief systems that would impact on one's decision making, and explore the possibility of challenging these unhelpful, negative thinking. CBT also involves mood monitoring and conducting of social experiments to debunk previously firmly held ideas or beliefs. Behavioural strategies are also taught and practised during therapy sessions to alleviate anxiety symptoms and distress that may accompany the negative thoughts. CBT is thus also applicable to treating anxiety and mood disorders. Depending on the nature of the case, other forms of therapy such as supportive psychotherapy, interpersonal therapy and family therapy may be necessary.