MANAGING GENDER DYSPHORIA IN CHILDREN
A NEED FOR CAUTION

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The safety and protection of children is one of societies' highest priorities. It is of paramount importance that any social, psychological, or medical interventions performed on a child should not cause harm and should increase their well-being. Due to children's inherent vulnerability, additional safeguards are put into place to protect their rights and to ensure their welfare.[1] In the USA and Europe there has been a surge in the number of children being diagnosed with gender dysphoria (i.e., clinically significant feelings of discomfort or distress, or functional impairment related to incongruence between the gender that a patient sees themselves as, and their birth classified gender)[2] and then undergoing social and medical transition (i.e., puberty blockers and cross-sex hormones).[3] This dramatic increase has also been noted in South Africa.[4] This raises the question as to whether the medical fraternity are critically assessing the benefits and harms posed by these interventions.

THE EVIDENCE BASE SUPPORTING AFFIRMATIVE TREATMENT OF GENDER DYSPHORIC CHILDREN

The evidence base supporting affirmative treatment of minors (< 18 years of age) with dysphoria due to gender identity is very weak and the risks to children are not clearly understood. Worldwide, reports from national regulatory authorities (Sweden,[5,6] Finland,[7] UK,[8]) and physician societies (The French National Academy of Medicine,[9] The Royal Australian and New Zealand College of Psychiatrists[8] and the Society for Evidence Based Gender Medicine[10]), have raised concerns about the weak level of supporting evidence, as well as the unknown risks posed to children.

1) The Swedish National Board of Health and Welfare (Socialstyrelsen/NBHW) note that:

'Following a comprehensive review of evidence, the NBHW concluded that the evidence base for hormonal interventions for gender-dysphoric youth is of low quality, and that hormonal treatments may carry risks. NBHW also concluded that the evidence for pediatric transition comes from studies where the population was markedly different from the cases presenting for care today. In addition, NBHW noted increasing reports of detransition and transition-related regret among youth who transitioned in recent years.'[5,6]

IN THE LIGHT OF THE POOR EVIDENCE SWEDEN NOW ONLY OFFERS GENDER TRANSITION IN MINORS WHEN IT IS DONE AS PART OF A CLINICAL TRIAL.

2) In Finland, the Council for Choices in Health Care in Finland (COHERE Finland) write that:

'Research data on the treatment of dysphoria due to gender identity conflicts in minors is limited. COHERE considers that, moving forward, multi-professional clinics specialising in the diagnostics and treatment of gender identity conflicts at HUS (Helsinki University Hospital) and TAYS (Tampere University Hospital) should collect extensive information on the diagnostic process and the effects of different treatment methods on the mental wellbeing, social capacity, and quality of life of children and youth. There is also a need for more information on the disadvantages of procedures and on people who regret them.'[7]

3) The Independent Review of Gender Identity Services for Children and Young People (The Cass Review), commissioned by NHS England and NHS Improvement reports that:

> 'Evidence on the appropriate management of children and young people with gender incongruence and dysphoria is inconclusive both nationally and internationally…
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> … Internationally as well as nationally, longer-term follow-up data on children and young people who have been seen by gender identity services is limited, including for those who have received physical interventions; who were transferred to adult services and/or accessed private services; or who desisted, experienced regret or detransitioned…

… The Review is not able to provide definitive advice on the use of puberty blockers and feminising/masculinising hormones at this stage, due to gaps in the evidence base; however, recommendations will be developed as our research programme progresses.'[8]

4) The French National Academy of Medicine have issued a statement in which they note the following:

> 'However, great medical caution must be taken in children and adolescents, given the vulnerability, particularly psychological, of this population and the many undesirable effects and even serious complications that can be caused by some of the therapies available. In this regard, it is important to recall the recent decision (May 2021) of the Karolinska University Hospital in Stockholm to prohibit the use of puberty blockers.
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> If France allows the use of puberty blockers or cross-sex hormones with parental authorization and no age limitations, the greatest caution is needed in their use, taking into account the side-effects such as the impact on growth, bone weakening, risk of sterility, emotional and intellectual consequences and, for girls, menopause-like symptoms.'[9]

5) The Royal Australian and New Zealand College of Psychiatrists echo these sentiments as they write:

> 'At present, there is a paucity of quality evidence on the outcomes of those presenting with Gender Dysphoria. In particular, there is a need for better evidence in relation to outcomes for children and young people.'[11]

RESOLUTION OF GENDER DYSPHORIA DURING PUBERTY

These concerns become even greater when we note that in most cases, gender dysphoria in pre-adolescent children will disappear during puberty. In follow-up studies of prepubertal children (mainly boys) who were referred to clinics for assessment of gender dysphoria, the dysphoria persisted into adulthood for only 6-23% of children.[12,13] Thus, the vast majority of children will not persist with gender dysphoria after puberty.

Importantly, as specifically noted by the French National Academy of Medicine, there is 'no test to distinguish between persisting gender dysphoria and transient adolescent dysphoria.'[9] Further, it is common for children with gender dysphoria to have a wide variety of co-existing disorders such as anxiety, depression, oppositional defiant disorder, ADHD, psychosis, eating disorders, suicidal ideation, self-harm and autistic spectrum disorders, including Asperger's.[11,14-16]

In the light of these findings, the Council for Choices in Health Care in Finland emphasize that:

> 'If a child or young person experiencing gender-related anxiety has other simultaneous psychiatric symptoms requiring specialized medical care, treatment according to the nature and severity of the disorder must be arranged within the services of their own region, as no conclusions can be drawn on the stability of gender identity during the period of disorder caused by a psychiatric illness with symptoms that hamper development.'[7]

The Royal Australian and New Zealand College of Psychiatrists again note that:

> 'There is some evidence to suggest positive psychosocial outcomes for those who are supported in their gender identity.[17] However, evidence and professional opinion is divided as to whether an affirmative approach should be taken in relation to treatment of transgender children or whether other approaches are more appropriate…
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> …Approaches which don't include medical treatments may focus on utilising psychotherapy to aid individuals with Gender Dysphoria in exploring their gender identity, and aid alleviation of any co-existing mental health concerns identified in screening and assessment.'[13]

UNCERTAINTIES AROUND THE BENEFITS AND RISKS OF PUBERTY BLOCKERS AND CROSS-SEX HORMONES TO TREAT CHILDREN WITH GENDER DYSPHORIA

In 2020 the UK National Institute for Health and Care Excellence (NICE) undertook two systematic evidence reviews of the use of Gonadotropin-releasing hormone (GnRH) agonists (also known as "puberty blockers") and cross-sex hormones as treatments for gender dysphoric patients <18 years old.

GNRH AGONISTS (PUBERTY BLOCKERS) WERE FOUND TO CAUSE LITTLE OR NO CHANGE IN GENDER DYSPHORIA, MENTAL HEALTH, BODY IMAGE AND PSYCHOSOCIAL FUNCTIONING.[18]

In the few studies that did report change, the results could be attributable to bias or chance, or were deemed unreliable. The landmark Dutch study by De Vries et al.[16] was considered 'at high risk of bias,' and of 'poor quality overall.' The reviewers suggested that findings of no change may in practice be clinically significant, in view of the possibility that study subjects' distress might otherwise have increased. The reviewers cautioned that all the studies evaluated had results of 'very low' certainty and were subject to bias and confounding.

The review of cross-sex hormones noted 'a fundamental limitation of all the uncontrolled studies in this review is that any changes in scores from baseline to follow-up could be attributed to a regression-to-the-mean,' rather than the beneficial effects of hormone treatment.[18]

NO STUDY REPORTED CONCOMITANT TREATMENTS IN DETAIL, MEANING THAT IT IS UNCLEAR IF POSITIVE CHANGES WERE DUE TO HORMONES OR THE OTHER TREATMENTS PARTICIPANTS MAY HAVE RECEIVED.

The reviewers suggested that hormones may improve symptoms of gender dysphoria, mental health, and psychosocial functioning, but cautioned that potential benefits are of very low certainty and 'must be weighed against the largely unknown long-term safety profile of these treatments.'

These findings echo those from many other systematic reviews and editorials.[18-20] The Society for Evidence Based Gender Medicine notes the following:

> '…the significant uncertainties regarding the long-term risk/benefit profile of "gender-affirmative" hormonal interventions call for non-invasive approaches as the first line of treatment for youth. If pursued, invasive and potentially irreversible interventions for youth should only be administered in clinical trial settings with rigorous study designs capable of determining whether these interventions are beneficial. In addition to undergoing rigorous psychological and psychiatric evaluations, patients and their families should participate in a valid informed consent process. The latter must accurately disclose the limited prognostic ability of the gender dysphoria/gender incongruence diagnosis for young people, and the many uncertainties regarding the long-term mental and physical health outcomes of these poorly studied and largely experimental interventions.'

In addition, there are significant side effects associated with the use of puberty blockers and cross-sex hormones.[21-23] These include: osteoporosis, sexual dysfunction, infertility, poor mental health outcomes including depression or suicide, increased risk of heart disease, regret due to irreversible hormonal or surgical changes. In the light of these side effects and the concerns about the quality of evidence supporting these interventions it becomes essential to ensure that the treating teams obtain comprehensive informed consent from the patient and the family.[24]

CONCLUSION

This short review highlights the inconclusive nature of the evidence supporting the management of children and young people with gender incongruence and dysphoria. It is the constitutional right of each individual to make their own choices with regard to their gender expression and sexual orientation. However, irrespective of political, religious, or ideological differences, the protection of children should be our first priority. The importance of treading slowing, carefully, and humbly has been highlighted with the news that the NHS is facing a class-action lawsuit claiming clinical negligence being brought against the Tavistock gender clinic in the UK.[25]

It is incumbent upon South African clinicians to note the warning of the French National Academy of Medicine when they say that:

> *'…great medical caution must be taken in children and adolescents, given the vulnerability, particularly psychological, of this population and the many undesirable effects and even serious complications that can be caused by some of the therapies available."*[9]

POSTSCRIPT:

Links to content related to the latest publication/statement from the National Health Service, UK (NHS) regarding their approach to gender dysphoric children.

https://www.engage.england.nhs.uk/specialised-commissioning/gender-dysphoria-services/

https://segm.org/England-ends-gender-affirming-care

https://www.telegraph.co.uk/news/2022/10/23/children-who-think-transgender-just-going-phase-says-nhs/

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