Mental Status Examination revealed preference to be difficult child and the parenting practices were inconsistent. No family history of mental illness. He is a temperamentally any antenatal, natal, postnatal complications and without any consanguineous marriage delivered by natural birth, without externalizing behavioral problems. He is second born of non-seeking help to modify his interest in cross gender roles and currently, this had led to intense distress to parents, whom he had learned such behaviors through observation. Reportedly, his aunt also has many transgender friends from paternal aunt who encourages such cross gender roles. Disobedient, disrespectful behavior at school, for the past 6 years. He was diagnosed to have gender dysphoria with conduct disorder. We present this case for its unique presentation and emerging significance of gender identity related issues in recent times in the public domain.

**Keyword**: Gender dysphoria, gender non-conformity

**Introduction**: Gender Dysphoria generally refers to an individual’s affective and cognitive discontent with the assigned gender. As a diagnostic category, more specifically, it refers to the distress that may accompany the incongruence between one’s assigned gender and experienced or expressed gender. This discrepancy is the core of the diagnosis and there must be also evidence of distress. The current DSM 5 is more descriptive than DSM IV and focuses on dysphoria as the clinical problem, not identity per se. Gender dysphoria manifests itself differently in different age-groups and criteria for children are defined in a more concrete, behavioral manner than in adults.9

**Case report**: A 12 year old male child from suburban area, brought by parents, was observed to be mingling with girls frequently, making effeminate gestures, mimicking school teachers & other women, poor academic performance, refusal to comply with requests from elders, easy irritability, argumentative, disobedient, disrespectful behavior at school, for the past 6 years. He attributed his effeminate behaviors to his paternal aunt who encourages such cross gender roles. Reportedly, his aunt also has many transgender friends from whom he had learned such behaviors through observation. Currently, this had led to intense distress to parents, who initially thought that this was just a ‘passing off phase’. They sought help to modify his interest in cross gender roles and externalizing behavioral problems. He is second born of non-consanguineous marriage delivered by natural birth, without any antenatal, natal, postnatal complications and without any history of delay in neurodevelopmental milestones. There is no family history of mental illness. He is a temperamentally difficult child and the parenting practices were inconsistent. Mental Status Examination revealed preference to be opposite gender till one year ago, currently denies it, with concern and helplessness regarding his academic difficulties and lack of remorse for his unruly behavior with inconsistent, permissive & punitive parenting practices with significant scores in externalizing behavior in Child Behaviour Checklist with average level of intellectual performance. He scored positively on Gender Identity Questionnaire for children (GIQC) and Gender Identity Disorder Study Questionnaire version 2011-revealing preference for cross-sex roles in make believe play or fantasies of being the other sex & desire to participate in stereotypical games and pastimes of other sex, preference for playmates of other sex. Physical examination was normal. The boy was evaluated by neurologist, endocrinologist and his EEG, MRI of brain, serum hormonal assays were within normal limits. He was diagnosed to have Gender Dysphoria, Conduct Disorder of Childhood onset, Specific Learning Disorder. He was treated with Tab. Atomoxetine 10mg bd and behavioural modification using positive and negative reinforcement techniques for his conduct problems. Specific instructions and ‘one to one’ education of at least three hours per week for his academic difficulties were suggested. The boy and the parents were educated to have a non-critical approach towards issues like gender identity, non-conformity, dysphoria and the possibility of remission over a period of time. The child is in regular follow up and is maintaining well.

**Discussion**: Gender identity is defined as a person’s sense of being a girl or boy, woman or man.1,2. Gender non conformity refers to the extent to which a person’s gender identity, role, expression differs from the cultural norms prescribed for that particular sex.2. Gender dysphoria refers to discomfort or distress caused by a discrepancy between a person’s gender identity and that person’s sex assigned at birth, expect ed gender roles1. In children, gender dysphoria can manifest as statements of wanting be of other sex and as a broad range of ‘sex-typed behaviors’ shown by the other sex. The diagnosis of gender dysphoria is limited to those children who clearly state their wish to be the other gender and also based on child’s sex typed behaviors.3. The disjunction between gender identity and biological sex is easily observed in a variety of ‘surface behaviors’ that indicate cross-gender identification. Many children showing gender non-conformity do not grow up to be transgender adults.3 When the child do not state that they want to be opposite sex and do not report an aversion to their bodies, it can be particularly hard to discern whether their cross gender
behavior and preferences are a manifestation gender dysphoria or gender non conformity. Moreover, children with Gender dysphoria appear to have a ‘developmental lag’ in the acquisition ‘gender constancy’ which refers to a child’s realization that gender is fixed and does not change over time. Initially, most parents believe that their children are going through a phase and they will eventually outgrow it. Parents seek help when they begin to feel that the pattern of behavior is no longer a passing phase. Given the ubiquity of gender as a social category, this may lead to affective confusion in social interaction, poor peer relationship and emotional and behavioral problems. Children with gender dysphoria are at risk of developing co-occurring problems and the clinicians should be aware of the risk for co-morbidity and must realize that externalizing co-morbidity can make a child with gender dysphoria more vulnerable to social ostracism. The common co-morbidity includes mood disorders, disruptive and impulse control disorders, specific learning disorders which should be attended to. In children, there is clinical evidence that psychological treatments for gender dysphoria can contribute to its remission. Gender dysphoria can result from inappropriate learning experiences and the rational is to extinguish cross gender behavior and reinforce same gender behavior. The most common therapeutic approach is to help child feel more comfortable with a gender identity that matches the biological sex. This includes individual counseling, parent guided intervention in naturalistic environment, in limit setting on cross gender behavior, encouraging same sex peer relationship.

Conclusion:
Clinicians and parents should be aware that the gender dysphoric children are at risk for developing co-morbid mental illness and majority of gender dysphoric children may not be gender dysphoric in to their adulthood. Our goal is to help child negotiate the social complexities that result from the cross gender identity and alleviate distress.

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