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Gender-Related and Sexual Problems among Children and Adolescents

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Abstract

Purpose. Sexuality and gender-specific problems are a particularly neglected factor in the psychotherapy and psychiatric care of children. The present study investigated the frequency of general mental health problems and gender-related and sexual problems in three different German samples: 1) children and adolescents undergoing outpatient psychotherapy, 2) children and adolescents receiving outpatient psychiatric treatment, and 3) children and adolescents in an untreated control group.
Materials and methods. The study was a quantitative cross-sectional study with an online parent questionnaire via LimeSurvey, which included the assessment questionnaire for screening mental disorders (FBB-SCREEN), the Diagnostic System for Mental Disorders according to ICD-10 and DSM-5 for Children and Adolescents - III (DISYPS-III) and the Sex Problems Scale (SPS). Three samples were collected: control group, psychotherapy, outpatient psychiatric care.
Results. The results show that children and adolescents who were undergoing outpatient psychotherapy or psychiatric treatment are affected by psychological, gender-related and sexual problems both more frequently and to a greater extent than those in the general population. Gender identity issues were reported by 6% of parents, inappropriate sexual behaviour by 8%, and general sexual problems by 4%. Any gender identity or sexual problems were reported by 15% (control group: 13%, psychotherapy: 21%, outpatient psychiatric care: 39%).
Conclusions. The study underlines the importance of considering children's sexual and gender health in psychotherapeutic and psychiatric treatment. These findings highlight the need for further research in order to create representative data and develop targeted interventions.
Keywords: sexual problems, gender identity issues, mental health problems, children, adolescents

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Гендерные и сексуальные проблемы у детей и подростков

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Этическое заявление: исследование проводилось в соответствии с Хельсинкской декларацией.
Благодарности: выражаем благодарность всем участникам и нашим сетевым партнерам за поддержку во время исследования, а также всем участвующим учреждениям за поддержку в наборе клинической подвыборки.
Признание авторских рекомендаций: мы приняли к сведению рекомендации авторов и выполнили все пункты, касающиеся подачи материала.
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Резюме

Введение. Сексуальность и гендерные проблемы являются особенно игнорируемым фактором в психотерапии и психиатрической помощи детям. В настоящем исследовании изучалась частота общих психических проблем, а также проблем, связанных с полом и сексуальностью, в трех различных немецких выборках: 1) дети и подростки, проходящие амбулаторную психотерапию, 2) дети и подростки, получающие амбулаторное психиатрическое лечение, и 3) дети и подростки в контрольной группе, не получающей лечения.

Материалы и методы. Исследование представляло собой количественное перекрестное исследование с онлайн-опросником для родителей через LimeSurvey, который включал опросник для скрининга психических расстройств (FBB-SCREEN), Диагностическую систему психических расстройств по МКБ-10 и DSM-5 для детей и подростков – III (DISYPS-III) и Шкалу сексуальных проблем (SPS). Были собраны три выборки: контрольная группа, психотерапия, амбулаторная психиатрическая помощь.

Результаты. Дети и подростки, проходившие амбулаторную психотерапию или психиатрическое лечение, страдают от психологических, гендерных и сексуальных проблем чаще и в большей степени, чем дети и подростки из общей популяции. О проблемах гендерной идентичности сообщили 6% родителей, о неадекватном сексуальном поведении – 8%, а об общих сексуальных проблемах – 4%. О любых проблемах гендерной идентичности или сексуальных проблемах сообщили 15% (контрольная группа: 13%, психотерапия: 21%, амбулаторная психиатрическая помощь: 39%).

Заключение. Данное исследование подчеркивает важность учета сексуального и гендерного здоровья детей в психотерапевтическом и психиатрическом лечении. Эти данные подчеркивают необходимость дальнейших исследований для получения репрезентативных данных и разработки целенаправленных вмешательств.

Ключевые слова: сексуальные проблемы, проблемы гендерной идентичности, проблемы психического здоровья, дети, подростки

INTRODUCTION

For children and adolescents, there is a lack of current research on disorders and problems in the context of sexuality and gender [1, 2]. In principle, gender-related and sexual problems can occur from the age of three years [3–7].

Sexual problems in childhood and adolescence. The prevalence of sexual problems in childhood and adolescence is particularly difficult to determine. There is a lack of population-wide data. Study results from the current state of research are often based on smaller, non-representative or clinical studies [8–10].

In an older study of 516 patients in an American child psychiatry clinic, the general prevalence of sexual disorders was 9% in girls and 1.5% in boys [10]. Aggressive sexual assault was more common in boys, while excessive masturbation was more common in girls [10]. The lower limit for the prevalence of sexual disorders in children and adolescents can be assumed to be 2.0% and 2.3% respectively [8, 9].

Prevalence data on specific sexual problems in childhood and adolescence show a more differentiated picture. Sexual dysfunctions are rare, whereas sexual preference disorders are somewhat more common [8]. Clinically relevant disorders in male children and especially adolescents include fetishism, fetishistic transvestitism, ego-dystonic homosexuality, hypersexual symptoms and, in the context of adolescent forensics, pedophilic preference accentuation and exhibitionism [8]. In female children and especially adolescents, sexual maturation crises, ego-dystonic sexual orientation and sexual relationship disorders are clinically relevant [8]. Sexual risk-behavior is also present in adolescence [11].

Connections between general psychopathology and sexual problems have been established. Hypersexuality, for example, can be found more frequently with ADHD or bipolar disorders [12]. Paraphilias, sometimes in connection with sexual offenses, also correlate with psychiatric morbidity, for example personality disorders, mood and anxiety disorders, as well as substance abuse [13, 14].

Gender-related issues and gender dysphoria in children and adolescents. Transgender is not a disorder, but it can be unsettling for families [15]. With the revision of ICD-10 and the introduction of ICD-11, an important step was taken towards the depathologization and destigmatization of gender identity [16]. In the new ICD-11, the diagnosis "gender incongruence" was introduced, which describes the difference between the experienced gender identity and the gender assigned at birth. This diagnosis is now no longer listed under mental disorders [17]. The DSM-5, on the other hand, uses the term "gender dysphoria", which describes the clinically relevant distress that can arise from the discrepancy between the gender experienced and the biological sex [18]. This paradigm shift has led to all gender variations, including transgender and non-binary genders, being recognized as part of natural diversity [19].

The statistical frequency of trans identity varies in studies. A global study of around 28.000 trans* adults found that around a third of participants identified as trans male, trans female or non-binary [20]. A North American study found that 600 out of 100.000 young people under the age of 21 identified as transgender [21]. In the UK, 0.6% of young people were found to identify as transgender, which corresponds to around 44.000 young people [22]. The prevalence of gender dysphoria in children and adolescents is estimated to be between 0.6% and 1.7% [23].

Explanations for any clinically relevant psychological distress that may occur can be found, among other things, in the minority stress model, which is considered within the framework of a multimodal approach. The "minority stress model" [24, 25] distinguishes between four types of minority stressors: experiences of prejudice (discrimination, violence), rejection sensitivity, concealment and internalized homonegativity. Social and peer support can be understood as a direct predictor of a lower number of psychological symptoms or mental health [26, 27].

In terms of gender ratios, a trend can be observed that girls are more likely to present to medical services for gender-related and sexual problems in the preschool years and boys in earlier adolescence [3, 7, 28, 29].

Stang et al. [30] were able to use data from the Federal Statistical Office to confirm a need for care for sexual and gender-related health in children and adolescents. Statistics on topic-specific inpatient healthcare showed that the absolute frequency of diagnoses on the sexual and gender spectrum in the inpatient sector rose from 69 in 2000 to 155 in 2022. "Gender identity disorders" accounted for the largest share (n=142). Due to the earmarking of billing data for the statutory health insurance accredited medical care, no outpatient data could be included and therefore no statistics were collected for the outpatient sector. A research gap can be identified here.

■ RESEARCH QUESTION

In this study, we assess the frequency of sexual problems and gender-related issues among children and adolescents. A differentiation is to be made between children and adolescents who are undergoing psychotherapeutic or psychiatric care and children and adolescents who are not undergoing treatment. Moreover, we assess the correlations between sexual and gender-related problems and general psychopathology. The following hypotheses were tested:

H1: First, we explore the frequency of gender-related issues and sexual problems in children and adolescents. We assume that frequencies of gender-related issues are higher than frequencies of sexual problems.

H2: Children and adolescents who are not in psychotherapy are less affected by sexual problems than those in psychotherapy or psychiatric care. As some data suggest that transgender children and adolescents suffer from higher rates of psychological distress, we also expect significant (but smaller) differences between psychotherapy/psychiatry patients and the control group concerning gender-related issues.

H3: Sexual problems and gender identity issues are associated with other mental disorders.

H3a: Children and adolescents who are more affected by mental disorders have more sexual problems. The same (but smaller) differences are expected for gender identity issues.

H3b: Sexual problems and gender identity issues are associated with specific mental disorders in children and adolescents (ADHD, affective disorders, anxiety disorders).

H4: Gender and age differences with regard to sexual and gender-related problems are assessed in exploratory analyses. According to the literature, we expect higher rates of gender identity issues in girls and higher rates of sexual problems in boys.

MATERIALS AND METHODS

The study was a quantitative cross-sectional study (pre-registration: AsPredicted: 150387 from 11/09/2023 and 157585 from 11/01/2024). The instrument used was a parent online questionnaire via LimeSurvey. The overall questionnaire included the assessment questionnaire for screening mental disorders (FBB-SCREEN) of the Diagnostic System for Mental Disorders according to ICD-10 and DSM-5 for Children and Adolescents - III (DISYPS-III) [31] and the Sex Problems Scale [32] which consists of items from the Child Behavior Checklist (CBCL/6-18R) [33].

The FBB-SCREEN is a component of the Diagnostic System for Mental Disorders according to ICD-10 and DSM-5 for children and adolescents in the third version and has an internal consistency between α=.67 and α=.92 (Döpfner & Görtz-Dorten, 2017), with the exception of the Compulsion and Tic scales (α=.52). Items refer to the DSM-5 and ICD-10 diagnostic criteria, for example S01 "Is very inattentive or easily distracted or does not finish things they have started". Please refer to the results section for the items on the individual subscales. There is a four-level response format: 0=not at all, 1=a little, 2=to a large extent, 3=particularly. Age and gender norms are available, the norm sample refers to N=1960.

The Sex Problems Scale (SPS) [34] has already been used several times to assess sexual behavior problems [7, 32, 35–37]. This scale consists of six items that deal with sexual and gender-related problems in children and adolescents [34]. According to the CBCL template, the response format has three levels (0=not applicable, 1=somewhat or sometimes applicable, 2=exactly or often applicable). There is no norm sample for the SPS. The content-related, concurrent and discriminant validity have generally been confirmed [32, 38]. In the course of social, clinical and diagnostic changes over the years, it is becoming increasingly important to distinguish between sexual problems and gender identity issues. Therefore, the SPS as an overall scale is now outdated. An explorative factor analysis (principal component analysis, Varimax rotation) yielded a clear 3-factor solution. Factor 1 (Eigenvalue = 1.87) describes gender identity issues, factor 2 (Eigenvalue = 1.20) inappropriate sexual behaviour, and factor 3 (Eigenvalue = 1.15) general sexual problems in children and adolescents. In view of the small number of items per scale, a reliability calculation does not appear appropriate (Table 1). The intercorrelations of the three factors are small, but statistically significant (.119<r<.172, p<.001).

In addition, socio-demographic data, the psychotherapeutic or psychiatric treatment of the child, and the psychotherapy experience of the caregiver completing the questionnaire were assessed.

Table 1
Factor loadings on the SPS items

	Factor 1	Factor 2	Factor 3
Item 1. For boys: behaves like a girl. For girls: behaves like a boy	.845	.034	.066
Item 2. Plays with own genitals in public	.205	.824	–.022
Item 3. Plays around too much with their own genitals	–.047	.841	.127
Item 4. Has sexual problems	.062	.097	.790
Item 5. Thinks too much about sex	.085	.002	.824
Item 6. For boys: Would prefer to be a girl. For girls: Would prefer to be a boy	.844	.109	.090

Sample

Two samples were initially recruited: 1) caregivers of children undergoing psychotherapy (n=82), and 2) caregivers of children not undergoing psychotherapy (n=339). Subjects were recruited via social media, email distribution lists and personal networks by snowball principle. In addition, it was possible to interview an ad hoc sample of caregivers of children (n=13) who were undergoing outpatient specialist child and adolescent psychiatric care, but not psychotherapy. This sub-sample is examined in more detail in the explorative analyses. Table 2 summarizes further sociodemographic and clinical data on the three subsamples. Of the total sample, 27% of children attended elementary school, 11% "Mittelschule" (secondary lower track school in Germany), 23% "Realschule" (secondary middle track school) and 39% attended Gymnasium/FOS (secondary higher track school).

Prior to data collection, a review of ethical and legal aspects was carried out via the self-assessment provided by the Joint Ethics Committee of Bavarian Universities (GEHBa). No indications were found that would justify a review by an ethics committee. The study was conducted in compliance with the Declaration of Helsinki.

The data was analyzed using descriptive statistics and inferential statistics via SPSS (version 29.0.0.0.; Pearson product-moment correlations; T-tests with independent samples; analyses of variance).

Table 2
Descriptive data of the subgroups and the overall sample

	CG (n=339)	PT (n=82)	AP (n=13)	Total
Gender of caregiver (% female)	68%	81%	85%	71%
Gender of child (% female)	49%	60%	(No data available)	51%
	M (SD)	M (SD)	M (SD)	M (SD)
Age of caregiver	44.01 (7.02)	44.82 (7.20)	37.62 (4.87)	43.97 (7.08)
Age of child	12.03 (3.29)	12.84 (3.11)	9.54 (2.44)	12.11 (3.28)
ADHD[a]	0.63 (0.60)	1.19 (0.85)	1.00 (0.85)	0.75 (0.70)
SSV[a]	0,27 (0.32)	0.60 (0.52)	0.41 (0.38)	0.34 (0.39)
ANG[a]	0.32 (0.33)	0.74 (0.50)	0.56 (0.55)	0.41 (0.41)
DEP[a]	0.27 (0.33)	0.83 (0.56)	0.61 (0.57)	0.38 (0.45)
ENTW[a]	0.21 (0.36)	0.39 (0.40)	0.71 (0.66)	0.26 (0.39)
AUT[a]	0.19 (0.40)	0.55 (0.60)	0.71 (0.90)	0.27 (0.49)
ZWATIC[a]	0.12 (0.26)	0.32 (0.44)	0.51 (0.70)	0.17 (0.33)
EXT[a]	0.39 (0.37)	0.80 (0.56)	0.61 (0.49)	0.47 (0.45)
INT[a]	0.30 (0.31)	0.78 (0.49)	0.58 (0.54)	0.40 (0.40)
CON[a]	0.22 (0.36)	0.55 (0.50	0.67 (0.72)	0.30 (0.43)
GES[a]	0.27 (0.25)	0.65 (0.34)	0.59 (0.44)	0.35 (0.32)
FL[a]	0.30 (0.50)	1.21 (0.74)	1.08 (0.68)	0.50 (0.67)
SPS gender identity issues	0.04 (0.18)	0.05 (0.21)	0.12 (0.30)	0.04 (0.19)
SPS inappropriate sexual behaviour	0.05 (0.18)	0.04 (0.16)	0.23 (0.39)	0.05 (0.19)
SPS general sexual problems	0.01 (0.08)	0.08 (0.25)	0.08 (0.28)	0.03 (0.14)

Notes: N=434 after case exclusions. CG – No psychotherapy, PT – Psychotherapy, AP – Outpatient psychiatric treatment. [a] DISYPS FBB Screen (SSV – conduct disorder, ANG – Anxiety disorder, DEP – depression disorder, ENTW – developmental/excretion disorder, AUT – autism spectrum disorder, ZWATIC – Compulsive/tic disorder, EXT – global score externalizing disorders, INT – global score internalizing disorders, CON – contact behavior, GES – global score total, FL – dysfunction/suffering); SPS – sexual problems scale.

■ RESULTS

Mental health problems, sexual problems, gender identity issues

Table 2 shows the DISYPS-FBB screen scales for the control and psychotherapy/psychiatry groups. Regarding age and gender norms, Stanine values were computed and a screening diagnosis was assumed for all cases with a Stanine value of 7 or above (Table 3). Significant group differences were found for all scales. For example, 71% of parents in the psychotherapy group compared to 27% of parents in the control group confirmed the presence of at least one mental disorder. In the overall sample, the screening diagnosis frequencies ranged between 28% (obsessive-compulsive and tic disorders) and 41% (contact behavior disorders). One third of the total sample had a mental disorder according to the parents' screening assessment (Table 3).

Overall, gender identity issues were reported by 6% of parents, inappropriate sexual behaviour by 8%, and general sexual problems by 4% (at least one item of the respective factor answered in the affirmative). Any gender identity or sexual problems were reported by 15% (control group – CG: 13%, psychotherapy – PT: 21%, outpatient psychiatric care – AP: 39%). Concerning frequency of gender identity issues in the control group, psychotherapy and psychiatry group, we did not find significant differences (CG 6%, PT 7%, AP 15%, Chi-Square (2) = 2.26, p=.323). Inappropriate sexual behaviour war reported more frequently by parents of the psychiatry than the control and psychotherapy group (CG 7%, PT 7%, AP 31%, Chi-Square (2) = 9.77, p=.008). General sexual problems were reported most frequently in the psychotherapy group (CG 3%, PT 11%, AP 8%, Chi-Square (2) = 11.27, p=.004).

Hypothesis 3, that children and adolescents who are more affected by mental disorders have more sexual and gender-related problems, was supported by Pearson product-moment correlations. Table 4 shows the correlations between the three SPS factors (gender identity, inappropriate sexual behaviour, and general sexual problems)

Table 3
Screening diagnosis frequencies (age and gender norms FBB screen, cut-off: Stanine value 7)

	N (%) CG (n=339)	N (%) PT (n=58)	N (%) Total	Chi-square (1)
ADHD	112 (33%)	36 (62%)	148 (37%)	17.85, p<.001
SSV	112 (33%)	37 (64%)	149 (38%)	19.98, p<.001
ANG	122 (36%)	37 (64%)	159 (40%)	15.95, p<.001
DEP	87 (26%)	42 (72%)	129 (33%)	49.35, p<.001
ENTW	105 (31%)	36 (62%)	141 (36%)	20.76, p<.001
AUT	104 (31%)	33 (57%)	137 (35%)	15.06, p<.001
ZWATIC	83 (25%)	28 (48%)	111 (28%)	13.92, p<.001
EXT	102 (30%)	31 (53%)	133 (34%)	12.13, p<.001
INT	91 (27%)	38 (67%)	129 (33%)	35.23, p<.001
CON	126 (37%)	36 (62%)	162 (41%)	12.71, p<.001
GES	88 (27%)	39 (71%)	127 (33%)	40.84, p<.001

Notes: N=434 after case exclusions. CG – No psychotherapy, PT – Psychotherapy, AP – Outpatient psychiatric treatment. [a]DISYPS FBB Screen (SSV – conduct disorder, ANG – Anxiety disorder, DEP – depression disorder, ENTW – developmental/excretion disorder, AUT – autism spectrum disorder, ZWATIC – Compulsive/tic disorder, EXT – global score externalizing disorders, INT – global score internalizing disorders, CON – contact behavior, GES – global score total; SPS factors: % at least one item answered in the affirmative.

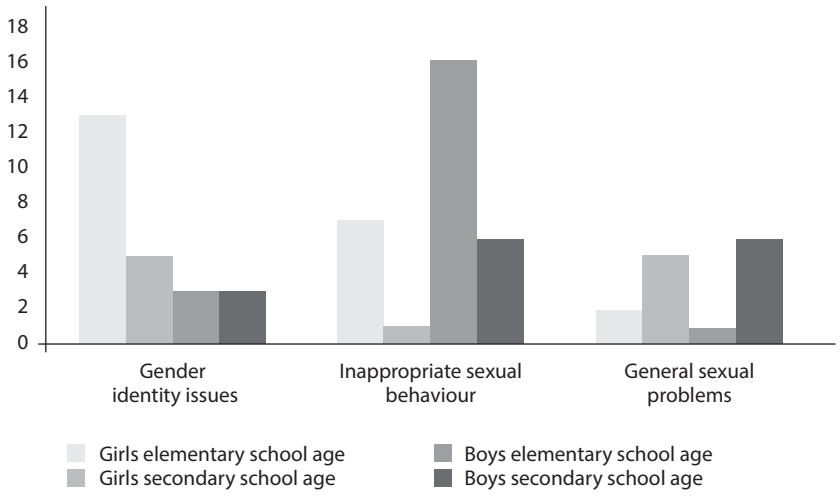
and screening of mental disorders by DISYPS-III parent rating. We found low to moderate correlations. Overall mental disorders showed a small but significant correlation to gender identity issues (r=.23) and moderate correlations (r=.28) to inappropriate sexual behaviour and general sexual problems. Mental disorders (screening) that were more closely linked to the SPS factors are autism spectrum disorders (e.g., to gender identity issues r=.26, and to inappropriate sexual behaviour r=.23), ADHD (e.g., to inappropriate sexual behaviour r=.23), conduct disorder (e.g., to general sexual problems r=.24), depression disorder (e.g., to general sexual problems r=.23), developmental/excretion disorders (e.g., to inappropriate sexual behaviour r=.30), compulsive disorders (e.g., inappropriate sexual behaviour r=.28) (Table 4). In the presence of a mental disorder in the screening, the frequency of sexual problems and gender identity issues was 25% (of those with any mental disorder in the screening: 9% gender identity issues, 12% inappropriate sexual behaviour, 9% general sexual problems).

Frequency of gender identity issues was slightly higher in girls than in boys (at least one item answered in the affirmative: girls 7% vs. boys 3%, Chi-Square (1) = 3.75, p=.053), whereas inappropriate sexual behaviour was more frequently reported for boys (at least one item answered in the affirmative: girls 3% vs. boys 10%, Chi-Square (1) = 7.71, p=.005). General sexual problems were reported in equal amount for boys and girls (at least one item answered in the affirmative: girls 4% vs. boys 4%, Chi-Square (1) = 0.05, p=.943). Finally, factor values of the three SPS factors were intercorrelated with childrens' age. We found a small but significant negative correlation between age and inappropriate sexual behaviour (r=–.20, p<.001) and a small but significant positive correlation between age and general sexual problems (r=.10, p=.047). Gender identity issues were negatively, but not significantly related to childrens' age (r=–.09, p=.052). Figure 1 shows the descriptive frequencies of the three SPS factors (at least one item answered in the affirmative) in relation to age group (elementary school age vs. secondary school age) and gender of

Table 4
Correlation of mental health problems and sexual problems/gender identity issues

	SPS gender identity issues	SPS inappropriate sexual behaviour	SPS general sexual problems
ADHD	.14**	.23***	.12***
SSV	.16***	.20***	.24***
ANG	.14**	.17**	.19***
DEP	.16***	.16**	.24***
ENTW	.15**	.30***	.17***
AUT	.26***	.24***	.13**
ZWATIC	.13**	.28***	.20***
EXT	.16***	.23***	.20***
INT	.16***	.18***	.23***
CON	.25***	.20***	.15**
GES	.23***	.28***	.28***

Notes: N=434 after exclusions. SPS (Sex Problems Scale), DISYPS-III subscales (FBB screen). CG – No psychotherapy, PT – Psychotherapy, AP – Outpatient psychiatric treatment. [a]DISYPS FBB Screen (SSV – conduct disorder, ANG – Anxiety disorder, DEP – depression disorder, ENTW – developmental/excretion disorder, AUT – autism spectrum disorder, ZWATIC – Compulsive/tic disorder, EXT – global score externalizing disorders, INT – global score internalizing disorders, CON – contact behavior, GES – global score total, FL – dysfunction/suffering). * p<.05 ** p<.01, *** p<.001.



Frequencies of the three SPS factors (at least one item answered in the affirmative) in relation to age group (elementary school age vs. secondary school age) and gender of child

child. Due to small sample sizes in the subgroups and the explorative character of these analyses, interaction of gender and age was not tested for significance.

■ DISCUSSION

Our results confirm the findings of the current state of research that sexual problems and gender-identity issues are prevalent in children and adolescents [3–7].

In our sample, 15% of parents reported at least one sexual problem or gender identity issue of their child. Gender identity issues (6%), inappropriate sexual behaviour (8%), and general sexual problems (4%) were equally frequent. The connection between mental disorders and sexual or gender-related problems postulated in the current state of research was also confirmed [12–14]. Sexual and gender-related problems were significantly related to all mental disorder scales. However, correlations were only small to moderate. In the presence of a mental disorder in the screening, the frequency of sexual and gender-related problems was 25%. Autism spectrum disorders, ADHD, developmental/excretion disorders and compulsive disorders were most frequently correlated to inappropriate sexual behaviour, whereas depression and conduct disorders were more closely related to general sexual problems. Our data show that children and adolescents undergoing psychotherapy or psychiatric treatment are more likely to have sexual problems (SPS) than subjects in the non-clinical sample. Therefore, sexual and gender-related problems must be regularly considered in the psychotherapeutic and psychiatric treatment of children and adolescents. Concerning gender-identity issues, we did not find any significant differences between the control group and the treatment groups. Similar to the small correlations between gender identity issues and screening mental disorders, this reflects the recent changes in diagnostic guidelines, according to which a different gender identity does not in itself indicate a mental disorder [3, 7, 28, 29].

As expected, girls showed higher frequencies of gender identity issues than boys, whereas boys (especially at a younger age) showed more inappropriate sexual behaviour from their parents' point of view. In general, younger children showed more inappropriate sexual behaviour, and older children/adolescents more general sexual problems. Interactions between assigned birth sex and age group could only be explored in descriptive data, indicating a decrease in gender identity issues over time in girls but not in boys. These age-gender interactions should be assessed in more depth in future studies.

Our data meet the call by Stang et al. [30] for frequency data on sexual and gender-related problems in children undergoing outpatient treatment: At least one gender or sexual problem was affirmed for approximately one-fifth of children and adolescents in psychotherapy. However, the results of our study do not claim to be representative. Based on our exploratory results, there is a fundamental need for care for children not only for general psychological problems, but also specifically for sexual and gender-related problems.

Limitations

The clinical samples were relatively small, which can be explained by challenges in the acquisition of test subjects in clinical settings. Another limitation concerns the construction of the SPS [32] with very heterogeneous and partly outdated gender-specific items of the CBCL/6-18R and therefore also the use of the SPS in our study. In particular, the gender-related items, which can also be interpreted in terms of gender incongruence, do not reflect the current state of scientific knowledge. Due to economic reasons and the lack of alternatives to a short scale for sexual and gender-related problems in children and adolescents, the decision was nevertheless made in favor of the SPS. By using exploratory factor analysis, we tried to reduce heterogeneity by using factor scales instead of a total SPS score. Factor analysis revealed a clear-cut three-factor solution. Due to the small item numbers (2 items per factor), reliability measures could not be computed. Future research should assess if the three-factor solution of the SPS can be replicated and should consider more up-to-date items that reflect the current state of scientific knowledge.

Furthermore, information was gathered by questioning caregivers instead of the children and adolescents themselves. For sexual problems and gender identity issues, symptoms may occur in private and without parents' knowledge. On the other hand, asking young children about sexual and gender-related symptoms raises ethical and methodological concerns (understanding of questions, social desirability, discomfort in interview situation etc.). When collecting findings on mental health in children and adolescents, it is important to take differences between informants into account [39–41]. In general, the correlation between self- and parental report is low to moderate [33]. A multi-method, multi-informant approach for assessment of sexual and gender-related issues would significantly improve data quality.

■ CONCLUSION

The study underlines the existence of mental and sexual/gender-related problems in childhood and adolescence, which often occur before the age of 14 and can remain unrecognized until adulthood [42–47].

Despite the methodological limitations of the study, the screening of sexual and gender-related problems in children and adolescents can be seen as a novelty and special feature for expanding the state of research.

Overall, the study contributes to closing significant research gaps and emphasizes the importance of improved data on the mental and sexual health of children and adolescents as well as the development of targeted intervention strategies [1, 2]. Our exploratory findings also underline the need for further research to collect representative data, particularly in the area of sexual and gender-related problems.

Implications for Practice

The study shows the relevance of sexual and gender-related problems in children and adolescents, especially when they are already undergoing psychotherapy. Clinicians and therapists should therefore cultivate awareness of sexual problems and gender identity issues in their practical work and should always consider sexuality and gender when assessing the reason for the consultation and the spontaneously reported symptoms as well as during the anamnesis. During treatment, it is also important to be aware of the relevance of the topic in the early stages of life and to target specific interventions to this.

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