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ORIGINAL ARTICLE

Discovering a diverse gender in adolescence: revelation of being. Exploratory study

Descubrir un género diverso en la adolescencia: revelación del ser. Estudio exploratorio

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What do we know about the subject matter of this study?

Gender identity is constructed from childhood. There is evidence regarding the terminology of diverse identities, clinical aspects, epidemiology, neurobiology, and management. However, studies on the transgender or non-binary experience among adolescents in Latin America are scarce.

What does this study contribute to what is already known?

Exploratory qualitative study using the Grounded Theory method. The experience of a diverse identity begins early with questioning the sex assigned at birth and intensifies during adolescence, with dysphoria being predominant. Self-acceptance, family support, and the beginning of affirmation are sources of resilience that facilitate the full revelation of gender-diversity.

Abstract

Gender identity is configured from childhood. **Objective:** to explore the experience in the construction of a diverse gender in adolescence in its family and social context. **Subject and Method:** Exploratory qualitative study that used the Grounded Theory method and its analytical techniques of coding, categorization, and constant comparison. 15 semi-structured interviews were conducted with youths aged between 12 and 21 years attending a Specialized Psychopedagogical Center in Medellín, Colombia, plus the contribution of close adult relatives in 3 of the interviews. The ethical requirements for this type of study were met. **Results:** The incongruence between body and gender identity begins with an internal conflict that allows the exploration of the self as a task inherent to the individual. Adolescence exacerbates the need for recognition of that identity. This study shows that gender identity is a dynamic process of individual construction, permeated by the family-social context, which is sometimes attacked by imposing hegemonic binary standards (male-female); archetypes that promote discrimination with serious consequences for physical and mental health.

Keywords:
Gender Dysphoria;
Transgender Identity;
Gender Non-Conforming People;
Qualitative Research;
Grounded Theory;
Teenagers

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Comprehensive management should embrace and facilitate the process of building a diverse gender in adolescence. **Conclusions:** The experience of a diverse gender begins in childhood with the feeling of body/gender identity incongruence, and intensifies in adolescence with dysphoria being predominant. Self-acceptance, family support, and the beginning of affirmation are sources of resilience that facilitate full disclosure of a diverse gender.

Introduction

Gender identity is the internal sense of being male, female, both, or neither; it is independent of sexual orientation[1]. Within the spectrum of human diversity, individuals with gender expression and identity that deviate from binary cultural norms (male/female) and the expectations of the sex assigned at birth are referred to as "gender non-conforming", "gender expansive", or "transgender[2]. The diagnosis of gender dysphoria, which means distress due to identity/body incongruence, is part of the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5), which replaced the clinical entity called "Gender Identity Disorder" in order to remove the connotation of mental disorder[3]. In our study, the term *gender-diverse* will be used as a proposal to cover the broad spectrum of gender identity as a condition of life and contribute to the depathologization process, creating a balance between the human right to identity and the need to require comprehensive healthcare support.

International studies have reported prevalences of this condition that vary from 0.17 to 1.3% of the population[4-6]. There is evidence on terminology, identity expression, and hormonal management[7] but there are few studies in the Latin American population, being a condition that from the medical point of view is little explored and recognized in this region of the world[8,9].

Current standards of care recognize that transgender identity begins its presentation in early childhood, which encourages research from the early stages[10]. Over the past two decades, there has been increased interest in understanding this condition, due to increased visibility of the transgender community by the media and activism, a 10- to 100-fold increase in prevalence in recent years, and increased healthcare seeking coupled with a growing concern for associated mental health problems[2,4,5,7,11].

In the process of constructing a diverse gender, the internal desire to identify with the desired gender and the normative cisgender social context are confronted. Young people integrate same-sex desire, behavior, and identity into their own life history as they appropriate narratives of sexual identity development, characterized by the challenge generated by the longed-for integration that conforms to the received sexual taxonomy[12]. On the other hand, the "Minority Stress Theory" allows an understanding of how experiencing prejudice and discrimination can contribute to internalized transphobia and negative expectations about the future which, at the same time, contribute to psychological disorders with a negative impact on health due to gender identity[13,14].

The lack of comprehensive healthcare programs for transgender children and adolescents represents an obstacle to safe social and medical affirmation[15], coupled with the fact that most research is conducted on adults[2,16]. Even though Colombia has Constitutional Court rulings that protect the rights of transgender persons, there is still social resistance to fully and openly accepting gender-diverse persons[17].

The objective of this study is to explore the experience in the construction of a diverse gender from adolescence in their family and social context, in order to make this condition visible to the medical community and contribute to comprehensive support in the early stages.

Subjects and Method

Qualitative study developed with the Grounded Theory method and its coding, categorization, and constant comparison techniques[18] which make it possible to advance in a greater understanding of the experience in the construction of a diverse gender by a group of adolescents, who embodied this reality in their family and social context. For data collection, a semi-structured interview script was designed and applied, for which the interviewers were trained in both data collection techniques and data analysis, which allowed standardizing the way of applying the interviews and subsequent coding.

Subjects

The gender-diverse population was selected for convenience through selective sampling at the *Centro Integral Psicopedagógico* (CEPI) in Medellín, Colombia. At this center, all users receive professional accompaniment by physical and mental health specialists, as well as legal advice. Semi-structured in-depth interviews were conducted with 15 participants aged between 12 and 21 years, between September 2019 and January 2021.

The inclusion criteria were individuals under 21 years of age with transgender identity or a diagnosis of gender dysphoria according to DSM-5 criteria, made by a specialist in sexology or psychiatry, who agreed to participate in the study. The definitions used in the study were clearly specified (table 1). The exclusion criteria were not having a clinical history in the CEPI, having a cognitive deficit, or having a major psychiatric disorder.

During the interview process, it was possible to participate alone or in the company of family members. Only 3 participants accepted the company and the contribution of a family member during the interviews, which were added to enrich the information provided. The researchers accepted the decision of the participants who attended alone and did not inquire about the reasons for this.

The questions in the script delved into their experience since they began to recognize their gender identity, and how their families, friends, and educational, social, and health institutions received them. The interview script is presented in Appendix 1 (available online).

Information collection

Initially, 9 face-to-face interviews were conducted. Subsequently, after the first analyses, the interview script was modified to deepen the aspects that were emerging, to go to people or events that maximized the opportunities to discover variations among the concepts and categories until achieving greater saturation. Six additional interviews were conducted virtually due to the conditions of the SARS-CoV-2 pandemic. Confidentiality was safeguarded by making only voice recordings with a pseudonym and only the interviewee and interviewer, as well as accompanying family members, attended virtually or in person. The material obtained was kept in the custody of the researchers only.

Analysis

The recordings were transcribed with subsequent verification of the fidelity of the data and the audios. The analysis had three stages: descriptive, analytical, and interpretative[19].

At the first descriptive stage, open coding was performed. After reaching an agreement to standardize the coding, the researchers compared the abstractions or codes obtained by each of them. The codes were then inductively grouped into descriptive categories, within which the most abstract properties or ideas were identified from the same number of dimensions that are groupings of codes.

In the second analytical stage, the properties and dimensions were related to construct an analytical category through axial coding, which includes a phenomenon, conditions, action, and interaction relationships

Table 1. Definitions used for research in gender-diverse adolescents

Gender identity: Intimate and subjective perception of feeling like a man, a woman, both, or neither. Not visible to other people[41].

Gender diverse:

- **Transgender (trans):** Individuals who persistently identify with a sex other than their natal or assigned gender at birth. "Trans" is a widely accepted shorthand term among transgender people[41].
  Transgender man: Person assigned female at birth but who identifies as a man.
  Transgender woman: Person assigned male at birth but who identifies as a woman.
- **Nonbinary gender:** People whose gender identity does not conform to the binary understanding of gender (Male or Female). Includes people who are genderless (agender), two genders (bi-gender), multiple genders (pan-gender), or gender fluid[41].

Gender Dysphoria: DSM-5 Criteria in Adolescents and Adults[2]

A. A marked incongruence between one's felt or expressed sex and one's assigned sex, lasting at least six months, as manifested by at least two of the following:

1. A marked incongruence between one's felt or expressed sex and one's primary or secondary sexual characteristics (or in young adolescents, one's expected secondary sex characteristics).
2. A strong desire to be rid of one's primary or secondary sexual characteristics because of a marked incongruence with one's felt or expressed sex (or in young adolescents, a desire to prevent the development of one's expected secondary sex characteristics).
3. A strong desire to possess the sexual characteristics, both primary and secondary, of the opposite sex.
4. A strong desire to be the other sex (or an alternative sex other than that assigned).
5. A strong desire to be treated as the other sex (or an alternative sex other than that assigned).
6. A strong belief that one has feelings and reactions typical of the other sex (or an alternative sex other than the one assigned).

B. The problem is associated with clinically significant distress or impairment in social, occupational, or other important functional areas.

and consequences, which in synthesis is the matrix of the paradigm of Grounded Theory (figure 1). The process was carried out through a constant comparative analysis[18,19], which was iterative, interactive, and systematic and involved codes, categories, theoretical references, emerging theory, and the researchers' points of view. The analysis of the interviews was performed in Word and the categories in Excel matrices.

Triangulation or search for patterns of convergence was carried out by the researchers by reading and analyzing each one of the transcribed interviews and making a common bet. This process was between researchers, but also of the sources of analysis (codes and categories emerged), and the perspectives of the researchers were compared openly[20]. Reflexivity was used to examine and become aware of the constructs used as starting points while acknowledging one's own limitations[21].

Ethical aspects

In the informed consent, the objectives and method of the study were explained to the participants, including the voice recording of the interview. The voluntary nature of their participation was clarified, as well as the signature of the informed consent for those aged 18 years or older, and the assent of those under 18 years of age together with parental authorization through the informed consent of the legal representative.

The research was approved by the Research Ethics Committee of the Faculty of Medicine of the *Universidad de Antioquia* (approval act: No. 015 of 2019).

Results

Thirteen of the 15 participants were younger than 18 years. The age at the onset of their diverse gender was before the age of 15 years in 9 participants. The predominant diverse gender was transgender females (baseline male) with 9 versus 6. All participants were in age-appropriate education and 8 of 15 participants were from low socioeconomic strata 1, 2, and 3 (table 2).

In total, 2281 codes were developed, which were grouped into 17 descriptive categories named: support, regret, seeking, identification, messages to others, hiding, perception of others, perception LGBTIQ (acronym for Lesbian, Gay, Bisexual, Transgender, Intersex, Queer), post-transition, pre-identification, rejection, relationships, revealing, health, feelings, taboo, and transition. From these categories, 136 properties or attributes emerged from the same number of dimensions. Table 3 shows an example of codes grouped in the dimension "discrimination" within the category "Taboo", as well as the property that emerged.

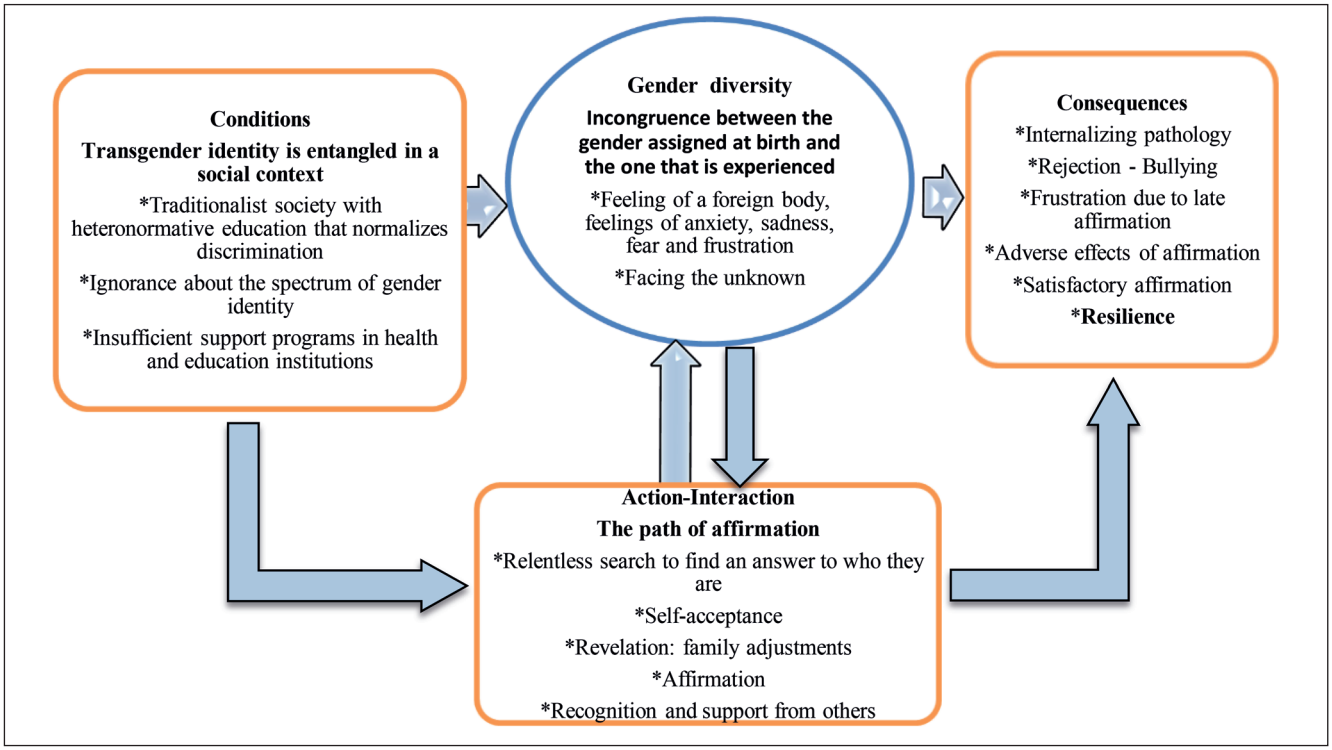

Figure 1. Gender diversity research paradigm matrix in adolescents.

Table 2. Sociodemographic characterization of gender-diverse adolescents

Interviewee	Age	Sex assigned at birth	Self-designation	Affirmation age	Studies	Occupation	Socioeconomic strata
1	21	Female	Transgender man	15	Completed high school	Unemployed	3
2	19	Male	Transgender woman	11	Completed high school	Unemployed	3
3	16	Female	Transgender man	14	Completed high school	High school student	4
4	20	Male	Transgender woman	14	Incomplete University	Psychology student	3
5	21	Female	Transgender man	19	Completed high school	Employee at publicity company	3
6	19	Male	Transgender man	16	Incomplete University	Medicine student	5
7	20	Female	Transgender man	16	Técnico	Unemployed	1
8	19	Male	Transgender woman	14	Completed high school	Model	6
9	19	Male	Transgender woman	12	Completed high school	Unemployed	6
10	19	Male	Transgender woman	15	Completed high school	Model	4
11	18	Male	Transgender woman	13	Incomplete University	University student	6
12	18	Female	Transgender man	13	Completed high school	Art student	4
13	12	Male	Transgender woman	8	Incomplete middle school	Fourth grade student	2
14	19	Male	Transgender woman	17	Completed high school	Employee	1
15	20	Male	Transgender woman	18	Completed high school	Unemployed	3

Socioeconomic stratum: economic classification level according to the housing and public services owned. It ranges from 1 (lowest) to 6 (highest).

Table 3. Example of codes grouped in the "discrimination" dimension within the descriptive category "Taboo" and the emerged property

Codes	Dimension	Descriptive category	Property or attribute
Facing taboo worrying about hearsay.	Discrimination	Taboo	The invisibility and pathologization of trans people create a taboo that promotes painful discrimination.
Being afraid of my mother's crying, my cousin's scolding, also of facing society with the truth, for fear of being labeled as "strange", I believed I was the only one.			
I went through the process alone, because I considered it taboo and thought my family and friends would consider me "bad" or "damaged."			
My father thought it was wrong for someone to step out of the mold of male or female.			
I thought everything was screwed in my house because I was gay and being transgender was going to be a big problem.			
They hit me on the hand if I picked up a Barbie			
It was outrageous to me that someone dared to say that being transgender was normal.			
They tried not to spark ideas in children when teaching about gender and sexual orientation.			
I wondered how people would take having a man's name and I was incredibly scared.			
It's always been known that I like women, but people get alarmed when they find out I'm trans.			
At first you feel bad about being singled out, but you change your way of thinking			
Facing comments from neighbors and friends.			

Next, each of the components of the central analytical category that includes the phenomenon is developed in prose: Incongruence between the gender assigned at birth and the one they experience, followed by the conditions in which the transgender identity develops in society. Subsequently, the relationships of action and interaction reflected in the process towards affirmation are presented, and finally the consequences of the phenomenon which is represented as conflicting feelings towards affirmation.

Incongruence between the gender assigned at birth and the gender they experience

The contradiction between the body and gender identity is a conflict that begins with self-knowledge. Gender identity is intrinsic and manifests itself in the self through a gradual process. Restoring identity is an ongoing task inherent to the individual. Between the ages of 3 and 8, there is from early childhood a constant questioning of gender. This is exacerbated in adolescence by physical changes and the recognition of sexual orientation.

> *"Not connecting your masculinity to your biological gender is an internal struggle. You are shaping yourself. I don't think I am, I am. My soul, my mind, and my body are those of a man" (Transgender man, 21 years old).*

> *"Since I was very little, around 6-7 years old, I used to pray to wake up as a woman and I used to say 'God, if you can do everything, let me wake up as a woman because it is very difficult to be a man'" (Transgender woman, 20 years old).*

> *"I never liked looking at myself in a mirror simply because I didn't want to see myself because I thought it was a horrible thing. It really hit me hard to see the changes towards the masculine side during adolescence and that's when I said, I feel like a woman" (Transgender woman, 19 years old).*

Transgender identity in society

Gender identity is a dynamic process of individual construction, permeated by the cultural and social context, which is sometimes attacked by imposing standards. Education resulting from a traditionalist culture binds sex, gender identity, and gender roles in only two archetypes (female-male) that are replicated in social structures. These stereotypes, ignorance, and pathologization promote discrimination while hindering the recognition and expression of gender identity.

> *"One doesn't wish to be straight... These are messages that are internalized from society and when you realize that you are none of those desirable things, it's devastating" (Transgender male, 18 years old).*

Educational institutions have a decisive role in the recognition, acceptance, and accompaniment of the administration, teachers, students, and their parents. Likewise, healthcare providers are cardinal; however, sometimes they lack healthcare programs for the transgender population, professionals with knowledge of this condition, and even healthcare with a gender perspective, sometimes leading to discrimination.

> *"To change my uniform, my parents and I had to go to the school principal, the priest, and the coordinator just to modify the uniform; they told me that no one would call me by the name I wanted, that they didn't have the authorization" (Transgender male, 16 years old).*

> *"At first, I only had psychiatric care and that was it because the endocrinologist told me that he didn't have knowledge of my condition so he couldn't treat me" (Transgender woman, 19 years old).*

In legislation, the experience may involve the change of name, gender, and sex, which accounts for a complex process that may involve biological (hormone therapy) and/or physical (surgeries) changes, depending on the decision of the adolescent and her or his family, with profound social and relational transformations. Sex-differentiated laws that do not consider gender become an obstacle. Likewise, the legal process can be more difficult due to age limitations, usually under 18 years of age.

> *"Legal advice was required for the change of identity documents, we finally achieved it at the age of 10" (Mother of a transgender girl, 12 years old).*

The process towards affirmation

Reaffirmation of gender identity requires self-exploration. The discovery of gender diversity, sexual orientation, roles, and coping possibilities after searching the Internet helps with identification. This leads to self-recognition and acceptance in private, allowing individuals to find the means to start their personal process, however, this can be limited by fear, especially from parents.

> *(after finding information on the Internet) "I felt like crying from happiness, I mean, I'm not the only one who has lived this torment, but there are more of us" (Transgender man, 21 years old).*

"I told my mom at 18, 'Mom, I need you to help me with this, I'm this way and that way', and my mom was silent. After a while I heard her crying. My fear came true" (Transgender man, 21 years old).

"When I was 13, I was told there was something called gender dysphoria... I read a little about what it was, how it was, and later I found out that there was such a thing as re-hormonization and all those kinds of processes that help people like me, I thought about it a lot and the doubt was recurrent, so I decided to start" (Transgender woman, 19 years old).

Revealing is the continuum for the reaffirmation of one's identity at the family and social level that is initiated by the closest circles verbally or non-verbally, through physical and behavioral changes. Those closest and first to know receive a vote of confidence that is expected to be reciprocated with acceptance and support. Revealing can provoke anything from acceptance to rejection. The process is distinct to each family member, mediated by human relationships and underlying knowledge. Human relationships can change. At times, the breakup may be perceived as an opportunity to freely reaffirm one's identity. The transgender community plays an important role at the societal level.

"My mom told me: 'It's hard, but give me time, I know that... you'll still be the same person' [...] I mean, my mom, in her love, doesn't care if my physical appearance changes; she will always be there, that's what made her accept me" (Transgender man, 21 years old).

From mixed feelings to affirmation

The contradiction between body and gender identity, difficulties during the experience, and discrimination can generate multiple feelings such as anger, helplessness, anxiety, sadness, fear, loneliness, guilt, and frustration. This can lead to depression and suicide. Resilience is crucial for coping with difficulties and developing affirmation.

"There was a day when I was going to the balcony and my mom noticed and said, 'Oh, of course, now you're going to jump because we don't accept you, so go ahead and jump, I still won't accept you'. There were many times of suicide attempts because it was like I couldn't find my place in the world" (Transgender man, 19 years old).

Gender affirmation also begins with self-questioning and a progressive expression of identity through bodily transformations and behavioral changes. The support of family and friends is fundamental. Subsequently, the support of specialized healthcare personnel from psychiatry, psychology, endocrinology, and plastic surgery, among other professions may be necessary depending on the individual process. The measures taken during the process may have adverse effects that cause fear, such as breast pain (due to breast compression); acne, headache, emotional changes (associated with hormone therapy); and loss of genital sensitivity (related to sex reassignment surgery). Particularly about surgery, there may be doubts and questions about the meaning of the body beyond genitality. This generates a complex social experience and finally, the process allows in some cases the fullness of gender identity and well-being (figure 2).

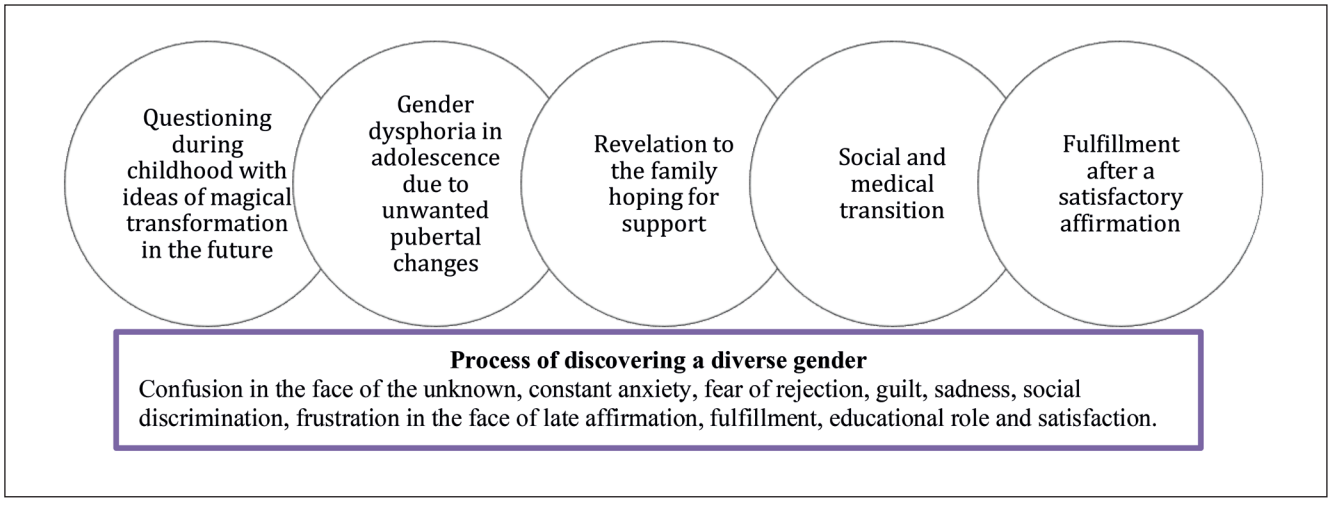

Figure 2. Dynamic process of gender diversity - transgender in adolescents.

"That girl told me she had a little bottle, and I asked 'Why, what is that?' and she told me it was a hormone, you put it here and inject it, and I didn't like it at all, and I told her no. I want the experts in that, the doctors, the ones who know about it" (Transgender girl, 12 years old).

"It's not a change of identity but a reaffirmation of my identity. If I had been a cisgender woman from the beginning, I wouldn't have half the strength of character I have" (Transgender woman, 20 years old).

Finally, the transgender person identifies a political and social role by assuming an educator role in gender diversity, telling their own stories and experiences in order to change paradigms. This issue must be disseminated from the niches of society (family and education) so that future transgender children find a more welcoming path.

"Being a trans woman already implies having a political body, you arrive and represent a community. It's like a heavier burden from those behind me; I must take on the responsibility to educate" (Transgender woman, 20 years old).

Discussion

Gender identity is a multidimensional construction that starts from the self-knowledge of belonging to a particular gender[22]. Literature indicates that gender incongruence usually begins in childhood or during puberty, where there is a marked nonconformity with the body and the affirmation of identity[23,24]. Previous studies indicate ages of presentation between 3 and 12 years of age[16,25,26]. This agrees with our work in which the questioning is before 15 years of age.

The initial response to the discovery of a diverse gender among the interviewed adolescents was the search for meaning in their existence and, as a practice, there was evidence of an internet search to explain the unknown. A previous study on the use of online resources by transgender youth aged between 14 and 22 years shows that the searches are related to the exploration of emotions, terminology, gender identity, and communities that share similar experiences as support to normalize their experience[27]. In this search, they went through a process of adopting and discarding different labels before finding a gender identifier that exactly matched their true identity.

The suffering that accompanies the process of discovering one's own identity is evident, including mental health effects. A multicenter study in the United States with gender-diverse adolescents reported symptoms of depression from 28.6 to 57.3% and anxiety from 22.1 to 66.6%[28]. Other studies report suicide attempts in up to 50%[29] and life-threatening behaviors compared with their cisgender peers[30]. Our accounts showed psycho-emotional components transversal to the process of discovering a diverse gender secondary to rejection and discrimination.

In the micro-social context, the family was the main source of support craved by the adolescents interviewed as influential in the process of affirming their gender. The U.S. Transgender Survey found that 60% had family support, 22% were neutral, and 18% were rejected, of which nearly twice as many were likely to have experienced homelessness (40% vs. 22%), to have engaged in sex work (16% vs. 9%), and to have attempted suicide (49% vs. 33%)[31]. Our interviewees showed that family, especially parents, are a source of resilience and support. According to previous studies, transgender youth who grow up in supportive environments can become psychologically functional individuals who are indistinguishable from their cisgender peers[32]. Family support is associated with a greater likelihood of connecting the transgender son/daughter to supportive physicians and resources, as well as being identified by transgender youth as the primary source of resilience[33].

Families of transgender adolescents also go through a process of transitioning through stages, as described by previous studies on family adjustment: awareness of gender nonconformity, confusion, negotiation, and balancing, with feelings of loss[33,34]. Despite social stigmatization and discrimination, caregivers adapt, seek forms of support, and struggle to achieve acceptance of their transgender children[35]. Our work evidenced this, as the families presented different reactions from initial rejection to acceptance; but there was agreement on the positive influence and need for family support on the part of the adolescents. In the school environment (principals, teachers, and classmates), support for adolescents was variable, with limitations, especially with the student coexistence manual, such as names according to legal documents, established uniforms, and bathroom entrances according to sex. This problem was reflected in a Canadian survey, where 90% of transgender youth heard daily or weekly transphobic comments from other students[36].

In relation to access to health services, some of the adolescents interviewed encountered barriers to access due to a lack of knowledge about comprehensive gender identity counseling and even discrimination by healthcare providers, as evidenced by the scientific literature on the problematic situation[37,38]. In recent years, countries such as the United States have shown a trend toward transphobia and prejudice against trans-

gender and gender-diverse children, reflected in a large number of initiatives that have become laws that seek to punish caregivers and physicians who support these children, even denying them routine healthcare, which has been shown to impact the high rates of suicide and depression in transgender youth[39]. Increased discriminatory rhetoric affects the mental health of these individuals, jeopardizing their safety[39].

Multiple academic societies advocate for the creation of multidisciplinary gender clinics that support counseling toward affirmation from an early age[40,41]. Timely and comprehensive accompaniment has been shown to improve body image, and dysphoria, and decrease the incidence of psychopathology including suicide[41-43]. Regarding the development of gender identity, qualitative research has suggested that it is presented in stages: body-mind dissonance, identity management and negotiation, and finally, affirmation[44,45]. This is consistent with the findings of our study, which focused on adolescents, although it should be noted that this is not a linear and unique process, as each individual experiences it differently.

One of the limitations of our study is that not all the emerging categories achieved the same development and depth, as occurred in the social and educational context, in addition to the individual-culture interaction, which is beyond the objectives of the study.

As a suggestion, it is urgent for health professionals to have a better understanding of the construction of transgender identity in order to improve the accompaniment in the care process, avoid pathologizing gender affirmation, and achieve a more effective acceptance, especially in the adolescent population. Continuous education of health personnel in the current standards of health care for transgender and gender-diverse people would enhance a responsible response to the demand for services of this type, in addition to overcoming stigma and discrimination by health personnel.

Conclusions

The construction of a diverse gender implies a dynamic but intimate process, which begins in childhood with an internal conflict that, after being explored by the individual, generates a feeling of incongruence between the gender assigned at birth and the one experienced. Adolescence exacerbates the need for recognition of this identity, as it is immersed in a family and social context that sometimes attacks by imposing hegemonic binary standards and promotes discrimination of adolescents with serious physical and mental consequences. Self-acceptance, as well as family and educational support, are determining factors in facilitating the full revelation and affirmation of a gender-diverse person. The stages described in this constructive process are neither linear nor homogeneous, as each one travels the road at her/his own risk toward the desired affirmation.

Ethical Responsibilities

Human Beings and animals protection: Disclosure the authors state that the procedures were followed according to the Declaration of Helsinki and the World Medical Association regarding human experimentation developed for the medical community.

Data confidentiality: The authors state that they have followed the protocols of their Center and Local regulations on the publication of patient data.

Rights to privacy and informed consent: The authors have obtained the informed consent of the patients and/or subjects referred to in the article. This document is in the possession of the correspondence author.

Conflicts of Interest

Authors declare no conflict of interest regarding the present study.

Financial Disclosure

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References

1. Safer JD, Tangpricha V. Care of Transgender Persons. N Engl J Med. 2019;381(25):2451-60. doi: 10.1056/NEJMcp1903650
2. Olson-Kennedy J, Cohen-Kettenis PT, Kreukels BPC, et al. Research Priorities for Gender Nonconforming/Transgender Youth: Gender Identity Development and Biopsychosocial Outcomes. Curr Opin Endocrinol Diabetes Obes. 2016;23(2):172-9. doi: 10.1097/MED.0000000000000236
3. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders [Internet]. Fifth Edition. American Psychiatric Association; 2013 [citado 14 de febrero de 2024]. Disponible en: https://psychiatryonline.org/doi/book/10.1176/appi.books.9780890425596
4. Connolly MD, Zervos MJ, Barone CJ, et al. The Mental Health of Transgender Youth: Advances in Understanding. J Adolesc Health Off Publ Soc Adolesc Med. 2016;59(5):489-95. doi: 10.1016/j.jadohealth.2016.06.012
5. Zucker KJ. Epidemiology of gender dysphoria and transgender identity. Sex Health. 2017;14(5):404-11. doi: 10.1071/SH17067
6. Winter S, Diamond M, Green J, et al. Transgender people: health at the margins of society. Lancet Lond Engl. 2016;388(10042):390-400. doi: 10.1016/S0140-6736(16)00683-8
7. Skordis N, Kyriakou A, Dror S, et al. Gender dysphoria in children and adolescents: an overview. Horm Athens Greece. 2020;19(3):267-76. doi: 10.1007/s42000-020-00174-1
8. Velasco RAF, Slusser K, Coats H. Stigma and healthcare access among transgender and gender-diverse people: A qualitative meta-synthesis. J Adv Nurs. 2022;78(10):3083-100. doi: 10.1111/jan.15323
9. Van Schuylenbergh J, Motmans J, Defreyne J, et al. Sexual health, transition-related risk behavior and need for health care among transgender sex workers. Int J Transgenderism. 2019;20(4):388-402. doi: 10.1080/15532739.2019.1617217
10. Coleman E, Radix AE, Bouman WP, et al. Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. Int J Transgender Health. 2022;23(Suppl 1):S1-259. doi: 10.1080/26895269.2022.2100644
11. Deutsch MB. Making It Count: Improving Estimates of the Size of Transgender and Gender Nonconforming Populations. LGBT Health. 2016;3(3):181-5. doi: 10.1089/lgbt.2016.0013
12. Hammack PL, Thompson EM, Pilecki A. Configurations of identity among sexual minority youth: context, desire, and narrative. J Youth Adolesc. 2009;38(7):867-83. doi: 10.1007/s10964-008-9342-3.
13. Hendricks ML, Testa RJ. A conceptual framework for clinical work with transgender and gender nonconforming clients: An adaptation of the Minority Stress Model. Prof Psychol Res Pract. 2012;43(5):460-7. doi: 10.1037/a0029597
14. Testa RJ, Habarth J, Peta J, et.al. Development of the Gender Minority Stress and Resilience Measure. Psychol Sex Orientat Gend Divers. 2015;2(1):65-77. doi: 10.1037/sgd0000081
15. Sequeria GM, Guler J, Reyes V, et al. Adolescent and Caregiver Perspectives on Receiving Gender-Affirming Care in Primary Care. Pediatrics. 2023;152(4):e2023062210. doi: 10.1542/peds.2023-062210
16. Vargas-Huicochea I, Robles R, Real T, et al. A Qualitative Study of the Acceptability of the Proposed ICD-11 Gender Incongruence of Childhood Diagnosis Among Transgender Adults Who Were Labeled Due to Their Gender Identity Since Childhood. Arch Sex Behav. 2018;47(8):2363-74. doi: 10.1007/s10508-018-1241-4
17. UNFPA Colombia [Internet]. 2019 [citado 29 de abril de 2024]. Lineamientos de Atención en los Servicios de Salud que Consideran el Enfoque Diferencial, de Género y No Discriminación para Personas LGBTI. Disponible en: https://colombia.unfpa.org/es/publications/lineamientos-atencion-servicios-salud-enfoque-genero
18. Morse JM. Critical issues in qualitative research methods. Sage Publications: London, United Kingdom 1994;395.
19. Yepes C. Teoría Fundamentada para investigación cualitativa en Medicina. [Internet]. Primera edición. EIA: Envigado, Colombia; 2023 [citado 14 de febrero de 2024]. 344. Disponible en: https://fondoeditorial.eia.edu.co/product/teoria-fundamentada-para-investigacion-cualitativa-en-medicina/
20. Rahman K. «Triangulation» Research Method as the Tool of Social Science Research. BUP journal. 2012;1:154-63.
21. Engward H, Davis G. Being reflexive in qualitative grounded theory: Discussion and application of a model of reflexivity. J Adv Nurs. 2015;71(7):1530-8. doi: 10.1111/jan.12653
22. Egan S, Perry D. Gender Identity: A Multidimensional Analysis With Implications for Psychosocial Adjustment. Dev Psychol. 2001; 37:451-63. doi: 10.1037//0012-1649.37.4.451
23. Arain M, Haque M, Johal L, et al. Maturation of the adolescent brain. Neuropsychiatr Dis Treat. 2013;9:449-61. doi: 10.2147/NDT.S39776
24. Turban JL, Beckwith N, Reisner SL, et al. Association Between Recalled Exposure to Gender Identity Conversion Efforts and Psychological Distress and Suicide Attempts Among Transgender Adults. JAMA Psychiatry. 2020;77(1):68-76. doi: 10.1001/jamapsychiatry.2019.2285
25. Olson KR, Durwood L, DeMeules M, et al. Mental Health of Transgender Children Who Are Supported in Their Identities. Pediatrics. 2016;137(3):e20153223. doi: 10.1542/peds.2015-3223
26. Olson KR, Key AC, Eaton NR. Gender cognition in transgender children. Psychol Sci. 2015;26(4):467-74. doi: 10.1177/0956797614568156
27. Evans YN, Gridley SJ, Crouch J, et al. Understanding Online Resource Use by Transgender Youth and Caregivers: A Qualitative Study. Transgender Health. 2017;2(1):129-39. doi: 10.1089/trgh.2017.0011
28. Chen D, Abrams M, Clark L, et al. Psychosocial Characteristics of Transgender Youth Seeking Gender-Affirming Medical Treatment: Baseline Findings from the TYC Study. J Adolesc Health Off Publ Soc Adolesc Med. 2021;68(6):1104-11. doi: 10.1016/j.jadohealth.2020.07.033
29. Olson J, Schrager SM, Belzer M, et al. Baseline Physiologic and Psychosocial Characteristics of Transgender Youth Seeking Care for Gender Dysphoria. J Adolesc Health Off Publ Soc Adolesc Med. 2015;57(4):374-80. doi: 10.1016/j.jadohealth.2015.04.027
30. Marconi E, Monti L, Marfoli A, et al. A systematic review on gender dysphoria in adolescents and young adults: focus on suicidal and self-harming ideation and behaviours. Child Adolesc Psychiatry Ment Health. 2023;17(1):110. doi: 10.1186/s13034-023-00654-3
31. The Report of the 2015 U.S. Transgender Survey [Internet]. [citado 14 de febrero de 2024]. Disponible en: https://search.issuelab.org/resource/the-report-of-the-2015-u-s-transgender-survey.html
32. de Vries ALC, McGuire JK, Steensma TD, et al. Young adult psychological outcome after puberty suppression and gender reassignment. Pediatrics. 2014;134(4):696-704. doi: 10.1542/peds.2013-2958
33. Katz-Wise SL, Budge SL, Fugate E, et al. Transactional Pathways of Transgender Identity Development in Transgender and Gender Nonconforming Youth and Caregivers from the Trans Youth Family Study. Int J Transgenderism. 2017;18(3):243-63.

doi: 10.1080/15532739.2017.1304312
34. Katz-Wise SL, Budge SL, Orovecz JJ, et.al. Imagining the future: Perspectives among youth and caregivers in the trans youth family study. J Couns Psychol. 2017;64(1):26-40. doi: 10.1037/cou0000186
35. Riley EA, Clemson L, Sitharthan G, et al. Surviving a gender-variant childhood: the views of transgender adults on the needs of gender-variant children and their parents. J Sex Marital Ther. 2013;39(3):241-63. doi: 10.1080/0092623X.2011.628439
36. Egale [Internet]. [citado 14 de febrero de 2024]. Youth Speak Up About Homophobia and Transphobia, The First National Climate Survey on Homophobia in Canadian Schools, Phase One Report - 2009. Disponible en: https://egale.ca/awareness/phase1/
37. Bauer GR, Hammond R, Travers R, et al. "I Don't Think This Is Theoretical; This Is Our Lives": How Erasure Impacts Health Care for Transgender People. J Assoc Nurses AIDS Care. 2009;20(5):348-61. doi: 10.1016/j.jana.2009.07.004
38. Gridley SJ, Crouch JM, Evans Y, et al. Youth and Caregiver Perspectives on Barriers to Gender-Affirming Health Care for Transgender Youth. J Adolesc Health Off Publ Soc Adolesc Med. 2016;59(3):254-61. doi: 10.1016/j.jadohealth.2016.03.017
39. Georges E, Brown ECB, Cohen RS. Prohibition of Gender-Affirming Care as a Form of Child Maltreatment: Reframing the Discussion. Pediatrics. 2023;153(1):e2023064292. doi: 10.1542/peds.2023-064292
40. de Vries ALC, Klink D, Cohen-Kettenis PT. What the Primary Care Pediatrician Needs to Know About Gender Incongruence and Gender Dysphoria in Children and Adolescents. Pediatr Clin North Am. 2016;63(6):1121-35. doi: 10.1016/j.pcl.2016.07.011
41. Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. J Clin Endocrinol Metab. 2017;102(11):3869-903. doi: 10.1210/jc.2017-01658
42. Bonifacio HJ, Rosenthal SM. Gender Variance and Dysphoria in Children and Adolescents. Pediatr Clin North Am. 2015;62(4):1001-16. doi: 10.1016/j.pcl.2015.04.013
43. Roden RC, Billman M, Francesco A, et al. Treatment Goals of Adolescents and Young Adults for Gender Dysphoria. Pediatrics. 2024;153(1):e2023062202. doi: 10.1542/peds.2023-062202
44. Morgan SW, Stevens PE. Transgender identity development as represented by a group of transgendered adults. Issues Ment Health Nurs. 2012;33(5):301-8. doi: 10.3109/01612840.2011.653657
45. Devor A. Witnessing and Mirroring: A Fourteen Stage Model of Transsexual Identity Formation. J Gay Lesbian Psychother. 2004;8:41-67. doi: 10.1300/J236v08n01_05