napp national association of practising psychiatrists

Managing Gender Dysphoria in Young People
The National Association of Practising Psychiatrists Guide

Gender dysphoria/incongruence in young people is a contested area of medical practice. This approach avoids political, social, religious and ideological positions.

This approach to developing guidelines for managing gender dysphoria [1] or gender incongruence [2] in children and adolescents aims to protect and safeguard the health, safety and welfare of the child. This guide prioritises the best interests of the child in accordance with human rights obligations under the United Nations Convention on the Rights of the Child [3].

Specifically, this guide:

> While respecting young people's views about their gender identity, it does so as part of the totality of their developmental and holistic clinical picture, and incorporates these into the clinical formulation. This approach requires that a comprehensive bio-psycho-social assessment of the young individual and their family be conducted before recommending specific treatment.
>
> Acknowledges that childhood and adolescence is a time of rapid physical and psycho-social growth and profound personal development, during which young people may question their identity, sexual orientation and gender. As the child matures and progresses through puberty this questioning usually transforms and resolves, and the young person, in the majority of cases, accepts his/her biological sex and adult body [4, 5].
>
> Understands that gender dysphoria/incongruence can be both a symptom and a syndrome. For a young person to have the syndrome of gender dysphoria/incongruence there must be a significant, established and prolonged pattern [2] of desire and behaviour that indicates the person insists they are a gender different to their biological sex and natal (birth assigned) gender.
>
> Recognises that gender dysphoria/incongruence can often be a manifestation of complex pre-existing family, social, psychological or psychiatric conditions or predisposing factors [6]. A holistic approach to assessment includes a comprehensive exploration for these potential conditions in order to more fully understand a child presenting with gender dysphoria/incongruence [7, 8]. Where these conditions are presenting as gender dysphoria/incongruence, the treatment of the underlying condition is a priority.

Individualised psycho-social interventions (e.g. psychoeducation, individual therapy, school-home liaison and family therapy) should be first-line treatments for young people with gender dysphoria/incongruence. Exploratory psychotherapy should be offered to all gender-questioning young people to identify the many potential sources of distress in their lives in addition to their gender concerns. Clinicians can apply a range of psychological interventions (e.g. supportive psychotherapy, CBT, dynamic psychotherapy and family therapy) to assist the young person clarify and resolve these contributory factors. Such approaches are consistent with established principles of comprehensive and systemic youth health care [7]. They should be undertaken before experimental puberty-blocking drugs [9] and other medical interventions (e.g. cross-sex hormones and sex reassignment surgery) are considered.

Psychotherapy for gender dysphoria in children and adolescents is a respectful, supportive and exploratory process that does not seek any particular outcome in relation to gender identity or sexual orientation. It seeks to understand the nature and meaning of the young person's gender distress and the context in which it has

arisen. Psychotherapy addresses the multiple factors that contribute to the young person's difficulties, helping to address issues that resolve distress and support ongoing development and maturation. Conversion therapies, on the other hand, aim to achieve a pre-determined outcome such as gender normativity or heterosexual orientation. Psychotherapy for gender dysphoria must NOT be conflated with conversion therapies.

Medical interventions to block puberty and cross-hormone treatment to achieve feminisation and masculinisation according to the young person's perceived gender are not fully reversible and can cause significant adverse effects on physical, cognitive, reproductive and psychosexual development [9, 10, 11, 12, 13, 14, 15, 16].

Currently, while some individuals report a successful transition, we are not aware of published long-term outcome studies that have followed up adults who have undergone childhood or adolescent transition that show substantial benefit. As a consequence, there is no consensus that medical treatments such as the use of puberty-blocking drugs, cross-sex hormones or sexual reassignment surgery lead to better future psycho-social adjustment [17, 18, 19, 20].

Increasing numbers of individuals who have undergone hormonal treatment and surgical interventions subsequently report experiencing regret and a wish to de-transition [21]. They describe significant psychological and physical suffering, including loss of fertility and sexual function as a consequence of decisions made when younger [22, 23, 24, 25, 26, 27].

Medico legal considerations must be fully appreciated in this area of clinical practice. Health professionals are exposed to significant legal risk:

- if a child or adolescent is found not to have been competent to give an informed consent;
- if in children under age 16 years both parents have not agreed to puberty suppression and cross-hormone treatment;
- if gender affirming treatment is not preceded by a comprehensive psycho-social assessment, that considers and excludes alternate diagnoses; or
- if the patient was not informed of all the risks of puberty blockers and cross-hormone treatment including their experimental nature [9].

Clinicians should therefore reflect carefully before recommending treatments for gender dysphoria/incongruence.

The still unproven risks and benefits of gender reassignment interventions make it imperative that parents and children under 18 years and young people over 18 years are made aware of the current evidence of potential harm regarding gender transition and provide fully informed consent before potentially damaging and irreversible treatment is commenced.

This cautious approach is also mirrored in general clinical guidance by national treatment advisory bodies in Finland, Sweden, France and the United Kingdom that recommend treatment methods for gender dysphoria in minors [28, 29, 30, 31]. In Finland, the recommendation is that among young people with gender dysphoria and significant psychiatric comorbidity no conclusions can be drawn on the stability of the gender identity of the child [28]. In the UK, the one specialised clinic in England (Tavistock Clinic) offering an affirmation approach to management of gender dysphoria in children and adolescents will be closed and replaced by regional clinics offering a more holistic model of care [32]. The author of the report that led to this decision (Dr Hilary Cass) raised substantial concerns about the effect of puberty blockers on developmental maturation and decision-making [32].

This guide adopts a personalised, non-ideological approach to the care of youth with gender dysphoria. As Dr Hilary Cass notes [33], the diagnostic process required by doctors who prescribe treatment for young individuals with this condition must include a diagnosis and differential diagnosis:

"I have also noticed some debate around the inclusion of the need for a diagnosis and differential diagnosis, and whether that means we are pathologising gender identity or seeing it as a mental health problem. I think it is worth clarifying what is meant by these terms.

Applying medical thinking to gender identity isn't required until and unless a young person needs treatment. The regulations are particularly tightly defined when a doctor is considering prescribing medication, and especially medication that may have some life-long effects. Doctors then have a professional obligation to go through a process of ensuring that it is appropriate for the health needs of the individual, which means making a positive diagnosis (what the condition is) and a differential diagnosis (what the condition isn't). This applies in all areas of medicine.

The process of differential diagnosis is neutral in terms of outcome - it's not about preferring one diagnosis over another; it's just about getting it right. It isn't about trying to rule out every conceivable explanation before confirming any particular diagnosis - only about ruling out other diagnoses that might be likely for that individual, or where getting it wrong and missing another diagnosis could have serious consequences. Achieving this involves taking a holistic, considered approach to each individual about the possible causes of their distress and identifying the most appropriate pathway for them. This must always be done with sensitivity and in partnership with the young person and their family.

This same requirement is reflected in the internationally developed Endocrine Society gender dysphoria/gender incongruence guidance which recommends that health professionals responsible for diagnosing gender dysphoria should meet a range of criteria including "the ability to make a distinction between GD [gender dysphoria] /gender incongruence and conditions that have similar features".

In preparing this guide, advice was obtained from a number of senior medical colleagues in child and adolescent psychiatry, adult psychiatry and forensic psychiatry as well as from physicians and psychologists who have cared for young people experiencing gender dysphoria/incongruence and legal practitioners who have experience in this field.

References

1. American Psychiatric Association (2013) *Diagnostic and Statistical Manual of Mental Disorders (5th ed.).* American Psychiatric Association Publishing, Washington D.C., United States of American.
2. World Health Organization (2018) *International classification of diseases for mortality and morbidity statistics* (11th Revision). Retrieved from https://icd.who.int/browse11/l-m/en, 20th September 2022.
3. UN Commission on Human Rights, *Convention on the Rights of the Child*. 7th March 1990, E/CN.4/RES/1990/74, available at https://www.refworld.org/docid/3b00f03d30.html [accessed 3rd November 2020].
4. Entwistle K. *Debate: Reality check – Detransitioner's testimonies require us to rethink gender dysphoria.* Child Adolesc Ment Health. 2020. doi:10.1111/camh.12380. Epub 2020 May 14.
5. Ristori J, Steensma T. *Gender dysphoria in childhood.* International Review of Psychiatry. 2016;28(1):13-20. doi:10.3109/09540261.2015.1115754. Epub 2016 Jan 12.
6. Kozlowska K, et al. Attachment patterns in children and adolescents with gender dyshoria. Frontiers in Psychology. 2021 Jan 12;11:582688. doi: 10.3389/fpsyg.2020.582688. eCollection 2020..
7. Kozlowska, K., McClure, G., Chudleigh, C., Maguire, A. M., Gessler, D., Scher, S., & Ambler, G. R. (2021). *Australian children and adolescents with gender dysphoria: Clinical presentations and challenges experienced by a multidisciplinary team and gender service. Human Systems*, *1*(1), 70–95. https://doi.org/10.1177/26344041211010777.
8. Kosky R. *Gender - disordered children: does inpatient treatment help?* Medical Journal of Australia 1987;146:565-69 (June 1, 1987). doi: 10.5694/j.1326-5377.1987.tb120415.x.
9. [2020] EWHC 3274 (Admin). https://www.judiciary.uk/wp-content/uploads/2020/12/Bell-v-Tavistock-Judgment.pdf.

10. Vlot MC, Klink DT, den Heijer M, Blankenstein MA, Rotteveel J, Heijboer AC. *Effect of pubertal suppression and cross-sex hormone therapy on bone turnover markers and bone mineral apparent density (BMAD) in transgender adolescents*. Bone. 2017;95:11-19. doi: 10.1016/j.bone.2016.11.008. Epub 2016 Nov 11.
11. Vlot MC, Wiepjes CM, de Jongh RT, T'Sjoen G, Heijboer AC, den Heijer M. *Gender-Affirming Hormone Treatment Decreases Bone Turnover in Transwomen and Older Transmen*. J Bone Miner Res. 2019 Oct;34(10):1862-1872. doi: 10.1002/jbmr.3762. Epub 2019 Aug 19. PMID: 31099910; PMCID: PMC6852079.
12. Schneider MA, Spritzer PM, Soll BMB, Fontanari AMV, Carneiro M, Tovar-Moll F, Costa AB, da Silva DC, Schwarz K, Anes M, Tramontina S, Lobato MIR. *Brain Maturation, Cognition and Voice Pattern in a Gender Dysphoria Case under Pubertal Suppression*. Front Hum Neurosci. 2017 Nov 14;11:528. doi: 10.3389/fnhum.2017.00528. PMID: 29184488; PMCID: PMC5694455.
13. Auer MK, Ebert T, Pietzner M, Defreyne J, Fuss J, Stalla GK, T'Sjoen G. *Effects of Sex Hormone Treatment on the Metabolic Syndrome in Transgender Individuals: Focus on Metabolic Cytokines*. J Clin Endocrinol Metab. 2018 Feb 1;103(2):790-802. doi: 10.1210/jc.2017-01559. PMID: 29216353.
14. Alzahrani T, Nguyen T, Ryan A, Dwairy A, McCaffrey J, Yunus R, Forgione J, Krepp J, Nagy C, Mazhari R, Reiner J. *Cardiovascular Disease Risk Factors and Myocardial Infarction in the Transgender Population*. Circ Cardiovasc Qual Outcomes. 2019 Apr;12(4):e005597. doi: 10.1161/CIRCOUTCOMES.119.005597. PMID: 30950651.
15. Nota NM, Wiepjes CM, de Blok CJM, Gooren LJG, Kreukels BPC, den Heijer M. *Occurrence of Acute Cardiovascular Events in Transgender Individuals Receiving Hormone Therapy*. Circulation. 2019 Mar 12;139(11):1461-1462. doi: 10.1161/CIRCULATIONAHA.118.038584. PMID: 30776252.
16. Goodman M, Nash R. *Examining health outcomes for people who are transgender*. https://www.pcori.org/research-results/2013/examining-health-outcomes-people-who-are-transgender. Updated 2014. Accessed Nov 7, 2019.
17. [22] Dhejne C, Lichtenstein P, Boman M, Johansson AL, Langstrom N, Landen M. *Long-term follow-up of transsexual persons undergoing sex reassignment surgery: Cohort study in Sweden*. PLoS One. 2011;6(2):e16885. doi: 10.1371/journal.pone.0016885. PMID: 21364939; PMCID: PMC3043071.
18. Bränström, R., & Pachankis JE. *Reduction in Mental Health Treatment Utilization Among Transgender Individuals After Gender-Affirming Surgeries: A Total Population Study*. American Journal of Psychiatry. 2019;177(8), 727- 734. https://doi.org/10.1176/appi.ajp.2019.19010080. Epub 2019 Oct 4. Erratum in: Am J Psychiatry. 2020 Aug 1;177(8):734. PMID: 31581798.
19. Correction to Bränström and Pachankis. American Journal of Psychiatry. 2020;177(8), 734-734. https://doi.org/10.1176/appi.ajp.2020.1778correction.
20. Kalin, N. *Reassessing Mental Health Treatment Utilization Reduction in Transgender Individuals After Gender Affirming Surgeries: A Comment by the Editor on the Process*. American Journal of Psychiatry. 2020;177(8), 764- 764. https://doi.org/10.1176/appi.ajp.2020.20060803. PMID: 32741283.
21. Vandenbussche E. *Detransition-related needs and support: a cross-sectional online survey*. Journal of homosexuality. 2021 Apr 30; 1-19. Doi: 10.1080/00918369.2021.1919479. Epub 2021 Apr 30. PMID: 33929297.
22. Lesbian Strength 2019 – Charlie Evans. YouTube. https://www.youtube.com/watch?v=-JazgA3AdUE. Published September 2019. Accessed November 1, 2019.
23. *Female detransition and reidentification: Survey results and interpretation*. archive website. https://guideonragingstars.tumblr.com/post/149877706175/female-detransition-and-reidentification-survey. Accessed Nov 7, 2019.
24. Pique resilience project website - https://www.piqueresproject.com/. Accessed Nov 7, 2019.
25. reddit.com. *Subreddit survey update!*: detrans. https://www.reddit.com/r/detrans/comments/azj8xd/subreddit_survey_update/. Published 2019. Accessed November 1, 2019.
26. reddit.com. *Has anyone been to gender therapy? What was your experience?*:https://www.reddit.com/r/detrans/comments/aeo5zd/has_anyone_been_to_gender_therapy_what_was_your/ Published 2019. Accessed November 1, 2019.
27. Tumblr: *Guide on raging stars. Female detransition and reidentification survey*. https://tinyurl.com/female-detrans-survey. Published 2016. Accessed November 1, 2019.
28. Council for Choices in Health Care in Finland (Palko/Cohere Finland) (2020). Recommendation of the Council for Choices in Health Care in Finland (PALKO/COHERE Finland): Medical Treatment Methods for Dysphoria Related to Gender Variance in Minors. Lingua Franca Translations (18 May, 2022), Certified English translation, Coconut Grove, Florida.

29. Linden T, MD PhD Director/Government Chief Medical Officer. The National Board of Health and Welfare, Sweden 2022.
30. National Academy of Medicine, France. *Medical Care of Children and Adolescents with Transgender Identity*. Unofficial translation by the Society for Evidence-based Gender Medicine (SEGM), March 2, 2022 - https://segm.org/sites/default/files/English%20Translation_22.2.25-Communique-PCRA-19-Medecine-et-transidentite-genre.pdf.
31. Cass, Hilary Dr. (2022) *Independent review of gender identity services for children and young people: Interim report* - https://cass.independent-review.uk/publications/interim-report/.
32. The Cass Independent Review. https://cass.independent-review.uk/publications/.
33. Cass, Hilary Dr. (2022) *Entry 6 – Following the interim report* - https://cass.independent-review.uk/entry-6-following-the-interim-report-march-2022/.

Co-authors of the National Association of Practising Psychiatrists Guide:

Dr Philip Morris AM MBBS BSc(med) PhD FRANZCP FAChAM(RACP)
President
National Association of Practising Psychiatrists

Dr Cary Breakey MB BS (Mon), FRACGP, DPM (Qld)
Consultant Child and Adolescent Psychiatrist

Dr Roberto D'Angelo Psy.D. FRANZCP, M.Med.(Psychotherapy), MBBS
American Psychoanalytic Association - Member
Psychiatrist and Psychoanalyst

Dr Vivienne Elton MBBS, FRANZCP
Vice-president
National Association of Practising Psychiatrists

Dr George Halasz MBBS, BMedSc, MRCPsych, FRANZCP
Consultant Child and Adolescent Psychiatrist

Prof Dianna Kenny PhD, MA (Sch Couns), BA (Hons), Dip Ed, Grad Dip FDR, FAPs, MAPA
Consulting Psychologist
Psychotherapist, Couple and Family Therapist

Co-signatories of the National Association of Practising Psychiatrists Guide:

Dr Alison Clayton MBBS MPM FRANZCP
Psychiatrist

Dr Vanessa Spiller BA(Psych)(Hons), MPsych (Clinical), PhD
Australian Psychological Society (MAPS) (FCCLP)
Clinical Psychiatrist

Dr Dylan Wilson MBBCh MRCPH FRAC
Paediatrician

Guide content last updated 16th August 2022.