



Deutsche Gesellschaft  
für Kinder- und Jugendpsychiatrie,  
Psychosomatik und Psychotherapie e.V.

## **Draft version of the AWMF guideline**

### **Gender incongruence and gender dysphoria**

#### **in childhood and adolescence - diagnosis and treatment (S2k)**

**AWMF Registry No. 028 - 014**

#### **Leading professional association**

German Society for Child and Adolescent Psychiatry, Psychosomatics and Psychotherapy (DGKJP)

#### **AWMF specialist societies involved**

German Society for Child and Adolescent Psychiatry, Psychosomatics and Psychotherapy (DGKJP, in charge)

Academy for Ethics in Medicine (AEM)

German Medical Society for Behavioral Therapy (DÄVT) German Society for Endocrinology (DGE)

German Society for Gynecology and Obstetrics (DGGG)

German Society for Pediatrics and Adolescent Medicine (DGKJ)

German Society for Pediatric and Adolescent Endocrinology and Diabetology (DGPAED) German Society for Medical Psychology (DGMP)

German Society for Psychiatry and Psychotherapy, Psychosomatics and Neurology (DGPPN) German Society for Psychoanalysis, Psychotherapy, Psychosomatics and Depth Psychology (DGPT) German Society for Sexual Research (DGfS)

German Society for Sexual Medicine, Sexual Therapy and Sexology (DGSMTW) German Society for Urology (DGU)

German College of Psychosomatic Medicine (DKPM)

**Other specialist organizations involved:**

Professional Association of Child and Adolescent Psychotherapists (bkj)

Professional Association of German Psychologists (BDP)

Professional Association for Child and Adolescent Psychiatry, Psychosomatics and Psychotherapy (BKJPP)

Federal Working Group of Chief Clinicians for Child and Adolescent Psychiatry, Psychosomatics and

Psychotherapy (BKJPP)

-psychotherapy (BAG)

Federal Chamber of Psychotherapists (BPtK)

German Society for Systemic Therapy, Counseling and Family Therapy (DGSF) Society for

Sexology (GSW)

Child and Adolescent Psychotherapy Behavioral Therapy (KJPVT) Austrian Society

for Child and Adolescent Psychiatry (ÖGKJP)

Swiss Society for Child and Adolescent Psychiatry and Psychotherapy (SGKJPP)

Association for lesbian, gay, bisexual, trans\*, intersex and queer people in psychology (VLSP)

Association of Analytical Child and Adolescent Psychotherapists in Germany (VAKJP)

**Participating representative organizations of treatment seekers:**

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Trans\* Children's Network (TraKiNe)

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# **Introduction**

## **1. The development of this guideline in the context of current debates**

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## **1. The development of this guideline in the context of current debates**

This AWMF guideline is intended to provide all healthcare professionals who deal with young transgender people with guidance for the best possible professionally informed care based on the current state of medical knowledge. Twenty-six medical and psychotherapeutic specialist organizations and two self-advocacy organizations were involved in its creation and consensus. This broad participation ensures that the recommendations in this guideline are based on a representative opinion of the professional community.

Despite the high level of media attention given to the issue of treating transgender young people, it should be noted that the number of young people with gender incongruence receiving medical treatment is low in absolute terms. The relative increase in treatment figures correlates with society's increasing openness to transgender life paths and the improvement in specialist care services. Rising treatment figures are not a special phenomenon in adolescence. They can be observed in similar proportions in adulthood. According to a recent extrapolation based on anonymized insurance data from BARMER<sup>1</sup>, the number of new hormonal treatments started by under-18-year-olds with gender incongruence increased 3.2-fold across Germany between 2014 and 2019 (from approx. 330 to approx. 1,060) and 3.5-fold for adults between the ages of 18 and 30 in the same period (from approx. 510 to approx. 1,800).

The medical care of transgender people is an interdisciplinary challenge in which the clinical expertise of experienced specialists is essential due to the small number of cases and the ethically justified impracticability of controlled clinical studies. For this guideline, the specialist societies largely delegated experts with many years of experience in the development and treatment of young transgender patients.

The following section discusses some of the challenges faced in preparing this guideline and the corresponding procedures.

### **1.1. Depathologization in the ICD-11 of the World Health Organization**

Over the past two decades, the medical community has undergone a paradigm shift in the understanding of non-conforming gender identities in terms of their depathologization. This step is comparable to the change in the treatment of homosexuality, which was removed from the catalog of psychiatric diagnoses in 1977. Accordingly, there are no so-called "gender identity disorders" in the ICD-11

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<sup>1</sup> The release of these figures was authorized by BARMER.

(F64) in the sense of a mental illness. Instead, the diagnosis of "Gender incongruence" (HA60) was newly introduced under a new heading "*conditions related to sexual health*" (WHO, 2022). Gender incongruence (GI) is not considered to be a disease per se, but nevertheless a health-relevant condition that may justify the need for medical treatment to avert or reduce the associated suffering known as "gender dysphoria" (GD). Therefore, the terms "Gender identity disorders" and "transsexualism" are not used in this guideline, despite the current transition phase in which diagnoses are still to be coded according to ICD-10 (WHO, 2019) for billing purposes.

## **1.2. Medical-ethical considerations in treatment decisions in adolescence**

If adolescents are diagnosed with persistent GI before they have reached biological maturity, treatment decisions for or against body-modifying measures are generally subject to a high ethical burden of justification and require careful consideration in each individual case. On the one hand, irreversible consequences of a treatment decision in favor of hormone treatment must be considered; on the other hand, postponing such treatment can lead to the consolidation of gender dysphoric distress due to the increasingly irreversible progression of the development of male or female body characteristics. This in turn can be associated with an increased risk of impaired long-term mental health. In this context, ethical trade-offs are required between protecting minors from potentially premature decisions that could be regretted at a later date and protecting young people's self-determination over their gender identity and their bodies. The involvement of the *Academy of Ethics in Medicine (AEM)* in the development of the guideline through the active ongoing participation of its delegated expert in the steering group was a valuable support for the reception of the relevant medical ethics discourse. In addition, the German Ethics Council organized a bioethics forum during the guideline development phase in February 2020, at which controversial ethical positions within the guideline commission on the above-mentioned ethical problems were openly discussed. The guidelines for treatment decisions subsequently published by the German Ethics Council in its ad hoc recommendation "*Trans Identity in Children and Adolescents Therapeutic Controversies - Ethical Orientations*" (German Ethics Council, 2020) were incorporated into the consensus-building process within the guideline commission. The issues associated with these questions

high requirements for determining the capacity of underage patients to give consent were addressed in a separate chapter on ethical and legal requirements (Chapter X→ "*Law and ethics*").

### **1.3. Dealing with the social transgender debate and discrimination**

During the work on the guideline, the topic of *transgender* was covered intensively in the media. The task of the guideline commission was to develop a medical guideline. Although it cannot be the task of an AWMF guideline to focus on the political concerns of the LGBTIQ community for acceptance by society as a whole, it is nevertheless necessary in any guideline work to conduct a respectful dialog with patients and their relatives on an equal footing.

Transgender has been pathologized for decades and many studies have documented widespread discrimination against trans people in the healthcare system. Two self-advocacy organizations participated in the drafting of the guidelines with voting rights. Efforts to ensure discrimination-sensitive treatment of trans people in the healthcare sector are reflected in a separate chapter on this topic (Chapter IX→ "*Professional interaction and discrimination-sensitive treatment of gender non-conforming children and adolescents*") as well as in an appropriate terminology, which is presented in tabular form in the → *Glossary*.

### **1.4. Integrating professional controversy and dealing with dissent**

The broad participation of 26 specialist organizations and two self-advocacy organizations in the development of the guideline and the involvement of specialist child and adolescent psychiatric treatment centers (Frankfurt, Hamburg, Munich, Münster, Zurich) with many years of experience at the start of the guideline work in the steering group ensured that the composition of the guideline commission reflected a representative overall picture of expert opinion. As expected, controversial discussions were held within the guideline commission. The guideline is preceded by a preamble, which was adopted with a strong consensus, in order to present some of the fundamental ethical and therapeutic attitudes within the guideline commission (Chapter I→ "*Preamble*" and section on "*Dealing with dissent*" in the Methods Report).

## 1.5. Preparation of recommendations with an overall weak evidence base

In preparing the guideline, the following two key quality objectives were pursued by strictly adhering to the AWMF rules and regulations based on the level of an S3 guideline:

- The aim of providing the *best possible information on the current state of knowledge* was achieved by systematically reviewing the literature and classifying and evaluating it transparently.
- The aim of achieving the *best possible orientation towards the current expert consensus on best practice* was implemented through moderated consensus of all recommendations with the maximum achievable consensus strength (>95% across all recommendations).

Due to a lack of controlled evidence of efficacy and an overall weak evidence base with regard to uncontrolled evidence of efficacy from case-cohort studies, no evidence-based recommendations were made in this guideline for the treatment of GI or GD; instead, all recommendations were developed on the basis of consensus. In agreement with the AWMF, this led to the decision to publish the guideline as an S2k guideline, even though the methodological structure of its preparation, in particular the systematic literature review, followed the regulations of an S3 guideline.

## 2. The epidemiology of gender incongruence

### 2.1. Frequency in adults and minors

Over the past 15 years, estimates based on scientific studies of the proportion of gender-nonconforming people in the overall population have changed. The new international guideline *Standards of Care - Version 8* of the World Professional Association for Transgender Health (WPATH, Coleman et al., 2022) states in an overview chapter that improved empirical studies on the frequency of transgender *and gender diverse persons (TGD)* in the general population have been published over the past ten years. More recent reviews summarize the available findings (Arcelus et al, 2015; Collin et al, 2016; Goodman et al, 2019; Meier & Labuski, 2013; Zhang et al, 2020). For epidemiological data on the *TGD population*, it is recommended to avoid the terms "incidence" and "prevalence", as they refer to diseases

refer. This is intended to avoid pathologizing gender-nonconforming people (Adams et al., 2017; Bouman et al., 2017).

Instead, the *Standards of Care* recommend using the terms "number" and "proportion" to refer to the absolute and relative size of the so-called *TGD population*. When evaluating individual study results, it is important to pay attention to the methodology of the survey, in particular the chosen approach to respondents and the selected case definitions. For example, frequency data diverge considerably depending on whether the data refer to people who have sought treatment in the healthcare system for a possible transgender diagnosis (GI or GD) (Collin et al., 2016; Meier & Labuski, 2013) or to people who have indicated a non-conforming gender identity in a population-based survey. Such population-based surveys are based on a broader definition of self-reported gender identities and therefore arrive at significantly higher figures.

The majority of studies published more than a decade ago calculated the number of patients treated in a particular clinical center and extrapolated to an estimated population size of the catchment area of the clinic in question, which may have led to a considerable underestimation of the incidence. For these reasons, only studies that have been published since 2009 and whose methodology provides a clear definition of TGD status and a precisely defined reference population were included in the *Standards of Care* study overview (Coleman et al., 2022). These are referenced subdivided according to

- Studies that report the proportion of gender-nonconforming people in the context of healthcare utilization;
- Studies based on population-based surveys with predominantly adult participants; and
- Studies based on surveys of young people in schools.

A total of six US studies analyzed data from the Veterans Health Affairs System, a health insurance system that covers more than nine million people. The proportion of transgender people in the total number of people insured in this system was determined to be between 0.02% and 0.08% based on service data and diagnosis codes (Blosnich et al., 2013; Dragon et al., 2017; Ewald et al., 2019; Jasuja et al., 2020; Kauth et al., 2014; Quinn et al., 2017). An important limitation of these studies was that people aged 65 and over tended to be overrepresented in the reference population.

In contrast, *population-representative studies* that relied on self-reported transgender status found significantly higher case numbers: Two American studies used the Behavioral Risk Factor Surveillance Study (BRFSS), a

annual telephone survey conducted in all 50 states of the USA (Conron et al., 2012; Crissman et al., 2017). Based on different annual surveys, both studies consistently report that around 0.5% of participants aged 18 and over answered "yes" to the question "Do you consider yourself transgender?". In an internet-based survey conducted on a representative sample of the Dutch population aged 15 to 70, 1.1% of people with a male sex assigned at birth and 0.8% of people with a female sex assigned at birth stated that they tended to identify with the opposite sex (Kuyper & Wijsen, 2014).

In a methodologically similar study in Belgium, which was conducted on a sample drawn from the country's population register, the proportion of people who self-identified as gender non-conforming was 0.7% for those assigned male at birth and 0.6% for those assigned female at birth (Van Caenegem et al., 2015). In a study of approximately 50,000 population-representative adult residents of the Stockholm region, the proportion of gender-nonconforming individuals was examined with differentiated questions on perceived gender identity, including the desire for body-modifying medical treatments (Åhs et al., 2018). A "strong desire" for hormone therapy or gender reassignment surgery was affirmed by 0.2% of respondents of both birth genders. In contrast, questions about gender-incongruent identity experiences and social transition wishes ("*I feel like someone of a different gender*" and "*I would like to live or be treated as someone of a different gender*") were answered in the affirmative by 0.8% to 1.2% of respondents. This should be seen as an indication that estimated proportional frequencies of people with a transgender or non-binary self-description are not to be equated with estimated frequencies of people with a desire for body-modifying medical measures. A representative survey of 6,000 adults in Brazil (Spizzirri et al., 2021) found a proportion of 1.9% gender-nonconforming people, of whom 0.7% described themselves as transgender and 1.2% as non-binary.

There are several school-based survey studies on the proportion of *gender non-conforming young people* under the age of 19. In a national cross-sectional survey of high schools in New Zealand (n=8,000), 1.2% of respondents identified as "*transgender*" or "*transsexual*". "gender-diverse", with a further 2.5% stating that they were not sure (Clark et al., 2014). In a survey of 14- to 18-year-old students in the US state of Minnesota (N = 81,000), 2.7% of respondents stated that they were "*transgender*" or "*gender diverse*" (Eisenberg et al., 2017). In the *Youth Risk Behavior Survey*, which is conducted every two years in the USA nationwide with high school students in grades 9-12 (age range 13-19 years)

*Survey (YRBS)*, 1.8% of the almost 120,000 participants in 19 urban regions in the 2017 survey said "Yes, I am transgender" and 1.6% said "I am not sure if I am transgender" (Johns et al., 2019). Only one study examined the proportion of children in a younger age group who described themselves as transgender. In the 2011 survey of n=2,700 students in grades 6-8 (age range 11-13) at public middle schools in San Francisco (Shields et al., 2013), 1.2% of respondents self-identified as "transgender" when asked "What is your gender?", with the response options being "female, male or transgender".

In summary, the reported data shows that in studies in which transgender status was determined on the basis of self-reporting, the percentage determined was between 0.3% and 0.5% for adults and between 1.2% and 2.7% for adolescents. If the definition was expanded to include a broader spectrum of gender non-conforming manifestations, such as uncertain or ambivalent gender identity, the corresponding percentages were higher: 0.5% to 4.5% for adults and 2.5% to 8.4% for adolescents. This indicates a broad and fluid spectrum of non-conforming or "queer" self-descriptions in adolescence, which cannot be equated with a medical diagnosis of GI, but requires internal differentiation.

In health system-based studies relying on diagnostic codes or other evidence documented in medical records, the proportions of transgender-related diagnoses identified ranged from 0.02% to 0.08%, which is less than one-tenth of the frequencies found in population-based representative surveys (see Table 1).

Vorläufige Fassung zur Kommentierung



Table 1: Proportion of TGD\* people in the total population estimated according to studies (Figures from Coleman et al, 2022)

	Transgender	Alle TGD
Gesundheitssystem-basierte Daten (F64-Diagnosen)	0,02–0,1 %	-
Repräsentative Surveys Erwachsene	0,3–0,5 %	0,3–4,5 %
Repräsentative Surveys Jugendliche:	1,2–2,7 %	2,5–8,4 %

TGD: "transgender and gender diverse" - German: "transgender and gender non-conforming"

## 2.2. What explains the increase in the number of cases?

In addition to the aforementioned differences in the frequency figures between health system-based and population-based surveys, another observation is the *steady increase* in the proportion of gender-nonconforming and trans people estimated on the basis of study results over the past two decades. This increase is reflected in the same way in the health systems, in population-based surveys and in the data on legal name and civil status changes (legal transition). Over the past ten years, the number of young people seeking special treatment services in the healthcare system for issues related to the "transgender" phenomenon has risen sharply internationally (Kaltiala et al., 2020). Similarly, the number of medical transition treatments for adult trans people has risen sharply. According to the Federal Statistical Office, the number of gender reassignment surgeries for adults in Germany tripled overall between 2012 and 2020, with a steady upward trend (Federal Statistical Office, 2023).

The increasing numbers of cases reported in the recent literature confirm the assumption that the proportions of gender-nonconforming and trans people in the population were underestimated in earlier studies (Olyslager & Conway, 2008). The trend towards a larger reported proportion of transgender or gender-nonconforming individuals in younger age groups is reflected in the conclusion of the authors of the *Standards of Care of the*

*WPATH*<sup>2</sup> (Coleman et al., 2022) and, in the opinion of other authors, most likely can be explained by socio-political changes with increasing tolerance and destigmatization as well as improvements in access to qualified healthcare, which in turn have different effects across generations (Ashley, 2019; Pang et al., 2020; Zhang et al., 2020). Evidence of this generational effect in this context is provided by the results of the last census in Canada, in which all people in the country's total population over the age of 15 were explicitly asked about their gender identity, among other things. In addition to "male" and "female", "transgender", "non-binary or "unsure" and "no response" were also explicitly offered as response options (Statistics Canada, 2022).

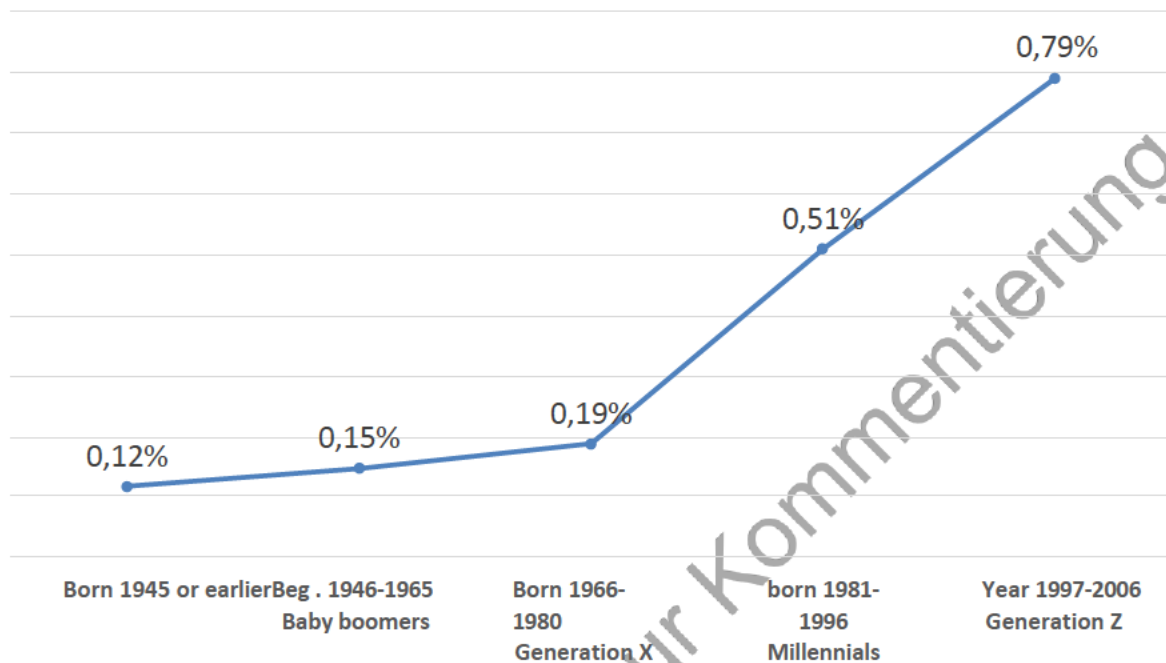
Based on this census data, 100,815 out of 30.5 million Canadians self-defined as transgender or non-binary, representing 0.33% of the population aged 15 years or older. An analysis by birth cohort showed that the trend towards higher proportions of trans people in younger age groups is not a specific phenomenon of adolescence, but rather a largely linear age kinetic over the adult life span from about the 1966-1980 birth cohorts (the so-called "Generation X") over the birth cohorts of subsequent decades (see Fig. 1 below). Although these results represent the most differentiated data available to date on a broad epidemiological basis, one limitation is that it remains unclear for the time being whether and how the population proportions reported in Canada can be compared with those in other countries.

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<sup>2</sup>WPATH - World Professional Association for Transgender Health

Fig.1:

Frequency distribution of transgender identity by age group in Canada (total population > 16 years, figures from Statistics Canada, 2022)



This generational effect, which can be seen throughout adulthood, indicates that the trend whereby younger people describe themselves as *trans* more often than older people *cannot* be explained solely by the developmental psychological characteristics of adolescence, as this can also be seen in younger adulthood.

### 2.3. Explanations for changes in the gender ratio

A largely unexplained observation to date is the increasing change in the reported relative frequency distribution between the sexes (gender ratio) over the past ten years in favor of the proportion of natively female or trans-male persons. This trend has been reported in particular in studies analyzing referrals to specialty clinics and data from integrated health systems and is reported primarily for adolescence, for which the reported gender ratio is consistently reported in the order of 80:20 in several studies (Aitken et al, 2015; De Graaf, Carmichael, et al, 2018; De Graaf, Giovanardi, et al, 2018; Steensma et al, 2018; Zhang et al, 2021). Among other things, this has led to a controversy as to whether persistent GI, especially in adolescents with female at birth

England) are based on this fear, among others. Thus, in the explanations of the Swedish health authority *Socialstyrelsen* and in the *Cass Interim Report* for the English *National Health Service (NHS)*, the currently more cautious recommendations for the indication of temporary puberty blockade, especially for adolescents with a sex assigned to female at birth, are justified and reference is made to the observation of this strongly shifted gender ratio among adolescents seeking treatment, which the authors believe has not been sufficiently clarified (Cass, 2022; Socialstyrelsen, 2022). Even if the currently unequal frequency distribution by birth gender of adolescents presenting to special centers for GD has not yet been conclusively clarified, two findings appear noteworthy for their relativizing classification:

- In a more recent analysis of  $N = 420$  cumulative assessments of people up to the age of 19 who had applied for a change of name and civil status under the German Transsexuals Act (TSG), which were almost without exception approved, a gender ratio of 80:20 was found for this age group in favor of applicants with sex assigned female at birth (Meyenburg et al., 2021). In this context, it is important to know the requirements for such an assessment under the TSG: This must be carried out by *two independent psychiatric or psychological experts* who must have relevant expertise in the diagnostic assessment of this group of people. Their explicit mandate as experts is to examine in detail whether the applicant has felt a persistent *and pronounced sense of belonging to the opposite sex* over a period of *at least three years* ("inner compulsion") and whether, after diagnostic assessment based on the current state of scientific knowledge, it *can be assumed* with a *very high degree of probability that this will no longer change*. Due to these assessment criteria, which are designed for maximum specificity (= prevention of false positive assignment), it would be expected that adolescents who, for example, are struggling with their birth gender in a temporary identity crisis, would not receive any positive confirmatory assessments. Accordingly, the reported unequal gender ratio in the cohort of this study *cannot* plausibly be explained by a *selective gender-related tendency* towards false positive cases due to identity-uncertain girls in puberty.
- There are indications that currently in Germany, the step of a socially experienced transition occurs on average at an age 10 years older for trans women than for trans men. This could explain why social transitions and therefore also medical treatment requests from trans women are made at an older age.

are significantly less common in women before the age of 20. These

This observation is reflected in the Germany-wide figures determined by the German Society for Transidentity and Intersexuality (dgti e.V.) on the frequency of so-called supplementary *ID cards* applied for by age and gender in the period 1999-2016, which can be interpreted as an indicator of the kinetics of social transitions (dgti e.V., Schaaf, 2019). This supplementary identity card is a low-threshold document that can be issued on request, with which trans people who are already living a social transition in everyday life but have not yet completed a legal change of name and marital status can easily identify themselves in everyday situations in conjunction with their official identity documents (dgti.org). This observation of different age frequencies requires further empirical examination in future studies, as long as no published peer-reviewed studies are available.

### 3. How does non-conforming gender identity develop?

The answer to the question of how non-conforming gender identity forms and develops has not been conclusively clarified. A brief outline of current explanatory models is provided here.

Traditional models of gender identity development in children and adolescents assume that biological and psychological processes control the development of gender identity in a way that typically corresponds to the sex assigned at birth (Martin et al., 2002; Stoller, 2020). According to these models, the variability of typical and atypical forms of the lived *gender role* unfolds normatively within a *gender identity that conforms to the birth sex*. If the development of gender identity remains consistent with the assigned gender in this sense, a person's *social gender role behavior* can therefore correspond more or less typically to the perceived sociocultural expectations. In the course of their development, adolescent (cis) girls can identify as "typically female" to varying degrees without fundamentally questioning their self-perception as a female person. In the same way, (cis) boys can identify more or less as female in the course of their development.

"typically male" without fundamentally questioning their self-perception as a male person.

In the case of transgender development leading to persistent GI, on the other hand, a perceived discomfort or "struggling" with perceived socio-cultural expectations of a female or male role *does not* constitute the core of the GI.

incongruent sense of identity. The incongruence between the permanent sense of belonging to a gender and the gender assigned at birth on the basis of congenital physical characteristics cannot be reduced to a "discomfort" with regard to the social gender role, according to the current common assumption. This assumption is supported by the clinical observation that the GD associated with GI cannot be permanently resolved simply by living out an atypical or non-conforming social gender role, e.g. as a masculine-typed female person (so-called "tomboy") or feminine-typed male person. Accordingly, after a complete social role change in all areas of life, adolescents with GI typically experience persistent gender dysphoria with regard to their own physical appearance, even if they feel consistently accepted in their social gender. In the case of a GI, the pronounced and persistent experience of incongruence with the assigned gender is therefore of a fundamental nature and goes well beyond the discomfort with a social gender role.

For the published state of knowledge on the question of which genetic, hormonal, neuronal and psychological factors are involved in the development of non-conforming gender identities, reference is made here to the available reviews (Ettner, 2020; Korpaisarn & Safer, 2019; Saleem & Rizvi, 2017; Skordis et al., 2020). In earlier decades, work on psychosocial models of development dominated. What these hypotheses for gender-nonconforming developments (L. M. Diamond & Butterworth, 2008; Martin et al., 2002; Stoller, 2020) have in common is that they do not differentiate between developments of children and adolescents with atypical role behavior and developments with persistent GI or GD, which can be seen as a weakness of these concepts.

Since the 1990s, biological models of development have been increasingly discussed, and there is some evidence from genetic, endocrinological and neuroscientific studies for their relevance in the context of an assumed multifactorial genesis. The findings are not unambiguous and must be considered preliminary. The assumption of *genetic influences* is based on observations of familial clusters of transgender people (Gomez-Gil et al., 2010; Green, 2000), as well as the observation of a high concordance rate of transgenerness in twin studies (Diamond, 2013). In one study, this was 39% for monozygotic twins compared to less than 1% for dizygotic twins (Heylens et al., 2012). Furthermore, molecular genetic findings on polymorphisms in oestrogen and androgen receptor genes associated with transsexuality have been reported (Bentz et al., 2008; Fernández et al., 2014b, 2014a, 2018; Hare et al., 2009; Henningsson et al., 2005).

There are some studies that suggest possible *prenatal influences of hormones* on the development of gender identity (Meyer-Bahlburg et al., 2008; Schneider et al., 2016). It is noteworthy that there is no evidence to date that deviating steroid hormone levels can still influence gender identity at a later stage of development, particularly after the onset of puberty. Hormonal influences on the expression of gender-typical role behavior in pubertal gender-conforming adolescents are common, but there is no evidence to date that the influence of pubertal steroid hormone levels can change a sense of belonging to a gender that has already been differentiated after the onset of puberty. For example, there are no known increased rates of GI (female to male) among women with post-pubertal hyperandrogenism (e.g. polycystic ovary syndrome as its most common cause).

*Neuronal correlates of transgender identities* in terms of brain structural findings, which can be used to differentiate cisgender from transgender individuals, are discussed on the basis of brain anatomical autopsy studies (Garcia-Falgueras & Swaab, 2008; Kruijver et al., 2000; Taziaux et al., 2012; Zhou et al., 1995). Structural MRI studies on the phenotypic differentiation of brain structural patterns of trans and cis individuals across both birth sex groups are also a currently growing branch of research, in which evidence is reported that transgender individuals could be a separate entity whose typical brain structural characteristics differ significantly from those of both cis-female and cis-male individuals (Flint et al, 2020; Mueller et al, 2021; Rametti, Carrillo, Gómez-Gil, Junque, Segovia, et al, 2011; Rametti, Carrillo, Gómez- Gil, Junque, Zubiarre-Elorza, et al, 2011; Savic & Arver, 2011; Zubiaurre-Elorza et al, 2013). Since both the brain anatomy and MRI studies mentioned are cross-sectional findings in adults, no causal relationships can be derived from them to date.

*In summary*, current knowledge indicates that genetic, hormonal, neurobiological and psychosocial factors appear to be involved in the development of GI in the sense of a multifactorial etiology (Ettner, 2020; Korpaisarn & Safer, 2019; Saleem & Rizvi, 2017; Skordis et al., 2020). However, the specific etiologic mechanisms and reciprocal interactions are not yet well understood.

## Glossary of important terms used in the guideline

Term	Explanations
<b>Treatment seekers</b>	The term "treatment seeker" is used in the text of the Guideline is used when it should be emphasized that in this context underage patients are meant together with their custodial relatives.
<b>Reference persons</b>	The term "caregivers" refers to all parents of children and young people, regardless of whether they are legally entitled to custody.
<b>cis, cisgender</b>	In continuous text as adjectives in juxtaposition to the terms trans or transgender are used to describe all persons whose gender identity corresponds to the gender assigned at birth on the basis of biological and anatomical characteristics.
<b>Coming out</b>	The term "coming out" is used in the guideline text to differentiate from the term → "social role change" to describe the entire process of increasingly "showing oneself" to one's social environment in a non-conforming gender role that corresponds to the currently perceived gender identity. Such a process often takes place in several stages and involves an increasing social radius.
<b>Desistance, Desisters</b>	The term "desisters" refers to the group of all of those for whom no corresponding persistence of gender dysphoria with a desire to transition is reported during adolescence (see Chapter II. → " <i>Variant developmental trajectories (persistence, desistance and detransition)</i> "). In the research literature and in the guideline, the term is used exclusively for developmental trajectories from childhood to adolescence.



<b>Detransition</b>	<p>In the guideline text, the term "detransition" is used for the</p> <p>The term is used in the first step of turning away from medical measures for a transition that has already begun or been completed. It is therefore only used if gender reassignment medical body-modifying medical measures have already taken place. This includes a variety of processes, including those in which gender incongruence persists or a non-binary identity is declared. Outside of the guideline text, the term is sometimes used more broadly, for example to refer to the reversal of a social role change before the start of medical measures.</p>
<b>Capacity to consent (D)/ Decision-making ability (A)/ judgment (CH)</b>	<p>In the legal systems of Germany, Austria</p> <p>The terms "informed consent" and "informed consent" are used differently in Germany and Switzerland but are synonymous with the ability of minors to give informed consent to a medical intervention. (see Chapter X. → <i>Ethics and law</i>)</p>
<b>Specialist</b>	<p>Term used in the guideline text for an</p> <p>Members of defined healthcare professions involved in diagnosis and treatment, e.g. doctors, psychologists or psychotherapists.</p>
<b>gender-nonconforming</b>	<p>The term gender-nonconforming is used here as a general <i>external description</i> to describe children and adolescents whose observable behavior or self-perceived identity does not correspond to the gender assigned at birth.</p> <p>The term is therefore used regardless of whether the medical diagnosis of persistent/persistent gender incongruence has (already) been made. The spectrum includes all children and adolescents with a corresponding self-description, including openly fluid developments (see Chapter V. → "<i>Psychotherapy and psychosocial interventions</i>").</p> <p>We use the term "gender-nonconforming" as a general descriptive generic term accordingly the standard practice in Anglo-American literature</p>

	<p>terms "gender-diverse" and "gender-variant" in order to avoid confusion with the term "diverse" used elsewhere in German for the third gender entry and the <i>variants of gender development</i> (intersexuality) referred to in the discourse on <i>Differences in Sexual Development</i> (DSD).</p>
<b>Gender dysphoria (GD)</b>	<p>The term gender dysphoria is understood in the sense of the DSM-5 diagnoses F64.0 and F64.2 (APA 2013) (see Chapter I. → "<i>Preamble to the guideline</i>"). It describes a state of discomfort, distress or suffering that occurs because a person's gender identity differs from the sex assigned at birth. Not all trans and non-binary people suffer from gender dysphoria. In order to distinguish precisely in the text of the guideline whether the term gender dysphoria (GD) refers to a diagnosis or a condition leading to a diagnosis, this is specified in the description, e. g. with the addition "Adolescents with diagnosed GI" or "Adolescents with gender dysphoric complaints/symptoms".</p>
<b>Gender incongruence (GI)</b>	<p>The term gender incongruence is understood in the sense of the ICD-11 diagnoses HA60 and HA61 (see Chapter I. → "<i>Preamble to the guideline</i>"). It describes the pronounced and persistent experience of a person that their gender identity does not match the sex assigned to them at birth. In order to be able to distinguish precisely in the text of the guideline whether a diagnosis or a condition leading to a diagnosis is meant, for example, the addition "adolescents with diagnosed GI" or "Young people with gender-nonconforming self-description".</p>
<b>Informed consent</b>	<p>Informed consent" - refers to the  In the context of medical treatment, the patient's consent to a medical measure based on sufficiently comprehensive information and explanation as well as reflected understanding.</p>

<p><b>Non-binary Gender identity, non-binary Gender identity</b></p>	<p>A non-binary gender identity is defined in the The term "gender identity" refers to a person's subjective perception of their <i>gender</i> beyond the binary gender binary of male and female. In the guideline text, we use the term as an umbrella term for various non-binary identifications, e.g. between male and female, beyond gender or gender identities that become fluid over the course of a person's life.</p>
<p><b>Non-binary Understanding of roles, non-binary understanding of roles</b></p>	<p>The term "non-binary understanding of roles" is used in the The term "non-binary gender identity" is used in differentiation to the term "non-binary gender identity" to describe a person's reflected understanding of their own gender role, which is not based on heteronormative ideas of "male" or "female". "female", but rather defines her own role beyond social role expectations. (see Chapter I. and V. → "<i>Preamble to the guideline</i>") and "<i>Psychotherapy and psychosocial interventions</i>").</p>
<p><b>Patient</b></p>	<p>The term patient is used in the text of the guideline in its social law meaning for the persons for whom a medical service to be provided in the healthcare system (including diagnostics and counseling) is defined ad personam (see Chapter I. → "<i>Preamble to the guideline</i>"). In places in the text where medical services are not the focus, we have deliberately omitted the term in the interests of depathologization.</p>
<p><b>Persistence, persistent</b></p>	<p>The term persistence is used to describe the persistence of gender incongruence after the onset of puberty into adolescence (see Chapter VII → Indications for body-modifying measures).</p>
<p><b>Psychotherapeutic process support</b></p>	<p>The term psychotherapeutic process support is not meant here in the narrower sense of the defined guideline psychotherapy, but includes all forms of psychosocial support provided by psychotherapeutically trained professional helpers with the aim of maintaining or improving the mental health of children and adolescents with GI/GD (see Chapter V. → "<i>Psychotherapy and psychosocial interventions</i>").</p>

<b>Custodian</b>	The term "custodian" is used in the guideline text used in accordance with the legal definition under national legislation (D/A/CH).
<b>Social role change, social transition</b>	In the guideline text, the terms "social role change" and "social transition" are used synonymously and in contrast to medical transition measures. This refers to the decision to not only dress and behave according to one's own wishes in some or all areas of life, for example, but to be consistently addressed and respected according to one's perceived gender identity (see, among other things, Chapter III.→ "Social role change in childhood").
<b>trans, transgender</b>	Synonymous adjectives that refer to the <b>Self-description</b> or expressed affiliation to a spectrum non-conforming gender identities (regardless of a diagnosis), non-binary trans identities are included here.
<b>Assigned gender Assigned gender</b>	The "sex assigned at birth" refers to a person's status as male, female or intersex, based on physical characteristics - usually based on the appearance of the external genitalia - at the time after birth, <i>according to the terminology of the ICD-11</i> . As the term "assigned sex" refers to this specific point in time, it always remains clearly defined over the course of a person's life, regardless of any medical medical transition treatments.

## I. Preamble to the guideline

### 1. Why a preamble?

This guideline provides medical recommendations on a topic in which the international medical community has undergone a paradigm shift over the past two decades. In 2015, the World Medical Association called for the recognition of non-conforming gender identities as non-pathological norm variants of human development and their consistent depathologization in all areas of medicine (World Medical Association, 2015). The previously held view that transgender was a psychopathological aberration of gender identity has proven to be scientifically untenable - similar to homosexuality, which was also considered a disorder until 1977. Accordingly, in the WHO's ICD-11 (World Health Organization, 2022), the category of so-called "*gender identity disorders*", as defined in the ICD-10 (WHO, 2019), and thus also the former psychiatric diagnosis of "*transsexualism*" were removed from the catalog of mental disorders.

The disorder concepts behind these diagnostic terms are considered obsolete, even if diagnoses are still to be coded according to the old ICD-10 (WHO, 2019) for the time being. Instead, in ICD-11 (WHO, 2022), the new diagnosis of *gender incongruence* has been redefined outside the catalog of mental disorders under a new heading of *conditions related to sexual health*. This has implications for the professional attitude towards people with non-conforming gender identities for healthcare professionals. Recommendations in this regard are detailed below in Chapter IX → "*Professional interaction and discrimination-sensitive treatment of gender-nonconforming children and adolescents*". Current guidelines from medical associations have already completed this paradigm shift towards consistent depathologization and extensive individualization of treatment paths, including the S3 guideline of the AWMF (Association of the Scientific Medical Societies in Germany) for adulthood "*Gender incongruence, gender dysphoria and trans health*" (AWMF, 2018).

German legislation has also come a long way with the law banning conversion treatments, which explicitly protects children and young people with a perceived non-conforming gender identity from attempts at therapy that are considered unethical.

followed this new direction. The declaration of the German Ethics Council (2020) emphasizes the need to protect the right to self-determination of children and adolescents with regard to their gender identity and calls for careful consideration of the benefits and risks of both the contemplated treatment *and the* decision not to undergo such treatment when making medical treatment decisions in adolescence. Here, the participation and self-determination of the minor must be taken into account just as appropriately as the protection against premature treatment decisions with possible harmful consequences in the event that gender incongruence does not persist.

These challenges lead to controversies of a fundamental nature, which are also being conducted in society and politics far beyond the field of medicine. There were also controversial discussions within the guideline commission from the outset. In the interests of a goal-oriented, transparent and constructive process, the Guidelines Commission has adopted the following approach to dealing with the fundamental issues mentioned:

- In internal discussions on consensus-based recommendations, the maximum possible consensus basis within the Commission should be explored with the aim of providing future users of the guideline with a professional orientation based on the strongest possible expert consensus (> 95%).
- In addition, the preamble presented below was approved by a strong consensus (> 95%) with the aim of prefacing the guideline text with a number of central principles that the Commission considers to be essential and that take appropriate account of current medical, ethical and legal discourse.

## 2. Text of the preamble

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Consented with strong consensus (> 95%)

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1. The guideline is based on the ethical principles of respect for the dignity and self-determination of the person as well as beneficence and non-harm and aims to implement these principles in the treatment setting.
2. The overarching aim of the guideline is to improve access for children and adolescents with gender incongruence<sup>1</sup> and/or gender dysphoria<sup>2</sup> to professional information and treatment based on scientifically and ethically recognized standards, thereby enabling them to achieve the best possible health development.
3. With respect for the dignity of those seeking treatment, the guideline supports the elimination of discrimination and the depathologization of persons whose gender identity does not correspond to their anatomical sex or sex assigned at birth. This is reflected, among other things, in the terminology used. The term "*gender identity disorder*" from ICD-10 (WHO, 2019) is therefore no longer used. Instead, according to ICD-11 (WHO, 2022) and DSM-5 (APA, 2013), the terms '*gender incongruence*' and "*Gender dysphoria*" is used.
4. Patients<sup>3</sup> with gender incongruence and/or gender dysphoria have diverse individual developmental trajectories. Counseling and treatment should therefore be tailored to individuals and their needs. The guideline is intended to provide professional orientation for the best possible individual treatment decisions.
5. In the process of its development, the guideline is committed to the idea of participation of all parties involved, including transgender people and their relatives. The evaluation of previous experiences of people seeking treatment<sup>4</sup> in the healthcare system is incorporated into the new version of the guideline, in particular to improve the range of treatment on offer and to avoid discrimination.

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<sup>1</sup> The term gender incongruence is understood in the sense of the ICD-11 diagnoses HA60 and HA61 (see glossary of terms).

<sup>2</sup> The term gender dysphoria is understood in the sense of the DSM-5 diagnoses F64.0 and F64.2 (APA 2013) (see glossary of terms).

<sup>3</sup> The term patient is used in the text of the guideline in its social law meaning for the persons for whom a medical service to be provided in the healthcare system (including diagnostics and counseling) is defined ad personam. <sup>4</sup> The term "person seeking treatment" is used in the text of the guideline when it should be emphasized that in this context it refers to underage patients together with their custodial relatives (see glossary of terms).

6. A person's gender identity is of a highly personal nature. Promoting self-determination and - where necessary - the ability to self-determine is therefore a key concern in the treatment setting with underage patients. Therapy approaches that are implicitly or explicitly based on the treatment goal of steering a person's sense of belonging to a particular gender in a certain direction are considered unethical.
7. Psychotherapeutic support<sup>5</sup> should be offered and made available at a low threshold to those seeking treatment, e.g. to support open-ended self-discovery, to strengthen self-confidence, to cope with experiences of discrimination or for psychological preparation and follow-up of steps in the transition process. An obligation to undergo psychotherapy as a condition for access to medical treatment is not ethically justified for reasons of respect for the dignity and self-determination of the person.
8. Decisions for medical measures that intervene in incomplete biological development imply a particular challenge and ethical responsibility for all those involved. On the one hand, the potential open-endedness of psychosexual and identity development to be assumed in individual cases and, on the other hand, the ever-increasing irreversibility of somatosexual maturity development and the possibly resulting increased risks to mental health must be taken into account. When deciding on medical treatment steps for puberty interruption or gender reassignment in adolescence, the expected benefits and risks must therefore be carefully weighed up. The possible consequential health risks of a decision for medical treatment that is subsequently regretted by those affected or a treatment that turns out to be misguided for other reasons must therefore be weighed against the health risks that may arise if medical treatment is postponed or not initiated.
9. The guideline is intended to serve as a professional basis for responsible medical treatment decisions, which are to be made jointly by practitioners, underage patients and their legal guardians in the sense of *shared decision making*. The guideline is intended to provide orientation for this, in particular for the requirements for adequate information and counseling,

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<sup>5</sup> The term psychotherapeutic support is not meant here in the narrower sense of the defined guideline psychotherapy, but includes all forms of psychosocial support provided by psychotherapeutically trained professional helpers (see explanations in Chapter V → "Psychotherapy and psychosocial interventions")



which enables those seeking treatment to understand the nature, significance and scope of the respective treatment options and to decide on them.

Vorläufige Leitlinie zur Kommentierung

## **Chapter II**

### **Variant development processes (persistence, desistence and detransition)**

- 1. Introduction and key questions**
- 2. The study situation**
  - 2.1. Early progression studies (60s to 80s of the 20th century)
  - 2.2. More recent studies (from 2008)
  - 2.3. Results of recent studies
- 3. Summary of the empirical state of knowledge**
  - 3.1. Persistence rates reported in previous studies
- 4. Progression with the outcome of later detransition**
- 5. Recommendations for professional advice**

Vorläufige Leitlinie zur Kommentierung

## 1. Introduction and key questions

The observation that there are many different courses of gender variant experience and behavior in childhood and adolescence raises the question of predictors for a lasting (=persisting) transgender identity beyond puberty into adulthood. This is particularly important if, in the case of diagnosed gender dysphoria in early adolescence, the question of an indication for hormonal puberty suppression arises and indications of a sufficiently high probability of predictable persistence of transgender development are to be evaluated from the course of development to date. The assumption of a permanent persistence of gender dysphoria is a decisive factor in the individual assessment of the benefits and risks that a decision for or against medical intervention in somatosexual development may entail. As developmental processes in childhood and adolescence can be highly variable and fluid, particularly with regard to identity development, the question of the assessability or "detectability" of persistent gender incongruence in children and adolescents is at the heart of ethical debates on medical treatment options for adolescents with gender dysphoria who wish to undergo puberty blockade or gender reassignment hormone treatment. In 2020, the German Ethics Council addressed this topic in a bioethics forum and subsequently adopted a recommendation. It outlines the ethical issues as follows:

"In the case of children and adolescents, already a particularly vulnerable group, the therapeutic measures considered in the context of trans identity require special ethical reflection. A tension arises from the fact that, on the one hand, the ability to reflect and make decisions is still developing in adolescents and, on the other hand, the physical development that takes place during puberty creates time pressure. In this situation, both the treatment options considered and their omission can have serious and sometimes irreversible consequences. For the adults involved - the custodial parents and the treating professionals - the task is also to take into account the child's ideas and wishes and to protect their welfare. The ethical challenge is to support minors on their path to their own gender identity and at the same time protect them from - sometimes irreversible - harm" (German Ethics Council, 2020).

Against the background that, within the known spectrum of developmental processes, there are both very clear courses of permanently persistent gender incongruence that can be recognized early in the course of development, as well as known courses, in which gender identity in adolescence remains fluid over a longer period of time and so-called *desistance* (= *dissolution*) of the gender-incongruent perception occurs, there is widespread international agreement among medical experts that adolescents with diagnostically confirmed gender incongruence should not be excluded from access to medical interventions as a matter of principle. The current national recommendations in Sweden, Finland and NHS England (excluding Scotland, Wales and Northern Ireland), which are more restrictive than the guidelines of international medical societies and this guideline, also contain recommendations for the indication of puberty blockers and sex reassignment hormone treatments in adolescence. They only define

stricter indication and access criteria (see chapter in the appendix → "*Divergent Treatment recommendations in other countries for children and adolescents with gender incongruence*").

Our guideline follows the recommendations of the German Ethics Council in that professional and ethically justifiable treatment decisions in adolescence can only be made on the basis of a comprehensive assessment of the individual case and an individual risk-benefit analysis. To this end, it is essential to have sufficient knowledge of the variance in the developmental trajectories of gender-nonconforming children and adolescents, which is presented in the following chapter. Finally, consensus-based recommendations are derived from this. With regard to the high clinical relevance of the diagnostic assessment of the persistence of gender incongruence as a

We refer to Chapter VII. → "*Indications for the use of Body-modifying medical interventions*".

**Key question to the guideline:**

- What findings are there on the spectrum of variant developmental trajectories of children and adolescents with gender-nonconforming behavior and on children and adolescents with indications of gender incongruence?
- Is there evidence for prognostically relevant characteristics in children and adolescents with signs of gender incongruence or gender dysphoria that can be used in the future to distinguish so-called "desisters" from "persisters"?

## 2. The study situation

First of all, it must be clarified how persistence and non-persistence (hereinafter referred to as *desistence* in the Anglo-American literature) are to be defined. To avoid unintended connotations, the historical origin of these terms should be critically mentioned. The term persistence was initially used in psychological literature for disorder-relevant problem behavior (e.g. in social behavior disorders), from which the meaning of "return to normal healthy behavior" could be derived for desistence (Temple Newhook et al., 2018). In the context of research on variant developmental trajectories of gender nonconformity from childhood to adolescence, these terms are established in a purely descriptive sense. A connotation in the sense of problem behavior or a departure from it is not intended. In the present empirical studies, a distinction is made between two groups of children from clinical utilization populations who presented clinically before entering puberty:

- The term *persisters* is used to describe the group of people who, in the course of puberty, showed persistent gender incongruence with gender dysphoria and usually continued on the path of transition, which was usually associated with medical treatment steps for puberty suppression and/or gender reassignment in adolescence.
- The term "*desisters*" is used to summarize the group of all those *children* for whom no corresponding persistence of gender dysphoria with a desire to transition was reported during adolescence. However, this does not allow any general conclusions to be drawn about the frequency with which these "desisters" permanently identified congruently with their birth gender - or were still in a fluid and therefore open-ended process of developing their adult gender identity at the time of the study survey (Steensma & Cohen-Kettenis, 2018; Temple Newhook et al., 2018). The two terms "persisters" and "Desisters" were introduced into the discussion for this context by the authors of the Dutch working group led by Cohen-Kettenis and Steensma, who were the first in the world to carry out puberty-suppressing and gender reassignment hormone treatments for adolescents with gender dysphoria at their specialized treatment center in Utrecht and later Amsterdam, following case-specific indications and publishing follow-up studies (Cohen-Kettenis & van Goozen, 1997; de Vries et al., 2011). Steensma and Cohen-Kettenis (2018) emphasize in a published

In retrospect, the author of the discussion paper emphasized that their follow-up studies are *not* suitable for deriving generalizable prevalence rates for "persisters" (so-called "persistence rates") due to their partly selective case composition. This was also not the aim of the follow-up studies. The primary aim of these studies was to show the range of variation in developmental trajectories and to identify *possible early recognizable characteristics* of persistent gender dysphoria with a desire for treatment in adolescence (Steensma & Cohen-Kettenis, 2018). This should help to increase decision-making certainty for upcoming indications for hormone treatment in minors (ibid.).

The phenomenological diversity of gender-nonconforming gender expression in children necessitates a conceptual sharpening for the description of developmental trajectories as well as a clear definition of the cohorts initially studied in childhood. In fact, previous studies have taken different approaches depending on the different questions asked. For example, earlier developmental studies from the 1960s to 1980s, which were based on a broad spectrum of children with gender-atypical behavior (predominantly birth-sex boys who displayed feminine behavior at an early age), reported high rates of later homosexual outcomes in adolescence. In contrast, more recent studies from 2008 onwards have looked more specifically at the developmental trajectories of children from clinical utilization populations of specialized gender clinics, where a "Gender identity disorder" (according to the earlier criteria of ICD 10 and DSM III-R or IV) was suspected or diagnosed. It is important to note here that the diagnostic criteria for *childhood gender dysphoria* in the *DSM-5* diagnostic system (*Diagnostic and Statistical Manual of Mental Disorders*, 2013) have been further narrowed in comparison to the older criteria for a so-called gender identity disorder in childhood according to ICD-10, DSM III-R or IV to the effect that the diagnosis according to DSM-5 (*Diagnostic and Statistical Manual of Mental Disorders*, 2013) can no longer be assigned if the focus is exclusively on gender-nonconforming role behavior. In order to meet the diagnostic criteria according to DSM-5 (*Diagnostic and Statistical Manual of Mental Disorders*, 2013), however, it is required that, among other things, there is a strong explicit positive identification with a gender other than the gender assigned at birth (i.e. demanding to belong to this gender instead of only showing role-typical behavior) and/or a pronounced body-related gender dysphoric distress (expressed discomfort with the congenital genitalia) (American Psychological Association, 2015). In order to fulfill the diagnostic criteria according to DSM-5 (*Diagnostic and*

*Statistical Manual of Mental Disorders*, 2013), at least one of the following gender dysphoric symptoms must be present:

- "strong desire to belong to the opposite sex or insist that this is so,"
- " strong discomfort about the anatomy of one's own genitals,"
- "strong desire for the physical sex characteristics of the subjectively experienced sex" (American Psychological Association, 2015, p. 620f, see DSM5 criteria in Chapter IV → "Indications")

Since the DSM 5 (*Diagnostic and Statistical Manual of Mental Disorders*, 2013) was not yet available at the time when the children examined in the present studies were diagnosed, there are no valid data on subsequent persistence frequencies of children diagnosed with childhood gender dysphoria according to the narrower DSM-5 criteria.

The definition of persistence based on the available studies describes children who have already made use of health services in prepuberty due to their gender-nonconforming experience and behavior and who, *after the onset of puberty*, showed persistent gender dysphoria and had transitioned accordingly, including the desire for gender reassignment hormone treatment. Based on their gender incongruence in childhood, these adolescents are considered *persisters*. In this respect, with regard to the limited available evidence, it must be noted that the available data on progression forms are not representative of all children with gender incongruence, but were obtained on the basis of observations of a special subgroup of these children, namely those who presented to a special institution (gender clinic) before puberty. For example, all adolescents with persistent (or desistent) gender dysphoria who were retrospectively reported to have gender-nonconforming behaviour in childhood, but who were not presented for specialized diagnostics as children (e.g. because their nonconforming gender expression was not seen as a problem by all involved), are not included in these studies.

## **2.1 Early progression studies (60s to 80s of the 20th century)**

A look at previous research shows the influence of the historical context on the respective approaches. The older follow-up studies, which were conducted between 1968

and 1987 and were previously used to assess the so-called "persistence rates" of gender-nonconforming behavior in childhood (Bakwin, 1968; Davenport, 1986; Green, 1979, 1987; Kosky, 1987; Lebovitz, 1972; Money & Russo, 1979; Zuger, 1978, 1984), have some special features that distinguish them from the more recent studies from 2008 onwards. In some of these publications, the connection between gender-nonconforming behavior in boys in childhood and a later detectable homosexual sexual orientation takes up a great deal of space. The titles of some of these publications<sup>1</sup> already show the strong focus on homosexual developmental processes and gender-variant expressions. They have sometimes been accused of being characterized by an effort to prevent homosexual development (Bakwin, 1968; Kosky, 1987). A further limitation of the studies is the often small sample size, which limits the comparability of subgroups (Zucker, 2005). The results of these studies are therefore not suitable for deriving an estimate of a general persistence rate for children with gender-nonconforming behavior. At best, they provide indications of the entire range of developmental trajectories, without allowing quantitative statements to be derived from them.

## **2.2 More recent studies (from 2008)**

No follow-up studies were published between 1987 and 2008. There were only provisionally reported data (Bradley & Zucker, 1990; Cohen-Kettenis, 2001), which were included in later publications (Ristori & Steensma, 2016).

As of 2008, four studies can be identified which, in the form of quantitative follow-up studies, primarily dealt with the course of a disease operationalized according to DSM IV or ICD 10.

"Gender identity disorder" with onset in childhood. It should be noted that two studies were conducted by the specialized clinic in Toronto and two studies by the specialized clinic in Utrecht/Amsterdam. The qualitative follow-up study by Steensma et al. (2011) should also be taken into account. In addition, the descriptive data of a sample from the Frankfurt specialty outpatient clinic, which is presented in the monograph by Meyenburg (2020), was included in the evaluation.

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<sup>1</sup> For example, Zuger (1984): "Early Effeminate Behavior in Boys. Outcome and Significance for Homosexuality" and Green (1987) "The 'sissy boy syndrome' and the development of homosexuality"



### **2.2.1 Quantitative studies**

The study by Wallien and Cohen Kettenis (2008) reports on the course of 77 Dutch children ( $N = 59$  birth-sex male;  $N = 18$  birth-sex female) who were on average 8.37 years old at the time of initial presentation at the Dutch *Gender Clinic* and on average 19.24 years old at the time of follow-up. The entire study period covered the years 1989 to 2005. 75.3% of the children were diagnosed with gender identity disorder (GID) according to DSM III-R at first presentation.

The study by Drummond et al. (2008) was also published in 2008, reporting on 25 birth-sex female children from Canada who were presented at the *Gender Clinic* in Toronto. Here, the mean age at the time of the childhood survey was 8.88 years and 23.24 years at the time of the respective follow-up. The period considered covers the years from 1975 to 2004. 60% of the children in this sample were diagnosed with GID (according to DSM versions III, III-R and IV).

The sample of the second Canadian study (Singh, 2012) comprises 139 birth-sex male children whose mean age at first presentation was 7.49 years and 20.58 years at follow-up. The corresponding data were collected between 1975 and 2009. The GID diagnosis (according to DSM versions III, III-R and IV) was made in 63.3% of the children.

The second Dutch study (Steensma et al., 2013) includes the cases of 127 children in total (of which  $N = 48$  birth-sex female and  $N = 79$  birth-sex male). The average age at baseline was 9.15 years and 16.14 years at follow-up. Data was collected between the years 2000 and 2008. 63% of the children were diagnosed with GID (according to DSM IV).

The studies mentioned differ from each other in some respects, both in terms of their methodological approaches and the results reported.

### **2.2.2 Qualitative study by Steensma et al. (2011)**

The aim of this analysis of 25 biographical interviews was to identify qualitative characteristics that differentiated the developmental trajectories of later *persisters* from those of later *desisters*. One of the key findings reported was that the age range between 10 and 13 was seen by both *persisters* and *desisters* as critical or largely decisive for the later course of development. In this context, the adolescents appeared to be particularly concerned with the physical

Changes in the course of the onset of puberty, the accompanying changes in the social environment and experiences with infatuation were significant. Furthermore, it was found that later *desisters* were more likely to have expressed *the desire* to belong to a different gender in childhood, while it was more typical for later *persisters* to articulate that they already actually belonged to the opposite gender (e.g. "I am a girl" vs. "I would rather be a girl").

### **2.2.3 Data from the Frankfurt special outpatient clinic**

The descriptive data of the clinical sample described by Meyenburg (2020) ( $N = 46$  at follow-up) show a large difference in the persistence rate depending on age at first presentation. A persistent course was significantly less common in children who were presented for the first time before the age of 12. Here, the proportion of *persisters* was 33%. In comparison, 88% of those who presented after the age of 13 - i.e. under the influence of pubertal development - showed a persistent course of GD. This corresponds to the clinical experience of relevant treatment centers and underlines the fact that gender dysphoria that (continues to) exist after the onset of puberty is much more likely to persist, whereas in comparison, signs of gender incongruence or gender dysphoria in childhood are much more likely to persist later.

### **2.2.4 Methodological differences in the definition of persistence and desistence**

Singh (2012) defines *persisters* as those participants who fulfill at least one of the following three criteria in the follow-up survey: (1) a mean score of 3 or lower on the *Gender Identity/Gender Dysphoria Questionnaire for Adolescents*, (2) two or more items on the *Gender Dysphoria Questionnaire*, (3) strong evidence of gender dysphoria from the interviews conducted. In Drummond et al. (2008), persistence was assumed if either the diagnosis of GID (according to DSM IV) was present at follow-up or if there were strong indications of this from the interviews conducted.

In the Dutch studies (Steensma et al., 2013; Wallien & Cohen-Kettenis, 2008), it is noticeable that the group of *desisters* does not only include those young people (or adults) who were identified as *desisters* in the context of personal participation in the follow-up surveys. Instead, all *non-responders* (those participants who were not reached for a follow-up survey) are also considered *desisters*. The background to this is that the Amsterdam clinic is the only one

This led the authors to assume that all former patients who no longer attended the clinic at a later date could be classified as *desisters*. Since there can be many reasons for non-participation or withdrawal from the study, the extent to which it is justified to include *non-responders* among the *desisters* was critically questioned (Temple Newhook et al., 2018). As Steensma and Cohen-Kettenis (2018) explain in a discussion paper on their studies, this approach was guided, among other things, by the operationalization of persistence, which primarily included the persistent desire to start gender reassignment hormone treatment *in adolescence*, whereas desistance was equated with non-persistence according to this operationalization. Accordingly, desistance in this definition is not to be equated with a permanent "reconciliation" with the physical birth sex, but can also include fluid developmental processes that remain open into adulthood with regard to gender identity (Steensma & Cohen-Kettenis, 2018). Furthermore, cases were included in which only parents were able to provide information.

## **2.3 Results of recent studies**

### **2.3.1 Persistence rates**

Due to the differences described with regard to the definition of persistence and desistance between the studies, it makes sense to present a differentiated presentation of the persistence rates and to carry out re-analyses (Nonhoff, 2018), which are illustrated in the following table.

Vorläufige Leitlinie zur Kommentierung

**Table 2:** Determined persistence rates of non-conforming gender identity in childhood depending on defined inclusion criteria

	Drummond et al, 2008	Singh 201213.03. 2024 19:48:00	Wallien & Cohen- Kettenis, 2008	Steensma et al, 2013
<i>N</i> to baseline	25	139	77	127
Age range at baseline	3 - 12	3 - 12	5 - 12	6 - 12
<i>M</i> (age) at baseline	8,9	7,5	8,4	9,2
Age range for follow-up	15 - 36	13 - 39	16 - 28	15 - 19
<i>M</i> (age) at follow-up	23,2	20,6	18,9	16,1
Persistence rates in %				
total as reported	12,0	12,2	27,3	37,0
total without nonresponders <sup>a</sup>	12,0	12,2	39,0	47,5
female <sup>b</sup>	12,0	-	50,0	50,0
Male <sup>b</sup>	-	12,2	20,3	29,1
with GID diagnosis <sup>c</sup>	13,3	13,6	36,2	55,0
with GID diagnosis, without nonresponder <sup>d</sup>	13,3	13,6	50,0	63,8
without GID diagnosis <sup>e</sup>	10,0	9,8	0,0	6,4

*Notes.* Age data in years, all other data (except *N*) in %.

<sup>a</sup> Those study participants who did not report back themselves or who were not available for a follow-up were not included here.

<sup>b</sup> "Female" or "male" refers to the gender assigned at birth.

Gender: Rates when only certain gender is considered

<sup>c</sup> rates if only cases with a GID diagnosis in childhood are considered.

<sup>d</sup> rates if only those cases are considered in which the participants both had a GID diagnosis in childhood and participated in the follow-up.

<sup>e</sup> Advice if no GID diagnosis was given in childhood.

As expected, the results presented in Table 2 show that the persistence rates determined in each case vary considerably depending on the inclusion criteria applied (diagnosis of "gender identity disorder" fulfilled in childhood?, non-responders counted as desisters?). This limits the generalizability of the persistence rates determined in each case with regard to their generalizability in the sense of a

probability of occurrence. In particular, blanket statements taken out of context without a precise definition of the initial criteria (age, GD diagnosis), such as e.g. the figure frequently quoted by the popular media, according to which 80% of gender dysphoric children and adolescents allegedly do not develop a permanent trans identity, cannot be supported by evidence. At best, the statement that a high to very high proportion of children with gender-nonconforming role behavior who do not meet the diagnostic criteria for gender dysphoria do not develop persistent gender dysphoria in adolescence can be supported by evidence. Furthermore, a strong center effect is noticeable. The persistence rates determined in Toronto were significantly lower than those in the Dutch studies. The underlying treatment concept, which diverged considerably between the two centers, must be viewed critically here. In Toronto, it was part of the explicit concept to recommend treatment for children with the aim of reducing the likelihood of persistence of transsexualism (Zucker et al., 2012).

From today's perspective, such an approach to treatment would not only be unethical, but would even be prohibited in Germany under the law passed in May 2020 to protect against conversion treatments. At least two possible biases must be taken into account when considering the treatment approach of the Gender Clinic in Toronto at the time (Temple Newhook et al., 2018): First, the aforementioned utilization context dictates that prepubescent children presented there were overrepresented, whose parents considered nonconforming gender expression to be problematic behavior combined with a desire to address their child's possible transsexuality "to avert". Second, since the basic professional attitude of the practitioners at this clinic was along the same lines, it would be expected that children who continued to exhibit gender dysphoric feelings or behavior as adolescents would be underrepresented in a sample studied there. In a clinic where a persistent course of children with gender incongruence was considered an unfavorable outcome, and where therapeutic efforts were made with the stated intention of making this outcome as unlikely as possible, it can be assumed that at least some of the children with persistent trans identity treated there were inhibited in the unhindered development of their identity. In the Amsterdam clinic, on the other hand, it was part of the explicit concept to approach all potential developmental trajectories of gender variant children with an open and accepting attitude, as it were, combined with the offer of a social transition with puberty-suppressing and

gender reassignment hormone treatment without connotating this as a favorable or unfavorable outcome (Steensma & Cohen-Kettenis, 2018).

The authors themselves also emphasize that the aim of the Dutch studies was not to determine a representative persistence rate, but to illustrate the range of variation in developmental trajectories and to identify discriminatory predictors that should help to facilitate the diagnostic assessment of persistent trajectories, especially in early adolescence (Steensma & Cohen-Kettenis, 2018).

### **2.3.2 Predictors**

In addition to the assessment of how likely or how frequent a persistent course is in general, the question of possible factors that allow a prediction in individual cases (predictors) is of particular interest. The following predictors were examined:

*Presence of a GID diagnosis<sup>2</sup> already in childhood* (Singh, 2012; Steensma et al., 2013; Wallien & Cohen-Kettenis, 2008)

- There were significantly higher persistence rates when a GID diagnosis was made in childhood compared to the utilization cases in which the (then) criteria for a GID diagnosis in childhood were not met.
- Wallien et al. (2008) point out that in their study a significant correlation between GID diagnosis in childhood and persistence was only found for the birth-sex boys and not for the girls.
- In contrast, Steensma et al. (2013) report a significant effect of a GID diagnosis in childhood on the probability of persistence, regardless of gender.

*The gender assigned at birth* (Steensma et al., 2013; Wallien & Cohen-Kettenis, 2008)

- The two Dutch studies both report a higher probability of persistence of gender dysphoria in natal girls and trans boys, respectively.

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<sup>2</sup> GID - Gender Identity Disorder of Childhood according to ICD-10, DSM-III-R or DSM-IV

*The age at the time of first presentation in childhood* (Singh, 2012; Steensma et al., 2013; Wallien & Cohen-Kettenis, 2008)

- Wallien et al. (2008) report no influence of age on the probability of persistence.
- The differentiated analysis by Steensma et al. (2013) generally suggests that the probability of persistence is lower in children who were younger at first presentation. However, due to the smaller subsample of birth-sex girls, this influence only proved to be significant for birth-sex boys when age was examined separately by gender as a predictor.
- Singh (2012) found a similar correlation: children who were older at the time of initial presentation in childhood were more likely to be later *persisters*.

*The expression of gender-incongruent behavior* (Drummond et al., 2008; Singh, 2012; Steensma et al., 2013; Wallien & Cohen-Kettenis, 2008)

- Drummond et al. (2008) and Singh (2012) point to a significant influence of gender-variant behavior in childhood on the probability of persistence.
- Wallien et al. (2008) report that the extent of gender variant behavior in childhood is a significant predictor for birth-sex boys but not for girls.
- In Steensma et al. (2013), all corresponding measures indicated a higher probability of persistence for high values in bivariate analyses.

*Completed early social role change* (Steensma et al., 2013)

- In general, an early social role change proved to be a significant predictor of persistent development (without causalities being able to be derived here). Separated by gender and within the framework of multivariate analyses, however, a significant influence was only found for birth-gender boys.

### 3. Summary of the empirical state of knowledge

Based on the current state of knowledge, some predictors can be derived in prepubertal childhood that are associated with a higher probability of persistent gender dysphoria in adolescence and adulthood. However, these predictors only have a *relative predictive value*. To date, *there is no reliable characteristic* that enables a prediction of a persistent developmental course into adolescence in the case of assumed gender incongruence or gender dysphoria *in childhood*.

In summary, the following empirically proven statements can be made:

#### 3.1 Persistence rates reported in previous studies

- For children who can be diagnosed with "childhood gender dysphoria" according to the narrower criteria of the *Diagnostic and Statistical Manual of Mental Disorders* (2013) before the onset of puberty, no persistence or desistance rates for gender dysphoria in adolescence have been documented to date.
- For children who have been diagnosed with a disorder before the onset of puberty "Gender identity disorder of childhood (according to earlier criteria of ICD-10 and DSM-III-R or DSM-IV), strongly diverging persistence rates for gender dysphoria in adolescence between 13% and 63% were reported in a heterogeneous study situation based on the utilization populations of two treatment centers. Due to methodological limitations, representative statements are not possible here either

##### 3.1.1 Predictor gender:

- Birth-gendered female children with signs of gender dysphoria were more likely to report persistent developmental trajectories of gender dysphoria in adolescence compared to birth-gendered male children (Steensma et al., 2013; Wallien & Cohen-Kettenis, 2008).



### **3.1.2 Predictor: Expression of gender-incongruent behavior and completed social role change**

- A high level of reported gender-incongruent experience and behavior or gender dysphoric symptoms in childhood as well as a social role change already completed in childhood<sup>3</sup> are associated with a correspondingly higher probability of persistence of gender dysphoria in adolescence (Drummond et al, 2008; Singh, 2012; Steensma et al, 2013; Wallien & Cohen-Kettenis, 2008).

### **3.1.3 Importance of age**

- The younger a child is before puberty at the time of a diagnostic presentation, the less predictable the likelihood of gender dysphoria persisting in adolescence within a wide range of developmental trajectories (Singh, 2012; Steensma et al., 2013).
- For the development of children in whom there are clear indications of childhood gender dysphoria before the onset of puberty, the age range of 10 to 13 years can be assumed to be the critical phase in which it typically becomes clear whether gender dysphoria persists or not.

Since the reported studies relate exclusively to the developmental trajectories of adolescents who were already presented in childhood at a specialized healthcare facility (gender clinic/special consultation hours) due to their gender-nonconforming behaviour, the reported data also do not allow any statement to be made about the prognostic probability of persistent gender dysphoria when gender dysphoric symptoms first become apparent to the social environment after the onset of puberty. Gender dysphoric symptoms can appear for the first time at any age. In particular, gender dysphoria can appear for the first time at any age due to a supposedly inconspicuous gender-conforming development reported by parents.

<sup>3</sup> In this context, no statement can be derived from the reported data regarding its direction of effect. In other words, no statement can be made as to whether a change of social role in childhood before the onset of puberty has an effect per se on the probability of a persistent course of development. A possible selection effect must be taken into account: Children with particularly early and therefore probably persistent gender incongruence are more likely to request a social role change in childhood (see Chapter III. → "Social role change in childhood").

Childhood does not per se indicate a low probability of a persistent outcome of a GD can be closed.

When providing professional counseling and support for children with suspected gender incongruence or gender dysphoria, the uncertainty of predicting the further course of development, in particular the fact that there is currently no criterion that can be used to predict the persistence or desistence of gender dysphoria in adolescence *before puberty*, must be taken into account appropriately.

### 3.2 Conclusion

In summary, the following empirically supported conclusions can be drawn from the current state of knowledge on the varied developmental trajectories of children with signs of gender incongruence and/or gender dysphoria:

- The data situation does not allow any generalizable assumptions to be made about the assumed persistence rates.
- Children who exhibit gender-nonconforming behavior before puberty often *do not* develop persistent gender dysphoria during puberty.
- Children before puberty who show pronounced signs of gender incongruence or gender dysphoria are more likely to persist later, especially if a diagnosis can be made in childhood.
- However, even if there are clear signs of gender incongruence before the onset of puberty, it is not possible to reliably predict persistence.
- In children in whom there are clear indications of gender incongruence before puberty, it typically becomes clear by the age of 13 whether gender incongruence persists under the influence of puberty.

This has the following implications for healthcare practice:

- In a child before the onset of puberty, it is not yet possible to predict *persistent gender incongruence in adolescence*, even if there are clear signs of gender incongruence in childhood (see recommendation II.K.3 at the end of this chapter).
- Recommendations for any medical interventions to support a transition are therefore obsolete before the onset of puberty (see recommendations in Chapter VII. → "*Indications for body-modifying medical interventions*").
- A diagnosis of *gender incongruence in childhood* (ICD-11: HA61) made before the onset of puberty can therefore not justify a need for medical action, but at best has the value of a documented early onset of the reported signs of gender incongruence with regard to a possible later indication for medical measures. (see recommendations in Chapter VII. → "*Indications for body-modifying medical interventions*").

#### 4. Progression with the outcome of later detransition

As mentioned above, the research literature refers to adolescents as desisters (as opposed to persisters) if gender incongruence, which was still present in *childhood*, was not consistently present in adolescence (Steensma & Cohen-Kettenis, 2018; Temple Newhook et al., 2018). It is therefore a construct from observational studies of clinical utilization populations from earlier decades, the results of which are only transferable to today's social context to a very limited extent, partly because gender-nonconforming behaviour in childhood is increasingly less problematized by today's adult world and therefore the use of professional healthcare services for prepubertal children is increasingly less seen as necessary. In more recent publications, the concept of "Detransitioners" was introduced, but is used inconsistently (Expósito-Campos, 2021): Basically, this refers to people who break off or (partially) reverse a transition they have begun, which can include steps of social, legal and/or medical transition that have been completed in the past. The reasons for this can vary. This can refer to people who, after a period of perceived trans identity and a completed role change, identify again with the gender they were assigned at birth or non-binary and therefore break off a transition that has already begun. However, it can also refer to people who, for external reasons

(social pressure, medical reasons, etc.) may cancel or reverse a transition. but for whom the perceived trans identity persists.

The desired discontinuation of gender reassignment treatment is of particular importance for patient safety issues and should therefore be considered here. In some cases, detransition after gender reassignment treatment is seen as a negative outcome (Cohn, 2023; Entwistle, 2021). Nevertheless, detransition should not be equated with "regret" (=regretting a previous wrong decision). In a meta-analysis, Bustos et al. (2021) estimate the frequency of regret after gender reassignment surgery in adults at less than 1% to 2% of those who have undergone surgery. However, people do not necessarily have to regret discontinued gender reassignment treatment, but sometimes also state that it was a positive step for them at the time of starting this treatment. It also happens that a detransition is temporary and is later followed by the resumption of e.g. gender reassignment hormone treatment (Littman, 2021; Turban et al., 2021). Detransition is therefore not necessarily to be understood as the final endpoint of gender dysphoric development, but can be temporary. To date, the phenomenon of detransition has been little researched (Butler & Hutchinson, 2020). The following original publications were identified for an overview of the empirical data on detransition following gender reassignment treatment on the basis of the previously systematically reviewed literature for the guideline and information from the guideline steering group:

In an English study (Boyd et al., 2022), a retrospective chart review of 41 patients who were treated with gender reassignment hormones was conducted in a general practice. Gender reassignment treatment began in almost all cases during adulthood. It was found that of the 41 people mentioned, 4 trans men (10%) discontinued the hormone treatment, i.e. detransitioned. These 4 people had previously been taking androgens for an average of 18 months and had not undergone gender reassignment surgery. No trans woman or non-binary person reported detransition. The authors report that 32% of the patients were not treated by a specialist for hormones. In addition, 62% were not treated according to the (inter)national treatment standards, although this mainly relates to somatomedical aspects and not to the standards of indication.

In another retrospective chart review from a specialist adult gender service in England, Hall et al. (2021) examined the treatment records of

175 patients. Other reports regarding psychiatric/psychotherapeutic treatments outside the treatment center were also included. Of the 175 people, 156 (89%) started gender reassignment hormone treatment. 61% of patients were assigned a male gender at birth and 39% were assigned a female gender. Patients had to be at least 17 years old at first presentation at the treatment center and the median age at first presentation was 25 years. In 12 patients (7% of 175), detransition occurred during treatment or up to 12 months after the start of hormone treatment. Of these, eight were natal males and four were natal females, which roughly corresponds to the general gender distribution in the sample. A further six cases showed some signs similar to detransition; however, no continuous hormone treatment had previously taken place in these cases.

In a community-based study, Littman (2021) surveyed 100 selected individuals with a reported experience of detransition. 93% of them discontinued gender reassignment treatment or had it reversed. 7% of respondents discontinued a puberty blockade. Participants were recruited via detransitioner groups on the internet and websites as well as mailing lists of specialized practitioners. Of the participants, 68% were assigned to the female gender at birth and 32% to the male gender. The participants were on average 22 years old ( $SD = 6$ ) when they first sought out practitioners for gender reassignment treatment or puberty blockade. It is therefore highly likely that only a small minority of respondents were under the age of 18 at the start of their medical transition. No specific analysis is available for this subgroup. On average, an interval of 3 years was reported between the start and discontinuation of hormone treatment. 50% of respondents reported strong or very strong regret about their transition.

The reasons for detransition were categorized by the author as non-exclusive in the following proportions: Recognition that perceived gender dysphoria was due to another mental disorder or trauma (58%); social pressure for original transition (20%); original transition was due to internalized misogyny (7%); social pressure (stigma, etc.) to detransition (29%); identification as non-binary (16%). 55% of respondents reported that they had been diagnosed with a mental disorder before the onset of gender dysphoria. 57% of respondents felt that the diagnosis before starting treatment was inadequate and at least 46% of respondents felt that they had not received sufficient information.

Turban et al. (2021) analyzed a comprehensive survey of trans people in the USA with regard to (past) detransitions. The sample therefore only includes people who identified (again or still) as trans at the time of the survey. 13% of respondents who had ever transitioned stated that they had (temporarily) detransitioned in the past. However, this does not necessarily refer to gender reassignment treatment. In the group of respondents with detransition experience, people of male or female birth gender were represented in roughly equal numbers (51% vs. 49%). The authors categorized the reasons for (temporary) detransition into the categories *external* (e.g. social pressure) versus *internal* (e.g. ambiguities regarding gender identity). There is no specific evaluation of reasons for the subgroup of respondents who transitioned before the age of 18. Of the respondents who had detransitioned in the past, 83% reported at least one external reason and 16% at least one internal reason.

In a community-based study, Vandebussche (2021) interviewed 237 selected people who described themselves as detransitioners. The participants were recruited via detransitioner groups on the internet and websites. Of the participants, 92% were assigned to the female gender at birth and 8% to the male gender, which may be due to selective recruitment. Of all respondents, approximately 64% reported prior gender reassignment hormone treatment and 30% reported (possibly additional) gender reassignment surgery. 25% began their medical transition before the age of 18. No specific evaluation is available for this subgroup. On average, an interval of 2 years was given between the start of treatment and detransition. Of all respondents, 60% expressed regret regarding transition and/or treatment. The following reasons for detransition were mentioned most frequently:

- "realized that my gender dysphoria was related to other issues" (70%),
- "health concerns" (62%) and
- "transition did not help my dysphoria" (50%).

A clear majority of respondents stated that they had been diagnosed with one or more mental disorders and 54% reported at least 3 co-occurring mental disorders. In addition, 78% of respondents stated that, in retrospect, they did not feel sufficiently or only partially informed about the treatments and interventions they had received.

In the clinical follow-up study by de Vries et al. (2014), the long-term courses of  $n = 55$  people were examined who, as adolescents, after careful indication and with assured ongoing professional process support, first received puberty blockade, then gender reassignment hormone treatment and then underwent gender reassignment surgery. On average, the duration between the start of gender reassignment hormone treatment and the interview was 4 years. Of the 55 people reported, no case of regret and/or detransition was reported. However, it should be noted that the sample studied is ideally selective in several respects. However, the results suggest that in order to reduce the outcome risk of later detransition when treatment decisions are made in adolescence, it makes sense to define professional standards for quality assurance in the determination of indications and professional process support.

In summary, only cautious conclusions can be drawn against the background of the sparse research on detransition with very selective samples. It should also be emphasized that the majority of the reviewed studies consider samples that examine detransition in people who began their medical transition as adults.

The chart reviews reviewed reported the frequency of detransition at 7% and 10% respectively. Turban et al. (2021) stated that 13% of those surveyed had mostly detransitioned passively in the past. In the clinical study by de Vries et al. (2014), there was no evidence of detransition in the small sample. Against the background of the stricter requirements in international guidelines for the indication of body-modifying treatments for adolescents compared to adults (Coleman et al., 2022), it can be assumed that the detransition rate is lower in people who started their treatment as adolescents than in the reported chart reviews on adults. Robert et al. (2022) provide an indication of this: This showed in a selective sample that at least 74% of those in the sample who had started gender reassignment hormone treatment as minors continued it after 4 years. In contrast, at least 64% of those who had started hormone treatment as adults continued this treatment in the same time interval, which shows an inferentially statistically significant lower rate of gender reassignment.

"continuation rate". However, this study should be interpreted with caution, as it only examined the positively documented continuation of hormone treatment. The reasons for undocumented continuation of treatment were not reported, so that detransition cannot be reliably assumed for these cases.

can be identified. Nevertheless, the data does not indicate a higher detransition rate for people who start gender reassignment treatment in adolescence compared to adulthood, but rather the opposite tendency.

The findings regarding the sex of assignment and the (previous) gender identity in detransitioned persons is inconsistent. While in some studies *detransitioners* with a female assignment gender are overrepresented (Boyd et al., 2022; Littman, 2021; Vandebussche, 2021), are in another other study, male *detransitioners* are overrepresented by assignment gender (Turban et al., 2021) or the gender ratio of *detransitioners* corresponds to the ratio in the overall sample (Hall et al., 2021). These deviations are presumably due to the strongly divergent sampling between the studies. The mean duration from the start of gender reassignment treatment to detransition is reported relatively similarly in the range of 1.5 years (Boyd et al., 2022) 3 years (Littman, 2021) and is significantly lower than the study interval of 8 years required by Cohn (2023).

While Littman (2021) and Vandebussche (2021) mainly report intrinsic factors for detransition and a subsequent renunciation of trans identity, Turban et al. (2021) mainly report extrinsic reasons for existing trans identity at the time of the survey. The frequency of *regret* among *detransitioners* was only surveyed in the two community-based studies (Littman, 2021; Vandebussche, 2021), where it was reported at 50% and 60% respectively. In these studies, 46% and 78% respectively also felt that they had not received sufficient information about the medical treatment they had started. From a clinical perspective, the chart review by Boyd et al. (2022) also found evidence of treatment that was not in line with the specialist and guideline requirements. It can be deduced that the risk of detransition is higher if medical transition treatments are not indicated and carried out in accordance with guidelines or are not sufficiently professional.

Accordingly, the WPATH Standards of Care (Coleman et al., 2022) formulate the following recommendation for the professional treatment of adolescents diagnosed with gender incongruence, pointing out that detransition is a rare phenomenon:

"[...] detransitioning may occur in young transgender adolescents and health care professionals should be aware of this." (Coleman et al., 2022, p. 547).



## 5. Recommendations for professional advice

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Consensus-based recommendation:

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**II. K1.** When providing professional counseling to children and adolescents with signs of gender incongruence/gender dysphoria (GI/GD) and their guardians and, if applicable, other caregivers, counselors should have comprehensive knowledge of the range of variations in possible gender-variant developmental trajectories in childhood and adolescence.

Consensus strength: strong consensus  
(>95%)

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Consensus-based  
recommendation:

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**II. K2.** If counseling takes place in connection with a desired or already initiated social role change, the child or adolescent, his/her guardians and, if applicable, other caregivers should be informed about the variety of developmental processes, including the possibility of later detransition.

Consensus strength: strong consensus  
(>95%)

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Consensus-based  
recommendation:

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**II. K3.** In children before the onset of puberty who show signs of childhood gender incongruence (according to ICD-11 HA61)<sup>4</sup>, healthcare professionals should assume that it is not possible to predict *persistent* gender incongruence in adolescence until the onset of puberty.

Consensus strength: strong consensus  
(>95%)

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<sup>4</sup> For the diagnostic criteria for childhood gender incongruence (HA61), see Chapter VII. →

*"Indications for body-modifying medical treatments".*

## **Chapter III**

### **Social role change in childhood**

- 1. Introduction and key questions**
- 2. Legal and ethical requirements**
- 3. The state of empirical knowledge**
- 4. Recommendations for professional advice**

Vorläufige Leitlinie zur Kommentierung

## 1. Introduction and key questions

The question of whether and to what extent gender-nonconforming children should be supported in making a complete social role change before the onset of puberty, i.e. to dress, behave and be addressed according to their own wishes in all areas of life, is the subject of controversial debate among experts. There are children who demand this persistently and with great insistence. In individual cases, an educational approach based primarily on the welfare of the child and their unimpaired socio-emotional development is required, which is fundamentally the responsibility and discretion of the parent or guardian and does not require a medically justified decision or even medical action. Nevertheless, children with signs of gender incongruence (GI) or gender dysphoria (GD) are presented in medical and psychosocial treatment contexts at any developmental age with the request for professional advice. Such counseling should then be based on the specialist knowledge available to date and made accessible to those seeking counseling. It is also not uncommon for educational institutions (daycare centers and elementary school) to request medical or psychological opinions in order to help professionally safeguard an educational approach or procedure that is oriented towards the child's well-being. As the earlier S1 guideline on "Gender identity disorders in childhood and adolescence" was also used in the past as a professional frame of reference for educational or family-psychological issues, despite its intention to focus on the medical treatment context, the authors of the guideline felt it was important to present the current state of knowledge and recommendations that could be derived from it, while exercising the necessary restraint with regard to educational issues.

### ***Key questions for the guideline:***

- What implications for further development can result from a social role change in childhood?
- What findings are there with regard to a possible accompanying social determination to a gender role in adolescence?
- What findings are there with regard to possible favorable or unfavorable effects of a social role change in childhood on the child's psychosocial and health development?

## 2. Legal and ethical requirements

In principle, the right to develop one's own personality is a right of a child that is protected by both the Basic Law and the UN Convention on the Rights of the Child as a human right. In the case of gender-nonconforming children, the potential openness of the later course of development from the onset of puberty must also be considered with regard to this development of personality, as it is known that the later course of development of gender identity in adolescence is subject to great variance (see Chapter II→ "*Variant courses of development*").

The ad hoc recommendation of the German Ethics Council on the professional support and treatment of children and adolescents with signs of transgender development states, among other things ([www.ethikrat.org](http://www.ethikrat.org)):

- "The general right of personality also includes the right to lead a life in accordance with one's own subjectively perceived gender identity and to be recognized in this identity.
- The child must be heard in all decision-making processes and their ideas and wishes must be taken into account in accordance with their maturity and age. This rule is all the more important as it concerns questions of personal identity, which the person concerned must ultimately decide for themselves."

In a recent treatise on the ethical discourse on social role transition in childhood and adolescence by Ashley (2019), it is emphasized that the decision for such a role transition, regardless of the age of the child, cannot be made as the result of a previously completed intrapsychic clarification of one's own gender identity. Rather, social role testing in the self-perceived gender role is embedded in the process of self-exploration in constant interaction with the social environment, even if this process can still be regarded as open-ended (Ashley, 2019).

Generalized, directive recommendations beyond encouraging an attitude that accepts the child's personality and remains open to a potentially fluid course of gender identity development cannot yet be substantiated by empirical evidence. It should also be borne in mind that a social role change in childhood, which takes place in all areas of life, is sometimes already a fact of life at the time of initial presentation in medical or psychotherapeutic care practice, which should be countered with a non-judgemental, non-discriminatory attitude.

(see Chapter IX → "*Professional interaction and discrimination-sensitive interaction with gender-nonconforming children and young people*").

### 3. The state of empirical knowledge

To date, there have only been very few empirical studies from the North American cultural area in which children who had undergone a social role change before the onset of puberty have been systematically examined. If one examines the results of these studies to see what effects a social role change can have on the development of the mental health of a child with GD, it must be emphasized in advance that only limited statements can be made in this regard. The reasons for this are

- In terms of their intention and design, the studies primarily investigated other issues.
- The children who had undergone a role change were selectively chosen and were more likely to have particularly pronounced signs of GI in childhood, combined with high self-confidence and a high level of support from their family environment. Therefore, in addition to a particularly strong expression of characteristics with regard to their gender-nonconforming behavior, these children had a high level of generally protective resources.
- To date, there are few reliable study results on the later outcome of these children after the onset of puberty. Only in a recent follow-up study with an observation period of five years after the start of a social role change in childhood ( $N = 237$ ) was a subgroup ( $N = 70$ ) 14 years or older (Olson et al., 2022).
- In particular, apart from anecdotal evidence of individual cases, there is no data available on how and under what circumstances a later social role transition to the birth sex role was psychosocially managed during adolescence.

Previously *investigated questions include* gender-role-related cognitions and characteristics of mental health in gender-nonconforming children after a completed social role change compared to peers with gender-conforming role expression (Durwood et al., 2017; Olson et al., 2015; Fast & Olson, 2017). In a post-analysis of available cross-sectional study data, characteristics of mental health and their predictors were also compared between children with pronounced gender-nonconforming behavior after role reversal and children with atypical gender expression without role reversal (Wong et

al., 2019). One study retrospectively examined the differential step-by-step course of social transition processes in childhood (Kuper et al., 2019). In addition, the experiences and reports of families who accompanied the role change of a child were qualitatively examined (Kovalanka et al., 2014; Olson et al., 2019). The largest follow-up study to date examines the course of gender identity development in a group of  $N = 237$  children five years after a complete social role change in childhood (Olson et al., 2022).

The following empirical results can be substantiated in this context by individual studies:

- 4- to 8-year-old children with pronounced signs of GI in childhood (inclusion criterion was, among other things that the children affirmed that they were boys or girls and did not just want to be) who had completed a social role change in all areas of everyday life with the support of their parents ( $N = 36$ ; 28  $m \rightarrow w$ , 8  $w \rightarrow m$ ) did not differ in their cognitions regarding gender self-attribution in relation to their perceived gender and gender-typical behavior or in their ideas about gender consistency in situations compared to siblings and control children comparable in age and sex at birth (Fast & Olson, 2017). They were consistently aware of their opposite birth gender to their sense of belonging. The only difference in their gender-related cognitions was that they viewed gender as a less stable construct over longer periods of time than other children, which can plausibly be explained by their own transition experience (*ibid.*).
- In a studied group of 5- to 12-year-old gender-nonconforming children who had completed a social role change with the support of their parents ( $N = 32$ ; 20  $m \rightarrow w$ , 12  $w \rightarrow m$ ), the study group differed in coherence and stringency of their gender-related cognitions (peer preference, object preference, gender identity, both implicit and explicit) neither from their siblings nor from external control children. The cognitions corresponded consistently and stringently to the affirmatively supported trans gender (Olson et al., 2015).
- In a group of 6- to 8-year-old gender-nonconforming children who had completed a social role change with the support of their parents ( $N = 46$ ; 14  $w \rightarrow m$ , 42  $m \rightarrow w$ ), they were comparatively less prone to gender stereotyping and were more open and accepting of gender nonconformity than children in a control group (Olson & Enright, 2017).

- In a group of 6- to 14-year-old gender-nonconforming children who had completed a social role change with the support of their parents ( $N = 116$ ), they showed no differences in self-esteem compared to control children ( $N = 122$ ) and siblings ( $N = 72$ ) (Durwood et al., 2017).
- In a group of 3-12-year-old gender-nonconforming children who had completed a social role change with the support of their parents ( $N = 73$ , 22 w→m; 51 m→w; 3→12J), there were no significant differences in the mental health outcomes of depression and anxiety compared to siblings and control children. There were also no differences in the outcome depression compared to the normal population. Slightly higher values were only found for anxiety compared to the normal population, although this difference was not significant (Olson et al., 2016).
- In a group of 9-14 year-old gender-nonconforming children who had completed a social role change with the support of their parents ( $N = 63$ ), they were not more depressed than comparable control children and siblings, but tended to be slightly more anxious (Durwood et al., 2017).
- In a case study of five families with children who underwent a role change (m→w) at the age of 7-10 years, it was reported that, from the parents' perspective, the children were primarily proactive in taking this step and that the parents were largely uninformed about the topic of gender non-conformity at the beginning. Nevertheless, in retrospect, very early gender-nonconforming behavior was reported (from the age of 1 or 2), which was initially classified differently by the parents. In the parents' perception, the supported role change predominantly led to positive psychological changes in the child (blossoming, self-confidence, etc.). Only in one case was a crisis-like development with suicidal tendencies reported as a reaction to the trans hostility experienced in the social environment and society (Kovalanka et al., 2014). The parents also reported widespread lack of information and sometimes unethical attitudes and statements by professional helpers in healthcare and schools, and the associated need to become experts on their own concerns (*ibid.*).
- In an analysis of cross-sectional data of 6-12 year old gender-nonconforming children, pooled from three previous studies, there were no significant differences in mental health scores between children with and without completed role reversal, although the two groups differed significantly in the expression of signs of GI or GD (Wong et al., 2019). Across both groups, social integration in peer relationships was consistently found to be



most important predictor of mental health, although the generalizability of this statement is low due to methodological limitations (*ibid.*).

- In a retrospective follow-up study of gender-nonconforming children and adolescents with completed or desired transition ( $N = 224$ ; age 6-17 y, 60% w→m; 40% m→w), 98% of whom received a DSM 5 diagnosis of GD, a wide range of variation in developmental trajectories before the onset of puberty and gender differences were found. In the natal male children, binary transgender role identification as a girl was more common before puberty, whereas natal female children showed mixed or non-binary gender expression more frequently before puberty. In addition, the sequence of steps in social outings (messages to the social environment) and lived transition (clothing, haircut, names and pronouns, official role change at school, etc.) as well as their gradual or non-gradual progression varied considerably (Kuper et al., 2019).
- In a comparative study, the parents of two stratified subgroups of children of both birth sexes with non-conforming gender role expression with and without a completed social role change ( $N = 60$  each) were asked about the decision-making processes for or against a completed social role change. In 83% of the children with a social role change, the parents stated that the decision was very clearly initiated by the child. In 75% of the cases that had not (yet) transitioned, the possibility of a transition was openly discussed between parents and child. In only 10% of the children who had not (yet) socially transitioned, the parents stated that they were largely responsible for this wait-and-see attitude (Olson et al., 2019). In an internet-based survey of parents whose children socially transitioned into their perceived gender ( $N = 266$ , 92% of whom transitioned before puberty), 68% stated that they had openly discussed the possibility of a later retransition in adolescence with their children (Olson et al., 2019) in order to maintain the openness of later developments in the child's imagination. Only a small proportion of parents of transitioned children (13%) expressed the fear that discussing the open option of later retransition could be interpreted by the child as non-acceptance of their subjective gender identity.
- There is little empirical data on developmental trajectories with a return to the gender role assigned at birth in adolescence. Such a course is reported in two individual cases in the Dutch studies on persistence and desistance (Steensma et al., 2013). Both of these birth-gender girls, who had already (partially) changed to the role of a boy, reported considerable difficulties in returning to the female role without

other accompanying psychosocial circumstances have been described (Steensma et al., 2011).

- Only in a more recent follow-up study of  $N = 317$  children with a gender-nonconforming gender identity at an average age of eight years who had completed a complete social role change with the support of their families before the onset of puberty were proportionate progressions into adolescence ( $N = 70$ ) reported (Olson et al., 2022). In this study, 94% of the children remained in the socially transitioned gender role after five years. 7.3% had retransitioned at least once, of which 1.3% changed back to their transgender role after a "phase of clarifying trial and error". Retransitions occurred more frequently if the first role change had already taken place before the age of six and were more often completed before the age of ten. At the time of the 5-year follow-up,  $N = 70$  adolescents had reached the age of 14, of whom only one person (1.7%) had retransitioned to their birth gender. The study shows that the vast majority of children who initiate a role change before puberty with the support of their parents remain in transition in the long term. On the other hand, the study also showed that retransitions in this group of children do occur in rarer cases (7%), which is important information in counseling in order to prepare children and parents for this possibility.

### **3.1. Summary of the empirical state of knowledge**

The following statements and conclusions on the option of a social role change in childhood can be derived from the empirical state of knowledge, which can serve as orientation for professional counseling:

- **T h e r e w a s** no evidence of increased psychosexual confusion, identity insecurity or otherwise conspicuous gender-related cognitions in children with GI who had undergone a social role change with the support of their parents. The latter predominantly corresponded stringently to the perceived gender affiliation. Accordingly, there are children with strongly pronounced GI in whom a transgender role identification is consistently coherent and not is an expression of general psychosexual insecurity or identity insecurity.
- There i s **evidence** that an affirmatively supported role change can have a positive effect on social integration and the child's self-confidence through the development of the child's personality in the course of prepubertal development.

- There is **evidence** that an affirmatively supported role change before the onset of puberty can have a positive effect on socio-emotional development.
- **Social integration** that is as unimpaired as possible **and acceptance in peer relationships that can be experienced are primarily** important factors for the positive socio-emotional development of children with GI or GD who have undergone a social role change.
- To date, **there is no reliable empirical evidence** on how the affirmative support of a gender-nonconforming child by their attachment figures in their perceived gender identity affects the future openness of gender identity development in puberty. Although the rate of persistence of a perceived transgender identity is very high, this seems to be explained by the selection of particularly clear developmental trajectories, which is typical of the child's proactive demand for a role change. Retransitions after a completed role change in childhood were described in rare cases (7% of cases in one study), although these occurred more frequently before puberty.
- To date, **there is no reliable empirical evidence** on how a restrictive approach by parents or guardians to the social expression of a gender-nonconforming role identification in children affects the course of a GI or GD and later identity self-discovery.
- To date, **there is no empirical evidence** on the psychosocial circumstances under which a return to the role of the gender assigned at birth is made more difficult or easier in the case of a later retransition after a role change experienced in childhood.

#### 4. Recommendations for professional advice

Consensus-based recommendation:

**III. K1.** In counseling children with gender incongruence or gender dysphoria who are considering a social role change before the onset of puberty and their guardians and, if applicable, other caregivers, the counselor should respect the child's right to free development of their personality.

Consensus strength: strong consensus (> 95%)

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Consensus-based recommendation:

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**III. K2.** In counselling children with gender incongruence or gender dysphoria who are considering a social role change before the onset of puberty and their guardians and, if applicable, other caregivers, the counsellor should try to sensitize the guardians to an attitude that enables the child to explore and develop their gender identity and social gender role in a self-determined way.

Consensus strength: strong consensus (> 95%)

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Consensus-based  
recommendation:

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**III. K3.** In counseling children with gender incongruence or gender dysphoria who are considering a social role change before the onset of puberty and their guardians and, if applicable, other caregivers, a (possible) social role change should be understood as a process that is to be shaped according to the needs of the child. The steps considered for testing the role change should be tailored to the individual life situation.

Consensus strength: strong consensus (>95%)

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Consensus-based  
recommendation:

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**III. K4.** In counselling children with gender incongruence or gender dysphoria who are considering a social role change before the onset of puberty and their guardians and, if applicable, other caregivers, the counsellor should offer professional support to protect the child and/or their caregivers from stigmatization and discrimination, regardless of the individual decision and life path of those affected.

Consensus strength: strong consensus (> 95%)

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## Chapter IV.

### **Associated mental disorders and health problems in children and adolescents with gender incongruence and gender dysphoria**

- 1. Introduction and key questions**
- 2. State of research on mental disorders and suicidal tendencies**
  - 2.1. Clinical interview and file studies
  - 2.2. Clinical questionnaire studies with children and adolescents at the start of or before treatment
  - 2.3. Non-clinical surveys of children and adolescents
  - 2.4. Eating disorders/ body image
  - 2.5. Abnormalities from the autism spectrum ("neurodiversity")
  - 2.6. Associated psychopathology after social transition in childhood
  - 2.7. Excursus: Associated psychopathology after social transition and after physical medicine measures in adolescence
  - 2.8. Explanatory approaches for the development of psychological abnormalities in children and adolescents with gender incongruence or gender dysphoria
- 3. Statements and recommendations**
  - 3.1. Statements on the state of scientific knowledge
  - 3.2. Recommendations

## 1. Introduction and key questions

Based on the widely documented and multifaceted increase in psychiatric morbidity among people who self-identify as transgender (hereinafter referred to as trans people), it is essential for practitioners to have knowledge of the spectrum of common mental health problems in trans people and their relevance for the clinical approach to the diagnosis and treatment of gender incongruence (GI) and gender dysphoria (GD) in childhood and adolescence. In particular, the recent increase in the reported overlap of gender dysphoric symptomatology with symptoms from the autism spectrum raises questions in this regard.

Before a diagnosis of persistent, i.e. *stable/persistent gender incongruence or gender dysphoria* in childhood and adolescence can be made with sufficient diagnostic clarity on the basis of existing symptoms and findings and a comprehensive consideration of the course of development in the individual case, any associated or co-occurring mental disorders must be diagnosed professionally and assessed with regard to their interdependence with gender dysphoric symptoms. The term *comorbidity* is deliberately not used in this chapter, as *gender incongruence (GI)* is not considered a disorder with disease value in the ICD-11, and in the DSM-5 the GI underlying *gender dysphoria* has no disease value per se (Skagerberg, Davidson, et al., 2013; Skagerberg, Parkinson, et al., 2013).

In particular, a careful assessment must be made as to whether and to what extent coinciding mental health problems interfere with diagnostic clarity in the determination of *stable/persistent gender incongruence or gender dysphoria* or with the indication or planning of certain treatment measures (see chapter V→

"*Psychotherapy and psychosocial interventions*" and Chapter VII→ "*Indications for body-modifying medical interventions*"). For an unbiased diagnostic approach and a valid understanding of the disorder in individual cases, it is essential that in the case of coincident mental health problems, no primarily theory-based assumptions are made about possible (co-)aetiological causes (see below consensus recommendations in this chapter). Mental health problems in trans people can occur both reactively as a variety of adjustment problems to an existing gender incongruence, as well as existing or having arisen independently of this. The possibility that, especially as long as an adolescent trans person has not yet been diagnosed with *stable/persistent gender incongruence or gender dysphoria*, other mental health problems could lead to temporary gender dysphoric symptoms should also be carefully considered.

By no means all young people who present themselves as belonging to a queer or trans spectrum present themselves, exhibit a *stable/persistent gender incongruence* or *gender dysphoria* or will develop one (see Chapter II→ "*Variant developmental trajectories*"). On the other hand, serious mental disorders that can significantly impair diagnostic clarity (such as psychoses or complex personality disorders with pronounced identity diffusion) are not per se evidence that *stable/persistent gender incongruence* or *gender dysphoria* does not exist, just as a person's non-heterosexual orientation would not be considered fundamentally unlikely or less credible in the presence of such a serious disorder. For the following chapter on the diagnosis and differential diagnosis of associated mental health problems in children and adolescents who present to health services with the question with the question whether a in need of treatment *gender incongruence* or *gender dysphoria* is present, the following key questions were formulated a priori for this guideline (see method report):

**Key questions for the guideline:**

- Which psychopathological problem areas are associated with gender incongruence or Beyond gender dysphoria in childhood and adolescence, should the practitioner pay particular attention?
- What influence do associated mental health problems have on treatment?
- What are the implications for the diagnosis and treatment of a co-occurring Autism Spectrum Disorder in underage patients with gender incongruence or gender dysphoria?
- What is the recommended diagnostic procedure for indications of gender incongruence, taking into account possible concomitant psychiatric or psychosomatic diagnoses that need to be considered?

## 2. State of research on mental disorders and suicidal tendencies

In children and adolescents who presented to the healthcare system with gender incongruence or gender dysphoria, previous studies have shown that in the majority of cases, *GI or GD* was not preceded by any other underlying psychiatric disorder (Meyer-Bahlburg, 2010; Steensma et al., 2011). Nevertheless, studies have often shown a wide range and prevalence of accompanying psychopathological abnormalities or disorders in young patients who present to a specialized clinical facility for diagnosis and treatment. These are significantly more pronounced in adolescents, i.e. from the onset of puberty, than in children. The most frequently described accompanying psychopathological abnormalities in adolescents with *GI or GD* are *depressive disorders, anxiety disorders, syndromes of self-injurious behavior and suicidal tendencies*. Irrespective of etiological issues that consider this symptom burden to be either reactive, pre-existing or contributory to *GI or GD*, a diagnostic assessment of existing psychopathological symptoms is therefore necessary, as these can interfere with *GI or GD* and the potential treatment process.

The state of research on mental disorders and suicidality in childhood and adolescence is presented below. A distinction is made between clinical chart reviews and interview studies (with reported clinical diagnoses), clinical questionnaire studies (primarily: Child Behavior Checklist/ Youth Self-Report) and population-representative studies, almost all of which report cross-sectionally collected data at the time of initial presentation or at the beginning of treatment (usually before treatment with gender reassignment measures). In addition, results in childhood (usually <12 years) and adolescence (≥12 years) are considered separately where possible, as gender dysphoric distress usually intensifies from the onset of puberty due to the onset of irreversible maturation processes in the body and the resulting steady increase in body dysphoria (Russell, 2003; Skagerberg, Davidson, et al., 2013; Skagerberg, Parkinson, et al., 2013; Steensma et al., 2011, 2014).

### 2.1. Clinical interview and file studies

Around half of the children and adolescents who took part in the existing *clinical interview or file studies* received at least *one other psychiatric diagnosis* in addition to a diagnosis of gender incongruence or gender dysphoria (Becker et al, 2014; D. Chen et al, 2017; M. Chen et al, 2016; Chodzen et al, 2018; Di Ceglie et al, 2002; Hewitt et al, 2012; Holt et al, 2016; Kaltiala-Heino et al, 2015; Khatchadourian et al, 2014; Nahata et al, 2017; Spack et al, 2012).



For example, D. Chen et al. (2017) reported at least one previous or current additional psychiatric diagnosis in 71% of the children they studied and Kaltiala-Heino et al. (2015) in 75% of the adolescents they studied.

Among the reported co-occurring diagnoses, *affective disorders*, depression and anxiety disorders consistently rank first at 32 to 78% (Becker et al., 2014; D. Chen et al., 2017; M. Chen et al, 2016; Chodzen et al, 2018; Di Ceglie et al, 2002; Holt et al, 2016; Kaltiala-Heino et al, 2015; Khatchadourian et al, 2014; Nahata et al, 2017; Olson et al, 2015; Peterson et al, 2017; Skagerberg, Parkinson, et al, 2013; Spack et al, 2012). One of the studies even reported anxiety and depression in 100% of the clinical population, but did not further differentiate the diagnoses (Hewitt et al., 2012). Increased prevalences are also reported for (*non-suicidal*) *self-harming behavior, suicidal thoughts or suicidal tendencies* in adolescents: Here, the figures for a previous suicide attempt (over the life span to date) range between 9 and 52% (Becker et al, 2014; M. Chen et al, 2016; Holt et al, 2016; Khatchadourian et al, 2014; Nahata et al, 2017; Peterson et al, 2017; Spack et al, 2012). Suicidality that is not further differentiated, e.g. in the form of suicidal thoughts (over the previous lifespan), and self-injurious behavior that is not further differentiated are reported for 13% to 75% (Becker et al, 2014; M. Chen et al, 2016; Di Ceglie et al, 2002; Holt et al, 2016; Kaltiala-Heino et al, 2015; Nahata et al, 2017; Olson et al, 2015; Skagerberg, Parkinson, et al, 2013; Spack et al, 2012).

In the present investigations based on the file studies, it must be taken into account that in most cases no differentiation was made between children and adolescents and therefore the reported prevalence of mental disorders in childhood may have been overestimated and in adolescence underestimated. In addition, some of the adolescents included in the study had already started body-modifying medical treatment and were at different stages of their transition process at the time of the evaluation.

## **2.2. Clinical questionnaire studies with children and adolescents at the start of or before treatment**

The results of clinical questionnaire studies also show that children and adolescents with diagnosed gender incongruence or gender dysphoria exhibit an increased level of psychological abnormalities at the beginning of treatment in a specialized clinic.

Although the results are inconsistent, children with GI or GD generally appear to be less severely distressed than adolescent patients, especially when looking at the *CBCL* scale scores (*Child Behavior Checklist*, Achenbach & Ruffle, 2000): Compared to the norm population, children measured using the CBCL scales more frequently exhibited mental disorders both in the

emotional experience as well as on the behavioral level and also differ from their siblings in this respect (Aitken et al, 2016; Cohen-Kettenis et al, 2003; Sievert et al, 2021; Steensma et al, 2014; Zucker et al, 1997). The T-norm values reported in these studies are in the clinically abnormal range in up to 62% of cases in childhood (above the 90th percentile; Aitken et al., 2016; Cohen-Kettenis et al., 2003; Steensma et al., 2014; Zucker et al., 1997, 2002).

Similarly, numerous questionnaire studies with samples of adolescents with GI or GD who had contacted a specialized clinical facility for GI or GD show increased levels of mental abnormalities in the clinically relevant range (de Graaf et al, 2018; de Vries et al, 2016; Levitan et al, 2019; Shiffman et al, 2016; Skagerberg, Davidson, et al, 2013; Skagerberg, Parkinson, et al, 2013; Zucker et al, 2002, 2012): 45 to 82% of adolescents showed externalizing abnormalities such as social behavioural problems and impulse control disorders and/or internalizing symptoms such as anxious-depressive moods, somatization tendencies and social withdrawal behaviour.

A similar pattern of problem areas can be seen across different countries: both in childhood and adolescence, internalizing problems are reported more frequently than externalizing problems when using the CBCL (Cohen-Kettenis et al, 2003; de Graaf et al, 2018; de Vries et al, 2016; Levitan et al, 2019; Röder et al, 2018; Sievert et al, 2021; Skagerberg, Davidson, et al, 2013; Skagerberg et al, 2015; Steensma et al, 2014; Zucker et al, 1997, 2012). This means that an *increased level of anxiety, depression and psychosomatic symptoms* and, in comparison, *relatively fewer aggressive or externalizing behavioural problems* are reported in this population.

If *disorder-specific diagnostic test inventories* such as the BDI (*Beck Depression Inventory*, Beck et al., 2011) and *standardized clinical interviews* are used instead of screening instruments such as the CBCL, the pattern of the results from the questionnaire studies is confirmed: In the clinical interview with parents of children with GI or GD, Wallien et al. (2007) recorded an additional psychiatric diagnosis for 52%, with internalizing (at 37%) occurring more frequently than externalizing disorders (at 23%). In the study by Kolbuck et al. (2019), 37% of 3- to 11-year-olds received at least one other psychiatric diagnosis in addition to the diagnosis of GI or GD.

Interview and questionnaire studies have also shown that affective disorders (anxiety and depression in up to 48% of cases) are particularly common in adolescents (Chodzen et al., 2018; de Vries et al., 2011). Olson et al. (2015) report depression measured using the BDI for a total of 35% of adolescents, suicidal thoughts in 51% and suicide attempts in 30% (*over the life span to date*).

Also, (*non-suicidal*) *self-injurious behavior and suicidality* are reported as frequently in the aforementioned clinical questionnaire studies as in clinical record studies (see Surace et al, 2020 for a meta-analysis of clinical studies; Aitken et al, 2016; Arcelus et al, 2016; Fisher et al, 2017): In a meta-analysis by Surace et al, (2020), self-injurious behavior was reported on average for 28% of all clinically presenting children, adolescents and young adults diagnosed with GI or GD, suicidal ideation was reported in 28% and suicide attempts occurred in 15% of cases studied (over the life span to date).

For their clinical sample of *children* diagnosed with GI or GD, Aitken et al. (2016) reported self-harming behavior/suicidal attempts in 19% of cases and suicidal thoughts in 19%. This means that the number of self-harm and suicide rates for children with GI or GD is still lower compared to adolescents, but significantly higher than in the non-clinical normal population. For *adolescents* with GI or GD, Arcelus et al. (2016) even report 46% non-suicidal self-injurious behavior (over the previous lifespan).

### 2.3. Non-clinical surveys of children and adolescents

Naturalistic surveys based on samples of adolescent trans people from youth welfare facilities (outside of a clinical utilization context) report similar results to those reported on the basis of clinical samples: These studies also indicate a **generally increased risk of mental health problems, depression, self-injurious behavior, and suicidality** (Becerra-Culqui et al, 2018; Clark et al, 2014; Grossman & D'Augelli, 2007; Katz-Wise et al., 2018; MacMullin et al, 2020; Nahata et al, 2017; Perez-Brumer et al, 2017; Peterson et al, 2017; Reisner et al, 2015; Taliaferro et al, 2018; van Beijsterveldt et al, 2006; Veale et al, 2017). It should be noted here that these populations had generally *not* received a *diagnosis of GI or GD*, but were identified by less specific self-descriptions ("transgender").

Depression and suicidality are also among the most frequently reported mental health problems in these studies (Becerra-Culqui et al., 2018; Clark et al., 2014; Reisner et al., 2015). The highest prevalence of depressive symptoms is reported for 41% of the adolescent transgender students surveyed (Clark et al., 2014) and for 51% in a self-help center (Reisner et al., 2015). Some authors, such as Becerra-Culqui et al. (2018), also report increased prevalence of ADHD.

Percentages between 9.1% (suicide attempt or self-harm) and 6.8% (suicidal thoughts) are reported for children from a self-help facility who exhibit so-called "gender-nonconforming experience and behavior", similar to the figures from clinical studies in GI or GD in childhood (MacMullin et al., 2020).

*Repeated (non-suicidal) self-injurious behavior* is reported between 2% and 75% and *suicidal ideation* between 5% and 65% of trans adolescent respondents from population-representative samples (for the past 12 months) (Becerra- Culqui et al, 2018; Gower et al, 2018; Perez-Brumer et al, 2017; Taliaferro et al, 2018; Veale et al, 2017) and between 12 and 49% (self-injurious behavior) and between 25 and 84% (suicidal ideation) of adolescents recruited in youth services (*for the period of the last 12 months*; Grossman & D'Augelli, 2007; Katz-Wise et al, 2018; Kuper et al, 2018; Reisner et al, 2015; Ross-Reed et al, 2019).

#### **2.4. Eating disorders/ body image**

Other problem areas, such as eating disorders or body image disorders, are only rarely examined or named in the aforementioned studies (13% eating problems in Holt et al., 2016, and 2% eating disorders in Kaltiala-Heino et al., 2015), although a negative body image has been reported for adolescent samples with GI or GD in studies on eating behavior and/or body image (Becker et al., 2018; McGuire et al., 2016). In addition, an influence of body image on quality of life is particularly evident in young people with GI or GD (Peterson et al., 2017; Röder et al., 2018). For example, Guss et al. (2017) reported an increased likelihood of unhealthy behavior with regard to body weight modification in adolescent trans individuals.

#### **2.5. Abnormalities from the autism spectrum ("neurodiversity")**

Around 25 quantitative studies conducted over the last 10 years indicate that GI and GD are more likely to overlap with abnormalities from the autism spectrum. This has been described predominantly for children and adolescents, but occasionally also for adults (Herrmann et al., 2021). The frequent occurrence of ASD symptoms in people with GI or GD is described, as well as in the reverse constellation (bi-directional coincidence). In Anglo-American literature, this symptomatic overlap with autism-typical symptoms is discussed, among other things, under the English term *neurodiversity*, which is introduced in relevant original works on this specific topic (Strang et al., 2019; Van Vlerken et al., 2020) and is also used in the corresponding chapter of the international guideline of the WPATH<sup>1</sup> (Coleman et al. 2022). As the term "neurodiversity" is not established in the German-language medical literature on autism spectrum disorders, it is not used in this guideline in this context.

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<sup>1</sup> WPATH: World Professional Association for Transgender Health

According to DSM-5, the diagnostic criteria for an autism spectrum disorder (ASD) include: persistent consistent deficits in social communication and interaction (A criterion), restricted and repetitive patterns of behavior, interests or activities (B criterion), the presence of symptoms since early childhood (C criterion), and suffering or impairment in several areas of functioning (D criterion). The earlier distinction between different subgroups of autistic disorders (e.g. Asperger syndrome, early childhood autism) was first abandoned in the US classification system (DSM-5) and then internationally (ICD-11 of the WHO) and replaced by the concept of ASD.

However, the vast majority of publications to date have only examined *subclinical manifestations* of one of the two phenomena (ASD or GI or GD) in a clinical population of the respective other diagnostic group. For example, the frequency of *gender-nonconforming experience* or *gender variance* (GV) in clinical samples with ASD diagnoses and of so-called "*autistic traits*" in children and adolescents with GI or GD diagnoses has been investigated.

### **2.5.1. Gender dysphoric symptoms in ASD patients**

Methodologically, a few individual items in parent questionnaires (mostly CBCL) were often used to identify abnormalities in gender experience in children and adolescents with ASD (May et al., 2017; Strang et al., 2014; van der Miesen et al., 2018). An increased prevalence of 4-6.5% was found for gender-nonconforming experiences in children and adolescents with an ASD diagnosis. However, it is possible that there is generally an increased prevalence of gender-nonconforming behavior in developmental disorders and mental disorders (May et al., 2017), which has also been reported for ADHD (Strang et al., 2014; Thrower et al., 2020).

### **2.5.2. ASD symptoms in patients with gender incongruence/gender dysphoria**

Five empirical studies showed that 4.7-13.3% of all children and adolescents who presented to specialist consultations due to suspected GI or GD also received an ASD diagnosis, although in most cases only patient records were evaluated (Herrmann et al., 2020).

When ASD screening instruments were applied to children and adolescents with GI or GD, 14.5-68.0% of children and adolescents achieved cut-off values above the threshold. This is by no means to be equated with an ASD diagnosis, but merely describes an increased perception of autistic traits in the parents of children and adolescents with GD, which can also occur in the context of other psychiatric diagnoses (e.g. social interaction difficulties in the case of social phobia). Due to the low specificity, the use of ASD screening questionnaires is currently only explicitly recommended if there is clinical evidence of autism.

provides indications of the possible presence of an ASD diagnosis (AWMF S3 guideline on the diagnosis of ASD).

### **2.5.3. Coincident ASD and diagnosed gender incongruence or gender dysphoria**

To date, three quantitative studies have actually investigated the coincident presence of both diagnoses. The frequency of confirmed ASD diagnoses in children and adolescents with diagnosed GD was reported as 7.8%, 5.2% and 6.3% respectively (de Vries et al., 2010; Nahata et al., 2017; Spack et al., 2012). Since patients with both diagnoses are presumably presented clinically with increased urgency due to a variety of psychosocial problems (especially in the specialized facilities for GI and GD examined here), a so-called "presentation bias" was discussed as a limitation of the representativeness of the reported frequencies.

### **2.5.4. Differential diagnosis versus coincidence**

The literature to date shows an increased prevalence of both "autistic traits" in children and adolescents with GI or GD as well as gender variance or gender-nonconforming experiences in children and adolescents with ASD (bi-directional overlap of the phenomena of gender-nonconforming behavior and autism spectrum). Such a correlation is also reported for an overlap of confirmed diagnoses of ASD and GI or GD, albeit at a lower frequency (overview in Van Der Miesen et al., 2016).

Deficits in social integration are evident in both ASD and GI or GD. Psychosexual development is impeded, particularly in adolescence, and rigid thinking and excessive preoccupation with specific topics can determine the clinical picture in both cases. Described "*autistic traits*" in subclinical form (i.e. without the presence of ASD, e.g. in the form of communication and interaction difficulties in patients with GI or GD) could therefore also indicate impaired social integration or a social phobia. In addition to autism-related difficulties and delays in psychosexual development, a possible explanation for frequent *gender-nonconforming behavior* in subclinical forms, i.e. without the presence of GI or GD, is a low general role conformity typical of autistic individuals and an associated low level of psychosocial differences in gender role behavior in patients with ASD (Wattel et al., 2022).

In clinical care practice, however, there is also a subgroup of patients who persistently and permanently exhibit the full diagnostic picture of both gender incongruence and ASD. In this case, it cannot be assumed that there is an overlap of symptoms, but rather an actual coincidence. The risk of underdiagnosis and non-treatment or incorrect treatment

is present for both diagnoses if symptoms that persist for too long are mistakenly attributed to a phenomenon that was diagnosed first. This subgroup of people with a dual diagnosis of ASD and GI or GD must be considered particularly vulnerable - not least due to the risk of social isolation, which can be significantly exacerbated by both phenomena. However, the increased risk of more difficult access to specialist treatment should also be mentioned, which is associated on the one hand with the aforementioned risk of protracted misrecognition or non-recognition of the existence of a coincident dual diagnosis by treating professionals, and on the other hand with the possible need to integrate the clinical expertise for both diagnoses into a treatment plan (see recommendations below).

## **2.6. Associated psychopathology after social transition in childhood**

In some studies, children with GI or GD were examined who had already completed a complete social role change in all areas of everyday life with the support of their caregivers before the onset of puberty. These children were not found to have a significantly higher incidence of mental health problems than the average normal population (see Chapter III → "*Social role change in childhood*").

## **2.7. Associated psychopathology after social transition and after physical medicine measures in adolescence**

Follow-up studies with transitioned trans people who received staged somatomedical interventions starting in adolescence (puberty blockade, gender reassignment hormone treatment and surgery) provide consistent evidence of a favorable course of mental health and quality of life, although the study results are inconsistent with regard to the extent of persistent psychopathological abnormalities in adulthood (see detailed description of the study situation in Chapter VII → "*Indications for body-modifying medical interventions*").

## **2.8. Explanatory approaches for the development of psychological abnormalities in children and adolescents with gender incongruence or gender dysphoria**

From the predominantly cross-sectional study results on the prevalence and severity of accompanying mental disorders in adolescents with GI or GD, no statement can be made about the extent to which the associated psychopathology is a consequence of the stress associated with gender dysphoric distress or the extent to which the psychopathology is a consequence of gender dysphoric distress.

mental disorders may have developed independently of GI or GD. Accordingly, no statement can be made as to the extent to which, in the case of assumed reactive mental disorders as a result of GD, these are caused by aversive environmental experiences in the sense of insufficiently experienced social acceptance of transgender identity (so-called minority stress, see below) and/or by body-related dysphoria from the onset of puberty.

Some of the studies summarized here report correlations between an increased level of mental health problems and possible predictors and have statistically examined these as possible explanatory approaches: A number of studies point to the connection between generally increased mental health problems and experiences of discrimination based on one's own gender identity or external appearance (Aitken et al., 2016; Arcelus et al., 2016). This is explained by the *Minority Stress Model* (Meyer, 1995, 2003, 2015), which basically describes how psychological stress can develop from a variety of interpersonal and/or social circumstances. According to this model, the stress that minorities in particular experience (e.g. people who belong to the LGBTIQ spectrum) results from stress and conflicts that these people experience with their environment (Arcelus et al., 2016). Social or cultural intolerance towards gender-nonconforming individuals fosters experiences of discrimination or victimization among transgender individuals (for more information on the study situation, see Chapter IX→ "*Professional interaction and discrimination-sensitive treatment of gender-nonconforming children and adolescents*"). As children and adolescents with persistent GI or GD are at the extreme end of a gender-nonconforming ("queer") gender spectrum, it can be assumed that they are at an increased risk of having correspondingly aversive experiences with their social environment (Van Der Miesen et al., 2016) (see explanations in Chapter IX→ "*Professional interaction and discrimination-sensitive treatment of gender-nonconforming children and adolescents*" and Chapter V→ "*Psychotherapy and psychosocial interventions*").

Such a connection has been investigated in studies primarily on the basis of a so-called *Poor Peer Relations Index*: In the studies on this reported below, negative experiences in peer relationships were the most important predictor in the prediction of mental health problems in both children and adolescents with GI or GD (Aitken et al, 2016; de Graaf et al, 2018; de Vries et al, 2016; Levitan et al, 2019; Sievert et al, 2021; Steensma et al, 2014). Shiffman et al. (2016) also found three other statistically significant correlates of general emotional and behavioral problems in adolescents with GI or GD: 1. experiences of social exclusion due to transgender, 2. other experiences of exclusion, and 3. fewer friendships.



Although victimization is reported more frequently in adolescent trans people than in affected children, these aversive experiences sometimes occur in childhood, which may mean an increased risk of negative mental health outcomes in the long term (Katz-Wise et al., 2018; Ross-Reed et al., 2019; Steensma et al., 2014). For example, the studies by Kuper et al. (2018) and Perez-Brumer et al. (2017) consistently reported that experiences of victimization and depressive symptoms were the strongest predictive factors for suicidal ideation in transgender adolescents.

Young people with a GI or GD diagnosis and non-suicidal self-injurious behavior also exhibit general psychological problems and lower self-esteem (Arcelus et al., 2016). The majority of these adolescents (with self-injurious behavior) report having suffered more from discrimination or personal interpersonal problems in the past than those without self-injurious behavior.

However, the studies on peer relationships in childhood and adolescence by Aitken et al. (2016), de Vries et al. (2016), MacMullin et al. (2020), Steensma et al. (2014) and Zucker et al. (1997) also point out that poor peer relationships can also be an expression of greater psychosocial problems in general and, as a consequence, increased mental health problems. For example, some authors point out for childhood that exclusion and the presence of negative experiences with the environment are not sufficient as an exclusive explanation for the development of mental health problems, but that the experience of GI or GD per se can be a strong aversive long-term stressor (Aitken et al., 2016; Bockting, 2016; Grossman & D'Augelli, 2007; MacMullin et al., 2020; Zucker et al., 2012). Aitken et al. (2016) and MacMullin et al. (2020) also find an association between generally elevated emotional and behavioral problems and the presence of suicidality, which attenuated the influence of peer relationships when both factors were considered simultaneously. The authors conclude that experiencing GI or GD on its own can already represent a high stress burden for young people.

Furthermore, *minority stress* can also be experienced within one's own family, as the study by Grossman et al. (2005) has shown. Here, young people reported that between 53% and 63% of their parents reacted negatively to their own gender-nonconforming experiences and behavior. Here too, the authors conclude that there is a connection between psychological well-being and the experience of stress due to negative reactions in the family environment. This result was replicated on the basis of more recent studies on the importance of one's own family (Kolbuck et al., 2019; Levitan et al., 2019; Sievert et al., 2021; Simons et al., 2013) and is taken into account in a separate chapter of this guideline (see Chapter VI → "*Inclusion of the family environment*").

*relationship environment and family dynamics*"). Kolbuck et al. (2019) also point out that parents of children with GI or GD can also be exposed to *minority stress* themselves.

The role of teachers and schools should not be overlooked either: While transgender adolescents increasingly report victimization and problems or reduced quality of life in the school context (Röder et al., 2018; Shiffman et al., 2016; Toomey et al., 2010), the experience of school support appears to be associated with a lower frequency of reported victimization and self-harming behaviour (Ross-Reed et al., 2019).

Overall, the exact causes and correlates of psychological abnormalities and their interdependent interaction in children and adolescents with GI or GD have not yet been sufficiently researched. Authors such as Bockting (2016), de Vries et al. (2016) and Smith et al. (2001) emphasize that the lasting experience of incongruence between the perceived gender identity and the external appearance characterized by physical sexual characteristics (body-related gender dysphoria) already acts as a strong, persistent stressor in affected young people. Röder et al. (2018) also point out the connection between satisfaction with one's own body and quality of life in adolescents with GI or GD. Furthermore, the empirical studies do not allow any generalizable conclusions to be drawn about causal relationships. This means that no general statement can be made about the extent to which the psychological abnormalities frequently found in young trans people with and without diagnosed GI or GD are the result of a predominantly reactive stress load, or how often they are an expression of a primary psychopathology that has developed independently of GI or GD, in the course of which temporary gender dysphoric symptoms can also occur without developing into a stable/persistent GI or GD.

### 3. Statements and recommendations

#### 3.1. Statements on the state of scientific knowledge

On the basis of the systematic literature review presented in the previous sections, the following two statements on the state of knowledge received were agreed by the guideline commission:

<p><b>IV. E1.</b> There gives from cross-sectional studies evidence that that gender dysphoric <sup>among</sup> children and adolescents living in healthcare facilities are presented with clinically relevant psychopathological abnormalities that go beyond the reported gender dysphoria.</p>
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Strong evidence: more than 20 conclusive studies with a sufficient number of cases and methodological quality (Aitken et al, 2016; Arcelus et al, 2016; Becker et al, 2014; Chen et al, 2016; Chen et al, 2017; Chodzen et al, 2018; de Graaf et al, 2018; de Vries et al, 2011; de Vries et al, 2016; Di Ceglie et al, 2002; Fisher et al, 2017; Hewitt et al, 2012; Holt et al, 2016; Kaltiala-Heino et al, 2015; Khatchadourian et al, 2014; Nahata et al, 2017; Olson et al, 2015; Peterson et al, 2017; Shiffman et al, 2016; Skagerberg, Davidson, et al, 2013; Skagerberg, Parkinson, et al, 2013; Spack et al, 2012; Surace et al, 2020; Zucker et al, 2002; Zucker et al, 2012).

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Strong consensus (> 95%)

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**IV. E2.** There is evidence that clinically relevant psychopathological abnormalities that associated with gender incongruence or gender dysphoria in childhood and adolescence, and which go beyond reported GD distress, are more common in adolescents after the onset of puberty than in prepubertal children.

Moderate evidence: Comparison of results from more than 10 studies with a sufficient number of cases and methodological quality (Aitken et al, 2016; Arcelus et al, 2016, Cohen-Kettenis et al, 2003; de Graaf et al, 2018; de Vries et al, 2016; Kolbuck et al, 2019; Shiffman et al, 2016; Skagerberg et al, 2013; Steensma et al, 2014; Wallien et al, 2007; Zucker et al, 1997, Zucker et al, 2002).

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strong consensus (> 95%)

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Note: In the case of persistent GI, affected adolescents often report a sharp increase in body-related gender dysphoric distress from the onset of puberty, which leads to a pronounced and persistent stress load. This body-related distress often plays no or only a minor role in gender-nonconforming children before puberty, especially if they feel socially accepted in their perceived gender affiliation. This can be seen as an important factor in the significantly increased risk of mental illness among gender dysphoric adolescents.

It should be put into perspective that psychopathological symptoms are generally more common in adolescence than in childhood, which is explained by the particular vulnerability of this age group in connection with coping with the psychosocial and psychosexual developmental tasks of puberty.

## 3.2. Recommendations

### 3.2.1. General recommendations

Based on the knowledge presented in the previous sections and the clinical observations and treatment experiences of the experts involved in the guideline development, we provide the following *consensus-based recommendations* for the diagnostic and therapeutic approach to children and adolescents who present to the health care context because of a potentially existing or developing GI or GD.

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*Consensus-based recommendation:*

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**IV. K1.** Children and adolescents who present for diagnosis and/or treatment due to gender incongruence or gender dysphoria (GI/GD) should undergo a comprehensive child and adolescent psychiatric or psychotherapeutic assessment if there are indications of clinically relevant psychological or psychopathological abnormalities. The history of the reported abnormalities and their possible interactions with GI or GD should be carefully recorded.

Strong consensus (> 95%)

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Explanation: If there are no indications of clinically relevant psychological or psychopathological abnormalities and no psychotherapeutic treatment is desired, no further diagnostic measures are initially required. For example, general development-oriented counseling or counseling support in preparation for social role testing does not require a prior child and adolescent psychiatric or psychological diagnosis. However, this only applies as long as there is no desire for body-modifying medical treatment. A comprehensive diagnostic *assessment* is an absolute prerequisite for any indication for medical interventions (e.g. puberty blockade or sex-modifying hormone treatment), even in the current absence of psychopathological symptoms: it is necessary both for sufficient diagnostic certainty that a stable/persistent GI is present and for determining whether another mental disorder is present and needs to be addressed. This diagnostic assessment is also necessary to determine the capacity *for informed consent* (see Chapter VII→ "*Determining the indication for body-modifying medical interventions*").

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Consensus-based recommendation:

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**IV. K2.** If a child and adolescent psychiatric or psychotherapeutic diagnosis is carried out in children and adolescents with gender incongruence or gender dysphoria (gender incongruence or gender dysphoria), an anamnesis of previous development should be taken, on the basis of which the onset and course of gender-incongruent self-perceptions and any associated gender dysphoric symptoms are carefully traced.

Strong consensus (> 95%)

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Explanation: This recommendation applies regardless of the reason for and objective of the child and adolescent psychiatric or psychological diagnosis (diagnostic clarification of psychopathological symptoms, indication for psychotherapy or indication for somatomedical interventions).

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Consensus-based recommendation:

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**IV. K3.** In a child and adolescent psychiatric or psychotherapeutic diagnosis of children and adolescents with gender incongruence or gender dysphoria, specific attention should be paid to the possible presence of depression, anxiety disorder, self-injurious behavior and suicidal tendencies that require treatment.

Strong consensus (> 95%)

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Consensus-based recommendation:

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**IV. K4.** If a mental disorder requiring treatment is diagnosed in association with gender incongruence or gender dysphoria (GI/GD) in childhood or adolescence, specialist treatment should be offered. This should be individually designed as part of a treatment plan that includes any indicated GI/GD-specific treatment measures.

Strong consensus (> 95%)

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Explanation: The treatment of a diagnosed mental disorder should be specific to the disorder in accordance with the relevant guideline standards. However, this cannot usually be done in isolation from the psychological distress caused by persistent GI or GD. Such gender dysphoric distress is to be understood as a permanently effective and etiologically significant stressor within the framework of a disorder model to be developed on an individual basis, without the appropriate addressing of which in an integrated treatment plan, psychotherapeutic or pharmacotherapeutic interventions alone, which are geared towards anxious or depressive target symptoms, for example, often do not have a sufficient effect according to the predominant clinical experience of the experts involved in the development of the guidelines.

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Consensus-based recommendation:

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**IV. K5** When making a diagnostic assessment of psychopathological symptoms or mental disorders associated with gender incongruence or gender dysphoria (GI/GD), practitioners should avoid making sweeping assumptions about causal relationships. Instead, in an open dialog with patients, an attempt should be made to develop a case-specific disorder model with regard to the psychopathological symptoms and complaints. ( → see Chapter V on psychotherapy)

Strong consensus (> 95%)

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Explanation: If a diagnosis of GI has been confirmed, it is reasonable to assume that the resulting gender dysphoric distress in combination with aversive social experiences (*minority stress*) may be etiologically significant stressors, but this must be checked in each individual case during the diagnostic process. Psychopathological symptoms

may also have arisen independently of an existing GI or GD or have already existed before becoming aware of gender-incongruent feelings. Similarly, some mental disorders, even if they are also caused by the stressor of a GD, can develop a dynamic of their own that perpetuates the disorder, such as addiction disorders, eating disorders or pronounced social phobias with school absenteeism. The possibility that a primary mental disorder associated with pronounced general identity insecurity and/or identity diffusion can lead to temporary gender dysphoric symptoms that do not persist in the further course of development must also be considered in individual cases and, if necessary, carefully examined in the diagnostic process. If, for example, a personality disorder with pronounced identity diffusion is present in an individual case, this can make a diagnostic assessment considerably more difficult and require a longer diagnostic process. However, an "automatic" assumption that there is no persistent GI in such a case is equally unjustified and may need to be critically reviewed in the further course.

### **3.2.2. Special recommendations for indications of the coincident presence of an autism spectrum disorder (ASD)**

The diagnosis and support of those affected with indications of a coincident dual diagnosis of ASD and GI or GD is usually complex and time-consuming. Autism-related characteristics can considerably complicate and delay the professional differential diagnosis, support and treatment of adolescents who present with indications of the presence of GI or GD. If a professional diagnosis of GI or GD has been made, a coincident diagnosis of ASD does not justify the delay or non-indication of desired medical measures to support social transition.

Consensus-based recommendation:

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<p><b>IV. K6</b> In children and adolescents who present with gender dysphoric symptoms, attention should be paid to the possible presence of an autism spectrum disorder. If an autism spectrum disorder is suspected, the recommendations of the S3 guideline "Autism Spectrum Disorders in Childhood and Adolescence, Part 1: Diagnostics (AWMF Reg. No. 028-018) <b>should</b> be followed.</p>
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Strong consensus (> 95%)

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Explanation: Although a diagnostic overlap between ASD and GI or GD is disproportionately frequent, it is rare in absolute terms. A general autism screening is therefore unnecessary if there are no clinical indications of the possible presence of ASD. However, if there are clinical indications of the possible presence of an ASD, a guideline-compliant autism diagnosis should be initiated, whereby it is at the discretion of the examining specialist to use a screening instrument beforehand or, if there is already a clear clinical suspicion of an ASD, to initiate a standardized autism diagnosis directly.

Consensus-based recommendation:

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<b>IV. K7</b>	If children and adolescents with gender incongruence or gender dysphoria also have a diagnosed autism spectrum disorder, the expertise of both areas should be included in the professional support.
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Strong consensus (> 95%)

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Explanation: In the case of a dual diagnosis, the specific characteristics of both areas must be taken into account for professional further treatment planning in the medium and long term. This means that autism-specific clinical expertise is indispensable for understanding and treating GI and GD cases and vice versa.

#### 4. Summary:

##### **Diagnostic procedure for indications of gender incongruence, taking into account possible concomitant psychiatric diagnoses**

When diagnosing gender incongruence (GI), it should be noted that it is not defined as a mental disorder according to ICD-11. The diagnosis is therefore made according to ICD-11 in the sense of a health-relevant "*condition*". The patient's reflected and authentic self-disclosure of their non-conforming gender identity and its persistence in adolescence after the onset of puberty are diagnostically groundbreaking. The associated mental disorders frequently encountered in GI, if they are considered in the differential diagnosis, are not to be understood as "exclusion diagnoses" - neither in the sense that the presence of such a diagnosis speaks against the assumption of GI, nor that they



must be ruled out before a diagnosis of GI can be made. In the case of mental disorders that are accompanied by symptoms of body dissatisfaction, identity insecurity or social anxiety, for example, adolescents may temporarily identify as gender-nonconforming without developing persistent GI. On the other hand, persistent GI can cause identity insecurity, body dissatisfaction, anxiety symptoms and other secondary symptoms as it progresses. In individual cases, the diagnostic assessment must therefore be made carefully on the basis of the overall findings and the course of the accompanying psychopathological symptoms. As GI is not defined as a mental disorder (see above), the term "comorbid disorder" is not used in this guideline, but rather the terms "*coincident*" or "*mental disorder associated with GI*" are used throughout.

Differential diagnostic considerations in the sense of a differentiated diagnostic assessment of associated mental disorders in the suspected presence of GI are important because they may interfere with several aspects that are important for treatment decisions, namely, among others:

- with the diagnostic clarity regarding the self-disclosure on perceived gender identity (e.g. in the case of severe depressive symptoms with identity diffusion),
- with diagnostic clarity regarding expressed body dissatisfaction (e.g. in the case of eating disorders),
- with the stability of gender identity over time (e.g. in the case of unstable personality disorders),
- with the determination of capacity to consent (D)/capacity to judge (CH)/capacity to make decisions (A) on the basis of informed consent (e.g. in the case of mental disorders with cognitive constriction or pronounced emotional instability),
- with medical contraindications for hormonal treatments (e.g. anorexia with severe underweight or mental disorders with pronounced affectability and impulsivity).

The recommended procedure for determining the indication for body-modifying medical measures in the case of diagnosed persistent GI is described in → *Chapter VII*. In many cases, this is preceded by an in-depth psychiatric or psychotherapeutic diagnosis due to associated mental health problems. This section summarizes important principles and steps for an integrated diagnostic approach outlined in the previous chapter:

1. The suspicion of gender incongruence per se does not justify the need for psychiatric or psychotherapeutic diagnostics in the absence of psychopathological symptoms. In particular, there is no need for a differential or exclusion diagnosis in the absence of psychopathological symptoms.
2. However, a child and adolescent psychiatric or psychotherapeutic diagnosis is always indicated in cases of suspected gender incongruence if *one of the following three reasons* applies:
  - a. There are indications in the medical history and psychopathological findings of a mental disorder requiring treatment, which may need to be considered in interaction with the gender incongruence ( → see *recommendation IV. K1 above*). In this case, the diagnostic procedure follows the respective guideline standard of the mental disorder under consideration (e.g. depression, anxiety disorder, eating disorder or autism spectrum disorder). An individualized disorder model should be developed with the patient, which takes into account various possibilities of causal and reactive causal relationships between psychopathological symptoms on the one hand and gender dysphoric distress on the other (→ see *recommendation IV. K5 above*). Frequent and differential-diagnostically significant co-occurring mental disorders are listed in Table 3 below.
  - b. There is a desire for psychotherapeutic support. In this case, the diagnostic procedure follows the usual psychotherapeutic principles for a professional indication and goal formulation (see explanations in chapter V→ *"Psychotherapy and psychosocial interventions"*).
  - c. There is a desire for body-modifying medical treatment or such an indication is being considered. In this case, a detailed diagnosis, in which any associated mental disorders are taken into account, is an essential prerequisite for a professional indication (see explanations in Chapter VII→ *"Indications for body-modifying medical interventions"*).

Table. 3:

<i>Differential diagnoses and common co-occurring disorders in gender incongruence</i>
Depressive disorders
Social phobias
Personality disorders with identity diffusion
Eating disorders
Suicidal syndromes
Syndromes of self-injurious behavior
Autism spectrum disorders

3. For the clinical diagnosis of persistent GI as a health-relevant

"There are no standardized diagnostic tools for mental disorders without mental illness value according to ICD-11. The diagnosis is primarily based on the narrative exploration of the patient's self-experience over longer periods of time. Treating psychotherapeutic and medical professionals can be guided by the diagnostic criteria according to ICD-11 (see Chapter VII→ "Indication for body-modifying medical interventions"), according to which there is a pronounced and persistent incongruence between a person's perceived gender and their assigned gender, which justifies the reflected desire for a permanent and socially accepted transition. If body-modifying medical measures are considered in connection with such a desire for transition, the persistence of this pronounced feeling must be explored comprehensively with the person seeking treatment against the background of their previous development and life history, taking into account the perspective of their guardians, before an indication is given (see Chapter VII→ "Indications for body-modifying medical interventions", Recommendation VII. K3). The psychotherapeutic professional needs to have comprehensive knowledge of the range of variations in the development of gender-nonconforming children and adolescents. This includes knowledge of forms of progression that are associated with a

desistence or detransition (see Chapter II→ "*Developmental variants*"  
see recommendations II. K1 and II K2).

- The diagnostic criteria for *gender dysphoria in adolescence and adulthood according to the DSM-5* (see list in Chapter VII→ "*Indications for body-modifying medical interventions*") can also be used for a standardized diagnostic assessment of the degree of gender dysphoric distress in GI. *In addition*, four English-language questionnaire instruments validated for adolescence have been established internationally for the assessment of gender dysphoric symptoms, two of which have been validated in a German-language translation (see Table 4 below). Such symptom questionnaires are dispensable for clinical diagnostics because they have no valid diagnostic added value compared to the clinical DSM-5 criteria in individual cases. To date, they have mainly been used in cohort studies to measure symptom manifestations and their progression.

*Table 4: Validated questionnaire instruments for recording gender dysphoric symptoms*  
(according to Bloom et al., 2021; Bowman et al., 2022).

<b>Instrument</b>	<b>Authors</b>	<b>Year</b>	<b>Country</b>	<b>Perspective</b>	<b>German validation</b>
Gender Diversity Questionnaire ( <i>GDQ</i> )	Twist & de Graaf	2019	UK	Self-report	no
Gender Identity Questionnaire for Children ( <i>GIQ</i> )	Johnson et al. report	2004	Canada	External by parents	no
Gender Identity/Gender Dysphoria Questionnaire for Adolescents and Adults ( <i>GI/GDQ-AA</i> )	Deogracias et al.	2007	Canada	Self-report	Yes*
Utrecht Gender Dysphoria Scale ( <i>UGDS</i> )	Steensma et al.	2013	The Netherlands		Self-report Yes*

\*Schneider et al., 2016

The diagnosis of a co-occurring mental disorder may interfere with diagnostic clarity in the assessment of GI, but it does not per se rule out the presence of GI, nor does it per se constitute a contraindication for body-modifying measures. Possible interference between GI with gender dysphoric symptoms and a co-occurring mental disorder can be manifold and must be assessed on a case-by-case basis. This can sometimes require longer diagnostic process support to clarify the treatment approach.

justify. Here are two illustrative case studies that show how complex the diagnostic process is. process can be. Of course, similar case constellations can also take completely different courses in clinical practice.

*Case 1: Brian 16-21 years,*

*Autism spectrum disorder and gender incongruence*

Brian is a 16-year-old adolescent with transgender perception (female to male) who, at the time still living socially in the role of a girl, is registered in a special consultation for gender incongruence. Brian communicates very sparingly with the examiner, maintaining eye contact. His language seems simple. He clearly communicates that he feels like a boy, but has no idea how this can be implemented in everyday life. He wants to keep his girl's first name for the time being, as he already has it.

"for so long" and that it suited him. Nevertheless, he suffers greatly from the fact that those around him do not recognize him as a boy under his girl's name. The body dysphoria is very pronounced. He wishes he had a deep voice, male hair, a beard and more muscles on his upper arms and upper body. He also suffers greatly from menstruation and the sight of his female breasts. He had been socially isolated since childhood and had always had major problems with school performance, particularly in language subjects. The developmental anamnesis with Brian and his parents reveals a picture of a male gender identity that has been stable since early childhood, but so far without a clearly expressed desire to transition.

This is followed by a one-year phase of psychotherapeutic support. A great discrepancy between a high level of gender dysphoric distress on the one hand and a great fear of change on the other becomes apparent. Brian and the family are advised to take a lot of time for the upcoming decision-making process. He is supported in preparing the steps he wants to take very well. Brian finally decides to give up his female name and adopt a male first name. A detailed diagnostic assessment revealed the following diagnoses:

1. *persistent gender incongruence*; 2. *autism spectrum disorder*; 3. *average intelligence*.

In the therapeutic process, it seems important to work out with Brian to what extent the ambivalence towards transition steps that has persisted for several years could be related to self-insecurity with regard to his gender identity or rather to a fear of change and social anxiety resulting from autistic symptoms. At the age of almost 18, Brian decides to undergo testosterone treatment, for which an adolescent psychiatric indication is given. He also urgently wants a mastectomy. He often cries in despair during the sessions, but is unable to decide on an operation for over two years as he is very afraid of this step. He is again supported in taking his time to make the decision.

Looking back, Brian never questioned his gender identity. He had been clear about being male since early childhood. He needed open-ended support over a period of years in order to find out which measures were right for him. He registers for a preliminary mastectomy consultation

and then leaves again, only to sign up again a year later. At the age of 20, he has the operation after psychiatric indication. The follow-up at the age of 21 shows a high level of satisfaction with the gender reassignment measures of hormone treatment and mastectomy. Brian lives in a partner relationship with a young man.

*Case 2: Nick, 15-20 years old,*

*Anorexia and gender incongruence*

15-year-old Nick, who already lives in the male gender, is registered for a child and adolescent psychiatric consultation due to chronic restrictive anorexia nervosa, which has been chronic since the age of 12 and has already led to several hospitalizations. Nick, whose assigned gender at birth was female, explained that he felt like a boy. However, he had never expressed this during his previous hospital stays. From his developmental history, he reports typical boyish behavior and preferences in childhood, although he never explicitly expressed a desire to take steps to transition in this regard. It was not until puberty that a pronounced body dysphoria developed in relation to all secondary female sexual characteristics. In the process of prolonged psychotherapeutic support, the development of gender identity in the course of life and the background to the body dysphoria are reflected upon. The extent to which the eating disorder can be understood as a reaction to gender dysphoria is explored, or whether, conversely, the reported rejection of the female gender role could be understood as an expression of a psychosexual maturation conflict in the context of the eating disorder. It is becoming increasingly clear that the male gender identity has existed since childhood and that it was therefore not possible for Nick to experience female physical development in a way that was congruent with his personality. On the one hand, Nick can describe the development of the eating disorder in connection with his gender identity, but on the other hand, he can also clearly recognize that the eating disorder has now taken on a strong momentum of its own. He differentiates his body dissatisfaction according to different body features: The stomach feels "too fat", the breasts as "fundamentally wrong and inappropriate". After a year of psychotherapeutic support, Nick's request for a puberty blockade was granted. As a result, it turns out that weight gain occurs very quickly after Nick is given the prospect of a physically masculine development that is congruent with his identity. After four years of the eating disorder, Nick is able to gain weight stably up to the 25th BMI percentile. At the age of 17, he decides to undergo testosterone treatment and a mastectomy at the age of 18 while maintaining a stable normal weight. In the follow-up at the age of 20, a stable male identity, a high level of satisfaction with the gender reassignment measures and a complete remission of the eating disorder are evident.

## Chapter V

### Psychotherapy and psychosocial interventions

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## 1. Introduction and key questions

In previous professional recommendations on psychotherapeutic interventions for children and adolescents who present to the professional help system with signs of possible gender incongruence (GI) or gender dysphoria (GD), a remarkable discrepancy is noticeable. On the one hand, it is undisputedly emphasized that the offer of psychotherapeutic support is very important. In treatment recommendations of earlier decades, undergoing psychotherapy for trans people was even defined as an obligatory prerequisite for access to body-modifying medical measures.<sup>1</sup> On the other hand, previous relevant recommendations contained little or no definition of which interventions psychotherapeutic support for trans people should include or which therapeutic goals are useful or not useful. In other words, psychotherapy is often recommended, but usually remains a "black box" in the recommendations.

Based on the diagnosis of GI according to ICD-11 (World Health Organization, 2022), there is initially no indication or recommendation for psychotherapeutic measures, as it is not a mental disorder. The offer of psychotherapy in the narrower sense of the psychotherapy guideline therefore requires a separate indication in individual cases, which is justified by the presence of a mental disorder that is worthy of illness (see below). Nevertheless, psychotherapeutic process support to support gender identity development and its successful integration into overall personality development often appears useful. Accordingly, it is often requested and utilized by those seeking treatment. The diversity and complexity of developmental issues in childhood and adolescence, which usually go far beyond the gender issue, must be taken into account appropriately, especially with regard to the entire *identity development in adolescence* (Seiffge-Krenke, 2021).

The primary aim of the structure and content of this chapter is to provide psychotherapeutic professionals with a broad basis for professional orientation from the specific literature reviewed, without regulating a specific approach. Accordingly, the explanations focus on *professional attitudes* that need to be reflected upon, as well as on meaningful *possible goals of psychotherapeutic interventions*, which can be discussed with patients or clients on a case-by-case basis.

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<sup>1</sup> In the assessment guide published in 2020 by the Medical Service of the National Association of Statutory Health Insurance Funds (BGA-MDS; Medizinischer Dienst des Spitzenverbandes Bund der Krankenkassen e.V., 2020), whose authorship is not transparent, this outdated view is still held, although it is not compatible with the current state of scientific knowledge presented in the current S3 guideline for adults on *gender incongruence, gender dysphoria and trans\* health* (AMWF, 2018) or with the professional ethics of psychotherapists.



and their relatives. Overall, only a few guiding recommendations were agreed and emphasized by the guideline commission.

### Key questions for the guideline:

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- How bindingly can/should psychotherapy be recommended at which points of professional support for those seeking treatment?
  - Which differentiations between psychotherapy and low-frequency mental health counseling can be specified?
  - What does guideline-based professional support look like for patients who do not want or need psychotherapy?
  - What meaningful goals can be identified for psychotherapeutic interventions for adolescents with gender incongruence or gender dysphoria?
  - Which goals of psychotherapeutic interventions are obsolete in this context?
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## 2. General conditions for psychotherapeutic services

In practice, psychotherapeutic services for gender non-conforming children and adolescents are not limited to guideline psychotherapy, but include a broader spectrum of interventions. In order to differentiate appropriately qualified psychotherapeutic services from other *psychosocial counseling services* for trans people, we define them as follows in this chapter:

Definition:

*Psychotherapeutic support* for children and adolescents who present with signs of GI or GD is understood to mean all professional care services provided by licensed specialists with proven psychotherapeutic qualifications with the aim of maintaining or improving mental health.

In particular, this also includes low-frequency psychiatric-psychotherapeutic consultations that are offered as part of professional process support to support social transition and/or to accompany medical treatment.

transition steps are offered by licensed psychotherapeutically qualified specialists. In individual cases, the indication for psychotherapy in the narrower sense of the psychotherapy guidelines is based on existing symptoms, the associated psychosocial impairment, the subjective level of suffering and the desire for psychotherapeutic support. Since the presence of gender incongruence according to ICD-11 (World Health Organization, 2022) does not constitute a mental disorder per se, an independent diagnosis of a mental disorder should always be made, if necessary, to guide the indication for therapy, in which an existing gender dysphoric condition can also be reflected, e.g. depressive disorder, anxiety disorder, social phobia, <sup>F542</sup>, etc.

This procedure is also recommended for the outstanding transition period during which diagnoses are still coded according to ICD-10 (World Health Organization, 2019) in healthcare practice. This takes into account the fact that the changeover to ICD-11 in coding practice is expected to take place within the validity period of this guideline. In addition, the disorder concepts on which the F64 diagnoses of ICD-10 (gender identity disorders) are based are obsolete.

A regular obligation to undergo psychotherapy for those seeking treatment, e.g. as a precondition for access to somatomedical measures for gender reassignment, is unethical and obsolete. The AWMF's S3 guideline for adulthood makes the following consensus-based recommendation in this regard:

"Psychotherapy should not be used without a specific indication and should never be seen as a prerequisite for body-modifying treatments. The indication must be determined in accordance with the provisions of the Psychotherapy Directive" (AWMF, 2018, p. 45).

The international guideline *Standards of Care, Version 8* of the World Professional Association for Transgender Health (2022) formulates the following recommendation in this regard:

"We recommend that health professionals do not necessarily prescribe psychotherapy for transgender and gender non-conforming people before initiating gender reassignment treatment. It is recognized that psychotherapy may be helpful for some transgender and gender nonconforming individuals." (S. 177).

**Consensus-based recommendation (from the preamble to the guideline):**

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<sup>2</sup>F54: psychological factors in diseases classified elsewhere

**V. K1.** Psychotherapeutic support should be offered and made available to those seeking treatment as support and guidance, e.g. for open-ended self-discovery, to strengthen self-confidence, to overcome experiences of discrimination or for psychological preparation and follow-up of steps in the transition process. An obligation to undergo psychotherapy as a condition for access to somatomedical treatment is not ethically justified for reasons of respect for the dignity and self-determination of the person.

There are some specific aspects in the professional support of self-discovery and transition processes of children and adolescents with GI or GD which, depending on the individual case, may justify the offer of psychotherapeutic support if desired due to an increased mental health risk:

- As puberty progresses, irreversible body changes and the resulting exacerbation of gender dysphoric distress can create time pressure for treatment decisions on somatomedical interventions. Psychotherapeutically accompanied clarification processes may be necessary for their psychological preparation and medical indication (e.g. in the case of still open or fluid identity-finding processes in adolescence or to support the development of a sufficient capacity for consent).
- The mental health prognosis for GI or GD depends crucially on the experience of emotional support from the family. If a child's GI leads to conflicts in the parent-child relationship, this is a lasting burden for those affected and may make psychotherapeutic support necessary.
- The mental health prognosis depends decisively on the experience of social support and acceptance in the living environment, for which a self-confident social outing ("no longer hiding") is usually necessary, for the successful preparation of which psychotherapeutic support is often required.
- As members of a gender minority, people with GI often experience so-called *minority stress* in their living environment, which causes an increased risk of mental health problems and often requires psychotherapeutic support to cope with.
- A social transition in conjunction with somatomedical interventions in adolescence takes place in several stages over a number of years. These must be carried out in interaction

with the social environment in order to be integrated into the psychosexual and psychosocial development of identity. This can often be better achieved with psychotherapeutic support. Successful psychological integration, in turn, appears to reduce the risk of later feelings of disturbance ("A part of me is somehow missing"), as is sometimes reported in adult trans people who later wish to detransition.

- It seems sensible to promote the stability and coherence of one's own gender perception, especially in the case of uncertainty in the area of tension between inner conviction and livability in the social context of relationships

Günther, Teren & Wolf (2021) explain: "The gender-variant or trans\*gender experience of children and adolescents alone does not indicate a need for psychotherapy. However, psychotherapy [in the extended sense mentioned above] can be useful to support them in overcoming specific challenges that these children and adolescents face in family, school and other social contexts" (p.254).

This form of supportive, development-oriented process support, which also includes can contain psychoeducational elements, Dietrich (2021) explains:

"In the psychotherapeutic accompaniment of transitions in adolescence, a process-oriented and on the individual and changing needs of those seeking treatment. [...] we cannot [...] prescribe a strict treatment plan, a fixed goal, but must work this out together with the young person. The adolescent should be thoroughly and comprehensively informed about all steps [...] Such an approach also means that the therapists are able to accept the processual nature of development as such." (p. 19-20)

Beyond the unspecific recommendation for psychotherapeutic support, there is only scant information in the relevant specialist literature on how to address the *specific aspects* mentioned above that may be relevant in the psychotherapeutic support of children and adolescents with GI or GD and how to implement them in psychotherapeutic interventions. There are no evidence-based recommendations to date. The approach in individual cases must therefore be developed and designed on an individualized and needs-oriented basis with the person seeking treatment. Based on a comprehensive review of previous guideline recommendations, study results and other relevant literature, we have identified some important aspects for the application and design of psychotherapeutic interventions for this guideline in the sense of a current "State of the art" has been extracted, which can serve as orientation and inspiration for psychotherapeutic professionals. As no specific recommendations for concrete interventions or therapy methods or procedures can be derived from the entire scientific literature to date, the following recommendations have been made.

methods, in the following sections we concentrate on important aspects of a *psychotherapeutic attitude* and on *definable goals* of psychotherapeutic interventions that are relevant in this field.

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Consensus-based recommendation:

**V. K2.** When gender-nonconforming adolescents seek psychotherapeutic support, the format (setting, frequency, etc.) and goals should be based on individual needs. Goals should be discussed transparently between the psychotherapist and the person seeking treatment and mutually agreed upon.

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Consensus: strong consensus (> 95%)

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## 2.1 Excursus: Historical development of basic psychotherapeutic attitudes and concepts:

Various narrative reviews from earlier decades describe three partly conflicting concepts in the treatment of children and adolescents with gender dysphoria, each of which was based on a specifically defined attitude. (Korte et al, 2016; Leibowitz & Telingator, 2012; Menvielle & Gomez-Lobo, 2011; J. Olson et al, 2011; Spivey & Edwards-Leeper, 2019; Vance et al, 2014). These three concepts represent a historical development of prototypical "pure forms", which were based on various theoretical assumptions on the basis of which the respective attitude was founded:

1. The "**Live in your own skin**" model by Zucker et al. (2012). This model is based on the assumption that children still have a malleable "gender brain", with the main aim that the child can still learn to accept its birth gender in order to protect itself from later stigmatization and rejection. The psychotherapy offered was therefore aimed at the parents and the child, with recommendations to remove and replace gender-typical toys, change the choice of playmates and increase contact between the parent of the same gender. This was associated with a reduction in contact with the other parent. This model is considered historically outdated and obsolete, both in terms of its etiological assumptions and its recommended therapeutic goals and interventions. From today's perspective, a corresponding approach by therapists would not be

would not only be considered unethical, but if it were used with the intention of changing a child's sense of belonging to a gender in a defined direction, it would recently even be a criminal offense in <sup>Germany</sup><sup>3</sup>.

2. The "**watchful waiting**" model was developed by the Dutch team led by Cohen-Kettenis (1994). Essentially, this model provided for a sufficiently long phase of support for a child or adolescent, during which an **open-ended self-exploration with** regard to gender identity was to be supported. The child should not be "steered" in a particular direction, but encouraged to try things out in order to find the path that is most consistent with their inner experience of identity. In this concept, it was recommended that children who already showed GI before puberty should at least experience the beginnings of puberty in order to find out for themselves how the experience of identity develops, i.e. whether or not the GI persists in the sense of a stable, solidifying trans identity, under the impression that puberty development has begun. This is a kind of "observation over time" combined with the advice that the child does not yet commit to a gender role in all areas of life in relation to the outside world. The psychotherapy offer also provided for the creation of safe niches in the child's private space in which the child could partially live out transgender role behavior. The recommendation inherent in this approach to avoid a possibly premature "commitment" to a transgender role identification, especially in childhood, was based on the assumption that a later return to the social gender role assigned at birth (*retransition*) would be very difficult to cope with psychologically in the event of a later desistance of the GI. However, there is no empirical evidence for this assumption, only reports of corresponding clinical observations in a few individual cases from earlier decades, in which such a retransition in adolescence was accompanied by psychopathological abnormalities (Steensma et al., 2013). In these reported cases, however, it remained unclear which accompanying family or social factors could have contributed to this. There are now follow-up studies with larger numbers of cases of children who have already undergone a complete social role change before puberty (see Chapter III → "*Social role change in childhood*"). Their results - also on the processes with of a retransition - speak against these fundamental concerns about social transitions in childhood (Olson et al., 2022).

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<sup>3</sup> The "Act on the Prohibition of Conversion Treatments" passed by the Bundestag and Bundesrat in 2020 prohibits, among other things, all therapeutic offers to persons under the age of 18 that are "aimed at changing or suppressing sexual orientation or self-perceived gender identity" (§1, Federal Law Gazette I p. 1285)

3. The **"gender affirmative"** model, which also includes various psychosocial interventions, recommends validating a child's self-identified sense of gender affiliation and meeting them with an affirmative attitude (Ehrensaft, 2017; J. Olson et al., 2011; Spivey & Edwards-Leeper, 2019). If desired, the child and parents may also be supported before puberty to complete the child's social transition in all areas of life, including daycare and school. This model emphasizes the individualization of care and the avoidance of rigid therapy patterns.

Depending on the individual clinical situation on the path to self-discovery to accompanying a social outing, most current recommendations and approaches implicitly or explicitly refer to aspects of the "watchful waiting" and "gender-affirmative" therapy models.

The opinion of Korte et al. (2016) is an exception in the evaluation of the psychotherapy models mentioned. The authors consider the affirmative approach to be unfavorable because it allegedly starts from empirically unproven basic assumptions and tends to reinforce the identity conflicts of those affected rather than helping to resolve them. The result of this is that premature support for a social transition can lead to a later return to the "original gender" may be made more difficult by years of experienced affirmative validation of the transition. The authors do not report any experiences from therapeutically accompanied processes in this regard. In the literature, there is only a reference in the persistence/desistance studies by Steensma et al. (2011 & 2013) to two individual cases of birth-gender girls who had already (partially) changed into the role of a boy as children before puberty, in which considerable difficulties were reported in returning to the birth-gender role in the course of a desistance of gender dysphoria in adolescence. No further details are provided on other accompanying circumstances such as psychotherapeutic support (Steensma et al., 2011; see Chapter II → "*Social role change in childhood*").

### **3. Observational studies on psychotherapeutic interventions**

In the few observational studies on psychotherapeutic interventions with gender dysphoric children and adolescents to date, the number of cases is usually low, which relativizes their informative value.

Austin et al. (2018) accompanied 8 people between the ages of 16 and 18 by supporting them with coping strategies for rejection and bullying. As a result, the

Depression levels were reduced. However, the previous coping strategies remained unchanged.

Di Ceglie and Thümmel (2006) report on work with 10 parents of trans children with 6 thematic sessions as part of a cross-sectional study. The parents felt less isolated afterwards, discovered similarities with other parents, appreciated the contact with the specialists and the children also benefited from the work with the parents. The study by Levitan et al. (2019) focused on the investigation of social support. In 146 trans boys and 34 trans girls, it was shown that the social transition proceeds significantly better if the children are not left alone with their problems, but receive sufficient social support from parents, other caregivers and specialists.

In an evaluation study by Menvielle (2012) on a group intervention for families, it was reported that the moderated exchange between parents (42 parents with 31 trans children) in a group setting on site and via an internet platform helped to overcome the feeling of social exclusion. The children stated that, with the help of the intervention, they were more concerned with questions about their future active life choices (*empowerment*).

A pre-post study on open groups for adolescents aged 15 and over with gender dysphoria came to the following conclusions (Davidson et al., 2019): The openly expressed desire to transition was stronger or more frequent after this intervention than before. Respondents reported more social support and less social isolation after the group discussions. They still experienced rejection and negative judgments, but were able to deal with them better. This underlines the psychotherapeutic benefits of an affirmative group experience in terms of empowerment.

#### **4. Professional attitude in the psychotherapeutic support of gender-nonconforming, gender-incongruent and gender-dysphoric adolescents**

In the following sections, some important aspects of an appropriate therapeutic attitude are presented in condensed form from previous guidelines and from current contributions by individual authors, as discussed and recommended for psychotherapeutic process support in this field. These aspects are intended to serve as orientation for users of the guideline and encourage them to continuously reflect on their own attitude. We have refrained from making consensus-based concrete recommendations on basic therapeutic attitudes, as these are ultimately based on the reflected



It is the personal responsibility of each psychotherapeutic specialist and cannot and should not be regulated by a guideline.

#### 4.1 Non-binary understanding of gender

It is considered an important prerequisite for an appropriate professional attitude towards trans people that professional helpers have a reflective theoretical understanding of the development of gender identities. This should not be rooted in outdated assumptions of an exclusively binary gender binary or in cis and heteronormative ideas, but should also recognize non-binary gender identities and gender identities that become fluid over the course of a person's life (Ehrensaft, 2016; Quindeau, 2014a, 2014b).

The S3 guideline on *gender incongruence, gender dysphoria and trans\* health* for adulthood explains this in the explanatory text (AWMF, 2018, p.16):

"One of the assumptions to be questioned [by practitioners] is, for example, that one's own gender permanently corresponds to the physical sex characteristics and that gender identity is unchangeable in the course of a biography. Thus, encounters with trans\* people can confront the practitioner with their own gender identity, gender-related development and role expectations, as well as conflicts between acceptance and non-acceptance of their own body. Without reflection, such a confrontation can lead to defensiveness and avoidance as well as projective psychopathologization, which can jeopardize the development of a sustainable relationship (Güldenring, 2015)."

The *Guidelines for Psychological Practice with Transgender and Gender Nonconforming (TGNC) People* of the American Psychological Association (APA, 2015) states this in the first of 16 professional statements:

"Psychologists understand gender as a non-binary construct, that allows a range of gender identities and are of the opinion that a person's gender identity does not have to correspond to the biological sex assigned at birth" (quoted from AWMF, 2018, p.37).

The following recommendations are formulated in the monographic practical handbooks on gender dysphoria in childhood and adolescence by Dietrich (2021) and Meyenburg (2020):

- "It is necessary to abandon the deceptive idea of the possibility of a clear gender assignment, which is committed to the system of hetero- and cisnormative bisexuality. This idea does not reflect the reality of the lives of the people we encounter and also the reality of the lives of the practitioners" (Dietrich, 2021, p. 64). And further: "Only if we take the concept of an open-ended approach seriously and recognize the changeable nature of human identity and also the experience of gender identity as therapists can we signal verbally and non-verbally right from the start of support that everything that the person seeking help feels should have its place in therapy." (Dietrich, 2021, p. 65).
- "Practitioners should not express a binary view of gender. They should give great freedom to explore different possibilities of gender expression. (Meyenburg, 2020, p. 12)

#### **4.2 Accepting and open-minded attitude**

An unconditional acceptance of being trans as an equal and non-pathological variant of gender diversity is an elementary prerequisite for a trans-sensitive attitude (Wiesendanger, 2002). An unconditionally accepting attitude towards the current gender-related sense of belonging is therefore an important prerequisite for a therapeutic relationship. Any confusion and uncertainty that (possibly) arises ("trans or not trans?") may need to be endured in the therapeutic relationship" (Romer & Möller, 2020). It is recommended, especially from the first contact, to use first names and pronouns in the personal address according to the wishes and self-attribution of the person seeking treatment and to clarify this at the beginning of the conversation ("How would you like to be addressed by me in our conversation?").

This unconditionally accepting attitude does not contradict the knowledge of a wide range of developmental trajectories in childhood and adolescence, which is equally important for professional helpers (see Chapter II → "*Variant developmental trajectories*").

can belong to adolescence. Not all young people who feel they belong to a spectrum of "queer" forms of expression of gender diversity and describe themselves as "trans" develop a permanently persistent gender incongruence.

Rauchfleisch (2021) has formulated this as follows: "We must make it clear to children and young people that coming out requires a lot of strength and that it is therefore important for us to be precisely informed about their state of health so that we can work with them to stabilize their personality and thus enable them to successfully manage their transition (p. 192)."

The Guidelines for Psychological Practice with Transgender and Gender Nonconforming People (APA, 2015) contain one of 16 professional statements on this subject:

"8. psychologists working with gender questioning and TGNC adolescents understand the different developmental needs of children and adolescents and the fact that not all adolescents hold on to their TGNC identity in adulthood." (cited translation according to AWMF, 2018, p.38)

#### **4.3 Rejection of "reparative" therapy goals**

"Treatment methods that, based on the assumption of a psychopathological maldevelopment, aim to change gender identity and gender-typical behavior so that they are more in line with the gender assigned at birth have been tried without success. Today, such treatment methods are considered ethically unacceptable" (Meyenburg, 2020, p. 12). In Germany, attempts to treat minors with such "reparative" intention (so-called conversion treatments to change sexual orientation) or gender identity) has also been a punishable offense since 2020 (Act on Protection against Conversion Treatments, Federal Law Gazette I, p. 1285). Therefore, there is no need for a specific consensus-based recommendation in this guideline.

#### **4.4 Affirmative attitude**

Regardless of the therapy goals to be formulated in each case (see next section below), which are based on the individual needs of those seeking treatment and can therefore vary greatly in terms of *concrete affirmative support for individual transition steps* (from waiting to encouraging), depending on where the individual person currently stands in the process, a basic affirmative attitude is part of a trans-sensitive professional attitude. This should be based on the above-mentioned unbiased and unconditional acceptance of gender-nonconforming identities and encourage every person seeking treatment to explore themselves openly and without fear in a lively and open-minded way.

Encourage interaction with social role testing. Real or expected adversities in the social and institutional environment to which children and young people who want to try out gender non-conformity, come out as trans or may wish to undergo a social transition may be exposed must be recognized. The resulting specific need for social and professional support must also be recognized. When adopting such an affirmative attitude, the basic rules of therapeutic abstinence must be observed at the same time, e.g. in order not to give a person seeking treatment the feeling of pleasing or disappointing the therapist if, for example, a certain step of a transition is taken or not (yet) taken.

In the *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People* (APA, 2015), the following professional statements are relevant in this regard:

"6 Psychologists seek to recognize the influence of institutional barriers in the lives of TGNC clients and support the development of TGNC-friendly environments.

7 Psychologists believe that there is a need to promote social change to reduce the negative impact of stigma on the health and well-being of TGNC clients. [...]

11. psychologists believe that TGNC clients are more likely to achieve positive life outcomes if they receive social support or trans-affirmative care." (cited translation according to AWMF, 2018, p.38)

#### **4.5 Knowledge of or inquiries about trans-specific experiences**

For an empathic understanding of the individual experiences of trans people, it is important to specifically inquire about trans-specific life realities and socializations (Günther et al., 2021). This includes, among other things

- Experiences with minority stress and possibly discrimination (see Chapter IX → "*Professional interaction & discrimination-sensitive interaction with gender-nonconforming children & young people*")
- the possible associated processing and coping with internalized transphobic parts in the self-reference of those affected (Günther et al., 2021),
- subjective connections between sexual orientation and gender identity,
- specific effects of being trans on romantic and sexual relationships,

- Overlaps between gender-nonconforming identity and other culturally shaped identities in the subjective experience of those affected.

In the *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People* (APA, 2015), the following five of 16 professional statements are formulated:

- "2. psychologists understand gender identity and sexual orientation as different but interrelated constructs.
3. Psychologists try to understand the extent to which gender identity intersects with other cultural identities of transgender or gender non-conforming people.
4. Psychologists are aware of how their attitudes and knowledge about gender identity and gender expression may affect the quality of care they provide to TGNC clients and their families.
5. Psychologists recognize the extent to which stigma, prejudice, discrimination and violence affect the health and well-being of TGNC clients. [...]
12. psychologists strive to understand the effects that changes in gender identity and gender expression have on the romantic and sexual relationships of TGNC clients." (cited translation according to AWMF, 2018, p.37-38)

#### **4.6 Reflection on the therapeutic role and self-awareness**

When shaping a psychotherapeutic relationship, it is important to reflect critically and openly on aspects of a possible power and dependency gap. A real imbalance in this respect inevitably arises, for example, when psychotherapeutic practitioners themselves prepare indications and expert opinions for somatomedical interventions and thus formally assume a professional "gatekeeping function" for access to medical transition treatments. Such a structural power imbalance arises regardless of how affirmatively this function is performed. For psychotherapeutic practitioners, it is important to recognize the history of a health and legal system that is restrictive towards trans people, which extends far into the current reality of care. This includes, among other things, the fact that trans people have to undergo two independent psychological or psychiatric examinations for the legal recognition of their gender identity in accordance with the currently still valid Transsexuals Act (TSG).

experts in order for their trans identity to be recognized by a court. Furthermore, the assessment guideline published in 2020 by the Medical Service of the National Association of Statutory Health Insurance Funds (Medizinischer Dienst des Spitzenverbandes Bund der Krankenkassen e.V., 2020), whose authorship and associated scientific legitimacy is not transparent, stipulates that the trans person seeking treatment must have previously undergone guideline psychotherapy as a prerequisite for the reimbursement of costs for gender reassignment surgery indicated by the guidelines - to prove that this "treatment attempt" to alleviate existing gender dysphoria has been "exhausted". This requirement of the MDS is thus in open contradiction to the current S3 guideline published two years earlier (!) by the AWMF for adults with *gender incongruence, gender dysphoria and trans\* health* (AWMF, 2018), in which it is expressly stated on the basis of the recognized state of scientific knowledge that the requirement of mandatory psychotherapy as a prerequisite for access to surgical gender reassignment measures is scientifically untenable, unethical and therefore obsolete.

This outlined history of the instrumentalization of psychotherapy as a restrictive obstacle towards trans people in the healthcare system can also cause a subjectively perceived power imbalance in the psychotherapeutic relationship in the sense of latent mutual expectations and role attributions, even in a participatory and affirmative relationship design. It is important to reflect on this carefully and critically.

Furthermore, for the self-reflection of psychotherapeutic practitioners, in order to avoid latent defensive attitudes towards gender-diverse forms of expression and life, it is recommended that they have critically examined various aspects of their own gender and its development as part of their professional self-awareness.

The AWMF S3 guideline on *gender incongruence, gender dysphoria and trans\* health in adulthood* (AWMF, 2018) makes the following two consensus-based recommendations:

"If possible, practitioners should have critically reflected on their own gender-related development and their relationship to physical sexual characteristics in the context of self-awareness.

Self-reflection should include dealing with the confusion that can be caused by the contradiction between one's own perception and the self-presentation or self-description of those seeking treatment with regard to gender." (S.16)

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## **5. Tasks and objectives of psychotherapeutic interventions for gender-nonconforming, gender-incongruent and gender-dysphoric adolescents**

### **5.1 Involvement of parents and other family caregivers**

Successful psychosocial coping with a transition in adolescence depends crucially on support from the family environment of those affected (Romer & Möller, 2020; see Chapter VI → "*Involvement of the family environment and family dynamics*"). Therefore, "the importance of the close involvement of parents and other close family caregivers in the entire transition process and their professional support [...] cannot be emphasized enough" (Romer & Möller, 2020, p. 92). In this context, the psychotherapeutic professional has the task of "on the one hand, accepting the patient's aspirations in full and, on the other hand, acknowledging the [possibly existing] concerns and worries of the parents and, in the case of existing aetiological assumptions, informing them according to current specialist knowledge. The offer of a relationship with the adolescents and a working alliance with the parents also represent... [sometimes] a major challenge (Dietrich, 2021, pp. 10-11). Further details on this can be found in Chapter VI → "*Inclusion of the family environment and family dynamics*" of this guideline.

### **5.2 Support for self-exploration and self-discovery of gender non-conforming young people**

If adolescents who currently describe themselves as gender non-conforming and who are still in a rather fluid or volatile process of self-discovery, or who appear uncertain about their perceived trans identity, seek psychotherapeutic support, an important goal to be clarified in advance can be to accompany a process of self-exploration in constant interaction with social role testing, without suggesting any commitments for the future regarding a permanent desire to transition.

Ashley (2019) writes: "Exploration is not a step that precedes a [social] transition, but a process that runs through a transition. It is impossible to imagine a level of exploration [without social role testing] that makes us confident that a transition is appropriate for future identity development. Rather than [merely] questioning the young people, professional helpers should play a supportive role [here]." (S. 233)

Preuss (2021) writes accordingly, "The most important overriding treatment goal in the treatment of gender dysphoric children and adolescents, in whom it is not yet [...] [foreseeable] whether [persistent gender incongruence is present or not], is the resolution of inner confusion and the promotion of the ability to trust one's own sense of gender identity and to express oneself with it" (p. 180).

As Romer & Möller (2020) put it: "A psychotherapeutic service is thus understood as a development-oriented accompaniment. In the process of self-discovery with regard to a persistent [or non-persistent] trans\* identity, the focus is on support in introspective and socially exploratory self-exploration" (p. 91).

An important goal here can be to support gender-nonconforming young people in further developing the degree of certainty about their own gender identity through dialog. ("It's not about convincing others, it's about being sure of yourself"). Encouragement to question exclusively binary gender role expectations in the process of self-discovery and to reflect on non-binary role ideas and perspectives and explore them through everyday social experiences can be particularly useful in view of the likelihood of later detransition. For example, retrospective interviews with people who had experienced detransition reported, among other things, cases in which a non-binary gender identity was stated at the time of detransition, which had not yet been consciously felt at the time of the previous transition (Littman, 2021).

Consensus-based recommendation:

**V. K3.** Adolescents with gender nonconforming self-descriptions who seek psychotherapeutic support when their gender identity is still uncertain should be informed that exploratory social role explorations are important in order to dialogically support a process of introspection and self-reflection in connection with social interaction experiences. Protection against discrimination should be taken into account. In this process, young people should be supported in questioning gender-stereotypical role expectations and reflecting on the possibility of a non-binary understanding of gender roles.

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Consensus: strong consensus (> 95%)

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### 5.3 Self-acceptance and processing internalized trans negativity

A negative inner attitude towards being trans (internalized trans negativity) can arise from anticipated or already suffered experiences of discrimination. Social prejudices as well as a rejection of homosexual people and/or trans people shaped by cultural ideas in the family and social environment can contribute to young people experiencing themselves as "deficient, not right, a disappointment". This can be associated with severe self-esteem problems (Dietrich, 2021). Accordingly, better and more conflict-free self-acceptance is often a sensible goal in psychotherapeutic support

gender dysphoric adolescents. Romer & Möller (2020) write in this regard, "For the

An important goal of psychotherapy for adolescents with gender dysphoria is to support the integration of the gender-incongruent self-experience into a coherent self-image and its acceptance" (p. 89).

In the psychotherapeutic treatment of internalized trans negativity, it is important to embed it in real experiences of trans hostility in a social or medical context, as internalized trans hostility is often shameful for those affected (Günther et al., 2021). According to the Minority Stress Model, specific rules of silence and other experiences of trans hostility must therefore be considered as significant factors in the psychotherapeutic treatment of internalized trans negativity. Not talking about personally important internal processes, non-conforming gender identities and experiences of violence can serve to protect against further stigmatization, but can also hinder the activation and development of resources that are necessary for mobilizing self-empowerment and support options. (Günther et al., 2021). Reducing internalized transnegativity can make a significant contribution to strengthening the self-esteem and self-confidence of gender dysphoric adolescents and thus their resilience (*empowerment*). This in turn can be suitable for reducing the likelihood of bullying experiences, for example. The degree of self-confidence and (gender) conviction can be seen as protective for psychosocial stabilization, peer group acceptance and successful social relationships.

#### 5.4 Psychotherapeutic support for role testing and role changes

The open-ended and clarifying accompaniment of self-exploration processes in gender-nonconforming adolescents and affirmative support for exploratory role testing complement each other (see above). Early encouragement to try out gender-nonconforming roles in the sense of trying them out without fear (see above) counteracts the conditions for the development of internalized transnegativity described in the previous section and also opens up spaces for experiencing social gender diversity even on this side of a persistent gender incongruence (e.g. as a "Tom-Boy") including non-binary role models. A perceived "binary role fulfillment pressure" shaped by (supposed) social expectations was found to be a significant factor in surveys of formerly transitioned persons who later detransitioned after irreversible medical measures (so-called *detransitioners*) (Littman, 2021; Turban et al., 2021; Vandebussche, 2021). In this respect, encouraging gender non-conforming young people to try out social roles as openly as possible, based on the acceptance of social gender diversity, can also be suitable for preventing a supposedly "alternative-free" self-commitment to an exclusively binary trans identity, which could turn out to be premature later on. Therefore, an "ethics of gender exploration" that encourages gender-nonconforming children and adolescents to try out social roles at an early stage (Ashley, 2019; see above) is also justified with regard to the prevention of later detransitions that occur after medical transition treatments, which are then regretted (so-called *regrets*). In this sense, encouraging gender-nonconforming children and adolescents to try out new roles to support open-ended self-exploration makes sense. Sometimes professional opinions from psychotherapeutic specialists are important in order to promote the support of such role testing in educational institutions.

As no psychotherapeutic support is usually required in connection with social role testing in childhood beyond an accepting educational approach, the relevant recommendations are explained in a separate chapter III → "*Social role change in childhood*".

If adolescents with gender incongruence or gender dysphoria wish to undergo a social transition, the affirmative accompaniment of all upcoming steps and their preparation is usually at the forefront of psychotherapeutic process support, as is the dialogically accompanied processing of the personal experiences made. Particularly against the historical background of earlier treatment guidelines, in which a psychotherapeutically accompanied

As a complete role reversal was recommended as a mandatory prerequisite for the medical indication for gender reassignment hormone treatment, for example, it is advisable to communicate to those seeking treatment that ongoing biographical reflection on the experiences associated with social transition is a supportive psychotherapeutic offer and not a "hurdle".

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Consensus-based recommendation:

<p><b>V. K4.</b> Children and adolescents with gender incongruence or gender dysphoria who have started a social transition or are aiming to do so can be offered psychotherapeutic process support to prepare for individual decisions and to reflect on the associated experiences.</p>
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Consensus: strong consensus (> 95%)

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For such process support - especially if there is no coinciding mental disorder requiring treatment (such as depression or social anxiety)

- often low-frequency appointments (e.g. 1-3 appointments per quarter) are sufficient, which e.g. in the context of psychiatric or psychosomatic counseling. Direct or indirect support from therapeutic professionals in exchange with institutions (school, training place, employer) can also be helpful or necessary (e.g. written certificates to endorse social role testing in everyday school life or similar).

### **5.5 Openness to doubts, desistent courses and the possibility of later detransition**

Encouraging gender-nonconforming young people to openly explore their roles in their social environment implies that young people who describe themselves as trans may not remain with this self-description in the long term. This also includes the option of retracting an already completed social outing (social detransition). This possibility should be mentioned from the outset when encouraging young people to explore their social roles and **k e p t** in mind in dialog with them, for which the mental space should remain open. In particular

Self-insecure adolescents can tend to develop fears when such doubts arise that they could "disappoint" a therapist or the trans community who was previously perceived as affirmative. This can lead to an inner inhibition to address their own doubts about the persistence of their own trans identity within the psychotherapeutic relationship. In order to counteract such fears and inhibitions, it is advisable to explicitly dispel potential misunderstandings in this regard, such as the affirmative attitude of the psychotherapeutic professional ("be the person you are and don't necessarily follow an image that others have made of you").

Consensus-based recommendation:

~~V. K5. Psychotherapeutic professionals who accompany gender nonconforming adolescents~~ in the process of social role exploration or social transition **should** convey that they are open to any doubts and uncertainties that may arise with regard to transition and to thoughts of desistance or detransition.

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Consensus: strong consensus (> 95%)

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## 5.6 Working on topics relating to body image and body reference

In gender dysphoric adolescents, negative body feelings, needs and emotions such as disgust, shame, envy, anger and self-hatred are often very present as a result of body dysphoria and may require psychotherapeutic processing support with the aim of promoting the psychosexual integration of one's own body image. In this context, a critical examination of internalized (normative) body images and the limits of the realizability of body ideals is also advisable as a non-trans-specific topic, as is the exploration and processing of psychosexual maturation conflicts, which can also occur in cis adolescents and which are therefore not "automatically" to be understood in the specific context of gender dysphoria. Furthermore, careful monitoring of the integration of the body image in the course of the physical changes brought about by somatomedical measures (their psychological anticipation and post-processing) should not be forgotten. This can sometimes be a very important aspect of psychotherapeutic process support.

## 5.7 Love, partnership and sexuality

Adolescents with gender incongruence or gender dysphoria who seek psychotherapeutic support can be expected to have a wide range of previous experiences, desires and possibly associated insecurities in the areas of love, partnership and sexuality. Some young people already have sexual experience and/or are in a committed romantic relationship, others cannot even imagine this for themselves and still others state that they cannot imagine having their own sexual relationships until they have undergone gender reassignment surgery at the earliest - and of course there is everything in between. Likewise, some young people are very well informed about the diversity of sexual lifestyles and their realization through networking with the LGBTQ community (often more comprehensively than many psychotherapeutic professionals) and thus show a confident approach, while others appear very insecure overall in dealing with this topic area.

In terms of sexual orientation, it can be assumed that trans people as a whole are significantly more diverse than the average population. For example, in a survey of adult trans people ( $N = 6368$ ), only 22% of respondents stated a "heterosexual" orientation ("straight") from the perspective of the trans gender (i.e. trans men, for example, stated that they were predominantly attracted to the female gender), while 74% of respondents stated other orientations from the "queer" spectrum (e.g. bisexual, homosexual from the perspective of the trans gender), "queer" or "other") (Herman, 2016). Therefore, when asking adolescents about this topic, psychotherapeutic professionals should be as open and unbiased as possible towards gender diversity and as free as possible from heteronormative ideas. In particular, if they have already had longer experiences with a lived social transition in all areas of life, young people can often differentiate very clearly in their self-description between their perceived gender identity and their sexual orientation. For other adolescents who are in the process of open self-discovery in this regard, it can be helpful if this can also be explored in the context of psychotherapeutic support in a dialogical and anxiety-free manner. On the part of the psychotherapeutic specialist, it is primarily a matter of signalling that this topic can be discussed openly and impartially and is not avoided or tabooed. To this end, it is often necessary to address the topic of sexuality openly, whereby this should be done with appropriate sensitivity. However, it is up to the young people to decide to what extent they want to address this topic and talk about it. In particular, an appropriate level of sensitivity to the fact that the collective perception of trans people is that reports are present seems necessary.

The study also shows that in the past (and in some cases still today), forced explorations of the topic of sexuality by psychiatric-psychotherapeutic professionals are sometimes perceived as very intrusive, e.g. when, in the context of assessments for a change of civil status under the previous TSG, detailed descriptions of masturbation practices and associated fantasies are requested. This would be a questionable practice in view of the specific expert question of whether a person has felt a permanent and stable affiliation to a particular gender for at least three years.

## **5.8 Coping with negative feelings in the case of persistent gender dysphoria**

Even if there is no causal psychotherapeutic treatment for gender dysphoria, because by definition it is based on gender incongruence, which in turn is a permanent internal disposition of a person that cannot be influenced by psychosocial interventions, psychotherapeutic interventions can be helpful in better coping with the negative emotions and stress associated with gender dysphoria. This can in no way replace the primary and only permanently effective intervention that can lead to a lasting improvement in the mental health prognosis - namely supporting the development of the personality in harmony with the perceived gender and its social acceptance - possibly in conjunction with medically indicated body-modifying measures. <sup>4</sup> If the social transition of gender dysphoric adolescents is accompanied by psychotherapy (possibly in parallel with somatomedical measures), general treatment techniques for coping with negative feelings and stress states, such as those commonly used in the treatment of depressive and anxiety disorders and trauma-related disorders, can be applied. In this case, it may be necessary to check whether the extent of the burden or impairment caused by negative feelings and stress states justifies the assignment of a coincident psychiatric diagnosis and, in conjunction with this, the determination of

<sup>4</sup> A contradictory stipulation in the current assessment guidelines of the Medical Service of the National Association of Statutory Health Insurance Funds (2020), according to which, before approval of cost coverage for gender reassignment surgery indicated by the guidelines is granted in every case, a gender reassignment surgery must be carried out.

The fact that, in individual cases, additional proof must be provided that the GD could not have been treated sufficiently effectively with psychotherapeutic means alone by means of psychotherapy that has already been carried out without success is not compatible with the current state of scientific knowledge and is unethical and questionable in terms of its conformity with social law. It requires those affected to undergo a costly and, according to current knowledge, ineffective therapy (psychotherapy alone for gender dysphoria) as a prerequisite for the reimbursement of costs for guideline-compliant treatment.

psychotherapeutic need for treatment within the meaning of the Psychotherapy Directive.

## **5.9 Support in the development of full capacity to consent to somatomedical measures**

While persons of legal age, provided they are in full possession of their mental faculties and not mentally disabled, are generally considered capable of consenting to complex medical interventions, a special feature of the treatment of minors with gender incongruence or gender dysphoria is that their capacity to consent must be established on a case-by-case basis and specifically for each medical intervention to be indicated (see Chapter X → "Legal basis & ethical principles"). gender dysphoria is that their capacity to consent must be determined in each individual case and specifically for each medical intervention to be indicated as part of the indication process (see Chapter X → "*Legal basis & ethical requirements for the treatment of minors with gender incongruence*" and Chapter VII → "*Indications for body-modifying medical interventions*"). Professional support for the reflective processes of adolescents with gender incongruence or gender dysphoria seeking treatment in obtaining full capacity to consent can be an important component of psychotherapeutic process support, especially when comprehensive reflections on the far-reaching consequences of treatment and its irreversibility are pending. Questions such as what influence medical transition treatment will have on one's own relationship, life and family planning and possible infertility; or whether or not precautionary cryopreservation to preserve fertility makes sense for the individual, can touch on very personal issues that cannot be adequately addressed with the help of medical information alone, but rather require in-depth and recurring reflection in order to be sustainably integrated into one's own consciousness and psychosexual self-image.

Based on the S3 guideline for adulthood *Gender incongruence, gender dysphoria and trans\* health* (AWMF, 2018) and the WPATH *Standards of Care 8* (Coleman et al., 2022), the following possible goals of psychotherapeutic interventions for gender-nonconforming adolescents and adolescents with gender incongruence or gender dysphoria are listed for orientation purposes and should be considered when planning interventions based on the needs of the individual case:

**Possible goals and topics to be addressed in psychotherapeutic support for gender-**

**nonconforming<sup>5</sup>, gender-incongruent and**

**gender dysphoric adolescents:**

- Support with self-exploration and finding your identity
- Promoting self-acceptance, self-esteem and self-confidence
- Coping with feelings of shame and guilt as well as internalized transnegativity
- Supporting the coming out process
- Supporting communication within the family in the event of family acceptance problems
- Support with social role testing and reflection on experiences made in this way
- Dealing with aversive experiences of discrimination and trans hostility
- Talks on love, partnership and sexuality
- Discussion offer on body image and body reference
- Support in preparing decisions on body-modifying treatments (including obtaining full capacity to consent)
- Support with the psychosexual integration of body changes after body-modifying treatments
- Support in coping with negative feelings and stress in cases of persistent gender dysphoria

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<sup>5</sup> The term gender-nonconforming is used here as a generic term, even if it is intended to include young people who have not (yet) been diagnosed with persistent/persistent GI, i.e. the question of gender identity is still considered to be open.



## **Chapter VI**

### **Inclusion of the family relationship environment and family dynamics**

#### **1. Introduction and key question**

#### **2. Statements and recommendations**

2.1. Statements on the state of scientific knowledge

2.2. Recommendations

Vorläufige Leitlinie zur Kommentierung

## 1 Introduction and key question

When children and adolescents show symptoms of gender incongruence or gender dysphoria (GI or GD), this usually has a profound impact on their family environment. For parents and siblings (but also for family members outside the nuclear family), this means an adjustment that in most cases is initially accompanied by a high level of uncertainty. Relationships within the family can change negatively as a result and make necessary educational interventions more difficult (e.g. because the parents do not attach adequate or too much importance to the symptoms of GI or GD).

In the case of persistent courses in adolescence, parents are increasingly confronted with decisions regarding physical transition (puberty blockade, hormone therapy, surgical measures), which trigger understandable fears and worries. On the other hand, there is often a vehement desire on the part of the adolescents concerned to start somatomedical measures quickly. This often leads to polarization, which can quickly put a strain on the parent-child relationship. Professional helpers are easily drawn into this polarization and then risk no longer being able to provide family-based counselling and support, as is usual in the field of child and adolescent psychotherapy and psychiatry/adolescent medicine.

However, family acceptance of the young people concerned is an essential prerequisite for role exploration/experiencing everyday life and also appears to be an important parameter for the mental health of those affected in the long term. Therefore, the inclusion of the family environment, especially if there are reservations, rejections or fears about the topic of GI or GD, is very important in the counseling process.

In very rare cases, children's welfare may be at risk, which must then be named and dealt with accordingly.

### Key question to the guideline:

Which family constellations and influencing factors should be given particular attention with regard to the need for their exploration and any resulting action steps?

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Children and young people with a non-conforming gender identity have needs and have to make decisions that also affect other family members and their environment. They are particularly dependent on family support in their identity development and especially when making decisions about transitioning. Family dynamic processes play a significant role in this. The fact that the

It is well known from child and adolescent psychiatry, youth welfare and family therapy that family dynamics play an important role in particularly vulnerable children and adolescents, both in terms of family stress factors and protective resources. There is no doubt that children and adolescents with GI and/or GD belong to such a vulnerable group, as clearly demonstrated by the increased rates of suicidality and self-harm described above (Eisenberg et al., 2017; Strauss et al., 2017; Travers et al., 2012; Veale et al., 2017, and many more, see Chapter IV→ "*Associated mental health problems and health problems in children and adolescents with gender incongruence and gender dysphoria*"). This guideline therefore devotes a separate chapter to the topic of family dynamics.

Unfortunately, in the entire breadth of research in the field of GI and GD, there are only a few studies that have - at least implicitly - also investigated issues relating to specific family dynamics. The literature reviewed for this chapter therefore largely overlaps with the literature reviewed in other chapters of the guideline. These are original studies, systemic reviews, overview articles, existing guidelines and treatment approaches that address the topic of family dynamics in at least one question, conclusion or (treatment) recommendation.

If the topic is considered with a focus on family dynamics, the different interests and intentions of those involved should also be recognized and taken into account. Children and young people often have to rely on decisions that their parents make on their behalf as guardians. It can be assumed that parents assume that the goals that correspond to their own views on the best interests of the child are also in the best interests of their child and are therefore most likely to seek out care and treatment services that reflect their own views and attitudes (Byne et al., 2012). In the best-case scenario, the views of the children and parents coincide or are at least close to each other. Such families are often already very well informed about gender diversity and have networked with other families. Several studies have reported that this form of networking in the sense of peer support was associated with positive life satisfaction, low sexual risk behavior and a low level of depressive symptoms in children and adolescents (Johns et al., 2018; Travers et al., 2012; Veale et al., 2017, etc.). Children and adolescents in these families often showed no or only very minor mental health problems (e.g. Dierckx et al., 2016; Kaltiala-Heino et al., 2018). These families may therefore often need no or only selective professional support from psychotherapeutic specialists.

However, there are also families in which there are conflicts within the family about the GI or GD of a child or adolescent. There are reports of sometimes negative reactions or even rejection by the parents. Reasons for this can include shame and stigmatization or fear of stigmatization. Parents' fear of not doing the "right thing" and a lack of support and information are also mentioned (Dierckx et al., 2016).

Professionals who are well informed and have an accepting and supportive attitude were perceived by the parents surveyed as positive and helpful in developing appropriate strategies for dealing with the child's GI or GD (Sharek et al., 2018).

Particular attention must be paid when children and adolescents with a non-conforming gender identity experience rejection by their own family, including aggressive statements, especially if this is accompanied by specific authoritarian parenting methods and punitive sanctions by the parents (Adelson, 2012). The values and norms of the individual ethnic group or religious community can play a major role in this (Gartner & Sterzing, 2018). Several authors point out that negative reactions, statements and exclusion by peers or family pose a particular developmental and health risk for the child. Examples cited include the weakening of protective factors against suicidal tendencies and dysfunctional coping strategies such as running away or prostitution etc. (Strauss et al., 2017; Travers et al., 2012). It should be noted here that negatively burdened family and peer relationships can also be regarded as a non-specific risk factor for mental health problems. Furthermore, it is not possible to make any reliable statements about causal relationships, as interactions (in the sense that mental health problems can be a burden on relationships) must also be taken into account.

Acceptance and support from one's own family is a significant protective factor for the mental health of children and adolescents with GI or GD. This underlines how important the involvement of parents/family is for the mental health of children and adolescents. However, it also shows the need for support for parents so that they are able to accompany their children appropriately. Supporting non-binary children and adolescents, who are at a particularly high risk of developing internalizing mental health symptoms, is also challenging (Kovalanka et al., 2017).

## 2. statements and recommendations

### 2.1 Statements on the state of scientific knowledge

**VI. E1.** There is evidence that for children and adolescents with gender incongruence or gender dysphoria, a family environment that accepts and supports their perceived gender identity is a significant protective factor for their mental health.

Strong evidence:

> 10 studies with similar results (Aramburu Alegría, 2018; Catalpa & McGuire, 2018; Gray et al, 2016; Katz-Wise et al, 2017, 2018; Kolbuck et al, 2019; Kuvalanka et al, 2014; Levitan et al, 2019; McConnell et al, 2016; Pariseau et al, 2019; Ryan et al, 2010; Veale et al, 2017; Wilson et al, 2016).

Consensus: Strong consensus (>95%)

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**VI. E2. There is** evidence that children and adolescents with gender incongruence or gender dysphoria who experience *a low or lack of acceptance* of their perceived gender identity in their family environment have an increased risk of depressive disorders and suicidal tendencies as well as self-harming risk behavior .<sup>1</sup>

Weak evidence:

5 studies with similar results (Aramburu Alegría, 2018; McConnell et al, 2016; Pariseau et al, 2019; Simons et al, 2013; Travers et al, 2012).

Consensus: Strong consensus (>95%)

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<sup>1</sup> This statement refers to an increase compared to a standard population.

## 2.2 Recommendations

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Consensus-based recommendation:

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**VI. K1.** Custodians and guardians should be informed that attempts at therapy aimed at changing the child's sense of belonging to a gender contrary to their expressed feelings are harmful and unethical.

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Consensus: strong consensus (> 95%)

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Explanation: The term "child" is not used here to refer to an age group, but to the social and legal relationship with custodians and guardians. It therefore also refers to young people. The term "expressed feelings" does not only include explicitly verbal expressions, but can also include behavioral expressions, provided that these clearly express the child's sense of belonging to a gender.

At this point, the following statement from the preamble (→ *Chapter I.*) is emphasized once again:

"A person's gender identity is of a highly personal nature. The promotion of self-determination and - where necessary - the ability to self-determine is therefore an essential concern in the treatment setting with underage patients. Therapy approaches that are implicitly or explicitly based on the treatment goal of steering a person's sense of belonging to a particular gender in a certain direction are considered unethical."

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Consensus-based  
recommendation

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**VI K2.** Guardians and educators should be informed that for children and adolescents with gender incongruence or gender dysphoria, the safe and constant experience of being accepted and supported by their own family is essential for self-discovery and, depending on the progression, for a social coming out, role testing and transition for a favorable course of mental health.

Strong consensus (> 95%)

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Explanation: In this context, the term "transition" can refer to social, legal and/or medical transition treatment, depending on the situation. The term "social coming out" refers to the entire process of increasingly "coming out" to one's social environment in the gender role that corresponds to one's currently perceived gender identity. Such a process often involves several steps (see glossary).

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Consensus-based recommendation:

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**VI K3.** Custodians and educators should be advised to support a safe social space for exploring gender roles in all developmental processes of gender-nonconforming children and adolescents and, depending on the progression, also a safe social space for the possible later change of a lived gender role.

Strong consensus (> 95%)

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Explanation: Last but not least, in order to increase decision-making certainty in the event of medical treatment decisions for gender reassignment measures that may have to be reviewed at a later date, social role testing should be advocated as openly as possible, which should serve, among other things, to explore the long-term coherence and viability of the desired gender role in the context of social experiences. This implies that the option of, for example, later reversing a trans outing should be explicitly addressed and, if necessary, supported for exploratory role explorations.

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Consensus-based  
recommendation:

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**VI K4.** Parents and guardians of gender-nonconforming children and adolescents should be informed about the services offered by parent groups of self-advocacy organizations as an opportunity for networking and mutual support.

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Consensus: strong consensus (>95%)

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Consensus-based  
recommendation:

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**VI K5.** Custodians and parents who come forward with their child because of the possible existence of gender incongruence or gender dysphoria should be offered professional process support with the aim of helping the child, with the involvement of the family, to explore their own gender identity and to overcome the possible psychosocial difficulties associated with gender incongruence or gender dysphoria.

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Consensus: strong consensus  
(>95%)

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Consensus-based  
recommendation:

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**VI K6.** If the ideas and wishes of minors and their legal guardians with regard to how the family should deal with the child's or adolescent's non-conforming gender identity are not compatible, process support for the family system by a suitable specialist with expertise in family therapy should be recommended with the aim of promoting an accepting and supportive attitude towards the child's/adolescent's gender identity. Such process support is only recommended if no harmful effects on the child's health are to be expected.

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Consensus: strong consensus (>95%)

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Explanation: The term "family therapy expertise" in this recommendation *does not refer* to a formal certificate of a specific qualification in this field, but to the professional skills and experience of the specialist concerned.



## **Chapter VII**

# **Indication for body-modifying medical interventions**

### **1. Introduction and key questions**

### **2. Limitations of the study situation**

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## 1. Introduction and key questions

Body-modifying medical interventions for people with gender incongruence (GI) aim to prevent or reduce persistent body-related gender dysphoric distress by temporarily halting pubertal maturation or by harmonizing physical appearance. There is a consensus in current guidelines that it is important for a lasting positive effect on mental health that such medical measures are embedded in a social transition accompanied by self-acceptance and experienced social acceptance (AWMF, 2018; Coleman et al., 2022). The indication for these interventions is particularly complex and professionally challenging in adolescence. In this chapter, the professional requirements to be considered for an interdisciplinary indication are explained. It should be emphasized in advance that, in addition to formal requirements for the professional qualifications of the specialists involved, special specialist knowledge and previous experience are essential.

### **VII K0 Consensus-based recommendation**

Specialist knowledge and several years of experience in the process support and treatment of adolescents with gender incongruence are required for a professional indication. Professionals without sufficient specialist knowledge and experience in this area should consult a sufficiently experienced specialist or a specialized outpatient clinic or treatment center to ensure that an indication is made.

Explanation: This involvement of proven expertise is not formally defined and depends on the individual circumstances within a care and training landscape that is constantly evolving as a learning system. This can, for example, take the form of an independent medical second opinion, through a consultative co-assessment, through collegial intervention or supervision, or through case conferences in quality circles.

**Key questions:**

- What specialist expertise should be assumed for the indication of body-modifying medical measures in cases of gender incongruence in adolescence?
- What should be considered when diagnosing gender incongruence or gender dysphoria in adolescence with regard to the indication for body-modifying medical measures?
- What needs to be considered when diagnosing and treating associated mental disorders with regard to the indication for medical measures?
- What development-related diagnostic considerations should be taken into account when determining the indications for medical interventions?
- What recommendations can be made for the gradation and sequence of indications for various medical treatment steps?
- At what age or maturity stage of pubertal development can which medical treatment steps generally be recommended?
- What requirements must be checked for the informed consent of underage patients and their legal guardians before an indication for body-modifying measures is given?

**2. Limitations of the study situation**

The literature search conducted as part of the guideline development for the indication of puberty-delaying and gender reassignment interventions in children and adolescents with gender incongruence or gender dysphoria revealed only a small number of relevant original studies in which the outcome of these interventions was examined in a follow-up design ( $N = 10$ ), with a particular lack of studies with a higher level of evidence (Mahfouda et al., 2019). In addition to the small number of published studies, the limited evidence base is also due to methodological limitations with regard to the level of evidence of the studies in this context. Conducting randomized controlled and blinded studies in which one group of gender-incongruent or gender-dysphoric children and adolescents receives puberty-delaying or gender reassignment interventions and the other does not, does not appear to be ethically justifiable. In principle, blinding is not possible with hormonal interventions. Withholding effective puberty-delaying or gender reassignment interventions in the course of randomization for study purposes is unacceptable if there is a desire for such an intervention on the part of the affected persons and their guardians and a corresponding

This is difficult to justify in view of the suffering of those affected and would probably lead to a very low willingness to participate in such a study. In addition, there is a lack of a justifiable evidence-based alternative treatment option in the sense of a previously established and proven treatment. In particular, psychotherapy alone cannot be regarded as a suitable treatment to effectively reduce or avert gender dysphoria in cases of diagnosed persistent gender incongruence.

The systematically reviewed literature therefore mainly refers to clinical follow-up cohort studies. These studies examined adolescents with diagnosed gender incongruence or gender dysphoria who received puberty-delaying or gender reassignment treatment on the basis of the indication provided by the practitioners and the corresponding wishes of those affected and their guardians. In some cases, the clinical course of children and adolescents with gender incongruence or gender dysphoria for whom no indication for these treatments was given or for whom there was (still) no desire for them on the part of the affected person or their guardians was also reported for comparison. This results in correspondingly large group differences between the sub-cohorts compared. A different degree of severity of the associated psychopathology or differences in the extent of gender dysphoria and the associated psychological distress can be assumed for the groups with an indication versus those without an indication. There are no comparative studies between groups of treated adolescents in which different indication criteria were applied.

Against the background of the data situation outlined above, conclusions on the basic indication of puberty-delaying and gender reassignment treatments in minors can only be drawn from the follow-up data on mental and physical health and the social situation after treatment has been carried out. In the available follow-up studies, various medical measures had been carried out at the time of the follow-up survey, mostly in combination with psychotherapeutic measures (Becker-Hebly et al., 2021; Chen et al., 2023; Costa et al., 2015; de Vries et al., 2014; Klink et al., 2015; Tordoff et al., 2022; Vlot et al., 2017). For methodological reasons, the outcomes measured in these longitudinal study results can therefore usually not be attributed to a single intervention, but only allow statements to be made about the outcome of adolescents with gender dysphoria after undergoing an "overall package", which includes both psychosocially and medically supported transition with careful indication and professional process support.

The systematic reviews of the British NICE (National Institute for Health and Care Excellence (NICE), 2020a, 2020b) on the state of the evidence on puberty-blocking and gender reassignment hormone treatments in adolescence state that the studies available at the time of the reviews point overall in the direction of a favorable outcome after medical interventions for the mental health of adolescents with gender dysphoria. The level of evidence according to the criteria of evidence-based medicine is assessed as "very uncertain" on the basis of the available studies with regard to the specific interventions (puberty suppression and gender reassignment hormone therapy). One of the reasons given is the small sample size of the studies, most of which are observational studies without a control group. It is also stated that comorbidities and concomitant treatments are insufficiently reported or controlled in the existing studies. According to the NICE assessment, the studies are also from only a few specialized treatment centers, mainly in Europe, so that selection effects limit the transferability of the results.

The evidence base for treatment with puberty blockers is assessed as even more uncertain compared to gender reassignment hormone treatment in adolescence, for which the authors conclude on the basis of five original studies that a favorable effect on the outcome parameters for mental health can be considered "probable" (see below).

This is critically discussed in the present interim report of the so-called *Cass Review*, which is to develop further recommendations for the future treatment standards of adolescents with gender dysphoria for the National Health Service England (NHS) on the basis of the NICE reviews, among other things. The author points out that puberty blockade alone cannot be an effective treatment for gender dysphoria: Puberty blockers cannot permanently alleviate body-related distress in an adolescent with gender dysphoria. They merely provide those affected with a temporary reprieve during which no further irreversible body changes occur in the course of pubertal maturation. The outcome after puberty blockade alone can therefore not be expected to go significantly beyond averting a further worsening of body dysphoric distress, which would be expected in the case of no treatment (Cass, 2022). The measurable effect of puberty blockade alone can therefore at best consist of a temporary reduction in psychosocial and emotional stress through the de-actualization of the fear of progression of physical maturation and through the prospect of a staged body-modifying transition treatment.

### **3. Outcome studies on psychopathology, life satisfaction and gender dysphoria after body-modifying interventions**

A longitudinal study from the Netherlands (de Vries et al., 2011) with a sample of 70 gender-incongruent adolescents (47.1% trans-female and 52.9% trans-male) with an average age of 13.65 years (range: 11.1-17.0) found a significant reduction in emotional symptoms and behavioral problems after almost two years of puberty blockade with GnRH analogs. Before the start of treatment, 44.4% of the participants showed emotional or behavioral problems in the clinically relevant range. After treatment, this proportion decreased to 22.2%. In particular, there was a significant reduction in depression with a reduction in the raw score of the Beck Depression Inventory (BDI) from 8.31 (cut-off for depression at 14) before treatment to a score of 4.95 at the time of follow-up. There was also a statistically significant improvement in global functioning from an average of 70.24 (upper range of some mild psychiatric symptoms) to 73.90 (range of transient symptoms). In contrast, the level of dissatisfaction with one's own body did not change statistically significantly after puberty blockade alone, as expected. The sample consisted of adolescents with persistent gender dysphoria carefully diagnosed according to defined criteria after the onset of puberty. All adolescents in this study continued puberty blockade over the course of the study and subsequently began gender reassignment hormone treatment.

In a further follow-up to a subsample of the previous study, 55 young adults (40.0% trans-female and 60.0% trans-male) who had undergone a staged medical transition treatment begun in adolescence, initially with puberty blockade and subsequent gender reassignment hormone administration and gender reassignment surgery, were examined after an average observation period of seven years (de Vries et al., 2014). Statistically significant and clinically relevant improvements in global functional level, psychopathological symptom burden, extent of behavioral problems, health-related quality of life and subjective life satisfaction, as well as a statistically significant decrease in body dissatisfaction were observed over the course of the study. While the initial values for psychopathological symptom burden and health-related quality of life before the start of puberty suppression were largely in the range of clinical abnormality, the average scores for health-related quality of life, general life satisfaction and the extent of psychopathological symptom burden after puberty suppression were in the range of clinical abnormality.

of fully completed body-modifying transition treatment in the reference range of population-representative standardization samples. In this study, the adolescents were admitted for the body-modifying treatments according to defined criteria for treatment in adolescence. Only adolescents with a binary transgender identity and without concomitant psychiatric diagnoses that could interfere with the diagnosis or treatment of gender dysphoria were included. In addition, all included adolescents received professional process support from the treatment center throughout all medical transition steps (Cohen-Kettenis et al., 2008).

In a study from the UK (Costa et al., 2015), 201 adolescents aged 15.52 years on average (range: 12-17) initially received psychological support over several months. Of these, 121 adolescents (38.5% trans-female and 61.5% trans-male) were given a positive indication for puberty blockade 6 months after the baseline survey. Of these, 60 were immediately treated with puberty blockade (group 1). For the remaining 61, the decision to start puberty blockade was postponed due to various uncertainties (group 2). In most cases, this was due to the presence of increased and more complex psychological abnormalities. Group 2 continued to receive only unspecified psychological support during the data collection for this study. The groups formed as part of this study are therefore not comparable because they differed systematically from the baseline survey in their clinical appearance. They can therefore only be reported as separate follow-up cohorts. Both groups showed a statistically significant improvement in global functional level at follow-up. A specific add-on effect of pubertal blockade cannot be inferred from the reported data. The results underline the heterogeneity of the patient group with regard to accompanying psychopathological abnormalities.

In the largest follow-up study to date with 148 US adolescents by Kuper et al. (2020), these were only treated with puberty blockade ( $N = 25$ , mean age of 13.7 years with a range of 9.8-14.9) or with feminizing or masculinizing hormone treatment ( $N = 123$ , mean age of 16.2 years with a range of 13.2-18.6). After an average follow-up period of 14.9 months, the adolescents' self-reported mean values showed a clear reduction in gender dysphoria with an improvement in their body satisfaction, slight to moderate improvements in depressive symptoms and an equally slight improvement in anxiety symptoms. These changes were statistically significant.

A follow-up study from Germany (Becker-Hebly et al., 2021), predominantly after treatment with puberty blockade, sex reassignment hormones or surgery, came to similar conclusions. The data from 75 people (14.7% trans-female and 85.3% trans-male) with an average age at baseline measurement of 15.56 years (range 11-18). There were slight to moderate descriptive improvements in psychopathology after a survey period of two years on average. Inferential statistical significance was not tested.

A follow-up study with preliminary results from Switzerland (Pauli et al., 2020) by 51 adolescents (23.9% trans-female and 76.1% trans-male; average age at baseline 16.3 years, range 13-19), most of whom were treated by puberty blockade or with gender reassignment hormones, showed similar results over an average survey period of two years. Only the trans-female adolescents showed a reduction in the overall psychopathological score. However, this change was not inferentially significant due to the small number of cases ( $N = 12$ ) and could not be shown for the trans-male adolescents. A completed social transition proved to be a positive predictive factor for aspects of life satisfaction.

In five of the six follow-up studies reported above, it should be noted that the follow-up data was collected after 12-24 months compared to the long-term follow-up interval of seven years in one of the two Dutch studies (de Vries et al., 2014). It should also be noted that in some of the follow-up studies mentioned, not all adolescents initially received puberty blockade, but in three studies some of the sample received gender reassignment hormone treatment directly due to their advanced age at the start of treatment.

In a further naturalistic follow-up study over a total period of 12 months (Tordoff et al., 2022), 104 US adolescents and young adults who attended a specialized treatment center were examined (26.0% trans female, 60.6% trans male, 13.4% non-binary or unknown). Their average age at the start of the study was 15.8 years (range: 13-20). The frequency of self-harming behavior or suicidal thoughts was found to be 45% in the group of adolescents who had not previously received physical therapy at the baseline measurement. After 12 months, it was 37% in the adolescents who had been treated with puberty blockade or gender reassignment hormones. However, the reported data from this study do not allow any statement to be made about the extent to which this moderate decrease is attributable to a treatment effect or not, as the reported control group of non-treated individuals



( $N = 6$ ) is too small and cannot be considered comparable due to assumed group differences.

A retrospective comparative study (Turban et al., 2020) of adults who define themselves as trans examined the subgroups of those who were treated intermittently with puberty blockers during adolescence ( $N = 89$ ) and those who desired but did not receive them. Those who had received puberty blockade according to their wishes showed a statistically significantly lower lifetime prevalence of suicidality compared to those who had not received it despite their wishes.

In a secondary analysis of data from the U.S. Transgender Survey, which included over 27,000 adult trans people (26.2% trans-female, 29.6% trans-male and 44.2% non-binary or other gender identity), the relationship between gender reassignment hormone therapy and outcome measures for mental health (current psychosocial stress and suicidal thoughts) was retrospectively investigated (Turban et al., 2022). Here, the subgroups were differentiated according to whether such hormone treatment was started in adolescence (14-17Y;  $N = 481$ ) or only after the age of 18 ( $N = 12,257$ ). A further subgroup was defined as those who stated that they had never received such hormone treatment despite a corresponding desire for it ( $N = 8860$ ). After statistically controlling for various potentially confounding variables, a statistically significantly lower frequency of suicidal thoughts in the past twelve months and significantly lower current psychosocial distress were found in the group treated in adolescence compared to those treated in adulthood. As expected, the outcome values for mental health were again significantly worse for those who were not treated despite their wish than for those treated from adulthood onwards. This can be interpreted as an indication of a favorable effect on long-term mental health of hormone treatment beginning in adolescence in the case of persistent gender incongruence.

For the latter two studies, however, the possible biases due to retrospective surveys must be considered as a limitation. For example, it is conceivable that people with better baseline mental health scores may have earlier access to gender reassignment treatment, which could overestimate the positive effect of starting the intervention earlier. Possible selection effects in the overall sample due to recruitment via organizations of the *trans community* also limit the transferability to other samples. However, this should not have a distorting effect on the internal comparison by age group at the start of treatment.

### 3.1. Comparison with the study situation in adulthood

The evidence for a favorable health outcome of gender reassignment medical interventions in adult patients with gender dysphoria is much more comprehensive. This must be taken into account when evaluating the expected effectiveness of these treatments in adolescents. In a meta-analysis,  $N = 28$  studies with a total of  $N = 1833$  patients ( $N = 1093$  trans-female,  $N = 801$  trans-male) who underwent medical transition treatment for gender reassignment, which included hormone therapy, were evaluated (Murad et al., 2010). Overall, 80% of those treated reported a significant improvement in gender dysphoria (95% CI = 68- 89%; 8 studies;  $I^2 = 82\%$ ); 78% reported a significant improvement in psychological symptoms (95% CI = 56-94%; 7 studies;  $I^2 = 86\%$ ); 80% reported a significant improvement in quality of life (95% CI = 72-88%; 16 studies;  $I^2 = 78\%$ ); and 72% reported a significant improvement in sexual function (95% CI = 60-81%; 15 studies;  $I^2 = 78\%$ ). However, as these were predominantly non-controlled observational studies, the level of evidence is still classified as low despite the high number of cases.

### 3.2. Outcome studies on possible somatic and cognitive sequelae of medical interventions in adolescence

Some argue that the use of puberty blockers in adolescence could entail unforeseeable consequential risks with regard to somatic or cognitive sequelae. It should be noted here that guideline-based treatment with puberty blockers and/or sex-reassigning hormones in adolescence should only ever be carried out after careful professional indication, age-related individualized risk-benefit assessment and ongoing endocrinological control with appropriate monitoring of all important medical parameters. In addition, the duration of puberty blockade should always be limited to an extent that appears justifiable from an endocrinological perspective, in particular to minimize the risk of harmful effects on later bone density (for aspects of treatment safety, see Chapter VIII → "*Somatic aspects of hormonal interventions*").

The following studies on somatic and cognitive outcomes following medical interventions were reviewed as part of the guideline development process:

A study (Staphorsius et al., 2015) with adolescents diagnosed *with* what was then still called "*gender identity disorder*" (GIS) according to the diagnostic criteria of the

DSM-IV (American Psychiatric Association, 2000) investigated the influence of pubertal blockade on executive functions, here in the sense of the ability to plan and operationalized with the "Tower of London Task" (ToL) and fMRI scans. The underlying question was whether a temporary pubertal blockade in adolescence could lead to maturational deficits in the prefrontal cortex. Twenty adolescents undergoing puberty blockade (40% trans-female, 60% trans-male) and 20 adolescents without medical treatment (50% trans-male and 50% trans-female) took part. Their average age was 15.4 years (min. 12 years). The participants in the intervention group had been treated with puberty blockade for an average of 1.6 years ( $SD = 1.0$ ). Apart from lower accuracy in the ToL tasks by trans girls treated with puberty blockade compared with the control group, there were no statistically significant negative effects of puberty blockade on the executive functions investigated.

Another study (Arnoldussen et al., 2022) was able to show that in 72 participants (27 trans-female and 45 trans-male) after an almost 8-year follow-up interval following puberty blockade and subsequent gender reassignment hormone treatment, the educational level and career success in relation to the IQ measured before treatment was within the range of the educational level and career success expected from data from the normal population.

Four studies (Joseph et al., 2019; Klink et al., 2015; Schagen et al., 2020; Vlot et al., 2017) on somatic parameters examined, among other things, bone density after puberty blockade and subsequent sex-reassignment hormone administration. What the studies have in common is that a statistically significant decrease in absolute bone density was observed under puberty blockade. This was predominantly restored to normal levels of bone density under subsequent sex reassignment hormone treatment, although the results are partly inconsistent in that in two individual studies this re-normalization of bone density did not occur completely in one subgroup of each sex.

In one study (Vlot et al., 2017), the bone density of trans women normalized, whereas the bone density of trans men remained on average below the normal values for cis women of the same age. In another study (Schagen et al., 2020), the bone density of trans men normalized completely, whereas only in trans women the reduced bone density could not be completely renormalized under gender reassignment hormone treatment. The individual study results are reported in Chapter VIII → "*Somatic aspects of hormonal interventions*".

In summary, there are clear indications from the partly heterogeneous study situation that special requirements must be placed on professional implementation when determining the indication for puberty blockade with possible subsequent sex reassignment hormone administration to minimize potential somatic side effects. In particular, a rationally considered time limit for puberty blockade from a physiological point of view appears important in order to minimize somatic risks (see Chapter VIII → "*Somatic aspects of hormonal interventions*").

Further results on the somatic effects of hormone treatments, including the possible effects of early pubertal blockade on the necessity, feasibility or non-necessity of later sex reassignment surgery (e.g. non-necessity of a later mastectomy in trans boys or effects on surgical procedures in the case of a later desire for genital reassignment in trans girls) are also reported and discussed in Chapter VIII → "*Somatic aspects of hormonal interventions*".

### **3.3. Follow-up studies on the course of gender incongruence after the start of medical treatments (including desistance)**

In the first Dutch follow-up study by De Vries et al. (2011) reported above, all adolescents without exception who had started treatment with puberty blockers later also started gender reassignment hormone treatment. A more recent retrospective study from the same treatment center put this result into perspective. Of 143 adolescents who were treated with puberty blockers between 2010 and 2018, 125 (87%) subsequently continued treatment with gender reassignment hormones. On average, this happened after 12 months for the trans girls and after 10 months for the trans boys (Brik et al., 2020). Five adolescents were still too young to start gender reassignment hormone treatment at the time of the study, in five adolescents the gender dysphoria had not persisted in the course of the treatment and four adolescents did not continue the puberty blockade for other reasons (e.g. undesirable side effects).

These progression data support the assumption that after the start of a professionally indicated puberty blockade, which temporarily prevents the irreversible development of secondary sexual characteristics of the body in any direction, the possibility of gender incongruence persists in the further course of development. The pubertal blockade therefore does not occur in a

"Determination" on the path to subsequent gender reassignment hormone treatment

the same. This underlines the fundamental rationale of puberty blockade, according to which it can provide a temporary window of opportunity to reflect on gender identity and temporarily de-factualize the fear of further pubertal development.

In a Canadian study of 27 gender dysphoric adolescents who were treated with puberty blockade, 19 (70.4%) underwent gender reassignment hormone therapy (Khatchadourian et al., 2014). Only one trans girl was reported as not wanting to continue the transition. The others discontinued puberty blockade for other reasons (e.g. undesirable side effects).

### **3.4. Follow-up studies on gender reassignment surgery**

There is little literature on sex reassignment surgery in minors. According to the current international guideline recommendations of the WPATH (Coleman et al., 2022), mastectomy surgery after gender reassignment hormone treatment may be indicated in adolescent trans boys with persistent gender incongruence and high gender dysphoric distress in relation to the female breast (see below). Studies of trans male adolescents with a desire for a mastectomy have shown that breast dysphoria in those affected was associated with greatly increased rates of anxiety, depression and stress and can lead to functional limitations, such as avoidance of sports or swimming activities (Mehring et al., 2021; Olson-Kennedy et al., 2018; Sood et al., 2021). Follow-up studies of adolescents who underwent mastectomy to reduce breast dysphoria showed good surgical outcomes, satisfaction with the results and minimal regret during the study follow-up period (Marinkovic & Newfield, 2017; Olson-Kennedy et al., 2018). One study reported that after initiation of testosterone administration in male trans adolescents, dysphoria in relation to the female breast can increase progressively (Olson-Kennedy et al., 2018).

### **3.5. Surveys of treatment seekers on fertility and indication criteria**

One study showed that there is a discrepancy between the (still) low utilization of medical measures for fertility protection (cryopreservation) by young people who start body-modifying treatments due to gender incongruence or gender dysphoria and a higher number of people who express a desire to have children after having undergone body-modifying treatment in the past (De Roo et al., 2016). This indicates that the importance of a potential desire to have children later in life in young trans people has so far been underestimated by healthcare professionals. A

Medical information and advice on medical options for fertility protection should therefore be provided before the indication for body-modifying interventions (see recommendations below).

In a qualitative survey of 13 Dutch adolescents with gender dysphoria who had started their first medical transition treatment at an average age of 16 years and 11 months, it was found that most of them considered the setting of a minimum age limit for the indication of puberty blockade to be problematic and an individual developmental approach to be more appropriate. With regard to the known lack of studies on possible long-term somatic consequences of puberty blockade, the adolescents stated that although they would like to see more data on this, they would not question the indication for themselves due to their high level of suffering without any other treatment alternative due to the lack of data (Vrouenraets et al., 2016).

Apparently, for the respondents, the concrete foreseeable consequences of an increasingly irreversible progression of the development of secondary sexual characteristics in the event of non-treatment outweighed the uncertainty of the data on possible long-term consequences of treatment. In another study involving a survey of 15 trans adolescents and young adults from the USA aged 18 on average, those affected expressed a desire for individualized, more flexible access to puberty-suppressing and gender reassignment measures (Gridley et al., 2016).

#### **4. Summary of the evaluation of the evidence base**

Overall, it can be stated that reported data from previous non-controlled clinical cohort studies on hormonal interventions in adolescents with diagnosed gender incongruence or gender dysphoria provide consistent evidence for a favorable outcome of the measured parameters for mental health and life satisfaction if gender reassignment hormone treatment was at least part of the treatment. The level of evidence is weak due to the methodological limitations discussed above. For the reported Dutch cohort studies in particular, the transferability of the results is questionable due to selection effects resulting from ideally narrow inclusion criteria and the fact that three studies originate from the same center.

Results limited. The systematic review of the British National Institute for Health and Care Excellence (2020b) states the following<sup>1</sup>:

"The results of five uncontrolled, observational studies (Achille et al, 2020; Allen et al, 2019; Kaltiala et al, 2020; Kuper et al, 2020; López De Lara et al, 2020) suggest that in children and adolescents with gender dysphoria, gender reassignment hormone treatment is likely to improve symptoms of gender dysphoria and possibly also depression, anxiety, quality of life, suicidality and psychosocial functioning. The effects of treatment on body image are unclear. All results were of very low certainty [in terms of their level of evidence]." (2020b, p. 50).

However, in studies in which the reported intervention consisted solely of puberty blockade, there was at best weak evidence for a favorable outcome on the measured parameters (National Institute for Health and Care Excellence (NICE), 2020a). This can be explained by the rationale of this phase of staged treatment: by temporarily halting an increasingly irreversible virilization or feminization of physical appearance, it is not to be expected that body-related gender dysphoric distress can be permanently reduced. It is therefore more a question of avoiding a worsening of this distress that is to be expected without treatment (Cass, 2022; National Institute for Health and Care Excellence (NICE), 2020a).

*Evidence-based statement:*

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<p><b>VII. E1.</b> There is evidence from uncontrolled follow-up studies that patients with persistent gender dysphoria diagnosed in adolescence who receive <i>stepped body-modifying treatment</i> in the context of <i>socially supported transition</i> show a long-term improvement in quality of life and mental health in adulthood.</p>
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*Evidence level:* low (2 studies with different cohorts from the same center)

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References: (Cohen-Kettenis & van Goozen, 1997; de Vries et al., 2011, 2014).

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<sup>1</sup> Own specialist translation by authors of the guideline commission

In the reported studies, such a *staged body-modifying treatment* generally included a *specific indication* in each case:

1. a temporary suppression of puberty;
2. a subsequent sex reassignment hormone treatment; and
3. gender reassignment surgery at a later date.

All patients included in the reported studies were given an interdisciplinary indication according to the so-called *Dutch Protocol* and continuous professional support over the entire duration of the transition process.

## **5. Recommendations from previous guidelines and review articles for the indication**

Most of the current guidelines and review articles with recommendations for the indication of body-modifying measures in adolescents with gender incongruence or gender dysphoria contain similar or mutually compatible statements. These can be subdivided into recommendations on the required professional qualifications of the person giving the indication, on prior psychological-psychiatric diagnostic and therapeutic measures, on somatic preliminary examinations and on the requirements for informed consent of those affected.

The following international guidelines and recommendations are based on a transparent guideline development methodology:

*Guidelines of international medical societies:*

- *World Professional Association for Transgender Health (WPATH)* - Standards of care for the health of transgender and gender diverse people, Version 8 (Coleman et al., 2022): Full compliance with NICE criteria, including independent external literature review, broad involvement of recognized international experts, structured Delphi procedure for consensus finding (comparable to AWMF S3 level)
- *Endocrine Society* - Endocrine treatment of gender-dysphoric/gender-incongruent persons: an Endocrine Society Clinical Practice Guideline (Hembree et al., 2017): Systematic literature search and systematic literature review, grading of recommendations according to strength of evidence, expert consensus and consensus by several participating professional societies (comparable to AWMF S3 level).



*Guidelines of national medical societies:*

- *Royal Australian and New Zealand College of Psychiatrists (RANZCP, Medical Association for Psychiatry/Child and Adolescent Psychiatry):* Recognizing and addressing the mental health needs of people experiencing Gender Dysphoria / Gender Incongruence (RANZCP, 2021): Simple consensus-based practice recommendations from a medical society (most comparable to S1 level).
- *American Pediatric Association* - Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents (Rafferty et al., 2018): Simple consensus-based practice recommendations from a medical specialty society (most comparable to S1 level)

The systematic DELBI assessments of the methodological quality of all guidelines reviewed can be found in Table 2 of the guideline report (p. 13).

### **5.1. Standards for the professional qualification of the specialist who makes the indication**

The above-mentioned international guidelines specify criteria regarding the professional qualifications of the specialists who are to provide the indication for body-modifying treatment in children and adolescents with gender incongruence. The current guideline of the *World Professional Association for Transgender Health* requires a mental health professional at postgraduate level with additional training and expertise in the topic of gender identity development and gender incongruence. For professionals working with gender dysphoric adolescents on the autism spectrum, expertise in this area or collaboration with professionals with specific expertise in this area is also required (Coleman et al., 2022).

The *Endocrine Society's* guideline also requires a mental health specialist with qualifications in psychiatric diagnostics to determine the indication. In addition, specific knowledge of the differential diagnosis of gender incongruence, criteria for body-modifying treatments for gender incongruence and the ability to assess the patient's reflected understanding of possible treatment measures and possible psychosocial circumstances that may interfere with treatment are required. Regular participation in further training activities is also required (Hembree et al., 2017).

The recommendation of the *Royal Australian and New Zealand College of Psychiatrists (RANZCP)* defines (child and adolescent) psychiatrists alongside other "mental health

professionals" as suitable specialists for determining indications (RANZCP, 2021). Reference is made to the necessary experience of the practitioners, but this is not defined further. It also emphasizes the importance of interdisciplinary collaboration in the indication process.

The American Pediatric Association guideline (Rafferty et al., 2018) calls for collaboration between pediatric or endocrinology professionals and mental health professionals with expertise in developmental psychology and gender incongruence.

## **5.2. Psychiatric-psychotherapeutic diagnostic and therapeutic measures**

In all existing guidelines and narrative reviews, the basic prerequisite for the indication of body-modifying measures in adolescents is the presence of diagnostically confirmed stable/persistent gender incongruence or gender dysphoria. This is usually described as "persistent", with no minimum duration and no clear criteria for a prognosis of persistence for the future (Agana et al., 2019; Hembree et al., 2017). In the current WPATH guideline, gender incongruence lasting *several years* is required for the indication of gender reassignment hormone treatment due to its partial irreversibility:

"Given potential shifts in gender-related experiences and needs during adolescence, it is important to establish the young person has experienced several years of persistent gender diversity/incongruence prior to initiating less reversible treatments such as gender-affirming hormones or surgeries." (Coleman et al., 2022, p. 60).

For the indication of a pubertal blockade, a pubertal blockade is also indicated via a However, it is stated that a period of several years for the developmental processes in early puberty cannot be demanded for practical reasons and would not be suitable to avert the stress that would result from the progression of pubertal body changes:

"However, in this age group of younger adolescents, several years is not always practical nor necessary given the remission of the treatment as a means to buy time while avoiding distress from irreversible pubertal changes." (Coleman et al., 2022, p. 60).

Both the definition of the diagnosis of gender incongruence according to ICD-11 (WHO, 2022) and the diagnosis of gender dysphoria according to DSM-5 (APA, 2013) explicitly include non-binary variants of gender identity. Therefore, in all newer

guidelines based on this definition explicitly do not exclude young people with non-binary gender identity from body-modifying treatments (T'Sjoen et al., 2020).

The international guidelines and review articles unanimously call for a psychological-psychiatric *assessment* to be carried out before a body-modifying measure is indicated, taking into account the accompanying psychological circumstances and any co-existing psychopathological disorders (Agana et al, 2019; Coleman et al, 2022; Hembree et al, 2017; RANZCP, 2021), whereby the assessment of resilience factors and resources is also explicitly emphasized in some cases (T'Sjoen et al, 2020). The recommendations of the RANZCP (2021) also specify that the circumstances of the initial onset of gender dysphoria should be explored. All guidelines and recommendations point out that before starting treatment, it must be ensured that, in the case of diagnostically confirmed gender incongruence or gender dysphoria, any existing associated mental disorder is diagnosed professionally and should not interfere with diagnostic clarity regarding gender incongruence or with the implementation of body-modifying treatment. If necessary, the treatment should be adapted to these particularities.

As described in Chapter IV → "*Associated mental disorders and health problems in children and adolescents with gender incongruence and gender dysphoria*", psychiatric morbidity in children and adolescents with gender incongruence or gender dysphoria is high. Since, according to the clinical experience of the experts involved in the development of the guidelines, accompanying psychopathology in adolescents with gender incongruence or gender dysphoria is often caused by the accompanying circumstances of gender dysphoria (including body dysphoric stress, psychosocial problems in the environment due to lack of acceptance, minority stress, experiences of discrimination, internalized transnegativity, etc.), mental disorders per se should not be seen as a contraindication for body modification measures.

The aim of body-modifying measures with a confirmed diagnosis is to alleviate body dysphoria and psychological distress and thus the psychopathological burden. Current guidelines and review articles therefore recommend that in the presence of a mental disorder coinciding with a diagnosed gender incongruence, this must be professionally addressed and treated within an integrated treatment concept if body-modifying measures are considered (Agana et al., 2019; Coleman et al., 2022; Hembree et al., 2017; RANZCP, 2021).

With regard to the social environment, previous international guidelines recommend ensuring that these measures are sufficiently supported by the family or other social environment before the indication for body-modifying measures is given. However, the accompanying psychotherapy that was still required in earlier decades as a mandatory prerequisite for the indication (Möller et al., 2014) is no longer included in current international guidelines (Coleman et al., 2022; Hembree et al., 2017). The indication for psychotherapeutic support depends on the need in each individual case (see recommendations in Chapter V → *"Psychotherapy and psychosocial interventions"*).

### **5.3. Somatic preliminary examinations**

With regard to somatic preliminary examinations, it should be ensured in accordance with existing guidelines that there is no somatic contraindication for the respective body-modifying treatment (Hembree et al., 2017; Rafferty et al., 2018; T'Sjoen et al., 2020). Further recommendations on this are set out in Chapter VIII → *"Somatic aspects of hormonal interventions"*.

### **5.4. Preconditions for the informed consent of minors**

All existing recommendations of international guidelines call for adolescents and their guardians to be informed in detail about the mechanisms of action and consequences, including possible side effects, of the body-modifying treatment indicated (Agana et al., 2019; Coleman et al., 2022; Hembree et al., 2017; RANZCP, 2021). In particular, this information should also include the possible effects on fertility, sexuality, relationship experience, body experience and the effects of each measure on any further gender reassignment body modification measures (Coleman et al., 2022; T'Sjoen et al., 2020). Uncertainties in decision-making and the evidence base should also be pointed out (RANZCP, 2021). In addition, informed decision-making and the ability to give informed consent must be properly documented (RANZCP, 2021).

The informed consent of those affected who are capable of giving consent (D), making decisions (A) or exercising judgment (CH) is paramount before a decision for treatment is made; depending on the level of maturity of the adolescents and the legal situation in the countries, the consent of the legal guardians is also decisive in the case of minors (Agana et al., 2019; Coleman et al., 2022; Hembree et al., 2017). Clear age limits for the indication of body-modifying measures are still specified in some older guidelines, such as the age of 12 years for pubertal blockade (Byne et al., 2012). In the guideline of the

Endocrine Society states that the necessary mental maturity for informed consent to gender reassignment hormone treatment is usually reached around the age of 16, but in individual cases an earlier indication from the age of 14 may be justified (Hembree et al., 2017). There, a developmental and maturity-related approach without a fixed age limit is recommended for gender reassignment mastectomy, but the age limit of 18 years is still specified for gender reassignment genital surgery (Hembree et al., 2017).

In the current WPATH guidelines (Coleman et al., 2022), the recommendation of respective age limits for staged individual body-modifying treatment steps was also abandoned in favor of a developmental-psychological approach and indication according to individual somatosexual and psychological maturity. This also corresponds to the legal situation in Germany and the corresponding legal situation in Switzerland and Austria for the determination of the capacity of minors to consent to/decide on/judge medical interventions. This is not to be assessed on the basis of age limits, but on an individual basis (see Chapter X → "Law and ethics").

For both puberty blockade and gender reassignment hormone therapy, the indication should be decided on a case-by-case basis after assessing the expected benefits and risks of a treatment step and depending on the individual level of maturity of those affected, together with those affected and their legal guardians (Coleman et al., 2022). According to the WPATH guideline *Standards of Care*, a mastectomy may be indicated for underage trans male patients with gender incongruence in cases of severe gender dysphoria and careful consideration of the expected advantages and disadvantages of this treatment step (Coleman et al., 2022). For further surgical procedures such as vaginoplasty or surgical breast augmentation in minors, a minimum duration of 12 months of prior sex reassignment hormone treatment is required. Phalloplasty is not recommended for minors (Coleman et al., 2022).

## **6. To the recommendations**

### **6.1. Fundamentals**

For each indication, the wishes of the person seeking treatment must be individually clarified and taken into account. Possible advantages and disadvantages of the treatments, information

about the prognosis and treatment risks must be communicated transparently and comprehensibly in a process of *shared decision making* in dialog with those seeking treatment and their guardians (see preamble and explanations on treatment decisions in Chapter X → "*Law and ethics*").

## **6.2. Puberty blockade**

A puberty block serves to prevent the development or progression of secondary sexual characteristics (e.g. breast growth, beard, voice change, gender-typical facial features, gender-typical physique, etc.) in adolescents with diagnosed gender incongruence or gender dysphoria. This blockade of ongoing puberty, which is always only carried out for a limited period of time, does not yet serve the purpose of gender reassignment, but is primarily intended to prevent the progression of somatosexual maturation from further increasing the resulting gender dysphoric distress. This can temporarily de-actualize existing gender dysphoric distress, which in turn can contribute to the temporary improvement of accompanying psychological symptoms such as depression and puberty block, without measurably reducing the symptoms of gender dysphoria (de Vries et al., 2011).

According to widely recognized endocrinological opinion, which is supported by the available evidence for the use of GnRH analogs in *pubertas praecox*, the Endocrine Society's international guideline states that temporary pubertal blockade is completely reversible with regard to its somatic effects (Hembree et al., 2017). This means that further genetically determined pubertal maturation can take place completely when treatment is discontinued. Accordingly, the complete development of secondary sexual characteristics in the sex assigned at birth can be made up for with the time delay caused by the treatment (Hembree et al., 2017). Possible effects on final body size must be taken into account due to a possible delayed closure of the epiphyseal fissure (see Chapter VIII → "*Somatic aspects of hormonal interventions*").

In the current guidelines of international medical societies (Coleman et al., 2022; Hembree et al., 2017) and on the basis of the clinical experience of the vast majority of experts involved in the development of these guidelines, there is a broad consensus that temporary puberty suppression with GnRH analogues is a medically well-founded treatment option for a high probability of persistent puberty if indicated by a specialist.

gender incongruence in adolescence. For treatment decisions, the currently available level of evidence according to the criteria of the *Oxford Centre for Evidence-Based Medicine* (OCEBM, 2011) is no higher than level IV (i.e. evidence based on uncontrolled descriptive cohort studies and case series).

In addition, the treatment recommendation is based on the known hormonal mechanisms and the many years of clinical experience and clinical studies on puberty suppression in *pubertas praecox*. The corresponding evidence level V according to the OCEBM criteria (OCEBM, 2011) *Reasoning by Mechanism* or *Mechanistic Evidence* (Aronson, 2020; Howick et al., 2009) is often the guiding principle for endocrinological interventions such as hormone replacement therapies, for which there are generally no controlled studies in the absence of an alternative treatment. Accordingly, the current interim report of the *Cass Review* (2022), which prepares national treatment recommendations for adolescents with gender incongruence for the National Health Service England (NHS), points out that as long as the available evidence from follow-up studies is uncertain, an *experience-based expert consensus that is as broad as possible* - and established through structured exchange as a *learning system* - should continue to serve as a provisional basis for treatment decisions. A professional treatment recommendation for complex medical interventions requires an individual assessment of the expected benefits and risks to be considered. These must be discussed in detail with the patient and their legal guardians.

### **6.2.1. Desired psychosocial effects of a puberty blockade**

The rationale behind puberty blockade, as set out in current international guideline recommendations from the *WPATH*, the *Endocrine Society* and the *American Pediatric Association* (Coleman et al., 2022; Hembree et al., 2017; Rafferty et al., 2018), is to temporarily halt the progressive and irreversible virilization or feminization of physical appearance. In adolescents diagnosed with gender incongruence, body-related gender dysphoric distress can thus be de-actualized or its intensification can be halted. This is intended to create a window of opportunity which, with the help of professional process support, can be used to prepare a sufficient capacity for consent (D)/capacity for judgment (CH)/capacity for decision-making (A) with regard to any later desired gender reassignment hormone treatment. Although puberty blockade in the above sense is reversible, it cannot be ruled out,

that their implementation could influence psychosexual development, e.g. by delaying pubertal brain maturation processes. This is taken into account when determining the indication by, among other things, requiring the presence of *persistent gender incongruence in adolescence* (see recommendations below). In addition, those affected and their guardians should be made aware of the insufficient evidence in this regard so that they can take this into account in their decision-making process.

One potential benefit of an initial puberty blockade may be that the decision for or against the start of gender reassignment hormone treatment can be postponed for a limited period of time without having to accept the further irreversible progression of virilization or feminization of the body as part of genetically programmed maturational development. This leaves open the possibility of gender incongruence persisting without having to accept serious consequences for physical development in the much more likely event of its persistence, which would be expected to increase the level of suffering later on. Adolescents with a very probable persistent gender incongruence can use this time window to become more certain about the temporal stability/persistence or possible fluidity of their perceived gender identity. This implies the possibility that, in the course of further process support, a puberty blockade that has been started can be discontinued if the adolescent concerned decides not to continue the transition and wants to continue living in the gender assigned at birth or in a non-binary identity without gender reassignment measures. Such cases of desistance after the onset of a puberty blockade are rare, which is to be expected due to the strict requirements for an indication and the necessary care of prior process support. However, they do occur and are reported in existing follow-up studies with a frequency of 0-4% (see above).

**Case study:** *Desistance after one and a half years of pubertal blockade* (Rölver et al., 2022)

Alexa, who was born female, presents herself as a boy at the age of 12 under the name of "Claus" before. She had had an unremarkable childhood in the female gender without any particularly gender-typical or atypical behavior. With the onset of puberty at the age of eleven and a half, increasing gender dysphoric symptoms developed with rejection of female body changes and an increasingly masculine experience of identity. At the initial presentation, the patient reported pronounced depressive symptoms and a desire to be outwardly



to want to live as a boy. Due to the depression and, in the further course, self-harm, a high frequency psychotherapy lasting nine months is initiated. During this time, "Claus" undergoes a complete social role change to the male gender, which in "his" experience and in the perception of his parents contributes to a psychological stabilization with a decrease in the depressive symptoms, although the body-related gender dysphoria persists. After a total of 10 months of clinical follow-up, a puberty blockade with GnRH analogs is initiated on the basis of gender dysphoria diagnosed according to DSM-5 in conjunction with a moderate depressive episode following informed consent by the patient and parents. This leads to a sustained reduction in gender dysphoric stress. "Claus" is able to cope stably with everyday life for several months. Outpatient psychotherapy is continued. After approx. 18 months of puberty blockade, the depressive symptoms worsen again, leading to inpatient admission to our clinic. The almost 15-year-old "Claus" says that the decision to undergo testosterone treatment has plunged "him" into a crisis, as this treatment is also not suitable for him.

feels "somehow wrong". Under therapeutic supervision, a decision is made together with the parents to stop the puberty blockade. "Claus" initially continues to live socially in the male role under his male first name, but deals intensively with the inner processes triggered by the onset of menstruation and progressive breast growth soon afterwards. Outpatient psychotherapy is resumed. A year and a half later, now almost 17 years old, the teenager decides to take on the female birth name "Alexa" again. At the same time, she is prescribed a progestin-only pill to suppress her menses, as this continues to cause her a great deal of stress. In her very reflective self-reflection, Alexa now describes her identity as non-binary, whereby she accepts the external appearance of her female body. In retrospect, she stands by the path she took, including the puberty blockade, and states that she needed this time for her own self-discovery.

Waiting without body-modifying intervention is not a neutral option for the time interval of waiting (Coteman et al., 2022, German Ethics Council, 2020). Progression of somatosexual maturation is expected to aggravate gender dysphoric distress, as there is no other treatment option for relief. Therefore, the potential advantages and disadvantages of treatment or the omission of treatment must be weighed up in a very careful process to determine the appropriate indication (German Ethics Council, 2020).

The somatic aspects of pubertal blockage to be considered and the Clinical treatment guidelines for implementation are presented in Chapter VIII → "*Somatic aspects of hormonal interventions*" of this guideline. A puberty blockade requires careful indication by a psychological-psychiatric and a

endocrinology specialist. In complex cases, medical ethics experts can be consulted for decision-making.

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Consensus-based recommendation:

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<b>VII K0</b>	Specialist knowledge and several years of experience in the process support and treatment of adolescents with gender incongruence are required for a professional indication. Professionals without sufficient specialist knowledge and experience in this area should consult a sufficiently experienced specialist to ensure that an indication is made.  specialist or a specialized outpatient clinic or a specialized Consult a treatment center.
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Consensus strength: strong consensus (> 95%)

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Explanation: This involvement of proven expertise is not formally defined and depends on the individual circumstances within a care and training landscape that is constantly evolving as a learning system. This can, for example, take the form of an independent medical second opinion, through a consultative co-assessment, through collegial intervision or supervision, or through case conferences in quality circles.

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Consensus-based recommendation:

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<b>VII K1.</b>	A indication for puberty blockade in adolescents with Gender incongruence or gender dysphoria should be treated in two ways <sup>2</sup> and requires interdisciplinary expertise and cooperation. The prerequisite for this indication is a diagnostic assessment by a child and adolescent psychiatrist or psychotherapist that is appropriate to the urgency and complexity of the individual situation. The somatic part of the indication should be assessed with regard to its prerequisites (pubertal stage of maturity, absence of somatic contraindications, etc.) by an experienced psychiatrist or psychotherapist.
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pediatric endocrinology specialist.

Consensus strength: strong consensus (> 95%)

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<sup>2</sup> The term "two-pronged" here refers to the interdisciplinary cooperation described below between psychiatric-psychotherapeutic and somatic medical expertise.

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Consensus-based recommendation:

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**VII K2.** The expertise of the persons who provide the child and adolescent psychiatric-psychotherapeutic-psychotherapeutic part of the indication for puberty blockade in adolescents with gender incongruence or gender dysphoria should meet the following formal requirements:

**General qualifications:**

One of the following qualifications specific to childhood and adolescence:

D:

- Specialist designation for child and adolescent psychiatry and psychotherapy
- License for child and adolescent psychotherapy
- Specialist designation for pediatrics and adolescent medicine with additional designation for psychotherapy

CH:

- Specialist in child and adolescent psychiatry and psychotherapy (Foederatio Medicorum Helveticorum/FMH)
- Federally recognized psychotherapist

A:

- Specialist in child and adolescent psychiatry or specialist in child and adolescent psychiatry and psychotherapeutic medicine
- Registration as Psychotherapist with further training in Infant, child and adolescent psychotherapy

Or, alternatively, with proven clinical expertise in the diagnosis and treatment of children and adolescents:

D:

- Specialist area designation for psychiatry and Psychotherapy, psychotherapeutic medicine or psychosomatic medicine and psychotherapy
- License for Psychological Psychotherapy CH:
- Specialist in psychiatry and psychotherapy/FMH)

A:

- Specialist in psychiatry and psychotherapeutic medicine, specialist in psychiatry and neurology
- Registration as a psychotherapist, registration as a clinical psychologist

Consensus strength: strong consensus (> 95%)

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A prerequisite for the indication of puberty blockade is the identification of stable/persistent *gender incongruence in adolescence* according to the diagnostic criteria of ICD 11 ((WHO, 2022) with concomitant gender dysphoric distress. The latter can manifest itself in an anticipatory fear of the progression of feminization or virilization of the physical appearance without psychosocial impairments already having occurred (see below). The diagnostic criteria for gender dysphoria in adolescence and adulthood according to DSM-5 (APA, 2013) can also be used to assess the extent to which clinically relevant gender dysphoria exists or could be expected as pubertal maturation progresses. A double diagnosis (i.e. gender incongruence according to ICD-11 and gender dysphoria according to DSM-5) is not necessary here. If the criteria for gender dysphoria according to DSM-5 are also met, this should be recorded in the clinical <sup>documentation<sup>3</sup></sup>.

The sole diagnosis of *gender incongruence in childhood* before the onset of puberty (ICD-11, HA61) is not sufficient for an indication, as it is not sufficiently meaningful with regard to its persistent or desistent course of development (see Chapter II → "*Variant courses of development*"). Nevertheless, a diagnosis of *gender incongruence in childhood* that has already been documented in the pre-pubertal developmental history can be used for the overall assessment of a developmental course in order to confirm a diagnosis at an early pubertal stage. For example, the literature on persistent vs. desistent developmental trajectories describes that although desistent trajectories are common after the onset of puberty in the case of gender dysphoria that has appeared in childhood, in cases of persistence this usually continues until the age of 13 under the influence of the puberty that has begun.

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<sup>3</sup> For research contexts in particular, it is advisable to document how often patients with GI were also diagnosed with GD according to DSM-5 due to the international comparability of the samples studied.

maturity development becomes clear (Steensma et al., 2011, 2013 see Chapter II → "*Variant development processes*").

**Fig. 2: Diagnostic criteria for gender incongruence in adolescence and adulthood** (HA60/ICD-11, WHO, 2022).

Gender incongruence in adolescence and adulthood is characterized by

- a *marked and [persistent] incongruence* between a person's perceived gender and their assigned gender, often leading to a *desire to "transition" in order to live and be accepted as a person of the experienced gender*, through hormone treatment, surgery or other health services, in order to *adapt* the person's body *to the experienced gender as much as possible and desired*.

The diagnosis cannot be made before the onset of puberty. Gender variant behaviors and preferences alone are not a basis for assigning the diagnosis.

**Fig. 3: Diagnostic criteria for gender incongruence in childhood** (HA61/ICD-11, WHO, 2022).

Gender incongruence in childhood is characterized by a *marked incongruence* between a person's experienced/expressed gender and their assigned gender in pre-pubertal children.

This includes:

- the strong desire to be a gender other than the assigned gender,
- a strong aversion of the child to its sexual anatomy or expected secondary sexual characteristics and/or a strong desire for the primary and/or expected secondary sexual characteristics that correspond to the experienced sex,
- as well as fantasy games, toys, games or activities and playmates that are typical for the experienced gender and not for the assigned gender.

The incongruence must *have existed for about 2 years*. Gender variant behaviors and preferences alone are not a basis for assigning the diagnosis.

**Fig. 4: Diagnostic criteria of gender dysphoria in the adolescence and adulthood according to DSM 5 (APA, 2013, p. 621)**

- A. A pronounced discrepancy between gender and gender of assignment **that has existed for at least 6 months**, whereby **at least two of the following criteria** must be met:
1. Pronounced discrepancy between gender and the primary and/or secondary sexual characteristics (or, in the case of adolescents, the expected secondary sexual characteristics).
  2. Pronounced desire to get rid of one's own primary and/or secondary sexual characteristics (or, in adolescents, the desire to prevent the development of the expected secondary sexual characteristics).
  3. Pronounced desire for the primary and/or secondary sexual characteristics of the opposite sex.
  4. Pronounced desire to belong to the opposite sex (or an alternative sex) Gender that differs from the gender of assignment).
  5. Pronounced desire to be treated like the opposite sex (or like an alternative gender that differs from the assigned sex).
  6. Pronounced conviction to exhibit the typical feelings and reactions of the other gender (or those of an alternative gender that differs from the assigned gender).
- B. Clinically relevant suffering or impairment in social, educational or other important areas of functioning.

In adolescents who are still at an early stage of puberty, the identification of gender dysphoric distress can primarily relate to an expressed anticipatory fear of a progressive virilization or feminization of the physical appearance, which is experienced and rejected as not matching the perceived own gender. Such predominantly anticipatory stress is particularly typical for adolescents who have already undergone a social role change in childhood and live with a high level of social satisfaction and acceptance in their perceived gender and therefore no longer have any reason to feel distressed by the social gender role assigned to them. In such cases, in the opinion of the

The vast majority of the experts involved in the guideline development considered it unethical and incompatible with the ethical principle of "non-harm" to wait for the course of pubertal maturation in an adolescent who is currently not significantly psychosocially impaired until a "sufficiently pathological" physical dysphoric condition with mental impairments can be determined.

According to the studies we have reviewed, there are no empirically validated individual criteria for determining the long-term stability/persistence of gender incongruence or gender dysphoria. It is therefore the responsibility of the psychiatric-psychotherapeutic specialist with experience in the exploration of various gender identity developments in children and adolescents to develop an individual assessment and prognosis in a joint discussion with the affected person and their guardians based on the overall picture of the available psychological findings, the descriptions and reflections of the affected person and their life history.

This usually requires diagnostic-explorative process support over several appointments and weeks or months. In addition to experience in the diagnostic assessment of reported gender-incongruent or gender dysphoric symptoms, it is particularly important for the psychiatric-psychotherapeutic specialist to have comprehensive knowledge of the range of variations in the relevant developmental processes. This includes knowledge of trajectories that are associated with desistance of gender dysphoria during adolescence or with later detransition after completed transition (see Chapter II → "*Variant developmental trajectories*").

Consensus-based recommendation:

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<p><b>VII K3.</b> The prerequisite for the indication of a puberty blockade should be the presence of a stable/persistent gender incongruence (GI) after the onset of puberty (according to the diagnostic criteria for GI in adolescence/ ICD-11 HA60) with existing gender dysphoric distress. The diagnostic assessment should be carried out as part of a collaboration between the psychiatric/psychotherapeutic/psychotherapeutic specialist and the patient and their guardians/caregivers on the basis of careful exploration of the patient's mental health and psychological symptoms. findings and life history.</p>
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Consensus strength: strong consensus (> 95%)

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In the event of indications of psychopathological abnormalities, the recommendations in Chapter IV → "*Associated psychological abnormalities and health problems in children and adolescents with*

*Gender incongruence and gender dysphoria*", in particular in order to avoid overlooking a mental disorder requiring treatment whose symptoms could overlap or interfere with gender dysphoric symptoms. This can make it more difficult to achieve the diagnostic clarity required to establish an indication, which can lead to longer diagnostic processes in individual cases.

#### **6.2.2. Special case: Initiation of a puberty blockade with a high degree of urgency**

In practice, particularly in the case of gender incongruence and high gender dysphoric distress in the early stages of puberty development, a high time pressure can arise for those affected, which creates a correspondingly increased pressure to act. After the onset of puberty, the progression of irreversible body changes can be associated with lifelong effects on body dysphoria and quality of life (e.g. male voice change, female breast growth), so that prompt intervention is often indicated. In these cases, long waiting times (e.g. more than 6 months) for an appointment for a child and adolescent psychiatric or psychotherapeutic indication assessment would not be medically justifiable.

In individual cases, however, a situation may arise for care-related reasons in which the child and adolescent psychiatric/psychotherapeutic diagnosis described above, which is usually required for an indication, cannot be carried out within a reasonable period of time. This may mean that the reversibility of the intervention must be weighed against the non-reversibility of the consequences of waiting too long and that it may be justified, in order to prevent damage to health, for an experienced pediatric endocrinologist to initiate a puberty blockade for a few months if a diagnosis of gender incongruence has been made in adolescence, subject to the proviso that a professional child and adolescent psychiatric-psychotherapeutic diagnosis and indication assessment is carried out immediately. The patient and guardians must be informed of this provisional nature, which implies that the puberty blockade would have to be discontinued if the adolescent psychiatric-psychotherapeutic part of the indication is not confirmed.



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Consensus-based recommendation:

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**VII K4.** In individual cases, the progressive pubertal development of maturity can lead to a time pressure may arise where, in order to avert irreversible bodily changes (e.g. male voice change, female breast growth), a puberty blockade can be initiated promptly by the pediatric endocrinology specialist due to its urgency with a provisional indication, if the implementation of child and adolescent psychiatric-psychotherapeutic (KJP) process support for an indication would mean an unacceptable delay. In such a justified case, diagnostic child and adolescent psychiatric-psychotherapeutic (KJP) process support should be provided in order to safeguard the indication can be made up in a timely manner.

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Consensus strength: strong consensus (> 95%)

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### **6.2.3. Importance of sexual orientation and non-binary self-descriptions**

Both sexual orientation and gender identity can develop fluidly during adolescence. A transgender coming out may be preceded by a temporary homosexual exploration ("trying out") and vice versa. According to the clinical observations of the experts involved in drawing up the guidelines, many adolescent patients with gender incongruence are very differentiated in their self-disclosure on the issue of their sexual orientation ("one has nothing to do with the other for me"). In addition, there is usually little fear of contact with homosexual or bisexual orientations, which supports the hypothesis sometimes put forward that a supposedly transgender identification of adolescents could be a manifestation of a sexual orientation.

"averted homosexuality" are put into perspective. Furthermore, community-based surveys reported that only a minority of adult trans people stated a clear heterosexual orientation ("straight") in their perceived gender, whereas most trans people surveyed stated a sexual orientation within the queer, bisexual or fluid spectrum (Katz-Wise et al., 2016).

Sexual orientation is therefore not decisive for the indication of body-modifying measures in the event of gender incongruence. Any unequal treatment of patients depending on their sexual orientation would be

unethical and discriminatory. However, it cannot be ruled out that the reported sexual orientation and gender identity of individual adolescents who are in a general adolescent maturation crisis, for example, may interfere in a way that makes it difficult to determine persistent gender incongruence. Therefore, the exploration of the entire psychosexual development as part of a diagnostic process is important for the indication.

Consensus-based recommendation:

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<b>VII K5.</b> The Indications for puberty blockade in adolescents with adolescents with Gender incongruence or gender dysphoria should be treated independently of a binary The decision can be made regardless of a person's sense of belonging to a particular gender and regardless of sexual orientation.
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Consensus strength: strong consensus (> 95%)

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Special vote of the German Psychoanalytical Society (DPG) for a different recommendation:

<b>VII K5.</b> The Indications for puberty blockade in adolescents with adolescents with Gender incongruence or gender dysphoria should be treated independently of sexual orientation. orientation.
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This special vote to omit the reference to a binary sense of belonging from the recommendation was also made in the same way for the corresponding recommendations on gender reassignment hormone treatments and surgical interventions. The reasons for this special vote are set out in the recommendation on sex reassignment hormone treatments (VII. K15).

The current state of knowledge on the developmental trajectories of gender-incongruent or gender-dysphoric children into adolescence and adulthood is presented in Chapter II → "*Variant developmental trajectories*" of this guideline. Not all children who report symptoms of gender incongruence or gender dysphoria before puberty persist beyond puberty. In the samples of adolescents with already begun or advanced puberty that have been examined so far, which, after professional

However, it has been shown that only very few adolescents were treated with puberty blockade when the indication was established and that the vast majority subsequently requested gender reassignment interventions (Brik et al., 2020; de Vries et al., 2011, 2014; Khatchadourian et al., 2014). This corresponds to the expectation in that at the treatment center where these studies were conducted, each indication was preceded by professional process support and, among other things, the diagnosis of a high probability of persistent gender incongruence in adolescence was a defined entry criterion for the indication (see above).

Affected adolescents and their guardians must be comprehensively informed about the various courses of gender-incongruent and gender-dysphoric developments in children and adolescents. This also includes the information that, according to previous observations at most specialized treatment centers, the vast majority of those affected opt for treatment with sex-affirming hormones after puberty blockade has begun. Nevertheless, it should be pointed out that the decision to undergo puberty blockade does not necessarily imply a commitment to later sex reassignment hormone treatment, but that in the event of later desistance, complete sexual maturation in the sex assigned at birth would be possible without serious medical disadvantages.

In this respect, the temporary puberty block can be used as a justifiable temporary "moratorium" to protect against progressive irreversible changes to the body. The time window gained in this way can be used to adequately prepare a decision for or against hormonal adjustment, which is much more serious in its consequences.

#### **6.2.4. Possible onset of puberty blockade**

Based on the evidence presented in Chapter II → "*Variant developmental processes*", all previous guideline recommendations have so far unanimously called for puberty blockade not to be performed before the first hormonal pubertal surge in order to take into account the developmental aspect of gender identity in the context of early puberty. All the studies on the effects of puberty blockade on adolescents with gender incongruence or gender dysphoria mentioned at the beginning of this chapter under the title Original studies were carried out with the indication criterion of puberty of at least Tanner stage 2 having already begun. Earlier initiation of puberty blockade in prepubertal children is generally not recommended.

More recent guidelines are limited to the recommendation of puberty stage Tanner 2 as the indication limit (Coleman et al., 2022; Hembree et al., 2017). Even in later stages of puberty, puberty blockade can be useful if the person seeking treatment so wishes, if there is a pronounced gender incongruence or gender dysphoria, if the further development of secondary sexual characteristics is to be prevented for the time being, and if the adolescents concerned or their environment are not yet ready for or have decided on gender reassignment treatment or if the indication still appears premature for other reasons.

Consensus-based recommendation:

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**VII K6.** The indication for a puberty blockade in adolescents with Gender incongruence or gender dysphoria should not occur before Tanner stage 2 be provided.

Consensus strength: strong consensus (> 95%)

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Consensus-based recommendation:

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**VII K7.** The indication for a puberty blockade can also be at a later stage of puberty. If there is not yet an indication for gender reassignment hormone treatment, this can allow time for a decision to be made for or against further treatment steps and to reduce the risk of a gender reassignment surgery suffering can be useful.

Consensus strength: strong consensus (> 95%)

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There is no evidence on the question of whether puberty blockade should be preceded by a social transition for those affected. Previous guidelines call for persistent gender incongruence or gender dysphoria, although social transition is not explicitly mentioned (Agana et al., 2019; Hembree et al., 2017).

Whether or not a transition takes place in children and adolescents depends not only on the extent of gender incongruence or gender dysphoria, but also on the acceptance of such a transition by the family and school environment. The clinical experience of the experts involved in drawing up the guidelines often shows that

Cases in which there is a strong and long-standing gender incongruence with strong body-related gender dysphoria, but a social transition has not yet been implemented despite the desire to do so. In these cases, there is often a desire for a puberty block in order to gain time to find out about the possibilities of social transition and to seek advice on implementing social transition without changing physically in an undesired direction during this time, which would make social transition even more difficult at a later stage.

Consensus-based recommendation:

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<b>VII K8.</b> A social role change that has already been initiated or completed should be taken into account in the indication for a puberty blockade is not a necessary criterion.
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Consensus strength: strong consensus (> 95%)

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#### 6.2.5. Diagnosis and treatment of associated or co-occurring conditions

Due to the frequency of associated mental disorders in adolescents diagnosed with gender incongruence or gender dysphoria, any existing co-occurring mental disorders should be diagnosed and treated if necessary. A detailed description of the mental disorders frequently associated with gender incongruence in children and adolescents and their consideration in an individualized integrated disorder model, including differential diagnostic considerations, can be found in Chapter IV → "*Associated mental health problems and health problems in children and adolescents with gender incongruence and gender dysphoria*".

There are conditions and associated disorders to which particular attention should be paid when determining the indication for a body-modifying treatment for gender incongruence. These conditions and disorders are not to be understood as differential diagnoses in the classical medical sense, as their presence does not allow the conclusion that there is no persistent gender incongruence, nor does it per se constitute a relative or even absolute contraindication for the indication of body-modifying measures. However, according to the overwhelming clinical experience of the clinical experts involved in this guideline, these conditions and disorders can be linked in many ways to the indication for body modification measures.

interfere with each other and thus require longer diagnostic clarification processes to prepare an indication.

As explained in Chapter IV → "*Associated psychological abnormalities and health problems in children and adolescents with gender incongruence and gender dysphoria*", depending on the individual case constellation, these can be

- play a role in the development of gender dysphoria-like symptoms that are *not* based on permanent gender incongruence,
- occur independently of gender incongruence,
- as a consequence of gender incongruence and the increased psychological stress caused by it,
- interact in complex ways with gender incongruence or gender dysphoria.

**Table 5:**

Possible associated conditions and disorders to be considered in the diagnosis of gender incongruence before an indication for medical measures is given:

- Depressive disorders
- Disorders with social anxiety
- Syndromes with self-injurious behavior
- Eating disorders
- Personality disorders (especially with identity diffusion or self-uncertainty)
- adolescent maturation crises
- Autism spectrum disorders

Autism spectrum disorders play a special role, as their development as a consequence of gender incongruence should not be considered.

Professional psychiatric-psychotherapeutic diagnosis and treatment with the involvement of the family can be essential for a positive course of body-modifying treatment and further psychosocial development in adolescents with associated mental disorders. An integrated treatment plan must be drawn up for each individual case. However, as not all children and adolescents diagnosed with gender incongruence are affected by mental disorders, the need should be assessed on an individual basis. However, a prerequisite for puberty-restraining treatment is always a detailed child and adolescent psychiatric-psychotherapeutic diagnosis in order to ensure that

ensure that existing disorders are properly recognized and, if necessary, treated and do not interfere with body-modifying treatment. Possible interference between a diagnosed or suspected gender incongruence and another associated mental disorder can manifest itself and have a variety of effects. An associated mental disorder can, for example

- impair diagnostic clarity in the assessment of gender dysphoric symptoms,
- affect the feasibility of recommended social role testing in preparation for body-modifying treatment (e.g. social phobia with school absenteeism),
- affect the timing of planned interventions (e.g. anorectiform eating disorder with the need for weight rehabilitation before hormonal interventions),
- impair the psychosocial stability and medical treatment compliance sufficient for body-modifying treatment (e.g. patients with repeated acute psychiatric admission for borderline personality disorder),
- impair the capacity to consent/judge/decide with regard to body-modifying measures (e.g. acute mental crisis with a restricted view of current stressors).

If necessary, an individualized disorder model (see above) should be developed together with the adolescents concerned, which includes possible interactions between gender dysphoria and the co-occurring mental disorder (e.g. depression, self-injurious behaviour, social phobia or eating disorder). In an integrated treatment plan, if associated mental disorders are present, the indication for puberty-restraining treatment to de-actualize the gender dysphoric distress should be combined with or embedded in suitable psychosocial and psychotherapeutic interventions.

The following list summarizes the important steps in the procedure for associated conditions and disorders.

**Table 6: Procedure for indications of associated mental disorders**

1. Initiate a guideline-compliant diagnosis based on the respective disorder.
2. Check whether there is a need for treatment regardless of gender incongruence.
3. Dialogical development of an individualized disorder model for symptom genesis and possible interdependence between gender dysphoric experience and associated mental disorder.
4. Diagnostic assessment of the extent to which the associated disorder is associated with necessary  
The use of a medical device does not interfere with the requirements of an indication (e.g. with diagnostic clarity, capacity to consent or feasibility of a medical measure).
5. Plan the further course of action taking into account points 1-4 (e.g. extended  
Process support to clarify the requirements for an indication, involvement of external expertise or indication for the start of body-modifying treatment in parallel with treatment of the associated disorder).

#### **6.2.6. Important aspects of education**

Adolescent patients and their guardians must be informed about the mechanisms of action and consequences of puberty blockade, including possible side effects. This includes, in particular, possible effects on sexuality, fertility, subsequent gender reassignment measures such as genital surgery, relationship experience and body experience (see explanations on this in Chapter VIII → "Somatic aspects of hormonal interventions"). Reference should also be made to the available options for fertility protection (cryopreservation). It should be noted that the desire to have children often changes over the course of a woman's life and that not undergoing cryopreservation carries the risk of not being able to have children at a later date. The advantages of waiting until sufficient sexual maturity for cryopreservation in adolescents who have not yet developed accordingly must be weighed against the disadvantages of waiting and the associated increased development of irreversible secondary sexual characteristics.

Depending on their level of maturity, the information provided should support the adolescents as much as possible in the process of reaching a capacity for consent (D)/capacity for judgment (CH)/capacity for decision-making (A) and being able to make an informed decision (see explanations on this in Chapter X → "*Law and ethics*"). This includes identifying the potential advantages and disadvantages of the treatment and weighing them up together with the person concerned and their legal guardians.



In the context of informed consent, it should be clear that the adolescent has understood the possible positive and negative consequences of the intervention in question and has been able to adequately classify and weigh them up for themselves. The patient's required understanding of the intervention and its possible consequences therefore goes beyond mere factual knowledge.

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Consensus-based recommendation:

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<p><b>VII K9.</b> The indication for a pubertal blockade should include an examination of the capacity (D) / capacity of judgment (CH) / decision-making capacity (A) of the minor seeking treatment by a child and adolescent psychiatric or psychotherapeutic specialist. If the minor does not have sufficient capacity for consent / judgment / decision-making, this capacity should be promoted by the professionals involved in the training. become.</p>
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Consensus strength: strong consensus (> 95%)

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If a minor diagnosed with gender incongruence/gender dysphoria does not (yet) have capacity to consent (D)/capacity to make decisions (CH)/capacity to make decisions (A), the legal guardians can, if there are good reasons for starting treatment promptly (e.g. prevent an irreversible male voice change), the decision to block puberty can be made by the custodians, provided that the child was able to participate in this decision in accordance with its cognitive maturity and this corresponds to the clearly recognizable will of the child (see explanations on this in Chapter X → *"Law and ethics"*).

The support of the family environment for the transition and in particular for the initiation of body-modifying measures is of great importance for the mental health of children and adolescents with gender incongruence (see also Chapter VI → *"Inclusion of the family relationship environment and family dynamics"*). In cases where a persistent gender incongruence with the desire to transition is rejected by parents and other caregivers, there is a high risk of subsequent psychological disorders, especially depression and suicidal tendencies (see also Chapter IV → *"Associated psychological abnormalities and health problems in children and adolescents with gender incongruence and gender dysphoria"*).

In these cases, intensive family therapy should be used to support the caregivers in order to address their reservations about an accepting attitude towards their child's gender identity and, if possible, work through them so that an accepting framework can be created within the family. The aim of the family therapy process is to make room for the parents' concerns and to develop a joint process of understanding about suitable steps to support the adolescents concerned. This assumes that family therapy interventions are not expected to have any psychologically damaging effects on the adolescents concerned (e.g. in the case of physical separation supported by the youth welfare office following experiences of abuse if custody is retained).

Consensus-based recommendation:

<p><b>VII K10.</b> With given capacity to consent (D)/Capability of judgment (CH)          /(A) of the minor should be a co-consensus of the parties involved.          The child's legal guardians should be involved.</p>
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Consensus strength: strong consensus (> 95%)

Consensus-based recommendation:

<p><b>VII K11.</b> In cases where there is no co-consensus between the patient and their legal guardian intensive process support for the family system should be offered by a suitable specialist with family therapy expertise with the aim of enabling support for the patient. Such process support is only recommended if no harmful effects on the health/psychological well-being of the patient are to be expected. In such cases an examination of the best interests of the child is indicated.</p>
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Consensus strength: strong consensus (> 95%)

Explanation: Beyond the fundamental need to focus on the health of the child, the emphasis in this recommendation refers to case constellations in which there is reason to believe that a family therapy intervention involving the adolescent patient and their guardians could be harmful. One

Such an assumption should regularly lead to the case being examined under special questions of child welfare and, if necessary, child protection.

In cases in which no consensus regarding puberty-suppressing treatment can be reached between the affected person and their legal guardians or between the legal guardians themselves despite intensive process support, an independent body may need to initiate an assessment of whether the child's welfare is at risk and the appropriate steps to promote the child's welfare. This is the responsibility of the competent courts or authorities in the respective country and should not be assessed from a therapeutically biased position (for the legal regulations to be observed, see Chapter X → "*Law and ethics*").

#### **6.2.7. Somatic aspects to be considered**

A careful somatic examination by an endocrinologist-specialist should ensure that there is no somatic condition that could interfere with puberty-suppressing treatment. In special cases, the puberty-suppressing intervention must be adapted to the individual somatic situation.

In previous recommendations, the differential diagnosis of a somatosexual differentiation disorder from the DSD spectrum (somatic diversity of sex development, intersex condition) was required as a prerequisite for an indication for hormonal interventions in cases of gender incongruence or gender dysphoria. The coincidence of gender incongruence or gender dysphoria with a diagnosis from the DSD spectrum is rare. According to the currently available international guidelines (Coleman et al., 2022; Hembree et al., 2017) and in the overwhelming opinion of the experts involved in the development of this guideline, it is not a contraindication per se for body-modifying interventions in cases of diagnosed gender incongruence with gender dysphoria. In these situations, both psychological and somatic conditions must be carefully examined and the intervention should be adapted to the individual case. Corresponding recommendations can be found in Chapter VIII → "*Somatic aspects of hormonal interventions*".

### 6.3. Gender reassignment hormone treatment (GAH)

Gender-affirming hormone treatment (GAH) should be considered if adolescents with capacity to consent (D)/capable of judgment (CH)/capable of decision-making (A) with a confirmed diagnosis of gender incongruence according to ICD-11 (WHO, 2022) have a long-term desire for this treatment and persistent gender dysphoria. The legal guardians must be involved in the decision-making process in all cases, taking into account the legal framework and the family situation.

Professional support for this process is aimed at enabling the employee to take responsibility and informed decision of the underage patients in consensus with their legal guardians, carefully weighing up the benefits of the desired gender reassignment hormone treatment and the increasingly irreversible somatic consequences of both treatment and non-treatment (German Ethics Council, 2020).

Due to the increasing partial irreversibility of gender reassignment hormone treatment, a high degree of cognitive and socio-emotional maturity of minors is required for the decision. In cases of doubt, if the minor has not yet reached full capacity to consent (D)/capacity to judge (CH)/capacity to make decisions (A), the decision should not be made on behalf of the minor by their legal guardians due to the highly personal consequences of treatment or failure to undergo treatment. Instead, minors who wish to undergo treatment should be given intensive professional support, including the perspective of their legal guardians, to enable them to reach their own capacity to consent (D)/capacity to make decisions (CH)/capacity to make decisions (A) so that they can make an autonomous and informed decision.

The somatic consequences of gender reassignment hormone treatment and the medical recommendations for carrying out this intervention are described in Chapter VIII → "*Somatic aspects of hormonal interventions*". The start of gender reassignment hormone treatment requires careful indication in interdisciplinary cooperation by a psychiatric-psychotherapeutic specialist and an endocrinologist experienced in the treatment of adolescents (dual indication, see below). The latter may come from the field of pediatrics, internal endocrinology or (pediatric) gynecology. In complex cases, medical ethics specialists can be consulted for clarification.

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Consensus-based recommendation:

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**VII K12.** The indication for gender reassignment hormone treatment for Adolescents with gender incongruence or gender dysphoria should be treated in two ways and requires interdisciplinary expertise and cooperation. The prerequisite for an indication is an adolescent psychiatric or psychotherapeutic diagnostic assessment appropriate to the urgency and complexity of the individual <sup>situation</sup><sup>4</sup>. The somatic part of the indication should be assessed with regard to its prerequisites (pubertal stage of maturity, absence of somatic contraindications, etc.) by a endocrinologist experienced in the treatment of adolescents.

Consensus strength: strong consensus (> 95%)

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Checks and considerations to be made with regard to somatic contraindications to sex reassignment hormone treatment are described in Chapter VIII → "*Somatic aspects of hormonal interventions*".

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Consensus-based recommendation:

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**VII K13.** The expertise of the people who are responsible for child and adolescent <sup>psychiatric</sup> psychotherapeutic-psychiatric part of the indication for gender reassignment hormone treatment in adolescents with gender incongruence or gender dysphoria should fulfill the following formal requirements:

One of the following qualifications specific to adolescence: D:

- Specialist designation for child and adolescent psychiatry and psychotherapy
- License for child and adolescent psychotherapy
- Specialist designation for pediatrics and adolescent medicine with additional designation for psychotherapy

CH:

- FMH title in child and adolescent psychiatry and psychotherapy
- Federally recognized psychotherapist A:

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<sup>4</sup> For the technical requirements, see the following recommendation

- Specialist in child and adolescent psychiatry or specialist in child and adolescent psychiatry and psychotherapeutic medicine
- Registration as a psychotherapist with further training in infant, child and adolescent psychotherapy  
Adolescent psychotherapy

Or alternatively, with appropriate clinical expertise in the diagnosis and treatment of children and adolescents:

D:

- Specialist area designation for psychiatry and psychotherapy, Psychotherapeutic medicine or psychosomatic medicine and psychotherapy
- License for psychological psychotherapy

CH:

- FMH title in psychiatry and psychotherapy

A:

- Specialist in psychiatry and psychotherapeutic medicine, specialist in psychiatry and neurology
- Registration as a psychotherapist, registration as a clinical psychologist

Consensus strength: strong consensus (> 95% agreement)

Stable/persistent gender incongruence with concurrent gender dysphoria or gender dysphoria to be expected with increasing pubertal development is a prerequisite for an indication for gender reassignment hormone treatment.

Empirically validated individual criteria for the determination of a permanent Stability/persistence of gender incongruence or gender dysphoria are not present according to the studies we have reviewed. It is therefore up to the psychiatric-psychotherapeutic specialist to work out an individual assessment in a joint discussion with the affected person and their guardians based on the overall picture of the existing psychological findings, the descriptions and reflections of the affected person and their life story. This usually requires diagnostic-explorative process support over several appointments and weeks or months. In addition to experience in the diagnostic assessment of reported gender-incongruent or gender-dysphoric symptoms, it is particularly important for the psychiatric-psychotherapeutic specialist to have comprehensive knowledge of the range of variations in the relevant developmental processes,

including those associated with desistence of gender dysphoria during adolescence or with later detransition after completed transition.

In the current guideline of the WPATH *Standards of care for the health of transgender and gender diverse people, version 8*, it is recommended as a time criterion that before starting gender reassignment hormone treatment in adolescence, the affected person should report having experienced gender incongruence for several years (Coleman et al., 2022). The criterion of stable/persistent gender incongruence described in our guideline takes this recommendation into account.

The gender incongruence should be determined accordingly via a developmental psychological aspects *for a sufficiently long period of time*. When exploring the duration of gender incongruence or gender dysphoria, it should be noted that the internal experience is decisive, which can deviate considerably from the externally observable gender expression depending on the psychosocial situation. In developing these guidelines, we deliberately decided against specifying a formal time frame, partly because, in the experience of the experts involved, this is not a valid criterion for assessing the stability of inner coming-out processes and a formal time frame for a "pronounced and persistent" inner experience, as required by ICD-11, would also not be validly objectifiable. In practice, the extent to which a pronounced and persistent inner state can be assumed must therefore be assessed on a case-by-case basis, taking into account the overall development.

Consensus-based recommendation:

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<p><b>VII K14.</b> Prerequisite for the Indication a gender reassignment surgery</p> <p>Hormone treatment should the Presence a stable/persistent Gender incongruence (according to the diagnostic criteria of GI in adolescence/ ICD-11 HA60) with gender dysphoric distress that developed or intensified after the onset of puberty and the associated desire to develop the gender-specific physical changes expected as a result of hormone treatment. The diagnostic assessment should be carried out by a psychiatric-psychotherapeutic specialist in collaboration with the patient and their guardians/caregivers on the basis of an exploration of the psychological findings and life history.</p>
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Consensus strength: strong consensus (> 95%)

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### 6.3.1. Non-binary gender identities and fluid sexual orientation in adolescence

A particular diagnostic challenge is the non-binary identity experience of adolescents, which, in the experience of the experts involved in drawing up the guidelines, has recently been reported with increasing frequency. It may initially be unclear to what extent such a self-description is primarily an expression of a *non-binary understanding of social gender roles*, which does not necessarily go hand in hand with a permanent *non-binary gender identity*. Recommendations for the psychotherapeutic support of open-ended self-exploration and self-discovery processes in this regard are set out in Chapter V → "*Psychotherapy and psychosocial interventions*" of this guideline.

The following two case studies illustrate this variability.

#### *Case study 1: trans boy with initially non-binary self-description*

16-year-old Luisa introduces herself under her female first name at birth with the self-attribution "I am non-binary". In the exploration, a pronounced gender dysphoric experience with a reflected rejection of female role expectations and a strong feeling of disturbance towards the female sexual characteristics of her body is stated. The breasts have been tied off daily for several months. At the same time, the adolescent states at this point that she does not identify with the male gender either and expresses the fear that she could "jump out of the frying pan into the fire" if she transitions into a different gender role that is just as unsuitable for her as a person. In a psychotherapeutic process lasting several months, the adolescent is encouraged to consistently openly explore a social gender role that is right for her, which she engages in with reflected introspection. In the process, it becomes increasingly clear to her that a harmonious experience with her own gender identity can only be experienced in the long term in a body that appears male. A trial outing at school as a trans boy with the newly chosen male first name Milan leads to an increasing experience of congruence and psychological relief. The freedom gained through the previous non-binary self-exploration, being able to be an "atypical" young man without adopting typical expectations of a "male role", acts as an inner impetus for the desire to transition. Milan now wants testosterone treatment, the indication for which can be affirmed due to the now reliably diagnosable gender incongruence. Shortly after starting testosterone treatment, the legal change of name and civil status takes place. One year later, at the age of 18, he undergoes a mastectomy. As a boy, Milan successfully completes his A-levels at grammar school. Over the next two years, Milan's psychological development in the male gender is stable and accompanied by social and health-related well-being.



*Case study 2: Open-ended development over three years*

16-year-old Carla introduces herself with a non-binary self-description under her female first name at birth. She says that she rejects all male and female role ascriptions and imagines that she can feel more comfortable in a body that appears male within this perceived non-binarity. She dresses typically for a boy and has a short haircut. During the exploration, it is noticeable that there does not appear to be any pronounced body-related suffering pressure. The adolescent states that she could well imagine undergoing a transition and taking male hormones later on. In a psychotherapeutic process lasting several months, Carla is encouraged to openly explore a social gender role that she can experience as coherent. She initially decides to come out socially as a non-binary trans person and gives herself the male first name Benno, under which she now appears in all areas of everyday life. Benno experiences social acceptance in his family and at school and shows himself to be socially active and competent in many ways. Benno seems very satisfied and says that he is in no hurry to decide on a medical gender reassignment. Due to the unclear diagnostic picture - no gender incongruence can be diagnosed for the time being - Benno is advised to give himself at least two more years to explore his non-binary social roles and to live as the person he is without medically intervening in his own body. Benno seems relieved by this recommendation. The question of medical transition treatment no longer comes up in the appointments for over a year. At the same time, Benno appears stable and continues to be competent and self-effective in actively shaping his life - after successfully completing his A-levels.

There are no published data on the body-modifying treatment of non-binary adolescents, which is why particular caution is required when determining indications. On the other hand, both the ICD-11 and the DSM-5 explicitly include non-binary gender identities as part of the diagnostic spectrum for gender incongruence and gender dysphoria. As a result, it would be medically, socio-legally and ethically unacceptable to exclude non-binary people with gender incongruence and persistent gender dysphoria from professional treatment as a matter of principle. The above-mentioned problems and challenges must therefore be addressed in individualized case studies, which in adolescence may justify the need for a diagnostic process support with a longer clinical observation interval.

In the case of both sexual orientation and gender identity, the following are fluid developmental processes are possible in adolescence. A transgender coming out may be preceded by a temporary homosexual exploration ("trying out") and vice versa. According to the clinical observations of the experts involved in drawing up the guidelines, many of the adolescent patients with gender incongruence have come to the question of whether or not they are transgender.

The patients are very differentiated in their self-disclosure of their sexual orientation ("one has nothing to do with the other for me"). In particular, most patients have little fear of contact with homosexual or bisexual orientations, which relativizes an etiological explanation model that is sometimes put forward, namely that an alleged trans identity could perhaps be a case of "averted homosexuality".

Furthermore, community-based surveys reported that only a minority of adult trans people stated a clear heterosexual orientation ("straight") in their perceived gender, whereas most trans people surveyed stated a sexual orientation within the queer, bisexual or fluid spectrum (Katz-Wise et al., 2016). Sexual orientation is therefore not a determining factor for the indication of body-modifying measures in the case of gender incongruence. Unequal treatment of patients based on their sexual orientation would be unethical and discriminatory.

However, it cannot be ruled out that reported sexual orientation and gender identity may interfere in a way that makes it difficult to determine persistent gender incongruence in individual adolescents who are experiencing a general maturation crisis. Therefore, the exploration of the entire psychosexual development as part of a diagnostic process is important for the indication.

Consensus-based recommendation:

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<b>VII K15.</b> The indication for gender reassignment hormone treatment should be independent of the polarity or binarity of gender identity and independent of the sexual orientation of the patients.
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Consensus strength: strong consensus (> 95%)

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Special vote of the German Psychoanalytical Society (DPG) for a different recommendation:

<b>VII K15.</b> The indication for gender reassignment hormone treatment <b>should</b> be made regardless of the patient's sexual orientation.
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Reasons for this special vote of the DPG:

<b>(A) Lack of evidence</b>
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While there are a number of studies for binary trans adolescents (see chapter introduction) that at least give clear indications or provide isolated evidence of positive effects of GnRH analogs and gender reassignment hormone treatments on mental health, the empirical evidence for non-binary adolescents is completely unclear and at best speculative based on a few clinical empirical values (individual case decisions without knowledge of the long-term course). Current outcome studies, e.g. Achille (2020) and Becker-Hebly (2021), only look for

"female to male" or "male to female". Non-binary adolescents are not mentioned and not included in the study groups. The same applies to the Dutch cohort, for which some long-term follow-up and catamnesis data are available, but whose sample excluded non-binary developmental trajectories of somatic indications (Abbruzzese et al., 2023). In contrast, a study by Chen et al. (2023) and Kuper et al. (2020) explicitly included non-binary adolescents, but did not analyze whether non-binary identified adolescents benefit equally from the treatment as binary identified adolescents

### **(B) Psychosexuality and adolescence - theoretical assumptions**

As part of the adolescent development process, from early, through middle and late adolescence (Blos, 2001), psychological bisexuality is described in the new literature (Quindeau, 2019) as a normal process of exploring one's own identity, during which there are strong fluctuations in gender identification. This process represents a kind of transitional stage of testing and identification that, for most adolescents, leads to a clear (binary) gender identity and a clear sexual orientation. In this understanding, non-binary identification is not a pathological solution, but rather an expression of an inner confrontation with developmental tasks, separation from parental objects and the development of one's own autonomous abilities. In this way of thinking, early medical intervention in the case of persistent non-binary identification would be an interruption of the developmental process and, in the worst case, a body-modifying fixation of a transitional stage.

### **(C) Dealing with non-binarity in other guidelines and treatment recommendations**

Non-binary is only explicitly mentioned in the most recent WPATH recommendations (SOC-8), where the term "TSG youth" is used throughout, a term that includes "people who identify as non-binary" (Coleman et al., 2022, p. 252). However, no specific recommendations are included in dealing with non-binary identified adolescents. Rather, due to the lack of evidence and scarce clinical experience for body-modifying measures in non-binary courses in adolescence, it seems to be an ethical recommendation to take this subgroup seriously and explicitly not to exclude them, but also not to include them in indication recommendations. Similarly, in other European countries (see appendix and corresponding lists of the guidelines and/or treatment recommendations there), in some cases

clearly conservative criteria such as age norms are required and no position is taken on non-binary developmental processes with body-modifying treatment wishes.

In **summary**, the developmental-dynamic aspect, which is particularly significant here, the complete lack of empirical evidence and the mixture of undoubtedly sensible ethical principles and treatment decisions create a situation that makes it impossible to establish an indication for any body-modifying measure in adolescence.

In the international guidelines of the Endocrine Society from 2017 (Hembree et al., 2017), it was recommended that adolescents with gender dysphoria for whom an indication for somatomedical hormonal treatment is confirmed must be given a puberty blockade before initiating gender reassignment hormone therapy. This corresponded to the original Dutch treatment protocol, which was also the basis for the first follow-up cohort studies. In many places in medical care practice, this has led to puberty blockers being regularly used for a year or longer in late adolescence, e.g. in 16-year-old patients who have already fully matured.<sup>5</sup> With increasingly advanced maturity development, the potentially harmful side effects of puberty blockade (including anhedonia, reduced bone density, menopausal symptoms) must be weighted more heavily against the expected benefit of reducing gender dysphoric distress.

For this reason, the regular use of puberty blockers as a precursor to gender reassignment hormone therapy is now generally avoided. There is no evidence that puberty blockers must always be used in adolescents before gender reassignment hormone treatment can be started. Although the first follow-up studies reported exclusively on adolescents who first underwent puberty blockade and then received gender reassignment hormone treatment (de Vries et al., 2014), the samples of later studies also included adolescents who were treated with gender reassignment hormones without prior puberty blockade due to their already advanced pubertal maturation (Olson- Kennedy et al., 2018). For a differentiated presentation of the somatic implications of puberty blockade or gender reassignment hormone treatment, see Chapter VIII

→ "*Somatic aspects of hormonal interventions*".

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<sup>5</sup> This is still the strictly regulated practice in NHS England (as of June 2023), which has had a significant impact on the medical controversy there, because the risk-benefit assessment for the use of puberty blockers is usually negative in older adolescents whose pubertal maturation is largely complete.

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Consensus-based recommendation:

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**VII K16.** For the indication of gender reassignment hormone treatment for Adolescents **should** not be assumed to have previously experienced puberty blockade. was carried out.

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Consensus strength: strong consensus (> 95%)

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### 6.3.2. Social role testing in the perceived gender

As a rule, gender reassignment hormone treatment (GAH) is preceded by a social transition in as many areas of everyday life as possible. The available literature provides no information as to whether the adolescents studied also included those for whom gender reassignment hormone treatment was initiated prior to social transition. Current international guidelines unanimously require persistent gender incongruence or gender dysphoria as a prerequisite for an indication, although a completed social transition is not explicitly mentioned (Agana et al., 2019; Coleman et al., 2022; Hembree et al., 2017). A social transition prior to the GAH is recommended, as it gives those seeking treatment and their environment the indispensable security and confirmation that the chosen path is both a lasting experience for the person concerned and socially viable.

It also makes it easier for the social environment to adapt to the expected physical changes and protects treated adolescents from potentially irritated reactions from their social environment to the feminizing or virilizing changes in their physical appearance. According to the clinical experience of the experts involved in the development of the guidelines, there are individual cases in which there is a persistent desire for gender reassignment hormone treatment with a stable gender identity before the implementation of social transition in all areas of everyday life, usually combined with the desire to facilitate the social role change through the changes to be expected as a result of hormone treatment. In these cases, special emphasis should be placed on the changes that can realistically be expected. The psychosocial difficulties of those affected with regard to the implementation of the social transition should be addressed and the adolescents should receive support in this regard. In these cases, the young people should be informed that social fears can manifest themselves in

In terms of transition, it is not realistic to expect that gender reassignment hormone therapy alone will resolve these issues.

In any case, all effects on the environment should be adequately reflected upon by the person seeking treatment in preparation for GAH. Protection against discrimination must be a key consideration in counseling regarding social transition. To support young people in this process, reference should be made to existing community services (including peer counseling) and youth services.

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Consensus-based recommendation

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<p><b>VII K17.</b> In preparation for gender reassignment hormone treatment, a social testing of the desired gender role, provided this is compatible with protection against discrimination. In cases where social support from the environment is not sufficient, the transition process should be accompanied by psychotherapy. are offered.</p>
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Strong consensus (> 95%)

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### 6.3.3. Consideration of existing mental disorders

Due to the frequency of mental disorders in adolescents with gender *incongruence* or gender *dysphoria*, these disorders, if present, should be diagnosed and treated professionally if necessary (see Chapter IV → "Associated mental disorders and health problems in children and adolescents with gender *incongruence* and gender *dysphoria*" ). Sufficient psychosocial support for those affected and their families is an important factor for a positive course of body-modifying interventions and further development. However, since not all adolescents with gender *incongruence* are affected by mental disorders that require treatment, the need must be assessed on an individual basis. However, a prerequisite for an indication for hormone treatment is always a psychological and psychiatric examination (*assessment*) to ensure that any disorders are properly identified and, if necessary, treated and do not interfere with the body-modifying treatment.



A possible interference between a diagnosed or suspected gender incongruence and another associated mental disorder can manifest itself and have a variety of effects.

A coincident mental disorder can, for example

- impair diagnostic clarity in the assessment of gender dysphoric symptoms
- affect the feasibility of recommended social role testing in preparation for body-modifying treatment (e.g. social phobia with school absenteeism).
- affect the timing of planned interventions (e.g. anorectiform eating disorder with the need for weight rehabilitation before hormonal interventions).
- impair sufficient psychosocial stability and medical treatment compliance for body-modifying treatment (e.g. patients with repeated acute psychiatric admission for borderline personality disorder)
- impair the capacity to consent/judge/decide with regard to a treatment decision (e.g. acute mental crisis with a restricted view of current stressors).

Consensus-based recommendation:

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<p><b>VII K18.</b> Exists before an indication of a gender hormone treatment is a co-occurring mental disorder that goes beyond gender dysphoria and <del>interferes with treatment, a specialist psychiatric-psychotherapeutic intervention should be</del> recommended and offered in an integrated or networked treatment concept. In this dialog the treatment steps are prioritized with the patient.</p>
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Consensus strength: strong consensus (> 95%)

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#### 6.3.4. Informed consent, capacity to consent and informed consent

Important contents of comprehensive information for adolescents and their guardians about the mechanisms of action and consequences of sex reassignment hormone treatment, including possible side effects, are described in Chapter VIII → "Somatic

*Aspects of hormonal interventions*". This includes in particular the possible effects on sexuality, fertility, later gender reassignment measures such as operations, relationship experience and body experience. Information should also be provided on the available options for protecting fertility through cryopreservation. It should be pointed out that the desire to have children often changes over the course of a woman's life and that not undergoing cryopreservation may entail the risk of not being able to have children later on.

In view of the implications of a decision to undergo gender reassignment hormone treatment, it is essential that this decision can only be made independently by underage patients if they are fully capable of consent (D)/capable of judgment (CH)/capable of decision-making (A) (see Chapter X → "*Law and ethics*"). Depending on their level of maturity, the information provided should support young people in the process of achieving capacity for consent (D)/capacity for judgment (CH)/capacity for decision-making (A) and being able to make an informed decision. To this end, the general and individual advantages and disadvantages of treatment as well as of not undergoing treatment or postponing treatment to a later date must be identified, understood, individually assessed and weighed up together with the person concerned and their legal guardians. If a mentally disabled minor has a *permanently impaired capacity to consent (D)/capacity to judge (CH)/capacity to make decisions (A)*, the legal guardians can make the decision for gender reassignment hormone treatment - analogous to adults with legal guardianship - provided this corresponds to the clearly recognizable will of the person concerned (see Chapter X → "*Law and ethics*").

Consensus-based recommendation:

<b>VII K19</b>	<b>Ref</b>	<b>a</b>	<b>indication</b>	<b>for</b>	<b>one</b>	<b>gender reassignment</b>
						<b>surgery</b>
<p>hormone treatment in adolescence, adolescents and their guardians should be informed about the possible effects of treatment on sexuality, fertility, relationship experience, body experience, possible experiences of discrimination and further gender-modifying body-modifying treatment steps. The possibilities of fertility-preserving medical measures should be pointed out and access to specialized advice for this purpose.</p>						

Consensus strength: strong consensus (> 95%)



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Consensus-based recommendation:

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**VII K20.** The adolescent psychiatric-psychotherapeutic-psychotherapeutic part of the indication for gender reassignment hormone treatment should include an assessment of the patient's capacity to consent (D)/capacity to make decisions (CH)/capacity to make decisions (A).  
- in relation to the specific planned treatment - by the specialist giving the indication. If the minor does not have sufficient capacity to consent (D)/capacity to judge (CH)/capacity to make decisions (A), he/she should be encouraged to do so.  
ability.

Consensus strength: strong consensus (> 95%)

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### 6.3.5. Family support and consent of custodians

As already explained in the section on puberty-restraining treatment (see above), the support of the family environment for the transition process and in particular for the initiation of body modification measures is of great importance for the mental health of affected adolescents (see also Chapter VI → *"Involvement of the family relationship environment and family dynamics"*). In cases where adolescents experience long-term rejection by their parents and other family caregivers due to their transgender identity and desire to transition, there is a high risk of psychological disorders, particularly depression and suicidal tendencies (see also Chapter IV →

*"Associated mental disorders and health problems in children and adolescents with gender incongruence and gender dysphoria"*). In these cases, intensive family therapy should be used to support the caregivers in order to address their reservations about accepting their child's perceived gender identity and, if possible, work through them so that an accepting framework can be created within the family.

The aim of the family therapy process is to make room for the parents' concerns and to develop a joint process of agreement on suitable steps to support the adolescents concerned. This assumes that family therapy interventions are not expected to have any psychologically damaging effects on the adolescents concerned (e.g. in the case of physical separation imposed by the youth welfare office following experiences of abuse when custody has been retained).

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Consensus-based recommendation:

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**VII K21.** With given Capacity to consent (D)/Capability of judgment (CH)/Capacity (A) of the patient to make a decision regarding the performance of a gender reassignment hormone treatment, a co-consensus of the guardians should be sought.

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Consensus strength: strong consensus (> 95%)

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If in individual cases, despite intensive counseling, no co-consensus can be reached between those affected and their legal guardians regarding the implementation of a desired and medically indicated sex reassignment hormone treatment, a complex dilemma situation arises with regard to the health risks. On the one hand, in Germany, Austria and Switzerland, adolescents who are capable of giving consent can consent to the medical treatment they want on their own responsibility and with legal effect even without their parents' consent, i.e. a parental "veto" cannot be legally justified by custody in this case (see explanations in Chapter X → "*Law and ethics*").

On the other hand, the experienced rejection or non-support of a body-modifying measure by parents is a high burden for adolescents. The persistent suffering caused by not initiating a desired and otherwise professionally indicated measure must be weighed against this burden. In such a case constellation, intensive psychosocial measures should be considered for the health of the adolescent(s) concerned in order to support them on the path to shaping their life in accordance with their gender identity, which in individual cases may also include therapeutic support for a necessary detachment process. The legal regulations to be observed in the respective country are listed in Chapter X → "*Law and ethics*".

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Consensus-based recommendation:

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**VII K22.** In cases where there is no co-consensus between the patient and their legal guardian intensive process support for the family system should be offered by a suitable specialist with the aim of providing support for the patient. Such process support is only recommended if it does not have any harmful effects on the health/psychological well-being of the patient.  
are to be expected.

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Consensus strength: strong consensus (> 95%)

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#### 6.4. Sex reassignment surgery in adolescence

Gender reassignment operations for patients with gender incongruence/gender dysphoria are irreversible measures that can have significant and lasting consequences for the mental and somatic health of those affected, both in the positive sense of reducing suffering, body dissatisfaction and psychological stress and improving quality of life, and in the negative sense in the event of medical or psychosocial complications or in the event of later regret about the operation performed.

If, in the case of persistent gender incongruence or gender dysphoria in adolescence, gender reassignment surgery is desired by those affected before they reach the age of majority and the medical indication for this is to be examined, the procedure and the decision-making process must meet correspondingly high requirements in terms of both diagnostic clarity and the reliable determination of the patient's capacity to consent (D)/capacity to judge (CH)/capacity to make decisions (A), which are set out in Chapter X → "*Law and ethics*". Surgical interventions for genital reassignment are generally only performed after the 18 years of age. Particularly in the case of interventions that are associated with permanent infertility (i.e. if an orchiectomy, ovariectomy or hysterectomy is intended), the legal situation in Germany must be observed, which prohibits medical interventions with the aim of sterilization in minors (§§ 1631c BGB). In the case of intersex genitalia, this law allows exceptions to this, provided that these are expressly desired by the minors concerned, who are also capable of giving their consent (Sections 1631c & 1631d BGB). The question of whether such justified exceptions may also be legally permissible in the case of persistently high gender dysphoric distress in minors with persistent gender incongruence is discussed in Chapter X → "*Law and ethics*".

In addition, clinical experience to date has shown that the This means that there is an increasing number of adult trans people who do not wish to undergo genital surgery. Based on these considerations, the indication for gender reassignment surgery is therefore generally only recommended from the age of 18. The current international guideline *Standards of Care, version 8* of the WPATH does not exclude the possibility of an indication for genital reassignment surgery in adolescence.

is generally not recommended if strict indication criteria are observed. Only gender reassignment phalloplasty is expressly not recommended for minors (Coleman et al., 2022).

In the case of irreversible surgical interventions, the potential permanent damage to health in the event of a later desire for detransition must be weighed much more heavily than in the case of partially and progressively irreversible hormone treatments. This must be weighed up against the current gender dysphoric distress, which can be very high, particularly in the case of breast dysphoria in trans-male adolescents, and can have a considerable impact on mental health.

If, in the course of a permanently persistent gender incongruence after a complete transition, a stable gender identity has already been established for several years in adolescence, including a stable improved sense of congruence with the virilization or feminization of the physical appearance that has occurred under gender reassignment hormone treatment, hormone treatment, can with pronounced gender dysphoric distress and a corresponding desire for treatment, the indication for gender reassignment surgery can also be considered in adolescence. According to the clinical experience of the experts involved in drawing up the guidelines, this has so far almost exclusively concerned mastectomy in trans boys who have already been living stably in the male gender role for a long period of time and have further consolidated this role under ongoing testosterone treatment. Experience has shown that the gender dysphoria related to the appearance of the breast usually persists or can even increase during testosterone treatment.

This guideline only contains recommendations on the procedure for determining the indications for gender reassignment plastic surgery on the breast. Genital reassignment surgery is only recommended after the age of 18. The recommendations of the S3 guideline for adulthood *Gender incongruence, gender dysphoria and trans health* (AWMF, 2018) and the international guideline *Standards of Care 8* of the WPATH (Coleman et al., 2022) are relevant here.

Current international guidelines recommend a mastectomy if there is a justified indication for trans male minors are listed as a surgical option (Coleman et al., 2022; Hembree et al., 2017). In previous cohort studies, it has been reported that in cases of high individual suffering of those affected - especially in trans men who have already been treated with testosterone and have lived stably in the male gender for many years

adolescents - minors also receive sex reassignment mastectomies (Marinkovic & Newfield, 2017; Olson-Kennedy et al., 2018).

The available studies report a predominantly positive treatment outcome in terms of reduction of breast dysphoria and satisfaction of those treated. In many cases, trans male adolescents with gender dysphoria suffer considerably from breast dysphoria. According to the clinical experience of the experts involved in the development of the guidelines, this can result in health risks. Years of daily chest binding can lead to respiratory impairment and postural damage with back problems, which can severely restrict sporting activity. In addition, the psychosocial participation of many gender dysphoric adolescents is restricted, e.g. due to years of avoiding swimming pools or other social activities out of shame about their physical sexual characteristics not being in line with their gender identity. Access to the job market is also often more difficult for gender-incongruent young people after social transition without adjusting their physical appearance, as incongruences between the socially lived gender and the biological sex characteristics are externally visible and can encourage trans-hostile reactions from the social environment. It is therefore necessary to carefully weigh up the risks of gender reassignment surgery against the risks and burdens of non-surgically treated gender dysphoria in each individual case.

According to current guidelines, there is no evidence from study results for or against defined age limits for gender reassignment breast surgery in underage adolescents with diagnosed gender incongruence. The timing of the indication should therefore be based on the individual's state of health (Hembree et al., 2017). Aspects of psychological distress, cognitive and emotional maturity and the long-term stability of the diagnosis must be weighed up. Gender reassignment breast surgery in minors with gender incongruence or gender dysphoria therefore requires careful case-by-case indication determination in interdisciplinary cooperation between a psychological-psychiatric and a surgical specialist. In complex cases, medical-ethical specialists can be consulted for clarification.

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Consensus-based recommendation:

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**VII K23.** The indication for a sex reassignment mastectomy or sex reassignment surgery  
Surgical breast reduction in adolescents with gender incongruence or gender dysphoria should be a two-pronged approach and requires interdisciplinary expertise and cooperation. The prerequisite for an indication is a child and adolescent psychiatric or psychotherapeutic diagnostic assessment that is appropriate to the urgency and complexity of the individual situation<sup>6</sup>. The somatic part of the indication should be carried out by an experienced psychiatrist or psychotherapist specialist from the field of surgical medicine.

Consensus strength: strong consensus (> 95% agreement)

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Consensus-based recommendation:

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**VII K24.** The qualification of the specialist for the adolescent  
psychotherapeutic-psychotherapeutic part the Indication psychiatric one  
Gender reassignment mastectomy or breast reduction surgery in adolescents with gender incongruence or gender dysphoria should fulfill the following requirements:

One of the following qualifications specific to childhood and adolescence: D:

- Specialist designation for child and adolescent psychiatry and psychotherapy
- License for child and adolescent psychotherapy
- Specialist designation for pediatrics and adolescent medicine with additional designation for psychotherapy

CH:

- FMH title in child and adolescent psychiatry and psychotherapy
- Federally recognized psychotherapist

A:

- Specialist in child and adolescent psychiatry or specialist in child and adolescent psychiatry

Adolescent psychiatry and psychotherapeutic medicine

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<sup>6</sup>For the technical requirements, see the following recommendation (see below)



- Registration as a psychotherapist with further training in infant, child and adolescent psychotherapy

Adolescent psychotherapy

Or, alternatively, with proven clinical expertise in the diagnosis and treatment of adolescents:

D:

- Specialist area designation for psychiatry and psychotherapy, Psychotherapeutic medicine or psychosomatic medicine and psychotherapy
- License for psychological psychotherapy

CH:

- FMH title in psychiatry and psychotherapy

A:

- Specialist in psychiatry and psychotherapeutic medicine, specialist in psychiatry and neurology  
Registration as a psychotherapist, registration as a clinical psychologist

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Consensus strength: strong consensus (> 95% agreement)

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For the surgical part of the indication for gender reassignment surgery in minors and the surgical performance of such an operation, please refer to the explanations in the corresponding S2k guideline of the AWMF "Sex reassignment surgery for gender incongruence and gender dysphoria" (register number 043 - 052).

Stable/persistent gender incongruence according to the diagnostic criteria of ICD-11 with concomitant body-related gender dysphoric distress is a basic prerequisite for the indication of gender reassignment surgery. There are no valid individual criteria for the persistence/stability of gender incongruence or gender dysphoria that can be expected in the future and cannot currently be derived from the available studies. It is therefore the responsibility of the psychiatric-psychotherapeutic specialist with experience in the exploration of various gender identity developments in adolescents to develop an individual assessment based on the overall view of the psychological findings and the life history of the adolescent in a joint discussion with the person concerned and their guardians. In complex case constellations or if the psychiatric-psychotherapeutic specialist does not (yet) have sufficient specific knowledge of the adolescent's gender identity.

clinical experience in this field, it is at the discretion of the professionals involved in both disciplines to recommend to patients and their guardians that an additional, more experienced specialist second opinion by a psychiatric-psychotherapeutic specialist with proven experience be sought to confirm the indication.

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Consensus-based recommendation:

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**VII K25.** Prerequisite for the indication of gender reassignment surgery

Breast removal or reduction **should** be based on the presence of stable/persistent gender incongruence (according to the diagnostic criteria of GI in adolescence/ ICD-11: HA60) with gender dysphoric distress combined with a clear desire for a change in the organ or characteristic to be operated on. The assessment of the stability/persistence of the gender incongruence and the desire for treatment should be carried out by the psychiatric/psychotherapeutic specialist together with the patient and their guardians on the basis of a careful exploration of the patient's gender identity, psychological findings and life history.

Consensus strength: strong consensus (> 95% agreement)

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There have been no empirical studies to date on gender reassignment surgery for minors who fall into the non-binary spectrum of gender identity. For example, there are no follow-up data on the persistence/stability of non-binary gender identity in adolescence. It is also not yet known whether young trans people with a non-binary gender identity may have a higher probability of later regretting medical reassignment procedures.

The new classifications of DSM-V and ICD-11 exclude non-binary gender identities are explicitly included in the definition of gender dysphoria and gender incongruence. Both the AWMF S3 guideline (AWMF, 2018) for adulthood *gender incongruence, gender dysphoria and trans health* and the current new version of the international WPATH *Standards of Care* guideline (Coleman et al., 2022) also explicitly include people with non-binary gender identity in their recommendations for the indication of gender reassignment surgery. A fundamental exclusion of people with non-binary gender identity and persistent gender dysphoria from access to gender reassignment



body-modifying measures is therefore medically, ethically and socio-legally unacceptable. However, based on the current study situation, it is not yet possible to make an empirically sound recommendation on gender reassignment surgery for minors with non-binary gender identity. Decisions for indications must therefore be examined particularly carefully in each individual case and should be made after weighing up the gender dysphoric suffering, the long-term stability of the desire for treatment in this regard, the cognitive and emotional maturity of the person concerned in terms of capacity to consent (D)/capacity to make decisions (CH)/capacity to make decisions (A), taking into account all the expected advantages and disadvantages as well as the risks of such an operation.

The possibility of later regretting the surgical intervention, including its probability of occurrence, which cannot yet be validly assessed in comparison to binary-transgender individuals due to insufficient data, must be explained in particular. In cases of doubt, it is at the discretion of the mental health and surgical specialists involved to recommend obtaining a second opinion from a psychiatric-psychotherapeutic specialist experienced in the treatment of patients with gender incongruence and gender dysphoria in order to ensure an individualized indication.

Consensus-based recommendation:

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<p><b>VII K26.</b> The indication for a sex reassignment mastectomy or sex reassignment surgery Breast reduction should be performed regardless of the polarity or binarity of gender identity. and regardless of sexual orientation.</p>
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Consensus strength: strong consensus (> 95% agreement)

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Special vote of the German Psychoanalytical Society (DPG) for a different recommendation:

<p><b>VII K26.</b> The indication for a sex reassignment mastectomy or sex reassignment surgery Breast reduction surgery should be performed regardless of sexual orientation.</p>
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Note: The reasons for this special vote are set out in the corresponding recommendation on sex reassignment hormone treatment (VII. K15.).

As a rule, gender reassignment surgery for minors is preceded by several years of stable social transition and gender reassignment surgery.

hormone treatment over several months. The indication requires an assessment of the sufficient stability/persistence of the desire for treatment as well as the individual long-term psychosocial viability of a transition. There is no evidence to date for gender reassignment surgery without prior gender reassignment hormone administration, as previous guidelines stipulated the order of interventions and that gender reassignment hormones had to be taken before gender reassignment surgery.

Nevertheless, clinical experience shows that in individual cases, for example, there is a stable desire for a mastectomy without prior testosterone treatment. The new WPATH guidelines explicitly mention this possibility for individual cases, even in minors (Coleman et al., 2022). In clinical experience, such cases are more common in individuals with non-binary gender identity and/or a co-incident autism spectrum disorder. These cases require particularly careful examination with regard to persistent specific gender dysphoric distress and the stability of the desire for treatment in order to weigh up the health benefits and risks of such a procedure in each individual case.

There is also no information in the literature on the course of adolescent patients who have undergone gender reassignment surgery without prior social transition. There are clinical reports of cases of adult patients with non-binary identities in which neither social transition nor gender reassignment hormone treatment is desired, but there is a persistent desire for a gender reassignment mastectomy in cases of severe persistent body dysphoria with regard to the breast profile. In the S3 guideline for adulthood, an individualized approach is recommended for such case constellations, in which a previous social transition or testosterone treatment is not recommended as a mandatory prerequisite for the indication of a mastectomy (AWMF, 2018).

According to the predominantly unanimous opinion of the experts involved in drawing up the guidelines, in adolescence it is particularly important to adequately check the social viability of the perceived gender identity and to ensure that it remains stable in the long term, due to the otherwise largely unforeseeable risks of irreversible damage to health.

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Consensus-based recommendation:

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**VII K27.** For the preparation of a sex reassignment mastectomy or Breast reduction in adolescents with gender incongruence or gender dysphoria should be accompanied by social testing of the desired gender role, provided this is compatible with protection against discrimination. In cases where social support from the environment is not sufficient, psychotherapeutic support for the transition process should be provided. are offered.

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Consensus strength: strong consensus (> 95% agreement)

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According to the predominant experience of the experts working in the guideline commission, the first months after the start of gender reassignment hormone treatment for adolescents are often a phase in which further stabilization of the overall situation of those affected becomes apparent. An observation phase of at least 6 months prior to gender reassignment breast surgery therefore appears to be suitable to ensure that the persistence of a consolidated gender identity does not change under the impression of hormonally induced body changes. According to the clinical experience of surgeons specializing in gender reassignment breast surgery, breast tissue also changes when testosterone is administered, so that the cosmetic result of gender reassignment breast surgery may be favorably influenced by an interval of several months between the start of hormone treatment and the operation. According to the overwhelming clinical experience of the experts involved in the development of the guidelines, the period of at least 6 months has proven itself and is therefore considered sensible by the commission. The current international medical guidelines of the *Endocrine Society* and the *World Professional Association for Transgender Health (WPATH)* make no statement on the recommended minimum duration of hormone therapy.

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Consensus-based recommendation:

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**VII K28.** If gender reassignment hormone treatment has already been carried out, should be one following sex reassignment mastectomy or Breast reduction surgery requires a period of at least 6 months to reflect on the associated experiences are recommended

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Consensus strength: strong consensus (> 95% agreement)

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Consensus-based recommendation:

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**VII K29.** In justified individual cases, a gender reassignment mastectomy or breast reduction operation for adolescents with gender incongruence or Gender dysphoria without prior gender reassignment hormone treatment should be considered.

Consensus strength: strong consensus (> 95% agreement)

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#### 6.4.1. Diagnosis and treatment of associated mental disorders

Due to the frequency of mental disorders in gender-incongruent or gender-dysphoric adolescents, these disorders should be professionally diagnosed and treated if necessary. Psychosocial support for those affected and their families is essential for a positive course of body-modifying treatment and further health development. However, as not all adolescents with gender incongruence are affected by mental disorders, the need for professional psychosocial support must be assessed on an individual basis. Nevertheless, a prerequisite for a professional indication for gender reassignment surgery is always a psychological-psychiatric examination (assessment) to ensure that any existing mental health problems are adequately diagnosed and treated and do not interfere with diagnostic certainty or body-modifying treatment.

Consensus-based recommendation:

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**VII K30.** If there is an indication for a sex reassignment mastectomy resp. Breast reduction one above the gender dysphoric Suffering  
In the case of a co-occurring mental disorder that interferes with the treatment, an integrated pressure  
or networked treatment concept should include a specialized psychiatric-psychiatric  
treatment.

psychotherapeutic intervention is recommended.

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Consensus strength: strong consensus (> 95% agreement)

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#### 6.4.2. Capacity to give consent (D)/ Capacity to make decisions (CH)/ Capacity to make decisions (A)

Before a mastectomy or breast reduction surgery is indicated for adolescents with gender incongruence or gender dysphoria, patients and their legal guardians must be given comprehensive information about the possible consequences and complications of the operation as well as the possible effects on body image, relationship experience, sexuality and the ability to breastfeed. Possible advantages and disadvantages as well as risks of gender reassignment surgery should be pointed out and weighed up together with those affected and their legal guardians. The information should support the adolescents in the process of reaching their own capacity for consent (D)/capacity for judgment (CH)/capacity for decision-making (A) and thus being able to make an informed decision.

Likewise, in the event that genital reassignment surgery is desired or considered at a later date, care should be taken to provide information at an early stage about the available options for cryopreservation to preserve the patient's own reproductive capacity. When providing information, it should be pointed out that the desire to have children often changes over the course of a woman's life and that not undergoing cryopreservation carries the risk of a later unfulfilled desire to have children.

The capacity of consent (D), judgment (CH) or decision-making capacity (A) of minors with regard to a desired gender reassignment surgery includes careful reflection on the irreversibility of the intervention, the examination of advantages and disadvantages as well as risks and the examination of individual alternative ways of living the transition.

Consensus-based recommendation:

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<p><b>VII K31.</b> The indication for surgical measures for gender reassignment in adolescents with gender incongruence or gender dysphoria <b>should</b> have their capacity for consent (D) / capacity for judgment (CH) / capacity for decision-making (A) assessed by an adolescent psychiatric/psychotherapeutic/psychotherapeutic specialist. If the minor does not have sufficient capacity to consent (D)/capacity to make decisions (CH)/capacity to make decisions (A), the minor should be supported in this, to acquire this ability.</p>
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Consensus strength: strong consensus (> 95% agreement)

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Consensus-based recommendation:

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<b>VII K32.</b> With given capacity to consent (D)/ Judgment (CH)/ Decision-making capacity (A) of the minor should be a co-consensus of the <del>The child's legal guardians should be involved.</del>
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Consensus strength: strong consensus (> 95% agreement)

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Consensus-based recommendation:

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<b>VII K33.</b> In cases where there is no co-consensus between the patient and their legal intensive process support for the family system should be offered by a suitable specialist guardian with the aim of providing support for the patient. Such process support is only recommended if it does not have any harmful effects on the health/psychological well- being of the patient. are to be expected.
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Consensus strength: strong consensus (> 95% agreement)

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If, in individual cases, despite intensive counseling, no co-consensus can be reached between those affected and their legal guardians regarding the performance of a desired and medically indicated sex reassignment mastectomy or breast reduction, a complex dilemma situation arises with regard to health risks. On the one hand, in Germany, Austria and Switzerland, adolescents who are capable of giving consent can consent to the medical treatment they wish to undergo on their own responsibility and with legal effect even without their parents' consent, i.e. a parental "veto" cannot be legally justified by custody in this case (see explanations in Chapter X → "Law and ethics"). A treatment contract can also be signed by young people with statutory health insurance, at least from the age of 16 years of age can be concluded independently.<sup>7</sup>

On the other hand, the experienced rejection or non-support of a body-modifying measure by parents means a high burden for affected adolescents. The ongoing suffering caused by not undergoing professionally indicated treatment must be weighed against this burden. In such a case constellation, the

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<sup>7</sup> In the case of privately insured minors, the signature of the main insured person with custody is also required for this.

Intensive psychosocial measures should be considered in the interest of health and for the benefit of the adolescent(s) concerned in order to support them on the path to shaping their life in accordance with their gender identity, which may also include therapeutic support for a necessary transition process in individual cases. The legal regulations to be observed in each country are set out in Chapter X → *"Law and ethics"*.

#### **6.5. Recommended contents of an indication letter**

In line with the recommendations outlined in this chapter, a summary of what should be included in a child and adolescent psychiatric or psychotherapeutic letter of indication for body-modifying interventions in adolescence (i.e. puberty blockade, gender reassignment hormone treatment or breast surgery for gender reassignment) is provided. Such an indication letter should contain information on the following points, which are comprehensible for the co-treaters who are medically responsible for the somatic part of an indication to be developed on an interdisciplinary basis:

- Diagnostic assessment of a stable/persistent gender incongruence together with a justification based on the course of development to date.
- Previous and existing or anticipated gender dysphoric distress
- Previous or planned social role testing or social transition
- Mental health status and any accompanying mental health problems or disorders
- in the case of co-occurring mental disorders: diagnosis and diagnostic assessment of interdependence with gender dysphoria (individual disorder model) and integrated treatment plan
- persistent and reflected desire for medical intervention
- Differentiated assessment of capacity to consent (D)/capacity to make decisions (A)/capacity to make judgments (CH) on the basis of informed consent to desired treatment
- Informed about the possible prospect of a later detransition
- information provided on the possible effects of treatment on subsequent fertility and options for fertility protection
- Information provided about possible risks of the treatment

- Individual health risk-benefit assessment of the desired treatment in consideration of the option of no treatment or further waiting
- Information on the support of the family and social environment for the further transition, including co-consensus of the guardians

Vorläufige Leitlinie zur Kommentierung



## Chapter VIII

### Somatic aspects of hormonal interventions

#### 1. Introduction and key questions

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## 1. Introduction and key questions

Hormonal interventions as part of a staged and development-oriented treatment of adolescents with persistent gender incongruence (GI) or gender dysphoria (GD) are complex interventions in the course of pubertal development that require a careful individualized indication. This includes a risk-benefit assessment tailored to the circumstances of the individual case and correspondingly careful endocrinological risk management. The clinical experts involved in the preparation of this guideline predominantly share the view expressed in the current international guidelines of the *Endocrine Society* and the *World Professional Association for Transgender Health (WPATH)*, which were each prepared by recognized expert committees (Coleman et al., 2022; Hembree et al., 2017). According to this, a generalized risk-benefit assessment based solely on study data cannot do justice to the complexity of medical decision-making situations in this field, especially for the use of puberty blockers.

From an international perspective, it is therefore not surprising that the National Health Service England (NHS) has currently drawn an ambiguous benefit-risk balance for the use of puberty blockers. In future, they should only be recommended in the context of clinical studies (see chapter on critical discourse and deviating recommendations in other countries in the appendix). The treatment principles applied there to date, which strictly follow the original *Dutch Protocol*, deviate considerably from internationally established *best practice in some cases* (Pang et al., 2022). In England, for example, every adolescent diagnosed with GD still has to undergo puberty blockade for at least twelve months before indicated gender reassignment hormone treatment can begin. Due to the extremely long waiting times, many patients are already 16 years or older when treatment begins. They are therefore at an age at which the benefits of puberty blockade are questionable due to the fact that they have largely completed their maturation, while undesirable menopausal side effects predominate (Hembree et al., 2017; O'Connell et al., 2022).

Such artifacts from outdated treatment recommendations of past decades, which from today's perspective lead to misuse, have been included in the available study data and contribute to the ambiguous evidence situation. For hormonal interventions for the staged treatment of adolescents with diagnostically confirmed persistent GI or GD, the expected benefits and risks to be considered must therefore be weighed up on a case-by-case basis. Among other things, the stage of pubertal maturity at the start of treatment and the extent and duration of the gender dysphoric distress are taken into account. If puberty blockade is being considered, its appropriately planned

The time limit is an important aspect that must be taken into account in the individual risk-benefit assessment. In addition, as is generally the case with endocrinological interventions (e.g. hormone replacement therapies), *mechanistic evidence*, i.e. the most comprehensive possible knowledge of the physiological mechanisms set in motion and their desired and undesired effects, is of particular importance for the risk-benefit assessment in individual cases.

The following three key questions were formulated a priori by the Guideline Commission for this chapter:

*Key questions on somatic aspects of hormonal interventions in adolescence.*

- Which somatic aspects need to be taken into account in the endocrinological part of the indication, education and individual planning of hormonal interventions in adolescence?
- Can treatment with GnRH analogs for puberty suppression in adolescents with persistent gender incongruence/gender dysphoria be considered sufficiently safe with regard to known risks?
- Can sex reassignment hormone treatment with testosterone or estrogen in adolescents with persistent gender incongruence/gender dysphoria be considered sufficiently safe in view of the known risks?

The prerequisite for starting hormonal treatment is always a professional interdisciplinary assessment of the indications by qualified medical or psychotherapeutic specialists who have sufficient experience with the topic (see Chapter VII → "*Assessment of indications for body-modifying medical interventions*"). The desired and realistically achievable goal of hormonal treatment must be examined in each individual case and weighed up with the patient and their guardians together with the risks to be considered.

## 2. Treatment with GnRH analogs (puberty blockers)

### 2.1 Goals of puberty suppression

As explained in the previous chapter VII → "*Indications for body-modifying medical interventions*", according to the recommendations of current international medical guidelines, if persistent gender incongruence with gender dysphoric distress has been identified in an adolescent through a child and adolescent psychiatric or psychotherapeutic diagnosis, puberty-suppressing treatment can be considered from puberty development stage Tanner 2 at the earliest (Coleman et al, 2022; de Vries et al., 2006; Hembree et al., 2017). Alternatively, if pubertal maturation is already more advanced, suppressive hormone treatment (e.g. antiandrogens in trans-female adolescents) can be considered to counteract the progressive development of secondary sexual characteristics or, in trans-male adolescents, to suppress menstruation with a *progestin preparation* (see section 3 "Alternatives to puberty suppression" below).

Due to the mechanism of action of a puberty blockade (see below), only a *The progression of maturity development is prevented*, i.e. the maturity development that has already begun is "frozen" for a limited time at its level at the start of treatment. The rationale behind this is to de-actualize the main stressor of gender dysphoric distress, i.e. the progressive masculinization or feminization of physical appearance, by preventing its *progression*. To the extent that female or male sexual characteristics have already developed (e.g. female breast growth in trans-male adolescents or male voice change in trans-female adolescents), the physical stressor remains unchanged during treatment and only its *aggravation* is prevented. This should be kept in perspective when defining outcome measures in studies investigating the exclusive effect of puberty blockade (Cass, 2022). For example, it may be a realistic goal to keep a state of mental health that existed before treatment reasonably stable, i.e. to *prevent it from deteriorating*. This must be taken into account when evaluating the weak evidence in this regard for positive change effects of puberty suppression alone on mental health parameters. This could explain why, compared to the weak evidence for the sole benefit of temporary puberty blockade, the evidence for positive outcomes for mental health in *studies on gender reassignment hormone treatment* as well as on the long-term outcome of the "overall package" of *staged puberty suppression beginning in adolescence is more favorable*.

*transition treatment including later gender reassignment surgery* is clearer and more consistent (see explanations on the study situation in Chapter VII → "*Indications for body-modifying medical interventions*").

In individual cases, it must be considered that young people with persistent GI can experience lifelong health disadvantages if puberty progresses (German Ethics Council, 2020), e.g. through a long-term stigmatizing physical appearance with increased gender dysphoria and increased impairment of psychosocial participation, e.g. when entering into romantic relationships, going to the beach or swimming pool, etc. An important goal of temporary puberty suppression in adolescents is often to gain time for a mental maturation and reflection process before a decision can be made to undergo gender reassignment hormone treatment (Brik et al., 2020; van der Loos et al., 2022). This time is often needed, among other things, to acquire the necessary capacity to consent (D)/decision (A)/judge (CH), i.e. the ability to make an informed decision, before a partially irreversible gender reassignment intervention is initiated (see Chapter VII → "*Indications for body-modifying medical interventions*").

In the highly probable case of permanent persistence of GI at the start of treatment, the later appearance of a young trans person will largely correspond to the perceived gender after the initiation of later gender reassignment hormone treatment in adulthood, especially if pubertal maturation has been interrupted in its early stages. This means that they are largely spared lifelong stigmatization due to physical characteristics of the sex assigned at birth. In addition, later gender reassignment surgery such as mastectomies, laryngectomies, beard epilations or maxillofacial surgery are often no longer necessary if puberty suppression is started early.

## **2.2 Pharmacodynamics and pharmacokinetics of GnRH analogs**

GnRH analogs effectively suppress gonadotropins and thus also the production of sex hormones from the testicles and ovaries (Schagen et al., 2016). In this way, physical changes such as male voice change, beard growth or female breast growth can be prevented or halted. By preventing the progression of irreversible masculinization or feminization of the physical appearance (see above), the suffering of those affected should be relieved.

The depot GnRH agonists are continuously released from microcapsules and "block" the GnRH receptors of the pituitary gland through a prolonged half-life and lead to a decrease in the number of GnRH receptors and the sensitivity of the LH and FSH receptors.

producing cells (for a detailed description of the pharmacodynamics, see Lahlou et al., 2000). Since it is an agonist, puberty is activated at the start of therapy with an increase in gonadotropins. To shorten the "flare-up" phase, the interval between the first two injections can be shortened. Suppression of the gonadotropic axis occurs in approx. 80 % of patients after 6 months.

GnRH analogs are effective in suppressing gonadotropins (and therefore downstream sex steroids) in both trans-male and trans-female adolescents (de Vries et al., 2011). As a rule, leuprorelin depot 11.25 mg every three months or 22.5 mg s.c. every six months is used, alternatively triptorelin depot 22.5 mg i.m. every six months.

## **2.2. 2Possible effects on the growth forecast**

The increasing concentrations of sex hormones during puberty not only induce the progressive development of secondary sexual characteristics, but also influence bone growth (pubertal growth spurt). Suppression of puberty can therefore cause a slowdown in the rate of growth - but in return the epiphyseal joints remain open for longer. This can lead to an increased final size if used for several years, which can be particularly problematic for trans-female adolescents. However, recent studies have shown that temporary treatment with GnRH analogs followed by sex-reassigning hormone treatment had no relevant long-term effects on adult final height in adolescents of both sexes (Boogers et al., 2022; Willemsen et al., 2023).

### **2.2.2 Effects on fertility**

Puberty suppression using GnRH analogs is the first step in hormonal treatment to support social transition. If this is carried out at an early stage of puberty, the consequence of a later, seamlessly subsequent sex reassignment hormone treatment is usually *permanent infertility* due to a lack of maturation of the gonads and reproductive tract. Before starting puberty-blocking treatment, the question of possible future reduced fertility should therefore be discussed in detail and medical advice on *medical options for fertility protection should be offered* (see explanations in Chapter VII → "*Indications for body-modifying medical interventions*"). It is important to raise awareness of this in order to be able to keep the option of biological reproduction open for a young person at a later stage or to be able to use this option in the future.

option uninformed. In cases where oogenesis or spermiogenesis has not yet taken place by the time of menarche or spermarche, which in turn would be a prerequisite for being able to obtain eggs or sperm for cryopreservation, considerations in this regard may influence a decision on the question of when a desired and indicated puberty suppression should be started. This must be carefully weighed up against the existing gender dysphoric distress with regard to the health of the young person and the associated urgency of starting treatment. The young person concerned and their legal guardians must be involved in this consideration process (see explanations in Chapter VIII → "*Legal basis & ethical requirements for the treatment of minors with G*").

To date, the rate of utilization of fertility preservation measures in the form of cryopreservation among adolescents with gender incongruence who are seeking hormone therapy is still very low. In a study by Nahata et al. (2017), out of 72 trans adolescents, only two were birth-gender male (i.e. trans-female adolescents) who wanted fertility preservation. This finding is remarkable in comparison to surveys of adult trans people: in a comparative multicenter survey in Germany ( $N = 99$  trans female;  $N = 90$  trans male), adult trans people of both genders stated significantly more frequently that they were considering having children (trans women approx. 70%, trans men 47%) and that they were therefore looking for information on the possibilities of fertility preservation measures (Auer et al., 2018). It was remarkable that only 10% of trans women and 3% of trans men stated that they had actually decided to undergo cryopreservation after obtaining information (Auer et al., 2018). In addition to the fact that starting testosterone treatment preserves the functionality of the ovaries for later reactivation in the event of a desire to have children, two main reasons are given for the very low proportion of trans men: Firstly, the legal ban on egg donation in Germany, and secondly, the possibility that within a partner\* relationship with a cis woman, a joint desire to have children could realistically be realized through anonymous sperm donation (Auer et al., 2018).

Nevertheless, it can be assumed that the importance of this topic and thus the attitude of young people towards their own reproductive capacity may change in adulthood, which underlines the importance of comprehensive education. Fertility preservation counseling for young trans people is a relatively new and developing field in medical care. It is expected that in the coming years - and therefore also in future medical guidelines - there will be growing

importance (for current overviews see Lai et al., 2020; Nahata et al., 2017; Quinn et al., 2021). According to current experience reports, adolescents with GI and their guardians predominantly rate targeted information and professional support in the decision-making process for or against fertility-preserving measures before or at the start of hormonal treatment positively (Boguszewski et al., 2022).

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Consensus-based recommendation:

<p><b>VIII K1.</b> Before the start of puberty-interrupting or gender reassignment surgery hormone treatment should be informed about possible reduced fertility as a result of the treatment and the possibility of fertility-preserving measures.</p> <p>become.</p>
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strong consensus (> 95%)

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### 2.2.3 Effects on sexual sensitivity

With regard to the effects of hormonal interventions in adolescence on later sexual satisfaction and sensitivity, the study situation is inconsistent. Direct negative effects of hormonal interventions alone have not yet been proven. From the clinical experience of the experts involved in the development of the guidelines, it is known that trans male adolescents who have started testosterone treatment often report an increase in libido with increased sexual willingness. As these adolescents are sometimes sexually active in relationships with male romantic partners, which may include sexual intercourse (in which they usually still experience themselves as male), sexual activities should be asked about and, if necessary, the need for contraception should be pointed out, especially as ovulation is not reliably prevented during testosterone treatment. Trans-female adolescents undergoing oestrogen treatment mainly report that spontaneous erections decrease, but this is usually experienced as positive. In a recent study on the subsequent sexual satisfaction and sensitivity of adults after undergoing both hormonal and surgical gender reassignment treatments, it was reported that sexual sensitivity correlates in particular with general satisfaction with physical appearance (Gieles et al., 2023). This would tend to speak in favor of starting hormonal treatments in adolescence, as this is expected to lead to better results in terms of later satisfaction with one's own physical appearance and the associated experience of congruence as a male or female person.



#### 2.2.4 Effects on later surgical options for genital reassignment surgery

It is being discussed whether early puberty-suppressing treatment in trans-female patients, followed immediately by sex reassignment treatment with oestrogen in the event of sex reassignment surgery at a later stage, may be disadvantageous for the patient because pubertal penile growth is interrupted and therefore less penile skin may be available later for the formation of a sufficiently deep neovagina (Khatchadourian et al., 2014). Alternative solutions include augmentation with a free skin graft of the scrotum. If there is a greater need for skin tissue, if the scrotal skin would not be sufficient due to a hypoplastic scrotum as a result of early pubertal blockage, a free skin graft, e.g. from the lower abdomen. However, its removal can leave larger visible scars (Buncamper et al., 2017). In a review, it was reported that there was no significant difference in vaginal depth and patient satisfaction with or without a free skin graft in the alternative surgical techniques mentioned (Buncamper et al., 2017). Another established option is the creation of a primary sigmoid vagina (Bouman et al., 2016). Overall, this aspect therefore does not fundamentally speak against the early start of puberty-suppressing treatment if it has been professionally indicated. With regard to the options for genital alignment surgery following early puberty-blocking treatment, please refer to the current S2k guideline

*"Sex reassignment surgery for gender incongruence and gender dysphoria".*

However, the information that the choice of available surgical procedures may be smaller in the case of a later desired genital reassignment surgery in trans-female patients is important in the context of comprehensive information and must be weighed against the long-term consequences of a longer wait with regard to later satisfaction with the physical appearance. In the course of this consideration, particularly in trans-female patients who have been diagnosed with persistent GI at an early stage of puberty, it must be borne in mind that an irreversible voice mutation would set in as biological maturity progresses. The result would be a lifelong deep or male-sounding voice. This is associated with an increased risk of permanent gender dysphoric symptom burden.

## **2.3 Possible undesirable side effects of GnRH analogs**

According to the experience of the clinical experts involved in this guideline, undesirable somatic side effects are rather rare when used correctly, especially with regard to endocrinological monitoring and a reasonably limited duration of treatment. Local reactions such as subcutaneous hardening, bruising or allergy-related papules may occur at the injection sites; in very rare cases, abscess formation may occur. Adolescents who are already at an advanced stage of pubertal maturation at the start of treatment may experience *menopausal symptoms* such as hot flushes, sweating, mood swings, anhedonia and (less frequently) headaches during treatment with GnRH analogs. This must be taken into account in advanced pubertal development when *weighing up the individual risks and benefits*. In trans-male adolescents in particular, menopausal symptoms caused by the drop in estradiol are in the foreground. These often improve within a few weeks or months. Nevertheless, in view of these side effects, the use of a progestogen preparation is preferable in trans-male adolescents if their menses are to be suppressed as a priority in order to reduce their gender dysphoria (see below).

### **2.3.1 Laboratory checks to be carried out**

Gonadotropins are not usually completely suppressed during treatment with GnRH analogs. Nevertheless, treated trans-male adolescents usually do not have menses. Therefore, the determination of LH/FSH is not indicative in the assessment of hormone status. Instead, a suppressed estradiol or testosterone level to prepubertal values is a suitable indicator of effective pubertal suppression.

### **2.3.2 Effects on juvenile bone metabolism**

Long-term suppression of sex hormones in adolescence through GnRH analogue treatment could lead to the development of osteoporosis. Puberty blockade has an effect on bone metabolism. Four studies (Joseph et al., 2019; Klink et al., 2015; Schagen et al., 2020; Vlot et al., 2017) examined, among other things, bone density after puberty blockade and subsequent sex-reassigning hormone administration. What the studies have in common is that a statistically significant decrease in absolute bone density was observed after puberty blockade.

In the study by Klink et al. (2015; 15 trans females and 19 trans males; average age at onset of 15.0 years, range: 11 - 18 years), a temporary statistically significant reduction in bone density compared to the normal sample was found in the group of trans male adolescents in the period between the onset of puberty blockade and the start of treatment with gender reassignment hormones (average duration 1.5 years). In the further course of the subsequent gender reassignment hormone treatment, this difference to the normal sample decreased again significantly in the trans-male persons and the values reached the average normal range of an age cohort for the birth gender. In the group of trans-female adolescents, there were no statistically significant changes in bone density compared to the normal sample during the study period. In the study by Vlot (2017;  $N = 28$  trans-female and  $N = 42$  trans-male; average age at the start of treatment 13 years, range: 12 - 14 years), the t-value for bone density decreased statistically significantly for both reported genders in the period between the start of puberty blockade and the start of gender reassignment hormone treatment (duration for trans-female adolescents  $M = 2.5$  years and for trans-male adolescents  $M = 1.2$  years). It increased again statistically significantly for both groups within the first 24 months after the start of the gender reassignment hormones and reached the normal range for adult trans women on average for adult cis men. For adult trans men, however, bone density after 24 months was on average still below the population average for cis women. The study by Joseph et al. (2019;  $N = 10$  trans females and  $N = 21$  trans males; mean age at onset 15.1 years, range: 12-14 years) showed a statistically significant reduction in bone density over a period of 3 years under puberty blockade (without gender reassignment hormones). This study did not investigate the recompensation effect of subsequent gender reassignment hormone treatment.

Schagen et al. (2020) report a similar pattern ( $N = 10$  trans-female and  $N = 21$  trans-male; mean age at onset 15.1 years): There was *initially* a statistically significant reduction in bone density under pubertal blockade (mean duration: 1.89 years), which the trans-male adolescents, however, fully compensated for under later sex reassignment hormone treatment, but the trans-female adolescents tended not to fully compensate.<sup>1</sup>

Another study (Lee et al., 2020) showed that children and adolescents with GI or GD already had lower bone density *before puberty blockade*, which was often associated with less physical activity. The cause is thought to be the frequent

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<sup>1</sup> This was exactly the opposite of the above-mentioned study by Klink et al. (2015).

limited enjoyment of sporting activities in adolescents with gender dysphoria.

### 2.3.3 Other physical side effects

In another study (Schagen et al., 2016), physical health parameters were regularly recorded in  $N = 49$  trans-female and  $N = 67$  trans-male adolescents (average age: 13.9 years, range: 11 - 18 years) from the start of puberty blockade over a total of 12 months. Neither liver nor kidney parameters increased statistically significantly as a result of the puberty blockade, but actually decreased in trend. The BMI SDS (age-standardized body mass index) increased statistically significantly in trans-male adolescents, but not in trans-female adolescents. There was a statistically significant increase in body fat percentage for both groups, but this was not compared with a comparison sample or an age norm. It therefore remains unclear whether the increase is due to the puberty blockade. *No serious physical side effects* were observed. In other studies, no serious side effects were found in follow-up examinations of treated adolescents over a period of at least 6 months and up to 24 months (Jarín et al., 2017; Olson-Kennedy et al., 2018; Tack et al., 2016, 2017).

In summary, the partly heterogeneous study situation indicates that special care is required in the professional implementation of puberty blockade with possible subsequent sex reassignment hormone administration to minimize potential somatic side effects, particularly with regard to bone density. In particular, a rationally considered time limit for puberty blockade from a physiological point of view appears to be important in order to avoid somatic risks.

Consensus-based recommendation:

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<b>VIII K2.</b>	Before treatment with GnRH analogs for pubertal suppression, the following possible side effects, such as hot flushes and - with several years of treatment - the development of osteoporosis, should be considered.
Strong consensus (> 95%)	

### 2.3.4 Possible effects on psychosexual development

The extent to which puberty suppression with GnRH analogs in adolescents diagnosed with persistent gender incongruence after the onset of puberty can influence the further development of gender identity by preventing the physiological influence of steroid hormones on juvenile brain development is unclear. However, it is sometimes raised as a speculative objection. Hormonal influences on the expression of *gender-typical role behavior* in pubertal gender-conforming adolescents are known. However, there is no evidence to date that steroid hormones can still have a changing influence on an existing sense of belonging to a gender after the onset of puberty. Such a potential influence of steroid hormone levels on the course of later gender identity development is very likely in pre- and postnatal brain development. For example, in DSD <sup>individuals</sup><sup>2</sup> with adrenogenital syndrome who were assigned female sex after birth, it was shown that an increased *postnatal androgen level* increased the probability of later male identity development (Meyer-Bahlburg et al., 2008). In contrast, no increased rates of gender incongruence (female to male) are known to date, e.g. among adolescent girls or women with post-pubertal hyperandrogenism (e.g. polycystic ovary syndrome as its most common cause).

On the other hand, cohort studies and case reports have shown that, in individual cases, gender dysphoria can become desistent after the onset of puberty blockade (Brik et al., 2020; Rölver et al., 2022). This suggests that an open-ended or fluid further development of gender identity is also possible under puberty blockade. However, since inhibitory influences on psychosexual development in this regard cannot be ruled out with certainty, the use of puberty blockers is prohibited in the case of a diagnostically vague picture of an "uncertain identity" with regard to gender. For a proper indication, it is therefore necessary in any case that, according to diagnostic assessment, a stable persistent gender incongruence is highly probable after the onset of puberty (see explanations in Chapter VII → "*Indications for body-modifying medical interventions*").

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<sup>2</sup> DSD (Disorders of sex development): Spectrum of variants of sex development (also known as intersexuality)

### 3. Alternatives to puberty suppression in adolescence before the start of gender reassignment hormone treatment

#### 3.1 Treatment with progestogens when pubertal development is already largely complete

For the suppression of menses in trans-male adolescents, progestogen-containing oral contraceptives such as desogestrel (75 ug daily), Drospirenone (4 mg daily) or lynestrenol (5-10 mg daily) are orally applicable and cost-effective alternatives to GnRH analogs (Tack et al., 2016). Lynestrenol is currently not available on the German market, but can be obtained from international pharmacies (although it is not reimbursable for patients with statutory health insurance). Regularity (and even daily punctuality) of tablet intake is important for effective menses suppression. However, vaginal (spotting) bleeding sometimes occurs during this treatment. Doubling the dose of desogestrel (to 150 ug/day) or drospirenone (to 8 mg/day) or the use of chlormadinone 2-4 mg stops the menstrual or spotting bleeding in many cases.

Consensus-based recommendation:

<b>VIII K3.</b> If puberty development is already largely complete, the following can occur trans boys with gender dysphoria for the suppression of menstrual bleeding progestogen-containing pills can be used in the long-term cycle.
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Strong consensus (>95%)

#### 3.2 Treatment with antiandrogens

In trans-female adolescents whose male puberty is already advanced (voice change, adult testicular volume, increased body hair), antiandrogens such as cyproterone acetate can be used temporarily to suppress the androgen effect, e.g. on beard growth and male body hair (e.g. if time is still needed to prepare for oestrogen treatment or for overlapping treatment during the gradual build-up of oestrogen levels) (Tack et al., 2017). These drugs not only have a peripheral antiandrogenic effect, but also suppress the release of gonadotropins and subsequently testosterone centrally. Since the beginning of 2020, there has been a warning from the EMEA that 1 to 10 additional meningiomas in

10,000 patients treated with cyproterone acetate - especially after several years of therapy with high doses above 25 mg/day (Weill et al., 2021). Observations have also been reported that cyproterone acetate can have a negative effect on bone density, especially in the lumbar spine (Tack et al., 2018). Other antiandrogens such as spironolactone (Tangpricha & den Heijer, 2017), finasteride as a 5-alpha-reductase inhibitor (Spack, 2013) or bicalutamide (Neyman et al., 2019) can also be used as an alternative to cyproterone acetate.

Consensus-based recommendation:

<p><b>VIII K4.</b></p> <p>wit more h persistent Antandrogens can be used once pubertal development is largely complete. become.</p>	<p><b>To reduce androgen effects</b> in trans-female adolescents</p> <p>Gender incongruence resp. Gender dysphoria and</p>
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Strong consensus (>95%)

#### 4. Sex reassignment hormone treatment

Although the suppression of puberty, which is experienced as not congruent with one's own gender identity, through the use of GnRH analogues usually leads to a temporary de-actualization of psychological distress in gender dysphoric adolescents, this can only be a responsible temporary postponement of the decision as to whether gender reassignment hormone treatment is desired and indicated and, if so, when it should be initiated. Adolescents who are treated with puberty blockers because of their gender incongruence experience an increasing discrepancy between their own arrested physical development and the progressive puberty of their peers (Cohen-Kettenis & van Goozen, 1998). The absence of the desired secondary sexual characteristics in accordance with the perceived gender identity is usually perceived as increasingly stressful as age progresses. Most adolescents then want to undergo gender reassignment hormone treatment to change their body and adapt it to their perceived gender. This second step of a staged medical transition treatment must be prepared separately, including a careful review of the indication based on the course of development in the meantime. In rare individual cases, this review may result in a different reassessment of the



transition pathway followed by the adolescent up to desistance (see case study in Chapter VII → "Indication for body-modifying medical interventions"; Rölver et al., 2022). Diagnostic assessment in the context of indication testing again raises the question of the extent to which adolescents already have the necessary mental maturity to be able to assess the implications of the upcoming decision, including how the desired physical changes will affect their future life and in particular their sexuality and fertility (see explanations in Chapter VII → "Indication for *body-modifying medical interventions*")

#### 4.1 Sex reassignment hormone treatment for trans-male adolescents

The masculinization of the body of trans-male adolescents is achieved by testosterone, which is available in various forms of application. Length growth and skeletal age must be taken into account when increasing sex steroids.

In trans-male adolescents undergoing treatment with GnRH analogs, puberty induction can be performed in accordance with the available guidelines for the treatment of pubertas tarda or hypogonadism (Nordenström et al., 2022, AWMF, 2021).

A slower increase in the testosterone dosage is recommended for trans-male adolescents who have not yet reached adulthood in order to prevent the epiphyseal joints from closing too quickly. Before starting therapy, the bone age should be determined by means of an X-ray of the left hand. The "puberty induction" can be started with transdermal testosterone at 10 mg/day, which can then be increased to 25 mg/day after six months (also depending on bone age). In rare cases, 50 mg/day must be used to achieve a concentration in the adult male normal range. The testosterone gel should be rubbed daily on the inside of the forearms; alternatively, it can also be applied to the inside of the thighs or the chest.

Consensus-based recommendation:

<b>VIII K5.</b> Gender reassignment hormone treatment with testosterone
growth and skeletal age should be taken into account. In growing trans-male adolescents, the dosage of testosterone can be increased more slowly than in adolescents who are already growing, taking into account the growth prognosis.
adult adolescents.

Strong consensus (> 95%)



Testosterone antate in ampoules of 250 mg is also available for treatment. Puberty induction begins with 50-100 mg of testosterone antate intramuscularly once a month for the first 6 months in not yet fully grown trans-male adolescents. During the slow increase in dosage, overlapping treatment with GnRH analogs is recommended, in particular to avoid painful vaginal bleeding due to insufficiently suppressed menses.

Long-term hormone replacement therapy involves testosterone administration of 250 mg testosterone antate i.m. every 3-4 weeks. Alternatively, 1000 mg testosterone undecanoate can be administered as a depot preparation i.m. every 3-4 months. The trough level determines whether the application interval is shortened or extended. The aim is to achieve a testosterone level in the adult male normal range. If polyglobulia occurs (haematocrit over 50%), the interval should be extended.

If a trans-male adolescent patient is already fully grown, a full substitution dose can be started (testosterone undecanoate 1000 mg every three months. A "top-up" after six weeks, as recommended for male hypogonadism, is not necessary. Patients with obesity and high blood pressure should rather be treated with a transdermal preparation, as there appears to be an increased cardiovascular risk for this group of people (Seal, 2007).

Previous treatment with GnRH analogs can be discontinued after testosterone has been increased; vaginal bleeding then occurs only very rarely. However, menses may recur despite a suppressed gonadal axis if, for example, a high level of testosterone is aromatized to oestrogen in the fatty tissue. Ovarian cysts can also cause an increase in estradiol. This can cause the endometrium to build up, which then results in abortion bleeding in the event of hormone fluctuations. If vaginal bleeding occurs during testosterone treatment and the gonadotropins and/or estradiol are not suppressed, the additional intake of progestogens (e.g. desogestrel, drospirenone or chlormadinone) may be useful (see procedure under 2.). If bleeding persists despite this, a GnRH analog should be administered. In this situation, it is advisable to perform an ultrasound examination of the internal genitalia to evaluate the endometrium and ovaries.

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Consensus-based recommendation:

<p><b>VIII K6.</b> If bleeding occurs during testosterone treatment, the cause should be should be carefully evaluated. A progestogen preparation or a progestogen preparation can be overlapped. GnRH analogs can be used to suppress menstruation.</p>
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Strong consensus (> 95%)

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#### **4.1.1 Important contents of the education**

The most important contents of an explanation about testosterone treatment include the following information: A change of voice can occur as early as around two to three months after the start of sex reassignment hormone treatment, in some cases it takes longer; body hair also increases (upper lip fuzz, hair on arms, legs and stomach). However, it can take two to three years to develop a full beard and the extent depends on the familial hair pattern. The facial features become more angular as the process progresses and the musculature increases. The distribution of fat changes, making the physical appearance more masculine (Klaver et al., 2018). The clitoris grows so that a small phallus can develop. Patients should be made aware that these physical changes are largely irreversible, that they should also expect to develop androgenetic alopecia in the future (if genetically predisposed), that acne may occur, BMI may increase, HDL may decrease and polyglobulia may develop (Jarin et al., 2017). The latter is presumably responsible for the slightly increased risk of thrombosis. The long-term use of testosterone at a usual dose does not appear to pose a permanently increased health risk in trans-male patients without additional health risks (such as significant obesity or pronounced underweight). In the relevant study by Chan et al (2018), no lipid metabolism disorders (except for a drop in HDL cholesterol) or a deterioration in glucose metabolism parameters were reported. Furthermore, with regard to a possible future preservation of fertility (see above), it should be pointed out that although the possibility of later reactivation of the ovaries, including fertilizable eggs, remains after discontinuation of testosterone treatment, a decrease in fertility can still be expected, especially after prolonged suppression.

#### **4.2 Sex reassignment surgery hormone treatment for trans-female adolescents**

In trans-female adolescents, estrogen treatment not only aims to enable breast development and pubertal growth, but should also help to reduce the final size by accelerated closure of the epiphyseal joints in the case of an unfavorably high growth prognosis for an adult woman. Consequently, a full substitution dose of estradiol valerate or estradiol 2 mg/day can be started in rather large trans-female adolescents. The dose can be increased to 4 mg/day if necessary, depending on the estradiol concentration in the serum. The aim is to achieve an estradiol level in the upper adult female normal range,

to achieve good breast development. If the growth prognosis is very high (>185 cm), a high-dose ethinylestradiol treatment (100 ug/day) to slow down growth can be considered. An increased risk of thrombosis should be noted with this treatment. No additional suppressive therapy of the testicles is then required. Before starting sex-reassignment oestrogen treatment, it is advisable to carry out thrombophilia diagnostics to rule out (genetic) risk factors for thrombosis.

Consensus-based recommendation:

<b>VIII K7.</b> Ethinylestradiol can be used if the patient is not fully grown. trans girls there is a desire to reach the final size through an accelerated to limit epiphyseal closure.
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Strong consensus (> 95%)

#### 4.2.1 Important contents of the Enlightenment:

The most important contents of an estrogen treatment consultation include the following information: When taking estrogens, breast budding occurs after just a few weeks, which is also often accompanied by increased sensitivity to touch. It takes around 2-3 years for the breasts to fully develop, but the first year of treatment (and especially the first six months) seems to be quite decisive for the outcome (de Blok et al., 2018). If growth is unsatisfactory within the first few months under a good estradiol concentration, the breast will probably remain small. There is no evidence that the use of progesterone is conducive to increased breast development. As oestrogens are lipophilic, it is advisable to take the tablets with a meal. As an alternative to tablets, transdermal oestrogen treatment with a gel can also be carried out. This is particularly recommended for trans-female patients with risk factors for thromboembolism. There is still very little knowledge about the long-term *side effects* of gender reassignment hormone therapy in trans female patients, although statistically their risk of breast cancer increases - although it is still lower than the risk of breast cancer in adult cis women (Sonnenblick et al., 2018) or at least does not appear to be higher (Gooren et al., 2013). The long-term risk of cardiovascular disease remains unchanged for trans women on oestrogen treatment, in line with the "baseline risk" of cis men, but this can be attributed to the use of ethinylestradiol, which was common in the past.

is used. In a systematic review with meta-analysis by Khan et al. (2019), the incidence of venous thromboembolism in trans women under oestrogen treatment was 2.3 per 1000 person-years.

### 4.3 Clarification of off-label prescriptions

All preparations that are used for hormonal treatment of patients with GI or GD in accordance with the recommendations of this guideline and current international medical guidelines based on expert consensus are generally *off-label prescriptions*. This means that although these drugs are approved under pharmaceutical law for other medical areas of application and have therefore been tested for their basic safety of use in other areas of application (e.g. GnRH analogs for the treatment of pubertas praecox), they are not approved for the area of application of gender incongruence or gender dysphoria. This also applies to the use of testosterone and oestrogen for sex reassignment hormone treatment in adults. Due to the overall very low treatment numbers in this field of application and the non-feasibility of controlled efficacy studies (so-called phase 3 studies), no corresponding approval studies are to be expected in the foreseeable future, so that this off-label practice will continue in the medium term. Off-label prescriptions generally correspond to the guideline-based standard of care in pediatric and adolescent medicine. According to a review, off-label prescriptions are used in 42-90% of cases of inpatient medical treatment of children and adolescents, and in 46-64% of cases of outpatient medical treatment (Kimland & Odland, 2012). According to a recent meta-analysis, 82% of all international medical guideline recommendations for off-label treatments in childhood and adolescence are *based on weak or very weak evidence* according to the criteria of evidence-based medicine (Meng et al., 2022), i.e. they are largely based on uncontrolled cohort studies or on expert consensus in connection with study results from clinical studies with adult patients. The special information standards for off-label prescriptions for underage patients must be observed, as is usually the case in pediatric and adolescent medicine and psychiatry.

The tables on the following pages provide an overview of the most important information on somatic aspects of hormonal treatments in adolescence.

Table 7: Overview of risks and side effects of hormonal interventions for gender incongruence in adolescence

	Trans-female patients	Trans-male patients
GnRH analogs	local reactions such as subcutaneous hardening, bruising or bruising of the skin Allergic papules, in very rare cases abscess formation in the area of the injection site	
GnRH analogs for advanced puberty	<ul style="list-style-type: none"> <li>• <i>menopausal complaints</i> such as Hot flushes, sweating, mood swings, anhedonia and (more rarely) headaches</li> <li>• Temporary reduction in bone density</li> </ul>	
Progestogens		Intermediate bleeding
Antiandrogens (cyproterone acetate)	<ul style="list-style-type: none"> <li>• Increased risk of meningioma</li> <li>• Reduced bone density</li> </ul>	
Testosterone		<ul style="list-style-type: none"> <li>• Polyglobulia</li> <li>• Alopecia (baldness)</li> <li>• Acne</li> <li>• Decrease HDL cholesterol and increase in LDL cholesterol</li> <li>• Increased cardiovascular risk</li> <li>• Hypertension</li> </ul>
Oestrogens	Thrombosis risk Breast cancer risk slightly increased Macroprolactinoma Cholelithiasis	
Liver and Kidney values	No effects	
Fat metabolism	No effects	
Glucose metabolism	No effects	

Table 8: Expected timing of physical changes after the start of gender reassignment hormone therapy (adapted from Coleman et al., 2022)

<b>Effect of testosterone</b>		
	<b>Start</b>	<b>Maximum</b>
Skin	greasiness/acne	1-6 months
	1-6	1-2 years
Hair loss (balding)	Beard growth/body hair	6-12 months
	6-12	> 5 years
Increased muscle mass/ -Power	6-12	2-5 years
Fat	redistribution	1-6 months
Absence of	menstruation	1-6 months
	Clitoral enlargement	1-6 months
Vaginal	atrophy	1-6 months
Voice	change	1-6 months
<b>Effect of estrogen and antiandrogenic therapies</b>		
	<b>Start</b>	<b>Maximum</b>
Redistribution of	body fat	3-6 months
Decrease in muscle mass/ -Power	3-6	2-5 years
Skin appearance change/ reduced oiliness	3-6 months	1-2 years
Reduced sexual desire	1-3 months	unknown
Less frequent spontaneous erections	1-3	unknown
Reduced sperm production		3-6 months
Decreased	Breast growth	3-6 months
Decrease in	testicular volume	3-6 months
Increased	body hair	6-12 months
	scalp hair	variable
	variable Voice changes	none

Table 9: Dosage recommendations for the sex reassignment hormone treatment with testosterone (adapted from Coleman et al., 2022)

Hormone preparation used	Application	Dosage	Continuation of a puberty blockade or Menses suppression	Comment
<i>Trans-male adolescents: Therapy start with incomplete growth</i>				
Testosterone ant at (ampoules 250 mg)	intramuscular	Start: 50 mg every 4 weeks for 3-6 months, then increase to 100 mg every 4 weeks, individual increase up to 250 mg every 3-4 weeks. Weeks (adult dose)	Continue already initiated puberty blockade or progestogen treatment unchanged until the adult testosterone dose is reached. This can then be discontinued.	Dose increase depending on skeletal age and growth velocity; regular blood count checks necessary; in the case of polyglobulia, extend the injection interval or reduce the dose transdermally
Testosterone gel (different concentrations depending on the manufacturer, follow the dosage instructions)	transdermal	Starting dose: 10 mg testosterone gel every day for 6 months, increase to 25 - (50 mg) adult dose. Dose adjustment depending on the testosterone concentration (note that the blood sample should not be taken from the arm on which the testosterone gel was previously applied, as this would result in incorrectly high testosterone concentrations). can have).		
<i>Trans-male adolescents: Start of therapy after completed growth</i>				
Testosterone ant at (Ampoules 250 mg)	intramuscular	125 mg every 4 weeks for 3 months, then 250 mg every 3-4 weeks	In Tanner stages 4-5, puberty suppression is generally no longer started. Previous treatment with GnRH analogs or progestogens can be discontinued.	Once growth is complete, the adult dose can be started. A gradual increase in dosage is not necessary, but is usually well received. Dosage according to testosterone concentration at the end of the spray interval
Testosterone gel (different concentrations depending on the manufacturer, dosage instructions) note)	transdermal	25 mg testosterone gel every day for 3 months; if the testosterone concentration is then not in the adult range, increase if necessary. 50 mg per day		
Testosterone undec anat	intramuscular	1000 mg every 10-12 weeks with completed growth		



Table 10:

Current dosage recommendations for sex reassignment hormone treatment with oestrogen (adapted from Coleman et al., 2022)

Hormone preparation used	Application	Dosage	Continuation a puberty blockade	Comment
<i>Trans-female adolescents: Starting therapy for incomplete growth</i>				
Estradiol valerate In tablet form or in prepared in the pharmacy as drops (0.4 % solution, 1 tr. = 0.1 mg estradiol valerate)	orally	Start: 0.5 mg for 6 months, then increase to 1 mg/day for a further 3-6 months. Then increase to 2 mg adult dose 2-4 mg/day. Estradiol should be in the adult female normal range	The puberty blockade or anti-androgenic treatment must be continued unchanged even after the adult oestrogen dose has been reached.  No anti-androgenic or puberty-suppressing treatment is required during growth-retarding ethinylestradiol treatment	Hormone replacement therapy with estrogen does not sufficiently suppress the gonadal axis. Termination after gonadectomy or change of therapy to antiandrogens.  To reduce the targeted final length, the oestrogen dose can be rapidly increased or the adult dose can be started in the same way as growth-limiting hormone therapy. Alternatively, 100 µg/day of ethinylestradiol can be administered until the epiphyseal joints are closed. be given.
Estradiol patch 25 µg, 50 µg, 75 µg, 100 µg	transdermal	Start: ¼ of a 25 µg patch (= 6.2 µg) or 1/8 of a 50 µg patch for 3-6 months at night, then double for 6 months with an adhesion time of 24 hours. Adult dose 100 µg/day		
Estradiol gel, (0.62 mg per 1 g gel, Single dose 2.5 g/day)	transdermal	only suitable after puberty due to difficult dosing or in the case of particular risk factors for thrombosis		
<i>Trans-female adolescents: Start of therapy after completed growth</i>				
estradiol or estradiol valerate tablets	orally	Start with 1 mg/day for 6 months, then adult dose 2-4 mg/day.	The puberty blockade or anti-androgenic treatment must be continued unchanged even after an oestradiol concentration in the adult range has been reached.	There is no data that the additional administration of progesterone improves breast development. Oestrogen treatment can also be started with the adult dose.
Estradiol patch	transdermal	Start: 50 µg patch/day. Adult dose 100 µg/day		
Estradiol gel (0.62 mg per 1 g gel, single dose 2.5 g/day)	transdermal	1 dose of 2.5 g for 3-6 months, then increase to 2 doses. Adult dose 2-4 mg/day Stroke		



## **Chapter IX**

### **Professional interaction and discrimination-sensitive interaction with gender-nonconforming children and young people**

- 1. Introduction and key questions**
- 2. Definition and operationalization of the concept of discrimination**
- 3. National and international studies**
- 4. Discrimination by peers, consequences and protective factors**
- 5. Experiences of discrimination in the healthcare system**
- 6. Literature on recommendations for a discrimination-sensitive approach to trans people**
- 7. Statements on the state of scientific knowledge**
- 8. Consensus-based recommendations**

Vorläufige Leitlinie zur Kommentierung

## 1. Introduction and key questions

Young trans people are a minority and can therefore be affected by specific experiences of social marginalization or discrimination. In this respect, it is important for professionals to sensitize themselves to the social context in which these children and adolescents grow up and, among other things, to pay attention to experiences of discrimination that have taken place or threaten to take place. Gender non-conforming children and young people often report experiencing exclusion, stigmatization and even open hostility in their everyday experiences. These experiences can lead to psychological stress, with subsequent symptoms that can occur even before a transgender self-disclosure to the outside world (social outing).

Although the UN Convention on the Rights of the Child prohibits discrimination on the basis of sex or gender identity (e.g. Art.2: The right to non-discrimination; Art.19: The right to be protected from all forms of physical or mental violence, injury or abuse; Art.24: The right of the child to enjoy the highest attainable standard of health (UNICEF, 2022)), various national and international studies show that trans minors and their families often experience marginalization and devaluation not only in the social context, but also in the healthcare system (Edenfield et al., 2019; Fuchs et al., 2012; Mizock & Lewis, 2008).

Based on the results of a large-scale study on experiences of discrimination against trans people in the healthcare sector, which was carried out in several EU member states, the EU Agency for Fundamental Rights therefore demands that EU states ensure that healthcare staff are trained accordingly and that the needs of people with non-conforming gender identities are taken into account when designing health policy measures (European Union Agency for Fundamental Rights., 2014).

An additional effect that causes health risks for those affected is the anticipation of discrimination (Hädicke & Wiesemann, 2021). This can be seen, for example, when trans people avoid the healthcare system due to a well-founded fear of being discriminated against in the event of illness (Kcomt et al., 2020). It is therefore important for healthcare professionals to be informed about these experiences as well as their preconditions and consequences in order to derive recommendations for discrimination-sensitive practice and structural anti-discriminatory measures (e.g. calling out in the waiting room).

An informed and sensitive approach to experiences of discrimination is therefore an important prerequisite for providing targeted professional support to young trans people and their families.

If gender-nonconforming children, trans adolescents and their parents have experienced discrimination, this can influence the relationship building in the psychotherapeutic and medical setting. For example, restrained silence and mistrust can characterize the initial contact, with the result that the young trans person is perceived by the other person as "difficult to contact" or "difficult to deal with".

is perceived as "unreasonably demanding". It is therefore advisable to ask about such previous experiences in the anamnestic interview and validate them if necessary in order to make it easier to establish a relationship.

### Key questions for the guideline:

- What role do the experiences of people seeking treatment<sup>1</sup> with discrimination play in the process of advice and treatment when using health services?
- What can and should professional helpers pay attention to in the counseling and treatment process?

## 2. Definition and operationalization of the concept of discrimination

There are currently numerous definitions and interpretations of the concept of discrimination (Beigang et al., 2017; Ruhrmann, 2017). What the studies on which this chapter is based have in common is that discrimination is understood as the experience of exclusion and devaluation as a result of not conforming to social norms and ideas (usually with regard to gender).

Differences between the studies are evident in the definition and recording of experiences of exclusion and devaluation. While some studies focus in particular on experiences of *direct* discrimination, in which the targeted discrimination was based on gender, other studies also look at *indirect* discrimination, which is not necessarily based on a negative intention on the part of the discriminator, but often on a lack of information and carelessness, as well as *structural* discrimination, in which the discrimination is carried out by institutions such as

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<sup>1</sup> In the text of the guideline, the term "patient" is used in the social law sense for young people who make use of a healthcare service. The term "treatment seeker", on the other hand, also includes the custodial caregivers who are involved in this utilization.

practically established practices in the medical system (Council of Europe & Commissioner for Human Rights, 2011; Günther et al., 2021). In addition to different forms of discrimination, the studies also focus on different contexts/systems in which discrimination can occur: e.g. family, school or healthcare system. The following section therefore first presents studies that refer to several contexts. This is followed by a section with further studies relevant to the context of "school and peer relationships" as well as a section with findings on "experiences of discrimination in and through the healthcare system".

In this chapter, the term discrimination is based on the following definition by Hädicke and Wieseemann (2021):

Discrimination is understood to mean unequal treatment of members of a certain social group "with a lower status in the structure of social power relations", which "harms them, curtails their freedom rights, degrades them or impairs their equal opportunities" (Hädicke & Wieseemann, 2021, pp. 382-383). Intent is not a necessary prerequisite (ibid.).

### **3. National and international studies**

As there have been very few studies to date that depict the equal treatment and discrimination situation of trans minors and their relatives in German-speaking countries, studies on the situation of trans adolescents in other countries and the situation of older trans people must also be taken into account. There is a particular lack of studies that explicitly address the situation of gender-nonconforming prepubertal children. This highlights a great need for research and makes it difficult to estimate the extent of discrimination in German-speaking countries.

A German-language study with a qualitative research design was dedicated to the experiences of guardians of a trans child/young person in the German healthcare system and identified some significant barriers to healthcare for families (Mucha et al., 2022). Especially in paediatric care, experiences of uncertainty, lack of specialist knowledge and even disbelief and pathologization of trans identity were reported. As a result, treatment was sometimes discontinued (ibid.).

The findings of a cross-sectional study by Strauss et al. (2020) provide a detailed impression of the situation of young trans people in Australia. Using an anonymous online survey, 859 young people (assigned female gender at birth at 74.4%) between the ages of 14 and 25 ( $M= 19.37$   $SD=3.15$ ) who self-identified as trans and 194 parents or caregivers were interviewed. Among other things, they were asked about mental health and potentially distressing experiences in the healthcare system. The findings indicate a significantly higher prevalence of mental illness among the respondents compared to Australian non-trans young people: for example, 74.6% of the participants stated that they had already received a diagnosis of depression. A diagnosis in the area of anxiety disorders was reported by 72.2% of participants. In addition, 79.8% reported having self-harmed in the past, 82.4% reported having had suicidal thoughts in the past and 48.1% stated that they had already attempted suicide. As potentially stressful experiences that could be related to discrimination, participants reported rejection/rejection by peers (89%), problems at school/university (78.9%), bullying (74%), discrimination (68.9%), lack of family support (65,8%), isolation from services (60.1%), psychological abuse in the family (57.9%), problems with employment (41.9%), physical abuse in the family (24.8%), homelessness/problems with housing (22%) and physical abuse outside the family (16.2%). Furthermore, 19.6% of respondents stated that they were not satisfied with their GP treatment and 31.7% with their psychiatric treatment. The reasons given for this included the fact that those treating them refused to use their chosen first name and the corresponding pronoun when addressing them, declared transidentity to be a "development phase", and that those affected felt pathologized or had been denied the treatment they wanted. As a result, many of those affected reported that they had had to see several doctors or that visits to the doctor had been avoided.

A study by the European Union Agency for Fundamental Rights (2014) and findings from a qualitative interview study by Sauer and Meyer (2016) provide indications of the transferability of the above-mentioned Australian findings by Strauss et al. (2020) to trans youth in Germany.

The data from the aforementioned EU study depicts various aspects of equal treatment and discrimination of adult trans people within the EU (European Union Agency for Fundamental Rights, 2014). A total of 93,079 people over the age of 18 ( $M = 34$  years) were surveyed using an anonymous online survey. Of these, 6,771 people identified themselves as trans (including 1,329 Germans). EU-wide

54% of trans people surveyed stated that they had felt harassed or discriminated against in the past 12 months because they were perceived as trans. Younger, unemployed and trans people with a low income were more likely to state that they had felt discriminated against in the past year. In the employment context, trans people surveyed stated that 37% had felt discriminated against when looking for a job and 27% had felt discriminated against at work. In the context of education, around a quarter of trans people who had attended school/university themselves or had children at school/university reported having felt personally discriminated against by employees. Around a fifth of the trans people surveyed stated that they had felt discriminated against in the past year by healthcare staff or the relevant social services. Only a few people reported the last case of discrimination to the authorities. 60% did not report the relevant incident out of the conviction that it "would not help or change anything". In addition, 47% stated that it was not worth reporting incidents as this happens all the time. 30% did not know how/where the incident in question could have been reported. In addition to verbal experiences of discrimination, respondents were also asked about threats and experiences of physical violence and harassment.

Every second trans person reports an incident of violence or harassment in the past year. 44% of those who reported experiencing violence in the past year stated that this had happened three or more times. 8% of trans people had been physically or sexually assaulted or threatened with violence (due to being perceived as trans). Of the trans people surveyed who reported experiencing violence, 21% stated that they had reported the most recent case of hate-motivated violence to the police. Fears and restrictions in everyday life were reported as consequences of experiences of discrimination. For example, 32% of the trans people surveyed avoided acting out their gender role in public (for fear of being attacked, threatened or harassed). Half of them avoided places or locations due to corresponding fears. One in five stated that they avoided being open about their trans identity even at home (European Union Agency for Fundamental Rights, 2014).

As part of the qualitative study by Sauer and Meyer (2016), 15 trans people living in Germany (14 of whom were assigned female gender at birth) between the ages of 14 and 26 were asked about their self-image, their living situation and their perceived need for support from society and institutions. With regard to discrimination, around half of the respondents reported specific psychological stress, which was particularly often caused by family conflicts. In addition, the interviewees reported ostracism by peers (often classmates) and fears of being ostracized due to homosexual and gender-based discrimination.

transphobic behavior of others to avoid going to certain public places. Reported experiences of discrimination consist primarily of a lack of acceptance by parents, peers, teachers, doctors, etc. Discriminatory behavior ranges from refusing to use the chosen name to actual violence. Positive experiences were reported by those affected when they were met with sincere interest, good information and a positive and benevolent attitude, which was then described as a source of support (Sauer & Meyer, 2016).

#### 4. Discrimination by peers, consequences and protective factors

The systematic review by Collier et al. (2013) provides an overview of the consequences of peer victimization in adolescence due to sexual orientation and the expression of one's own trans identity. This is based on a total of 39 studies<sup>2</sup>, which often did not differentiate between sexual orientation and trans identity. The study results show that peer victimization correlates with various negative psychosocial and health outcomes. Peer victimization included: *verbal victimization*, *physical victimization*, *sexual victimization* (e.g. sexual abuse), *sexual harassment* (e.g. comments, gestures, sexual touching/ groping), *relational victimization* (being deliberately excluded from activities by peers), *indirect victimization* (negative/harmful rumors) and *cyberbullying*. The most frequently investigated outcome parameters in studies were sense of school belonging, depression and suicidality.

There were strong indications that those who experience victimization have a lower sense of belonging to their school and show higher levels of depressive symptoms. With regard to the relationship between victimization and suicidal thoughts or suicide attempts, the results vary: In large school-based samples, peer victimization moderated the association between sexual orientation (including trans identity) and suicidality. In pure LGB studies (excl. trans identity), on the other hand, there was no independent correlation between peer victimization and suicide attempts. The results regarding peer victimization suggest that it is important for those treating trans adolescents who have learning-related or other difficulties in/at school to ask specifically about any peer victimization they may have suffered. If such victimization is known, the possible victimization should be pointed out.

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<sup>2</sup> Of these, 12 studies with trans people

The presence of depression or suicidal thoughts should be specifically taken into account (see consensus-based recommendation below).

The correlation between suicidal thoughts and bullying experiences among trans adolescents compared to non-trans adolescents in the USA was examined in the study by Ybarra et al. (2015). Using an online survey, a total of 5,542 adolescents aged between 13 and 18 were interviewed; in the sample, 188 described themselves as transgender, 199 as gender non-conforming and 50 as "other gender". Of these, 48% of trans young people, 44% of gender non-conforming young people and 55% of young people who said they were of the "other gender" stated that they had experienced social exclusion or bullying in the past 12 months. Among male cisgender adolescents, this figure was 21% and among female adolescents 25%. When asked about suicidal thoughts in the past week, gender-nonconforming young people were significantly more likely to answer "yes" (41-53%) than cisgender young people (13-21%).

A study by Wilson et al. (2016) shows that trans young people can also be affected by multiple discrimination. The study surveyed 216 adolescent trans girls between the ages of 16 and 24. The study investigated the correlation between differences in mental health depending on the extent of experiences of discrimination and protective factors. 37% of respondents reported being exposed to a low level of discrimination. 45.9% reported experiencing high levels of transgender-related discrimination and 26.2% of young people reported experiencing high levels of racial discrimination. 15.9% reported experiencing both forms of discrimination to a high degree at the same time. Stress in connection with suicidal thoughts was increased in all discrimination conditions. Experiencing discrimination due to trans identity was associated with 2.6 times the risk of PTSD symptoms, 2.6 times the risk of depression and 7.7 times the risk of suicidal thoughts in this sample. In addition, specific outcomes were also found depending on the type of discrimination, which indicates the need for specific approaches for transgender-related, racial and mixed discrimination. In addition to non-specific resilience factors, the acceptance and support of trans identity by the family environment was found to be a significant protective factor that promotes mental health.

With 81,885 high school students (grades 9 and 11), 2,168 of whom identified as TGNC (transgender/nonconforming), the sample and control group sizes of the cross-sectional study by Eisenberg and colleagues (2017) are very large. The central questions of this study were the prevalence of TGNC identity in adolescents, differences in risk and protective factors in TGNC adolescents compared to cisgender adolescents, and differences in risk and protective factors in cisgender adolescents.



TGNC adolescents between the genders assigned at birth. In summary, it is reported that TGNC adolescents are more affected than the cisgender comparison group in all risk factors examined. Particularly with regard to emotional well-being, the differences between TGNC vs. cisgender are large: over 60% of TGNC adolescents stated that they had already had suicidal thoughts, compared to 20% of cisgender adolescents; of the TGNC adolescents, around one in three stated that they had already attempted suicide. Furthermore, TGNC young people also reported significantly more frequent experiences of bullying and discrimination. In terms of physical attacks: TGNC 25.1% (cisgender 12.7%), cyberbullying: TGNC 27.6% (cisgender 12.3%). Discrimination based on gender: TGNC 35.3% (cisgender 4.7%). Within the group of TGNC adolescents, this study found that adolescents assigned female at birth (trans boys) reported emotional stress and discrimination by peers significantly more often than adolescents assigned male at birth (trans girls) and had less pronounced protective factors such as family ties or a positive teacher/student relationship (ibid.).

The influence of risk and protective factors on the mental health of young people is also shown in a study by Veale et al. (2017). A total of 923 Canadian 14 to 25-year-olds were surveyed using an online survey. In the group of 14 to 18-year-olds (N=323), 64% reported having been socially excluded in the past year. Of these young people, 52% stated that they had (also) experienced bullying at school. A stigmatization index calculated from the reported cumulative experiences consistently predicted increased mental health problems, particularly in relation to non-suicidal self-harming behavior, the likelihood of exhibiting this behavior increased by 25% with each additional point in the stigmatization index. In contrast, all protective factors were negatively correlated with mental health problems, although not all met the criterion of an odds ratio of  $< 0.5$ . *Family connectedness* was the strongest protective factor. *Being close to school* was a significant protective factor with regard to extreme stress and extreme despair. The perception that friends care about you could predict a lower rate of suicide attempts.

A systematic review by Johns et al. (2018), which examines the findings of 21 studies on protective factors, provides a summarized overview of the importance and effectiveness of various protective factors. The age range of the study participants ranged from 11 to 26 years. The 21 articles examined a total of 27 factors in relation to positive effects on health and well-being.

of trans or gender-nonconforming young people. The following proved to be protective:

- At the individual level, this was the young people's self-esteem.
- In terms of relationships, support from parents/family and peers proved to be central to the well-being of young people. Adults outside the family also represent an important resource. Especially in cases where no support is provided by the family or peers. Such adults could, for example, be of help when it comes to helping families and peers gain a better understanding of gender non-conformity.
- At the (school) community level, so-called "gay-straight alliances" have proven to be protective for LGB young people. These are organizations led by students and supervised by a responsible teacher that advocate for a safe and supportive environment for LGBTQ people in schools, especially in the United States and Canada (ibid.).

The results of the study by Barbir and colleagues (2017) may provide a starting point for reducing discrimination by peers. They investigated the relationship between the social contact of cisgender heterosexual college students with trans people and their self-reported positive and negative attitudes and behavioral intentions towards trans people. The results of this study indicate that social contact such as friendships with trans people can influence self-reported attitudes toward trans people. Social contact can also influence self-reported behavioral intentions: Those who had at least one friendship with a transgender person in the present study reported fewer negative attitudes and behavioral intentions toward trans people, more positive behavioral intentions and views, and more supportive public intentions. Potential benefits of friendships with cisgender people for trans people also include access to mainstream society, a wider range of diverse perspectives and interactions, opportunities to increase knowledge and awareness of trans people's experiences, and possibly help in presenting themselves in the role of their chosen gender. Typical reported barriers to friendships with cisgender/heterosexual people included insufficient knowledge of gender issues, insensitive use of language and fewer shared experiences (ibid.).

## 5. Experiences of discrimination in the healthcare system

As described, trans people are also exposed to discrimination in the context of healthcare. This discrimination can occur both by people in the healthcare system who have been consulted for trans-specific issues and by all others, such as dentists, company doctors, vaccination consultations, etc. (European Union Agency Fundamental Rights. (European Union Agency for Fundamental Rights, 2014; Sauer & Meyer, 2016; Strauss et al., 2017). With regard to the reported rates of discriminatory experiences, a distinction must be made as to whether and how the concept of experiences of discrimination is operationalized in the respective studies.

Various online surveys recorded experiences of discrimination by adult trans people in the US healthcare system. Bradford, Reisner, Honnold and Xavier (2013) report that 41% of 387 trans respondents reported having experienced discriminatory behavior. Shires and Jaffee (2015) describe that 41% of 1,711 trans people surveyed (FTM) stated that they had been refused treatment, physically attacked, verbally harassed or verbally disrespected because of their trans identity. Kattari, Bakko, Hecht and Kinney (2020) report that 8% of 27,715 transgender and non-binary respondents reported a refusal of treatment from healthcare providers they sought out because of their trans identity. Less than 3% reported a refusal of treatment in healthcare contacts when the contact was for a reason other than trans identity.

Bradford and colleagues (2013) also report that low socioeconomic status, belonging to an ethnic minority, a younger age at the time of disclosure of trans identity and less support from the family are factors that are associated with an increased likelihood of discrimination in the healthcare system.

In a focus group study with 34 trans participants by Sperber and colleagues (2005), respondents described ignorance, a lack of sensitivity and discrimination as common in contacts with the healthcare system. In addition, it was stated that healthcare professionals often addressed trans issues when this was not relevant to treatment (e.g. in the case of fractures or infectious diseases).

The results of a comprehensive cross-sectional study by the Federal Ministry for Family Affairs, Senior Citizens, Women and Youth (2016) provide an assessment of the current situation and experiences of trans people in Germany: Data from 1,049 trans people was collected by means of an online survey. This included information from 117 trans children and adolescents (exact age unknown), whereby in 70% of these cases the questionnaire was completed by adults (usually a parent) on their behalf. With regard to the responses of the children and their relatives, approx. 75% stated

of respondents stated that they found psychotherapists to be empathetic, supportive and knowledgeable in their conversations. At the same time, around 33% of respondents experienced such conversations as pathologizing. Doctors were perceived as empathetic, supportive and knowledgeable by around 60% of the children, adolescents and their relatives surveyed. 28% of the participants felt rather pathologized. In response to the question "From which group of people/institution would you or your relative have liked more support?", 52.14% said school and kindergarten, 39.32% doctors, 34.19% family, friends, acquaintances and 25.64% psychotherapists.

The consequences of experiences of discrimination include fear of discrimination in contact with healthcare facilities (Grossman et al., 2016), concealment of one's own trans identity due to an inconsistent practitioner-patient relationship or fear of negative consequences (Rossman et al., 2017) and postponement or avoidance of medical treatment due to experiences of discrimination. In a study by Cruz and colleagues (2014), around half of the 4049 trans people surveyed stated that they had already postponed curative treatment due to their own trans identity, half of whom cited previous experiences of discrimination as the reason for this. In an online survey by Bauer and colleagues (2014), 21% of 433 trans people stated that they had already avoided going to an emergency medical service.

Canadian and US studies point to uncertainties on the part of practitioners when dealing with trans people. In a Canadian study by (Snelgrove et al., 2012), 13 doctors from various disciplines were asked about barriers for trans people in the healthcare system. In terms of their own experiences and assessments, the respondents stated that they had deficits in terms of the relevant specialist medical knowledge and found it very challenging to weigh up the ethical aspects of transition-related treatment. Doctors were often overwhelmed by not knowing who to turn to.

In another study on the stigmatization of trans people in the healthcare system by (Poteat et al., 2013), 12 doctors/nurses were interviewed alongside 55 trans people. A common theme among healthcare professionals was uncertainty in dealing specifically with trans people and with the fundamental classification of the phenomenon of "trans" (including the question of the need for treatment).

A subjectively perceived dilemma situation was reported by members of the nursing staff who were asked about their own insecurities in dealing with trans people (Beagan et al., 2012). On the one hand, the interviewees stated that they made an effort to avoid any differences in the treatment of trans people and other patients.

but also to recognize existing differences that are relevant to treatment.

In a study by Kitts (2010), 184 doctors at a US university hospital were asked about barriers to providing optimal care for LGBT young people. The majority stated that they did not feel sufficiently competent to talk to LGBT young people about their sexual orientation/gender identity. Accordingly, the desire for further training was expressed.

The results of various studies show that even short workshops can promote knowledge about discrimination and vulnerability of trans people in and their access to the healthcare system as well as skills in dealing with trans children and trans adolescents: For example, in a study by Kelley and colleagues (2008)

75 medical students attended a two-hour teaching unit on the topic of LGBT\* health. The impact on students' knowledge and attitudes towards the treatment of LGBT\* people was investigated. In the follow-up survey, significantly more students stated that access to the healthcare system is more difficult for LGBT\* people than for the average population. Fewer respondents than before were convinced that LGBT\* people rarely lived in stable partnerships. Fewer students than before the workshop stated that they were reluctant to treat people in matters of gender identity.

Similar findings were also found in a study by Safer and Pearce (2013). 74 medical students took part in a lecture as part of the endocrinology course. The effects on attitudes towards the treatment of trans people were examined. After the course, the number of students who would be uncomfortable treating trans people fell by 60%. In the follow-up survey, no student was of the opinion that trans issues were no longer relevant to medicine.

In addition, the number of students who would refuse such treatment fell significantly.

McGravey (2015) showed that discrimination-sensitive training workshops can also be useful in a psychotherapeutic context. The effectiveness of a workshop to expand knowledge and skills in dealing with LGBTQ young people was examined in 68 psychotherapeutically active school psychologists. In general, the measures of knowledge and skills for both significantly improved at the time of the follow-up survey.

## 6. Literature on recommendations for a discrimination-sensitive approach to trans people

The TGNC guidelines of the American Psychological Association (2015) and the Multicultural Guidelines of the American Psychological Association (2017) provide comprehensive orientation for professionals with regard to discrimination-sensitive work in the healthcare sector, as well as a well-founded intersectional perspective. Context-sensitive models such as the minority-stress model (Meyer, 2003) are presented in detail in a trans-specific adaptation for recording and processing experiences of discrimination and their health consequences in Rood et al. (2016). Wanner & Landsteiner (2019) provide a comprehensive description of attitudes and procedures that are particularly critical for trans people with regard to discrimination, which are based on the now outdated psychopathological conceptualizations of "transsexualism" still referred to in the ICD-10, and which were nevertheless influential in the health care of trans people for decades

## 7. Statements on the state of scientific knowledge

**IX. E1.** There is evidence from survey studies that trans minors and their legal guardians often report multiple experiences of discrimination in various areas of life, including healthcare.

Strong evidence

Number of studies: 25

(Bauer et al. 2014; Bradford et al. 2013; Federal Ministry for Family Affairs, Senior Citizens, Women and Youth, 2017; Collier et al. 2013; Cruz 2014; Cruz et al, 2016; ; Mucha et al, 2022; Rossman et al. 2017; Sauer and Meyer, 2016; Shires and Jaffee, 2015; Sperber et al. 2005; Strauss et al. 2017; Strauss et al. 2020; Veale et al. 2017; Wilson et al. 2016; Ybarra et al. 2015)

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Consensus: strong consensus (> 95%)

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**IX. E2.** There are indications that experiences of discrimination against trans minors and their legal guardians are not only made in individual interactions with practitioners, but also on a structural and institutional level.

Moderate evidence

Number of studies: 10

(Bauer et al. 2014; Bradford et al. 2013; Council of Europe Commissioner for Human Rights, 2011; Cruz 2014; Cruz et al, 2016; Günther et al. 2021; Hädicke & Wiesemann, 2021; Kcomt et al, 2020; Mucha et al, 2022; Rossman et al, 2017)

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Consensus: strong consensus (> 95%)

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**IX. E3.** In the case of reported experiences of discrimination against trans minors and their legal guardians in the healthcare system, there are also indications that these are often not caused by conscious or intentional attitudes on the part of healthcare professionals, but can arise due to insufficient specialist knowledge and/or professional uncertainty.

Weak evidence Number

of studies: 8

(Beagan et al. 2012; Kelly et al. 2008; Kitts, 2010; McGravey, 2015; Mucha et al, 2022; Poteat et al. 2013; Safer & Pearce, 2013; Snelgrove et al. 2012)

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Consensus: strong consensus (> 95%)

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## 8. Consensus-based recommendations

**IX. K1.** Treating party (Relatives all helping Occupational in healthcare) should be informed about the risks and forms of discrimination to which groups th trans minors and their guardians may be exposed. They should reflect on their own professional attitude regarding critically reflect on potentially discriminatory aspects.

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Consensus: strong consensus (> 95%)

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**IX. K2.** Treating party (Relatives all helping Occupational groups in the health care system) should, as far as possible and within the scope of their field of activity, contribute to the prevention of discrimination, including discrimination on a structural or institutional level.

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Consensus: strong consensus (> 95%)

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**IX. K3.** Treating party (Relatives all helping Occupational groups in the healthcare) should be informed about the psychological and health consequences of experiences of discrimination and apply this knowledge in their work. take into account.

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Consensus: strong consensus (> 95%)

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**IX. K4.** In the context of psychological-psychotherapeutic diagnostics, counseling and process support for children and adolescents presenting with GI/GD, experiences of discrimination should be asked about and taken into account as factors that promote illness.

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Consensus: strong consensus (> 95%)

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In addition to specifically asking about such experiences in the past, current experiences should also be asked about. In line with a resource-oriented approach, it is also advisable to ask specifically about positive experiences in the social context and in the healthcare system.

**IX. K5.** The social environment (e.g. schools, educational institutions, sports clubs, youth facilities, church congregation etc.) should be provided with educational and information services process support of trans minors, which also refer to information and counselling services offered by self-representation organizations of trans persons and their relatives.

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Consensus: strong consensus (> 95%)

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Explanation: Such an offer of professional support for those seeking treatment in their everyday social environment requires transparent agreement.

In other medical contexts, the terms "self-help" and "self-advocacy" are commonly used for counselling services organized by patients and their interest groups.

"Self-help organization" is not (or no longer) used in this field.

**IX. K6.** When addressing gender-nonconforming children and adolescents, practitioners should ask for the desired pronouns and first names and use them where possible depending on the situation. The same approach should also be taken in professional communication with other professionals and institutions involved, in consultation with those seeking treatment.

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Consensus: strong consensus (> 95%)

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It is important to communicate the importance of recognizing gender identity for the necessary trust and relationship building in treatment to legal guardians and other important caregivers who express reservations about a minor trans person's wish to be addressed according to their gender identity. It should be noted that the appropriate use of desired first names and pronouns does not imply any commitment with regard to future social, legal or medical steps of a transition.

## **Chapter X:**

### **Law and ethics - Legal foundations and ethical standards for the treatment of gender-incongruent minors**

- 1. Introduction**
- 2. Protective function of the legal system**
- 3. Right to self-determination and highly personal core area**
  - 3.1. Self-determination for minors capable of giving consent
  - 3.2. Self-determination for minors unable to give consent

Vorläufige Leitlinie zur Kommentierung

## 1. Introduction

The controversies in the medical community about somatomedical interventions for adolescents diagnosed with gender incongruence (GI) or gender dysphoria (GD) are often superficially fought over arguments about the uncertain evidence for this age group, but in essence touch on ethical and legal issues:

- How can the ethical dilemma that is particular to treatment decisions in adolescence be addressed, which consists of the fact that both treatment and its postponement or omission can have irreversible consequences for later long-term mental health (German Ethics Council, 2020)?
- How should the right to self-determination and the underlying ethical principle of promoting autonomy be weighted against protecting minors from treatment decisions with potentially fatal consequences that reach far into their future (Hädicke et al., 2023)?
- Under what conditions can minors give informed consent to puberty-suppressing or gender reassignment medical treatment (Giordano et al., 2021)?
- How is the necessary capacity to consent (D)/capacity to make decisions (A)/capacity of judgment (CH) to be examined and determined in the case of minors ?<sup>1</sup>
- How important is the involvement and consent of custodians in treatment decisions?

In this chapter, the relevant legal foundations are presented with primary reference to the German legal situation and important ethical standards from the international medical ethics discourse are discussed. This is intended to inform, orient and, if necessary, reassure practitioners when applying the guideline. Since the legal framework is binding in any case and ethical principles must be weighed against each other in responsible treatment decisions, this chapter does not contain any consensual recommendations.

## 2. Protective function of the legal system

"The German legal system establishes a double protective space for the somatomedical treatment of minors with gender dysphoria - first and foremost for the constitutionally guaranteed right of every person to express their gender identity.

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<sup>1</sup> For reasons of readability, the term "capacity to consent" relevant to the German legal situation is used in the following text of the chapter; the analogous terms from the Austrian and Swiss legal systems (decision-making capacity and capacity of judgment) are not repeated.

identity [see below], and then for the decision-making process in the triangle of the transgender person, their guardians and the practitioners. This protective space, which also includes high requirements with regard to compliance with evidence-based medical standards, the quality of the treatment process, the determination of capacity to consent and the provision of information to those involved, serves to safeguard these individual decision-making and treatment processes against third parties and instrumentalization of all kinds." (Gutmann, 2023, p. 4). The law thereby implements the central ethical challenge of "supporting minors on the path to their own gender identity and at the same time protecting them from - sometimes irreversible - harm" (German Ethics Council, 2020, p. 2).

The comprehensive diagnostic biopsychosocial assessment recommended by international medical guidelines based on expert consensus (Coleman et al., 2022; Hembree et al., 2017) and this guideline recommend a comprehensive diagnostic biopsychosocial assessment of the life situation of a trans minor (including their developmental history, their social and family environment, any diagnostic evaluation of other associated mental health problems, etc.) as an essential prerequisite for an indication for body modification measures. In German law, Section 630a (2) BGB (compliance with the required professional diagnosis and treatment standards), Section 630c BGB (duty to inform) and Section 630e BGB (individualized duty to inform) require an assessment of the trans person's life situation by the practitioner as an indispensable prerequisite for determining the indication for body-modifying measures (Gutmann, 2023).

### **3. Right to self-determination and highly personal core area**

The right to self-determination over one's own body is one of the fundamental personal rights. It applies to all medical and psychological-psychotherapeutic interventions, whether they are of a diagnostic, therapeutic or preventive nature. These are subject to the requirement of consent. In pediatrics and adolescent medicine, consent is given either by the minor capable of giving consent themselves or - in the case of incapacity to consent - by the legal representatives, usually the parents (Rixen, 2020; Rothärmel, 2004; Wapler, 2015).

Some areas are of a highly personal nature and cannot be decided on by a third party. This includes gender identity. Gender identity is part of the inviolable core area of private life. In principle, only the person concerned is authorized to make decisions about this (German Ethics Council, 2020; Siedenbiedel, 2016). Medical-psychotherapeutic measures must therefore aim to guarantee the self-determination of the person concerned about their gender identity as far as possible. Restricting the decision-making authority of minors is only permissible with the aim of ensuring a fully self-determined decision.

i.e. up to the point at which the person concerned is capable of giving consent (Siedenbiedel, 2016). Achieving the capacity to consent is therefore an important threshold for interventions to treat gender incongruence or gender dysphoria in underage patients.

### **3.1. Self-determination for minors capable of giving consent**

"In the case of minors, the capacity to consent [...] is not presumed in a generalized manner as in the case of adults, but requires a positive determination. Capacity to consent is not tied to a specific age and cannot be for constitutional reasons." (Gutmann, 2023, p. 4). If the minor is capable of giving consent, they alone are entitled to decide on medical and psychotherapeutic measures (Rixen, 2020). A self-determined decision requires comprehensive, comprehensible information about all aspects of the decision or non-decision. It is only possible if the person in the decision-making situation is free from external coercion (through threats from third parties, etc.) or internal coercion (through intoxication, hallucinations, etc.).

#### **3.1.1. Definition of the capacity to consent**

The ability to consent is a complex characteristic that encompasses both cognitive and emotional aspects of personality. It only emerges gradually in the course of personality development. It is not the same as intelligence.

The capacity to consent refers to a person's ability to understand the nature, meaning and consequences of an action and to determine their will accordingly. It includes the capacity for insight, judgment and control (Laufs et al., 2015). In detail, a person is capable of giving consent if they are able to do so,

- "(a) understand the purpose, necessity and urgency, likely course, possible consequences, potential risks and potential benefits of the intervention and of not carrying it out,
- b) to determine what value the legal interests concerned have for [it] and what alternatives [it] can choose from,
- c) to weigh up the pros and cons and make a decision,
- d) this decision and
- e) to act in accordance with the decision." (Genske, 2020, p. 347)

The assessment of the future risks and opportunities of an intervention or its omission poses a particular challenge when making decisions in childhood and adolescence. This is because in order to assess the value of the legal interests concerned, at least a certain amount of life experience is required, which children and adolescents do not have.

young people only gradually acquire in the course of their personal development. Another A specific difficulty arises from the fact that, in the case of adolescent patients, decisions to start or not to start treatment - with irreversible consequences to be taken into account in each case - must be made at a time when many aspects of identity and personality development are still subject to psychosocial development processes typical of adolescence (Deutscher Ethikrat, 2020; Seiffge-Krenke, 2021).

Nevertheless, according to a legal opinion by Gutmann (2023), generalizing objections to the capacity of minors to consent to complex medical interventions cannot be justified by the legal situation. "When it comes to somatomedical measures for the treatment of gender dysphoria, the assessment of a minor's capacity to consent must also take into account their level of development with regard to the perception and reflection of their own gender identity (their "gender identity maturity"). Cognitively mature minors with persistent gender incongruence or dysphoria may also regularly have the necessary judgment to be considered capable of giving consent to somatomedical treatment measures." (Gutmann, 2023, p. 5).

Nevertheless, the requirements for the *thoroughness of the determination of capacity to consent* (as well as the quality of the informed consent and the process of shared decision-making) are increased when partially or even completely irreversible somatomedical measures are involved (Gutmann, 2023). German law therefore sets demanding standards for the required procedure. Mandatory prerequisites for the fulfillment of the medical-psychotherapeutic duty of care when carrying out somatomedical measures for the treatment of a diagnosed gender incongruence or gender dysphoria include "precise and comprehensive discussions, inquiries, assessments, diagnostic steps and evaluations in order to be able to decide on the existence of the indication prerequisites, on the correct and professional procedure for the treatment and on the patient's ability to consent and to be able to adequately inform and educate him or her. These anamnesis, diagnosis and assessment procedures serve to ensure the integrity of the decision-making process and thus primarily to safeguard the interests and rights of the patients themselves" (Gutmann, 2023, p. 5).

### **3.1.2. Threshold of capacity to consent**

Capacity to consent is a threshold concept; it either exists or does not exist. It is only acquired in the course of individual personality development and depends on the complexity of the decision at hand (Lippert, 2016). Age limits

are occasionally mentioned as threshold values in the literature. For example, it is said that Ability to give consent from the age of 13 in individual cases, from the age of 15 years of age can usually be given. However, these should only be understood as reference values (Alderson, 2007, 2008; Duttge, 2013; Rixen, 2020). Capacity to consent is also not to be equated with legal capacity, for which rigid age limits apply (Genske, 2020). Furthermore, the prevailing opinion is that the threshold cannot be determined solely on the basis of objective factors characterizing the intervention. This means that serious, urgent or complication-prone interventions do not necessarily have their own age limits, but they can increase the requirements for capacity to consent (Lippert, 2016).

The capacity to consent must be assessed in each case individually and in relation to the situation, case and intervention (Laufs et al., 2015). The decisive factors are the individual maturity of the person, in the case of gender incongruence or gender dysphoria in particular the stability/persistence of gender identity to be assumed according to diagnostic assessment, and the individual, case- and intervention-related, concrete capacity for insight, judgment and control.

### **3.1.3. Examination of the ability to give consent**

The legal obligation to assess the presence of capacity to consent lies with the practitioner and is therefore a medical-psychotherapeutic task (Gutmann, 2023). The prerequisites for ensuring that minors' capacity to consent can be legally established apply in particular in treatment settings in which a longer-lasting, continuous doctor-patient relationship develops and exists (as recommended in international guidelines (Coleman et al., 2022)) and which are designed for a time-equalized and step-by-step decision-making process (Siedenbiedel, 2016). The assessment of minors' capacity to consent to complex medical interventions must be carried out by the person providing treatment, if necessary with the support of specialists with specific knowledge of the developmental psychology of childhood and adolescence. This is described for the scope of this guideline in the recommendations in Chapter VII →

*"Determination of indications for body-modifying medical interventions"* is ensured by the two-pronged procedure described there, according to which such an indication must be determined on an interdisciplinary basis with the involvement of a psychiatric-psychotherapeutic specialist and a specialist from somatic medicine.

The assessment of capacity to consent must also be carried out in personal discussions, and in the case of complex or high-consequence interventions in repeated discussions, supported by written information and explanatory material. The person providing information must ensure that the information has been understood (Laufs et al., 2015). The assessment of the ability to give consent must be documented in writing.

**Aspects to be examined when determining capacity to consent:**

In addition to an assessment of the mental and cognitive level of development and the assumed stability/persistence of a diagnosed gender incongruence, according to Gutmann (2023), it should be checked in separate discussions after the information has been provided whether the young patient can transfer the information received about the medical options to their own life perspective, i.e. whether they can explain it sufficiently plausibly,

- "which (positive and negative) aspects of his/her a) present and b) future situation and c) the options for action discussed in the informed consent discussion are particularly significant for him/her (in the light of his/her own life perspective);
- what the discussed treatment measure means for him/her and how it will affect his/her life, his/her everyday life and his/her relationship with family, friends and other people;
- what his/her goals are and what is most important to him/her;
- what he/she is prepared to give up for this;
- what his/her biggest fears are for his/her personal future;
- what is understood to be the greatest risk if the measure is implemented or not implemented;
- why he/she therefore weighs up the "pros and cons" of the measure in this way and not otherwise and has made his/her decision in this way;
- how he/she assesses the long-term significance of irreversible gender reassignment measures for his/her own life, particularly with regard to the effects of gender reassignment on his/her future sex life and the fact that, if necessary, an infertility-related renunciation of later biological parenthood may be perceived as a loss in the future;
- and how he/she assesses the possibility that the experience of his/her gender identity, his/her attitudes towards his/her gender-related needs could change in the future." (Gutmann, 2023, p. 43)

In order to determine the stability of these reflections, they should be spread out over time and deepened in at least two interviews (Gutmann, 2023.). In addition, with regard to the stability of the treatment decision, it should be examined whether the young person is in a position "to



- to come to a clear decision, this
- as their own decision, i.e. one for which they are responsible,
- communicate them clearly and
- also in the light of critical queries from the practitioners or the  
to be maintained by the custodian" (Gutmann, 2023, p. 44).

The international guideline *Standards of Care (Version 8)* of the WPATH<sup>2</sup> emphasizes how important it is for young patients to think for themselves about how to deal with irreversible consequences of treatment in the event of later detransition in order to determine their ability to give informed consent. The following questions are recommended to guide practitioners:

- "Can the young person think ahead into the future and consider the effects of a partially or completely irreversible measure?
- Does the young person have sufficient capacity for self-reflection to consider the possibility that gender needs and priorities may evolve over time and that gender priorities may also change at some point? -
- Has the young person thought about what they might do if their priorities in relation to gender were to change in the future?" (Coleman et al., 2022, p. 66)<sup>3</sup>.

### **3.2. Self-determination for minors who are unable to give consent**

#### **3.2.1. Participation**

Minors who are not capable of giving consent have a right to participation. This means that their opinion must be heard in all matters concerning them and taken into account in accordance with their age and maturity. The right to participation requires appropriate, age-appropriate and comprehensible information (Mengel et al., 2019; United Nations, 1989). Accordingly, a child who is not yet capable of giving consent (in accordance with Section 630e (5) sentence 1 BGB) must be informed of all circumstances relevant to their consent in a way that they understand, provided that they are able to understand the explanations based on their level of development and cognitive capacity (Gutmann, 2023).

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<sup>2</sup> WPATH - World Professional Association for Transgender Health

<sup>3</sup> Own specialist translation for this chapter

Participation is also necessary because, on the one hand, it helps the underage person to insight, judgment and control (Wapler, 2015). Secondly, it enables medical-psychotherapeutic staff to ascertain the abilities and personality development of the person undergoing treatment over the course of the treatment and thus to assess the developing capacity to consent with greater certainty (Wiesemann, 2020b). This gives rise to an important ethical principle for practitioners: In cases where a minor patient who wishes treatment does not (yet) have the capacity to consent, the young person must be supported in the process of further professional support to achieve this capacity (German Ethics Council, 2020).

This participation is therefore also necessary with regard to the minor's personal rights, because it helps them to develop their capacity for insight, judgment and control and thus to gradually establish their own capacity for consent.

### **3.2.2. Substitute consent and the best interests of the child**

Consent to medical-psychotherapeutic measures for minors who are unable to give consent is given on behalf of the fully informed custodians, usually the parents. Their decision must be based on the best interests of the child (Dettenborn, 2017; Dörries, 2003). Both the current and future well-being of the child are decisive for their welfare. Objective values such as health or physical integrity and subjective values such as quality of life or suffering must be given equal consideration and, if necessary, weighed against each other (Oommen-Halbach & Fangerau, 2019).

The will and subjective assessment of the child must always be taken into account (Wiesemann, 2020a). Decisions on elective measures with irreversible consequences for a later self-determined life in one's own gender identity should be postponed until the child has reached a later age at which it is able to give its own consent. As a rule, this applies to the decision to undergo gender reassignment hormone treatment due to the intended irreversible redirection of the development of secondary physical sexual characteristics. On the other hand, in the case of temporary puberty blockade due to its reversibility, if it is discontinued and no sex reassignment hormone treatment would follow, the proxy consent of the person with custody can be given if it can be justified that this is in the best interests and will of the child.

### **3.2.3. Co-consent of minor patient and legal guardian**

The more serious the decision to be made and the more difficult it is to determine the person's capacity to consent, the more likely it is that a co-consensus between the minor and the person with parental responsibility will make sense. As a rule, a co-consensus should also be sought because the caring support of the caregivers is a significant help for the minor concerned in coping with the life issues at hand (Schickhardt, 2016).

In the event of a conflict, the possibilities of an amicable joint decision should first be explored, as the long-term psychosocial implications of an ongoing conflict between parents and child over the issue of supporting the child's self-determined path in life as a trans person are considerable for both sides and therefore do not appear to be resolvable through custody proceedings alone (see explanations and recommendations in Chapter VI → "*Inclusion of the family relationship environment and family dynamics*" and Chapter VII "*Indications for body-modifying medical interventions*"). However, if a conflict proves to be persistently unresolvable despite all professional efforts, the best interests of the child must be regarded as the primary legal interest (Siedenbiedel, 2016). It is the responsibility of the youth welfare office to examine this if there is a suspicion that the child's welfare is at risk and, if necessary, to take appropriate steps to clarify the situation in the interests of the child's welfare.

Vorläufige Leitlinie zur Transidentifizierung

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Vorläufige Leitlinie zur Kommentierung

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# ANNEX: DIVERGENT TREATMENT RECOMMENDATIONS IN OTHER COUNTRIES FOR CHILDREN AND ADOLESCENTS WITH GENDER INCONGRUENCE

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## Overview

In recent years, it has become increasingly apparent that media reports on discourses in other countries are talking about a significantly more restrictive approach to treatment recommendations for adolescents that has begun or has been announced for the future. In particular, clear restrictions are increasingly being reported for treatment with puberty blockers. Some press reports give the impression that treatment with puberty blockers has now been completely stopped or "banned" in other European countries. Within Western industrialized countries, the latter applies to Republican-governed states in the USA, where increasing *legal bans* on hormonal treatments for adolescents have been enacted and are announced for the future. In Germany, such a *legal ban* has so far only been demanded by the AFD.

In Finland, Sweden and for the National Health Service England (not for Great Britain as a whole), relevant and in some cases binding changes to the relevant recommendations for treatment practice have been made or announced for the future, which require more restricted conditions for the use of puberty blockers in particular than in the recommendations of current international guidelines from medical societies and our guideline. In the following chapter, the current status of treatment recommendations in several other countries at the time of completion of this guideline, which differ significantly from the consensus recommendations of our guideline, is presented in detail. In particular, a distinction is made between the issuing institution, the type and significance of the respective document and the methodology behind the recommendation (type and composition of the committee, systematic literature review, structured consensus finding, etc.).

Tab 1:

Listing of divergent treatment recommendations in other countries

Country of origin	Publishing institution	Type of institution	Type of publication
Australia & New Zealand	Royal Australian and New Zealand College of Psychiatrists (RANZCP)	medical specialists Society for Psychiatry and KiJu-Psychiatry	<i>Non-binding</i> opinion
England	NHS England	(Commissioned by) national health service	Independent review & <i>binding</i> specification of services for future medical treatment. training centers in England
Finland	Palveluvalikoima (Council for Choices in Health Care in Finland)	government agency	<i>Binding</i> national recommendations for action
France	Académie nationale de médecine	Learned society by physicians from various disciplines; not a governmental or semi-governmental organization	Press release ( <i>non-binding</i> )
Norway (1)	Helsedirektoratet	National health authority	<i>Binding</i> national Guideline for the organization of the relevant health services
Norway (2)	Statens undersøkelseskomisjon for helse-og omsorg og opplysningsvesen (UKOM)	advise the government semi-governmental organizations organization	Report with <i>non-binding</i> Recommendations
Sweden	State reporting for medicinsk och social utvärdering (SBU) & Socialstyrelsen	both autonomous state agencies	Review & "Knowledge base" with <i>binding</i> recommendations
USA	American Academy of Pediatrics	largest children's and youth medical specialty society of the USA	Declaration of principle ("Policy Statement", <i>non-binding</i> )

## Australia & New Zealand: RANZCP

### Document:

Recognizing and addressing the mental health needs of people experiencing Gender Dysphoria / Gender Incongruence

### Publishing institution:

Royal Australian and New Zealand College of Psychiatrists (RANZCP; Australia & New Zealand; medical society for psychiatry and child psychiatry)

### Authors & year:

No authors named (2021)

### Type of publication:

Non-binding statement

### Participation of experts and professional associations

As no participants are named, the expertise of the authors cannot be assessed. No consultation or involvement of experts on gender dysphoria at KiJu is discernible.

The publisher itself is a medical-scientific specialist society. There is no evidence of consultation with other specialist societies (e.g. for endocrinology or pediatrics).

### Deviating recommendations:

No deviating recommendations for the treatment of children and adolescents recognizable.

Even if the statement is sometimes reported as particularly "cautious" in secondary sources, e.g. in the British Medical Journal by Block (2023), no deviating recommendations can be identified.

### Justification for recommendations:

Not applicable

### Consensus strength

Not specified

### Summarized DELBI assessment

Can be omitted because no deviating recommendations formulated

### Method-critical evaluation of the deviating recommendations

Can be omitted because no deviating recommendations formulated

## England (excluding Scotland, Wales and Northern Ireland): NHS England

### Document:

Independent review of gender identity services for children and young people: Interim report. February 2022 ("Cass Interim Report") & Interim service specification: Interim specialist service for children and young people with gender incongruence. First specification, June 2023

### Publishing institution:

NHS England

### Authors & year:

Cass, H. (2022) & for the interim service specification not mentioned

### Type of publication:

Independent review "from the outside" & service description for a medical center with recommendations for the future professional organizational orientation of care

### Participation of experts and professional associations

The physician Hillary Cass, who was commissioned to carry out the independent review, is considered a scientifically renowned pediatrician, although she has no proven special clinical or scientific expertise in the field of gender dysphoria in children and adolescents. According to the report, an interdisciplinary committee is working on the report, the members of which are not publicly known. Experts from the field of healthcare for children with gender dysphoria are not represented, which is in line with the concept of an independent and external review. According to the report, clinical experts from the health care of children and adolescents with gender dysphoria were consulted, as well as those seeking treatment and their relatives and parent organizations. It is unclear who was involved in these hearings. In an open letter published on the internet, former employees of the Tavistock Clinic complained that they were not involved in this consultation process. The current recommendations are therefore not based on a structured consensus of clinical experts. There is no evidence of consultation or involvement of specialist societies. It is also not clear whether the experts consulted were mandated by professional societies.

### Methodical approach:

- The **evidence assessment** is based on methodologically high-quality independent systematic literature reviews by the National Institute for Health and Care Excellence ("NICE") according to the criteria of evidence-based medicine (NICE, 2020a, 2020b). Their result: for puberty suppression and sex reassignment hormone treatments, the available evidence is to be classified as weak or "very low certainty" mainly due to methodological limitations (only cohort studies without control groups, possible selection effects due to ideal-typical sampling, etc.).
- However, the evaluation of the evidence was carried out exclusively from a methodological point of view using internationally recognized criteria of evidence-based medicine. The clinical recommendations derived from this have so far not included any proven clinical experience expertise, although this is explicitly formulated as a requirement in the Cass Review. There it is stated that as long as the evidence is uncertain, the broadest possible consensus of clinical experts should be sought as a basis for preliminary treatment recommendations, the implementation of which should also be designed as a "learning system". The latter should be ensured by 1. ongoing clinical exchange of experience among networked treatment centers, 2. ongoing evaluation through clinical follow-up studies.

Deviating recommendations:

1. External reviews of medical treatment decisions regarding puberty blockade and hormones as well as their documentation in individual cases before the start of treatment by an external review committee composed of interdisciplinary medical and legal experts.<sup>1</sup>
2. Announcement that treatments with puberty blockers will in future only be carried out as part of clinical studies for which a study design has yet to be developed.
3. Recommendation for a standardized collection of follow-up data in the long-term course of all treatments for gender dysphoria in children and adolescents, in the case of hormone treatment also follow-up into adulthood, in order to improve the long-term data situation ("treatment centers as a *learning system*").
4. Treatment with sex reassignment hormones from the age of 16 at the earliest.
5. Treatment with sex reassignment hormones only after at least 12 months of puberty blockade, even in older adolescents.

Justification for recommendations:

ad1 In the past, the Tavistock Clinic's documentation on information and decision-making was sometimes incomplete. However, as the indication for uncertain evidence is based on this, it is essential. The documentation should be based on international standards, such as the Endocrine Society guideline (Hembree et al., 2017).

ad2 The evidence regarding the treatment of children with gender dysphoria is not yet clear enough, which is why it is necessary to carry out the treatments in scientific studies.

ad3 As ad 2.

ad4 No explicit reason given. It can be assumed that the age refers to the original *Dutch protocol*, in which sex reassignment hormones were prescribed from the age of 16.

ad5 No explicit reason given. Here, too, it can be assumed that the condition refers to the original dutch protocol and is seen as useful to give young people time to make the decision for or against gender reassignment treatment.

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<sup>1</sup> These external reviews were launched by NHS England following a young woman's legal challenge against the Tavistock Clinic ("Bell v. Tavistock" case) as a precautionary measure in order to be better protected against future lawsuits of this kind. The former patient of the clinic had received puberty blockers for the first time at the age of 17 (!) on the basis of a diagnosed gender dysphoria and the declared wish to live in the male gender, followed by testosterone therapy which began at the age of 18. At the age of 20, she had a mastectomy. Several years later, she underwent a detransition and regretted her earlier treatment decisions. She also made public accusations against her former treatment providers that they had paid too little attention to the other mental health problems she had had as a teenager. The legal issue in the proceedings was not the accusation of faulty medical treatment, but merely the question of whether the then 17-year-old patient could be assumed to have legally effective independent capacity to consent to treatment with puberty blockers. The plaintiff was found to be in the right at first instance, which caused quite a stir in international press coverage. The judgment at first instance was overturned by the Court of Appeals and completely revised, which was ultimately confirmed by the Supreme Court. The international press hardly reported on this further course of events. Irrespective of a wave of lawsuits with similar cases expected according to media reports, no further cases of lawsuits have been reported to date. Nevertheless, this individual case has triggered increased awareness in the medical community of the question of how to deal appropriately with the possibility of later detransition when preparing treatment decisions in adolescence.

## Consensus strength

Not specified, composition

## Summarized DELBI evaluation (evaluation system for guidelines)

<i>Scope of application &amp; Purpose</i>	<i>Participation</i>	<i>Methodical Exactness</i>	<i>Clarity</i>	<i>General an-reversibility</i>	<i>Editorial Independence</i>	<i>Applicability in Germany</i>
0,66	0,42	0,48	0,33	0,33	0,17	0,44

## Critical evaluation of the deviating recommendations

The most important limitation with regard to the recommendations is that this is an *interim* report or service specification and that it explicitly refrains from a final assessment of most clinical issues. The recommendations made relate almost exclusively to organizational issues. The sparse database, which is highlighted by the methodologically high-quality evidence reviews by NICE (2020a, 2020b), is cited above all. One limitation that could possibly also be relevant in the final report is the lack of clarity regarding the type of decision making. Numerous interviews were conducted with practitioners, patients and caregivers. However, it is not clear how recommendations are systematically derived from these and from the evidence reviews. No consensus procedure is specified and important specialist groups (e.g. child and adolescent psychiatry) are not directly involved in the recommendation process. Neither at national level nor at international level were proven experts with clinical experience in the treatment of adolescents with gender dysphoria involved in an advisory capacity. Furthermore, it would be expected that declarations would be made with regard to funding and conflicts of interest of those involved. For example, Prof. G. Butler, a leading paediatric endocrinologist in the UK, publicly criticized the fact that the two newly named treatment centers in England, which are to take over care in the future, are both institutionally intertwined with Hillary Cass' former employer (quote, source Gary Butler).

- a. The recommendation of an "external review" as a quality assurance measure to increase patient safety seems unusual and presumably influenced by the specific situation in England. Only one specialized treatment center has existed there for decades, which is due to close in April 2024. The treatment monopoly that has grown there seems to be met with great mistrust. In other guidelines, the issue is usually addressed with recommendations on qualification requirements for the professionals involved. In other medical contexts, practicable procedures such as the dual control principle or obtaining an independent second professional opinion to confirm an indication are common.
- b. The planned collection of data on long-term follow-ups appears useful for improving the evidence base, provided that patients' rights are safeguarded and research and medical ethics aspects are taken into account.
- c. The age limit of "from around 16 years" is partly reflected in the treatment protocols of the studies that were included in the NICE review (especially in the *Dutch protocol*). Nevertheless, it is considered outdated and is no longer recommended in more recent international guidelines from medical societies (see chapter on indications).
- d. The recommendation that older adolescents who are at an advanced stage of maturation must undergo puberty blockade for at least 12 months before gender reassignment hormone treatment can be recommended in adolescence is also considered outdated and is no longer included in more recent guidelines from medical associations.



National treatment recommendations for gender dysphoria in KiJu - England (excluding Scotland, Wales and Northern Ireland): NHS England

(see chapter on indications). This procedure significantly increases the risk of menopausal side effects in older adolescents. The risk-benefit assessment of puberty blockade is therefore significantly more negative (Pang et al., 2022)<sup>2</sup>, which is likely to have contributed to the fact that treatment with puberty blockers has come under particular criticism in England, where this practice is still mandatory today.

Vorläufige Leitlinie zur Kommentierung

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1. <sup>2</sup>Pang, K. C., Wiggins, J., & Telfer, M. M. (2022). Gender identity services for children and young people in England. *bmj*, 377. <https://doi.org/10.1136/bmj.o825>

## Finland: Palveluvalikoima

### Document:

Alaikäisten sukupuoli-identiteetin variaatioihin liittyvän dysforian lääketieteelliset hoitomenetelmät (Medical treatment of dysphoria associated with gender identity variants in minors)

### Publishing institution:

Palveluvalikoima (Council for Choices in Health Care in Finland; Finland; state authority).

### Authors & year:

Lohiniva-Kerkelä, M. et al. (2020)

### Type of publication:

Binding national treatment recommendations

### Participation of experts and professional associations

The authors themselves are not experts in the treatment of children with gender dysphoria. Experts from the field of health care for children with gender dysphoria were involved in an advisory capacity. The recommendations themselves were apparently formulated without their direct involvement and not by expert consensus.

There is no evidence of consultation with or involvement of professional associations. It is also not apparent that the experts consulted were mandated by professional associations.

### Deviating recommendations:

1. Specific treatment of gender incongruence in KiJu only in specialized research centers (Helsinki and Tampere), after any mental disorders have been resolved (through treatment)
2. Puberty blockade "on a case-by-case basis after careful consideration and appropriate diagnostics". tests" possible
3. Sex reassignment hormone treatment in individual cases under the following conditions:
  - I. clinical assessment that gender dysphoria is persistent,
  - II. severe dysphoria present,
  - III. capacity to consent is given and
  - IV. No contraindications
4. no gender reassignment surgery before the age of 18 (including mastectomies)

### Justification for recommendations:

- a. There may be uncertainty about gender identity in adolescence. Assumed changes within the target group imply particular caution.
- b. Evidence from the database on the risks of puberty blockade, hormones and sex-angle therapy surgery in minors is too low. For this reason, irreversible measures before the age of 18 are not recommended.
- c. The financial costs of physical medical treatment are considerable. A public financed treatment can only be justified if the benefits are proven to be greater than the risks and costs. This does not mean that such treatment is unethical.

### Consensus strength

Not specified

## Summarized DELBI assessment

<i>Scope &amp; purpose</i>	<i>Participation</i>	<i>Methodical accuracy</i>	<i>Clarity</i>	<i>General applicability</i>	<i>Editorial independence</i>	<i>Applicability in Germany</i>
0,56	0,25	0,33	0,58	0,33	0	0,22

## Method-critical evaluation of the deviating recommendations

Overall, a moderately qualitative methodology for assessment. Systematic reviews were conducted and an ethical analysis was commissioned. The review was not carried out or documented in a methodologically appropriate manner in some cases (e.g. no criteria for inclusion or exclusion of studies in the review following a well-documented systematic literature search). It is particularly problematic that the methods used to reach a consensus on the recommendations are not presented. The recommendations cannot be derived from the literature review, nor is the process of their formulation and, if applicable, coordination transparent. No evidence levels or consensus strengths are given for the recommendations. Neither those affected nor clinical experts were directly involved in the development process. No editorial independence is documented.

ada A change in the population is assumed without taking into account biases in the survey and utilization.

ad b Physical medical measures are generally considered too risky if they are irreversible. There is no ethical consideration of the risks of omission in the absence of an alternative treatment (increase in gender dysphoria due to progressive maturation with lifelong consequences).

ad c It should be emphasized that the ethical analysis stresses that further treatment may be justified from a medical-ethical point of view. The restraint with regard to physical medical measures is derived in particular from the principle that publicly funded treatments require a proven benefit and efficiency and that, in a situation with unclear risks of treatment and equally unclear risks of non-treatment, non-treatment is preferable. Against the background of the different objectives (best possible patient care through a guideline versus justification of reimbursement of healthcare services here), there is therefore no transferability of the recommendations to medical guidelines.

## France: Académie nationale de médecine

### Document:

La médecine face à la transidentité de genre chez les enfants et les adolescents (Medicine in dealing with gender transidentity in children and adolescents)

### Publishing institution:

Académie nationale de médecine (France; self-recruiting learned society of physicians from various disciplines in France; no governmental or semi-governmental organization, no recognizable participation of clinical experts, no recognizable participation of the field of child and adolescent psychiatry)

### Authors & year:

None named (2022)

### Type of publication:

Press release

### Participation of experts and professional associations

No specific expertise for the healthcare of children with gender dysphoria is recognizable in the decision-making group. No recognizable experts were consulted.

The publisher itself is a selective medical scholarly society with no specific medical discipline. There is no evidence of consultation with specialist societies (e.g. for endocrinology or pediatrics).

### Deviating recommendations:

1. Caution when deciding on GnHR analogs and hormones
2. Caution regarding social media in adolescents with gender incongruence, assuming that the influence of social media in terms of influencing young people is involved in the increasing prevalence of gender dysphoria in adolescence ("rapid onset gender dysphoria").

### Justification for recommendations:

- Increase in use of treatment and prevalence of gender incongruence in children and adolescents
  - "phénomène d'allure épidémique" ("epidemic-like phenomenon")
- Possible reasons for increase: influence of social media, higher acceptance, influence of peers; risk of overdiagnosis
  - "problématique avant tout sociale" ("above all a social problem")
  - Source: Littman (2018)
- Side effects and risks of treatment with puberty blockers or hormones
  - No scientific source given

### Consensus strength

Majority recommendation (74.7% with 59 votes in favor, 20 against, 13 abstentions)

### Summarized DELBI assessment

<i>Scope of application &amp; Purpose</i>	<i>Participation</i>	<i>Methodical Accuracy</i>	<i>Clarity</i>	<i>General an-reversibility</i>	<i>Editorial Independence</i>	<i>Applicability in Germany</i>
0,22	0	0,05	0,25	0	0	0,06

### Method-critical evaluation of the deviating recommendations

Overall, the recommendations are not based on a systematic literature search or evaluation. They were adopted with a medium level of consensus. Furthermore, no thematic expertise is evident due to the lack of author names.

ad1 The paper reports no evidence base for a more restrictive caution compared to the professional recommendations of current international guidelines (Coleman et al., 2022).

ad2 Littman (2018) is cited as the sole source for this recommendation, but this study, which is only of very limited informative value, was not previously received with any recognizable methodological criticism (no survey of affected adolescents, exclusive survey of parents who were previously recruited internationally in designated trans-critical forums), but the results of this single study were adopted as empirical facts.

### Application relevance for healthcare practice in France:

This statement is a public recommendation by a panel of scholars and has no binding effect on practice.

According to written information from the leading treatment center for pediatric endocrinology specializing in adolescents with gender dysphoria

gy (Prof. Dr. Med. Laetitia Martinerie, Endocrinologie et Diabetologie Pédiatrique, Hôpital Robert Debré, Paris) will continue to be treated nationwide according to the current international standards of the WPATH (2022). Work is underway on the revision of an academically legitimized national practice guideline by transparently appointed expert committees in collaboration with European specialist societies. Experts hope that this will calm the public debate again.

## Norway 1: Helsedirektoratet

### Document:

Kjønnsinkongruens. Nasjonal faglig retningslinje (Gender incongruence. National professional guideline)

### Publishing institution:

Helsedirektoratet (Norway; national health authority)

### Authors & year:

Roland, B. et al. (2021)

### Type of publication:

Binding national guideline on the organization of the relevant healthcare services

### Participation of experts and professional associations

The members of the "reference group" themselves were experts in the treatment of gender dysphoria as well as representatives of those affected and were therefore directly involved in the development of the guideline. There is no evidence of consultation with or involvement of specialist societies. It is also not apparent that the experts consulted were mandated by professional associations.

### Deviating recommendations:

1. Diagnosis of gender incongruence possible by all doctors and psychologists. Indication of physical medical treatment ("assessment") by an interdisciplinary team with pediatric and sexological expertise (e.g. by pediatric psychiatrists or corresponding psychologists).
2. Sex reassignment hormones are recommended from the age of 16 at the earliest, before puberty blockade if necessary. The consent of a parent or guardian is required for every treatment up to the age of 18.
3. Sex reassignment surgery is generally excluded for minors. Exceptional mastectomy possible after appropriate indication and consent of the legal guardian.
4. Healthcare for children with gender incongruence should be organized on a decentralized basis. There should be interdisciplinary special outpatient clinics at regional level.
5. A national quality register should be set up.

### Justification for recommendations:

- The recommendations are in line with international guidelines (in particular WPATH, 2012 & Endocrine Society, 2017).
- There is no explicit justification for the age limit of 16 years for sex reassignment hormones. It can be assumed that this was set in line with the original *Dutch protocol* (de Vries et al., 2014). Furthermore, the consent of the legal guardians is required in Norwegian law for irreversible interventions.
- Decentralized care closer to home is seen as helpful for the KiJu, especially since a supportive broader environment (neighbourhood, school, etc.) is important for healthy identity development. A quality register is important for increasing the knowledge base and for quality assurance.

### Consensus strength

Not reported

## Summarized DELBI assessment

<i>Scope &amp; purpose</i>	<i>Participation</i>	<i>Methodical accuracy</i>	<i>Clarity</i>	<i>General applicability</i>	<i>Editorial independence</i>	<i>Applicability in Germany</i>
0,22	0,58	0,05	0,50	0	0	0,19

## Method-critical evaluation of the deviating recommendations

The guideline mainly addresses organizational aspects in the care of children with gender incongruence. Despite its designation as a guideline, it is not a clinical guideline, which is explicitly stated in the guideline. The clinical recommendations are not based on a systematic literature search or selection. Reference is often made to the international standards of care of the WPATH (Coleman et al., <sup>20123</sup>) and the Endocrine Society (Hembree, 2017). This seems easy to understand. There is no description of how recommendations are formulated and consensus reached. The broad involvement of specialist groups and other interest groups is a positive aspect.

ad1 This recommendation for children could be seen as a contradiction to the new WPATH-SoC (Coleman et al., 2022). There, an assessment by "mental health professionals" (KiJu psychiatrist or psychologist) is recommended for the indication of physical medical treatment for KiJu. psychotherapist) is suggested. This is not explicitly stated in this document, but only presented as a possibility. Reference is made to the need for "sexological" expertise. If this is to be understood as a deviation from the SoC, an explicit justification would have been desirable.

ad2 It is argued that in Norwegian law, the consent of the legal guardians is always required for irreversible treatments (which includes hormone treatment). This establishes a stricter criterion than under the WPATH-SoC (Hembree et al., 2022) or the German legal situation.

ad3 Analogous to ad 2.

ad4 The advantages of a decentralized design of specific healthcare (better accessibility for patients, better connection to the living environment, etc.) are mentioned. A discussion of possible disadvantages or problems would also have been desirable (e.g. more difficult to build up expertise in the treatment center, etc.).

ad5 This seems sensible from a research perspective, provided that patients' rights are respected and research and medical ethics aspects are taken into account.

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<sup>3</sup>The new version of the WPATH Standards of Care, Version 8 was published in 2022, i.e. 1 year after the publication of this Norwegian recommendation.

## Norway 2: UKOM

### Document:

Pasientsikkerhet for barn og unge med kjønnsinkongruens (Patient safety for children and adolescents with gender incongruence)

### Publishing institution:

Statens undersøkelseskomisjon for helse-og omsorgstjenesten (UKOM; semi-governmental organization advising the government)

### Authors & year:

None named (2023)

### Type of publication:

Report with non-binding recommendations (Phan, 2023), which recommends a revision of the existing guidelines of Helsedirektoratet (Norway 1).

### Participation of experts and professional associations

The authors themselves are not experts in the treatment of children with gender dysphoria. Experts from the field of health care for children with gender dysphoria were interviewed. The recommendations themselves were apparently formulated without their direct involvement and not by expert consensus. There is no evidence of consultation with or involvement of professional associations. It is also not apparent that the experts consulted were mandated by professional associations.

### Deviating recommendations:

1. Revision of the national guidelines (see "Norway 1; Helsedirektoratet") and supplementation in particular the following points
  - I. Definition of the necessary qualifications of diagnosticians and practitioners
  - II. Clearer recommendations on indications, contraindications, determination of capacity to consent and involvement of relatives
  - III. Clearer recommendations on the level of care (e.g. national specialist centers or primary care providers)
2. Carrying out puberty blockade and gender reassignment hormone treatment and  
In future, surgery in adolescents with gender incongruence should only be recommended in the context of clinical studies.
3. Introduction of a national quality register for puberty blockades and sexually transmitted diseases treatments.

### Justification for recommendations:

- There is no Norwegian systematic review on the treatment of gender incongruence. The national guideline is not based on such a review and is therefore not evidence-based. The national guideline leaves too much room for interpretation and is therefore not suitable for use.
- For safety reasons, given the unclear data situation, physical medicine treatment should only be used in clinical studies. Other interventions (e.g. counseling) are less invasive and therefore preferable.
  - The studies on outcomes of physical medicine treatment of children with gender incongruence are too small in sample size, with too short a follow-up and without a control group.



- Due to the reported increase in utilization and higher psychological stress, the results could not be transferred to current cohorts.
- There is not enough research on long-term side effects.
- The generation of sound knowledge about outcomes and side effects of treatment is necessary. In order to generate such knowledge, a national quality register and the implementation of treatments in clinical studies would be useful.

### Consensus strength

Not specified

### Summarized DELBI assessment

<i>Scope of application &amp; Purpose</i>	<i>Participation</i>	<i>Methodical Exactness</i>	<i>Clarity</i>	<i>General an-reversibility</i>	<i>Editorial Independence</i>	<i>Applicability in Germany</i>
0,33	0,17	0,05	0,66	0	0	0,05

### Critical evaluation of the deviating recommendations

Overall, the recommendations are not based on a systematic literature search or evaluation. There is no description of the way in which recommendations are formulated and consensus is reached.

Furthermore, the lack of author names means that no thematic expertise is evident.

ad1 The report draws attention to ambiguities in the guideline of the Helsedirektoratet. Some of these ambiguities do indeed appear to exist. For example, it remains unclear whether the involvement of a mental health professional (KiJu psychiatrist or psychotherapist) is optional for KiJu or whether this only applies to adults. With regard to the indication criteria, the standard guideline refers to the international guidelines, which initially seems appropriate, as these are themselves evidence- and consensus-based. It is not clear why a separate Norwegian systematic review would have to be carried out. However, a method-critical examination of the international guidelines used would have to be carried out, which is not actually the case in the Norwegian guideline. This should also be seen against the background that the focus of the guideline is on organizational and not clinical issues in the narrower sense.

ad2 A lack of evidence for puberty blockade and sex reassignment hormones is cited. It is correct that the Norwegian Helsedirektoratet guideline does not adequately discuss the evidence base for certain recommendations. It would have been necessary to conduct a *systematic* literature review and not selectively use results when claiming that there is generally not enough evidence and that treatments are therefore only experimental. Although reference is made to the reviews of the SBU (see "Sweden"), the evidence presented there is hardly discussed, but only the recommendations of Sosialstyrelsen (see "Sweden") based on it are referred to. It is also relevant here that no information is given about the way in which the consensus was reached. How the (anonymous) authors arrive at this recommendation from the evidence they have received remains unclear.

ad3 This demand is to be welcomed from a research perspective, provided that patients' rights are safeguarded and research and medical ethics aspects are taken into account. The recommendation can also already be found in the guidelines of the Helsinki Directorate.

**Application relevance for care:**

Future treatment standards in Norway will not be based on the UKOM recommendations, but on the existing guidelines of the Helsedirektoratet (Norway 1), which are to be revised with the involvement of interdisciplinary clinical expertise. The UKOM recommendations are not binding (Pham, 2023). How the Helsedirektoratet will react to this remains to be seen. It is clear that the debate about appropriate care is also about sovereignty over care resources (centralized or decentralized care structures). The associated conflicts of interest cannot be completely separated from arguments regarding the structural quality of care.

Vorläufige Leitlinie zur Kommentierung

## Sweden: SBU & Socialstyrelsen

### Document:

Hormonbehandling vid könsdysfori - barn och unga. En systematisk översikt och utvärdering av medicinska aspekter (Hormone therapy for gender dysphoria - children and adolescents. A systematic review and evaluation of the medical aspects) & Vård av barn och ungdomar med könsdysfori. Nationellt kunskapsstöd med rekommendationer till profession och beslutsfattare (Care of children and adolescents with gender dysphoria. National knowledge base with recommendations for professionals and decision makers)

### Publishing institution:

State Board for Medical and Social Welfare (SBU) & Socialstyrelsen (both autonomous state bodies)

### Authors & year:

Kriström, B. et al. (2022) & Bodin, M. et al. (2022)

### Type of publication:

Review & "knowledge base" with binding recommendations

### Participation of experts and professional associations

Experts in the treatment of children with gender dysphoria were represented in the "recommendation groups". In addition, experts from the field of health care for children with gender dysphoria were interviewed once. The decision-making process for a possible expert consensus is not reported. There is no evidence of consultation with or involvement of professional associations. There is also no evidence that the experts involved were mandated by professional associations.

### Deviating recommendations:

1. Screening for autism spectrum disorder and ADHD is recommended as standard if gender incongruence is suspected
2. Treatment with puberty blockade, hormones or surgery under the age of 18 should only be recommended in the context of clinical studies.
3. Until clinical trials have been started in accordance with 2. blockade before the age of 18 can be recommended under the following conditions:
  - I. Reaching at least Tanner stage 3 (not 2) and
  - II. stable psychosocial situation (in particular no neuropsychiatric or cognitive impairment or untreated mental disorders) and no severe obesity and
  - III. Stable gender incongruence with verifiable onset in childhood (early onset) or
  - IV. Gender incongruence with late onset with male assigned gender (with female assigned gender and late onset only m ini/m icropill for suppression of menstruation)
4. Until clinical studies according to 2. have been started, exceptional treatments with sex-altering hormones before the age of 18 under the following conditions:
  - I. Stable psychosocial situation (in particular no neuropsychiatric or cognitive disabilities) or untreated mental disorders)
  - II. Stable gender incongruence with verifiable onset in childhood (early onset),
  - III. previous puberty blockade with persistent transgender identification and

- IV. Reaching the age of 16.
- 5. Until clinical studies are started after 2., exceptionally mastectomy before the age of 18 under the same (here relevant) conditions as 4.

**Justification for recommendations:**

Studies with positive outcomes for puberty blockade or hormones are considered inadequate mainly because the sample size is too small, drop-out too high, follow-up too short and no control group.

Reasons for more cautious recommendations:

- a. Changes in the patient population are assumed
- b. Recent publications on detransition urge caution (e.g. Littman, 2018)
- c. There is an increasingly controversial debate among clinical experts about appropriate treatment recommendations

**Consensus strength**

Not specified, but dissent noted by experts

**Summarized DELBI assessment**

<i>Scope &amp; purpose</i>	<i>Participation</i>	<i>Methodical accuracy</i>	<i>Clarity</i>	<i>General applicability</i>	<i>Editorial independence</i>	<i>Applicability in Germany</i>
0,56	0,50	0,67	0,75	0	0,33	0,33

**Critical evaluation of the deviating recommendations**

In general, the reception of the evidence base can be described as methodologically high-quality. However, it does not contain any clinical recommendations that can be derived from it, but only recommendations for future research in this field, whereby it is noticeable that the authors are not familiar with the clinical field of application. For example, they recommend randomized controlled trials to improve the evidence base, which would not be ethically justifiable in the absence of an effective treatment alternative, without critically qualifying or classifying this. The overall presentation is clear. One problem is the lack of information on the consensus process with regard to the formulation of the recommendations, conflicts of interest, direct involvement of affected persons/patients in the development process, etc. There is a lack of conclusive justification for new recommendations with essentially the same data situation regarding treatment outcomes as before. In addition, a one-off consultation of experts was carried out in the form of a written survey on predefined questions. While general statements on empirical knowledge were agreed upon, it is not clear whether and, if so, how the formulation of recommendations was agreed upon. There is also no indication of the level of consensus, only that some experts held differing views.

Critical comments should be made on the individual deviating recommendations:

Ad 1: is incomprehensible why screening for the presence of an autism spectrum disorder and ADHD should be standard practice, regardless of whether there are any indications or suspicions at all from the medical history or clinical picture. Such standard screening without any indication of a clinical suspicion is not recommended by the corresponding S3 guidelines on the diagnostic procedure for suspected autism or ADHD.

Ad 2: Long-term clinical studies are necessary to improve the evidence base. However, the authors do not address the research ethics issues associated with their recommendation. In the absence of an effective alternative treatment for persistent gender dysphoria, access to an effective treatment should not be restricted.

The treatment of individual patients in accordance with the international guideline standard and clinically proven to a large extent should not be made dependent on consent to participate in a study.

Ad 3, 4, 5: These recommendations are ethically problematic, as they categorically exclude entire groups of patients (associated autism spectrum disorder, gender dysphoria with onset after puberty in natal girls, other co-occurring mental illness, etc.) from treatment in adolescence without the possibility of an individual case assessment. This discriminates against those seeking treatment on the basis of gender and those with concomitant psychiatric disorders. In particular, the requirement that access to hormonal treatment for adolescents with gender dysphoria should only be possible "with a verifiable onset in childhood" is problematic and clinically impracticable in two respects: 1. the reported inner experience of those affected, which is crucial for this, cannot be objectified in a verifiable way; 2. The idea that only adolescents who can report persistent gender dysphoria from their prepubertal childhood can be diagnosed with sufficient certainty contradicts the overwhelming clinical experience of the clinical experts involved in this guideline. A large proportion of patients who develop persistent gender dysphoria in adolescence report a largely inconspicuous or indifferent childhood development with regard to their gender identity and role.

Against this background, the reasons given for the more restrictive recommendations do not seem conclusive:

- ada A change in the population is assumed without taking into account biases in the survey and utilization behind this observation. Ultimately, it remains unclear why such a change implies a fundamental deviation from previous treatment standards, which have always required comprehensive and careful diagnostics and professional process support for each individual case.
- ad b Publications on detransition are considered without discussing their methodological limitations, while methodological limitations regarding the *dutch protocol* are discussed in great detail and are seen as an argument against puberty blockade and hormones. In particular, there is no discussion of the extent to which the studies on detransition provide any evidence at all that an increased probability of later detransition can be assumed in adolescents with gender dysphoria. In the reported publications on detransitioned persons, they predominantly stated that they had started their first hormone treatment in adulthood. No published case reports are cited in which detransition occurred after the start of puberty blockade or hormone treatment in adolescence, which is remarkable in view of almost 30 years of worldwide treatment practice with the *dutch protocol*.
- ad c It is difficult to assess the importance of the experience of the experts involved in making recommendations if the recommendations were obviously not formulated as part of a consensus process and the strength of consensus is not reported.



## USA: American Academy of Pediatrics

### Document:

Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents

### Publishing institution:

American Academy of Pediatrics (USA; largest pediatric and adolescent medical society in the USA)

### Authors & year:

Rafferty, J. et al. (2018)

### Type of publication:

Policy Statement

### Participation of experts and professional associations

The first author is a scientific expert in the treatment of children with gender dysphoria. It is explained that other statements from experts were taken into account. The nature of the statements, the way they were taken into account and the selection of respondents is not made transparent.

The publisher itself is a medical-scientific specialist society for pediatrics. There is no evidence of consultation with other specialist societies (e.g. for endocrinology or child and adolescent psychiatry). It is also not clear how the experts interviewed were selected.

### Deviating recommendations:

1. Indication for somatomedical treatment "if possible" and "ideally" with the involvement of a specialist for mental health in childhood and adolescence (e.g. child and adolescent psychiatrist).
2. Affirmation of gender identity is also important for prepubertal children.

### Justification for recommendations:

- a. Affirmation of gender identity is important for avoiding stigmatization and leads to better outcomes. No explicit reason is given as to why the indication for puberty blockade or gender reassignment hormones should only "ideally" or "if possible" take place on a multidisciplinary basis (i.e. with the involvement of mental health professionals). There may be structural reasons for this in the US healthcare system.
- b. Studies on desisting (gender incongruence in childhood with later cisgender identification) are outdated and not valid.

### Consensus strength

Not specified

### Summarized DELBI assessment

<i>Scope of application &amp; Purpose</i>	<i>Participation</i>	<i>Methodical Accuracy</i>	<i>Clarity</i>	<i>General an-reversibility</i>	<i>Editorial Independence</i>	<i>Applicability in Germany</i>
0,33	0,17	0,10	0,17	0	0,17	0,28

### Critical evaluation of the deviating recommendations

Overall, the recommendations are based on a rather weak evidence base. General objectives and scope of application are stated. The nature of the involvement of other professional groups remains unclear.

Ultimately, the first author is responsible for the text, including the recommendations. In this respect, it is not

a (structured) consensus process can be assumed. No systematic literature review was explicitly carried out. Numerous recommendations are not clearly described ("ideally"). No levels of evidence or recommendations were given. The general applicability and applicability in Germany seems questionable. Roughly comparable with an S1 guideline from the AWMF.

ad1 If the recommendation is meant to mean that a diagnosis by mental health professionals is not necessary for children, but only if requested by the family, this contradicts the guidelines of the Endocrine Society (Hembree et al., 2017) and the Standards of Care of the WPATH (Coleman et al., 2022). Although these do not provide for mandatory psychotherapy (in the sense of interventions), they do stipulate the need for professional diagnosis of mental health problems (assessment). The previous follow-up studies of physical medicine treatment for children with gender dysphoria have always included this as an important quality assurance measure in the treatment protocol.

ad2 It remains unclear what is specifically meant by affirmation, i.e. whether it is about respecting gender-nonconforming behavior or recommending a social role change in childhood. It should be noted that this is a decision made by the family in each individual case. With reference to the SoC of the WPATH (Coleman et al., 2022; or previous version) and the Endocrine Society (Hembree et al., 2017), a Tanner stage of 2 is required for the earliest possible onset of pubertal blockade. However, this requirement is not clear from the text itself. More clarity on this would be desirable.

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Vorläufige Leitlinie zur Kommentierung

## Tables for the DELBI- ratings

### England & Wales: NHS England & NICE

#### Documents:

- Independent review of gender identity services for children and young people: Interim report. February 2022 ("Cass Interim Report")
- Interim service specification: Interim specialist service for children and young people with gender in- congruence
- Evidence review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria (NICE, 2020a),
- Evidence review: Gender-affirming hormones for children and adolescents with gender dysphoria (NICE, 2020b)

#### Publishing institution:

Commissioned by NHS England & National Institute for Health and Care Excellence ("NICE")

#### DELBI domain 1: Scope and purpose

<i>Item 1</i>	<i>Item 2</i>	<i>Item 3</i>
Specific objectives are named without any expected The benefits are specifically described (3)	In the Interim Report and the Service Specification only a minority of the recommendations refer to empirical questions (2)	Clear description of patient group and supply area (4)

#### DELBI domain 2: Stakeholder participation

<i>Item 4</i>	<i>Item 5</i>	<i>Item 6</i>	<i>Item 7</i>
Names and specialist groups of the "Assurance Group" named on website, relevant specialist groups (e.g. KiJu psychiatry) included not included (2)	Patients indirectly through Discussion involved in the preparation of the Interim Report, no direct involvement (2)	User target group and indirect users named (4)	No pilot study evident (1)

#### DELBI domain 3: Methodological accuracy of guideline development

<i>Item 8</i>	<i>Item 9</i>	<i>Item 10</i>	<i>Item 11</i>	<i>Item 12</i>	<i>Item 13</i>	<i>Item 14</i>
all relevant Factors of a systematic Literature search indicated (4)	individualized treatment naming of In and out closing criteria, Overview as a slide agram available (4)	For Interim Report and service Specifications no consensus process described ben (1)	Not specified to side effects benefits and Risks to empirical recommendations (1)	Recommendations partly with Evidence linked to the trend, no evidence classes or Recommendation grade given (2)	no previous Appraisal of the visible (1)	Update through final report specified and contact persons and Methodology and Schedule presented (4)

#### DELBI domain 4: Clarity and design

<i>Item 15</i>	<i>Item 16</i>	<i>Item 17</i>	<i>Item 18</i>
Recommendations partially specific and clear, but not predominant (2)	no clinical options for actions named (1)	Key recommendations through easily and clearly identifiable (4)	no additional materials of the instruments (1)

#### DELBI domain 5: General applicability

<i>Item 19</i>	<i>Item 20</i>	<i>Item 21</i>
Some possible barriers are named, Partly suggestions for solution, no explicit Barrier analysis (3)	Financial effects in the interim report and not explicitly stated in the Service Specifications. cited discussed (1)	Measured variables partially named (e.g. patient satisfaction) without explicit reference to access to key recommendations (2)

#### DELBI domain 6: Editorial independence

<i>Item 22</i>	<i>Item 23</i>
Declaration by publisher as financier (2)	No declaration of conflicts of interest of the persons involved (1)

DELBI domain 7: Applicability in the German healthcare system

<i>Item 24</i>	<i>Item 25</i>	<i>Item 26</i>	<i>Item 27</i>	<i>Item 28</i>	<i>Item 29</i>
no clear difference the supply areas (1)	obsolete measures named without Information on the recipient degree of error (2)	Clinical procedure Decision-making and Diagram for Pro- process of informing consent (3)	Documents online retrievable, but not easy to find (2)	Concept for implementing mentation written with in relationship more relevant Groups and Feedback for final report (4)	General presentation development of the methodi approach, Methodology of the de- divorce process hardly described (2)

Vorläufige Leitlinie zur Kommentierung

## Finland: Palveluvalikoima

## Document:

Alaikäisten sukupuoli-identiteetin variaatioihin liittyvän dysforian lääketieteelliset hoitomenetelmät (Medical treatment of dysphoria associated with gender identity variants in minors)

## Publishing institution:

Palveluvalikoima (Council for Choices in Health Care in Finland; Finland; state agency)

## DELBI domain 1: Scope and purpose

<i>Item 1</i>	<i>Item 2</i>	<i>Item 3</i>
General, but no specific targets defined (2)	Some of the recommendations are based The following questions are named (2)	Clear description of patient group and supply area (4)

## DELBI domain 2: Stakeholder participation

<i>Item 4</i>	<i>Item 5</i>	<i>Item 6</i>	<i>Item 7</i>
Assignment of the specialist group not possible throughout (1; e.g. no information on the involvement of endocrinologists)	Patients indirectly through involved in discussion, no direct participation (2)	User target group, but not Indirect users clearly named (3)	No pilot study evident (1)

## DELBI domain 3: Methodological accuracy of guideline development

<i>Item 8</i>	<i>Item 9</i>	<i>Item 10</i>	<i>Item 11</i>	<i>Item 12</i>	<i>Item 13</i>	<i>Item 14</i>
all relevant Factors of a systematic Literature search indicated (4)	Only basic following criteria for single or Exclusion applied for example . No overview about frequency from exclusion according to PRISMA or similar (2)	Formal coordination methods used, each but no for-painting methods for recommendations indicated (2)	Benefits, risks and ancillary work are partly with literature we prove this. Comparison with "natural" Course or alternative pre hardly go placed (3)	No link of empowerment errors with Evidence shows no Evidence degrees of den-give (1)	no previous Appraisal of the visible (1)	no validity Duration specified (1)

## DELBI domain 4: Clarity and design

<i>Item 15</i>	<i>Item 16</i>	<i>Item 17</i>	<i>Item 18</i>
Recommendations partially specific and clear, but not predominant (2)	Options for action in part no clear decision criteria named (2)	Key recommendations through easily and clearly identifiable (4)	Reference to additional material, recommendations without recommendation grades (2)

## DELBI domain 5: General applicability

<i>Item 19</i>	<i>Item 20</i>	<i>Item 21</i>
organizational barriers not discussed (1)	Financial effects named, none Cost-benefit analysis or similar (3)	Measured variables or criteria for monitoring named, no reference to recommendations (2)

## DELBI domain 6: Editorial independence

<i>Item 22</i>	<i>Item 23</i>
No declaration on financing (1)	No declaration of conflicts of interest of the persons involved (1)

## DELBI domain 7: Applicability in the German healthcare system

<i>Item 24</i>	<i>Item 25</i>	<i>Item 26</i>	<i>Item 27</i>	<i>Item 28</i>	<i>Item 29</i>
no clear difference the supply areas (1)	obsolete measures named without Information on the recipient degree of error (2)	Clinical procedure Decision-making presented without Diagram or similar (2)	Open call-off of the Guideline with additional materials, long fibers solution but only on Finnish available. (1)	general con-implementation concept described (2)	General presentation development of the methodi approach, Methodology of the divorce process hardly described (2)

## France: Académie nationale de médecine

## Document:

La médecine face à la transidentité de genre chez les enfants et les adolescents (Medicine in dealing with gender transidentity in children and adolescents)

## Publishing institution:

Académie nationale de médecine (France; learned society of physicians from various disciplines in France; not a governmental or semi-governmental organization)

## DELBI domain 1: Scope and purpose

<i>Item 1</i>	<i>Item 2</i>	<i>Item 3</i>
Goal not specifically described (1)	Questions underlying the recommendations are only named selectively (2)	Simple naming of the target group without differentiating (2)

## DELBI domain 2: Stakeholder participation

<i>Item 4</i>	<i>Item 5</i>	<i>Item 6</i>	<i>Item 7</i>
Authors not named (1)	No involvement of patients ent*innen (1)	User target group not defined (1; "communauté médicale")	no pilot study (1)

## DELBI domain 3: Methodological accuracy of guideline development

<i>Item 8</i>	<i>Item 9</i>	<i>Item 10</i>	<i>Item 11</i>	<i>Item 12</i>	<i>Item 13</i>	<i>Item 14</i>
no systematic literature search (1)	no systematic literature selection (1)	Voting without apparent formal consideration (2)	Not specified on side effects, benefits and risks to recommendations (1)	no explicit Linking recommendations and literature (1)	no previous Appraisal (1)	no update indicated (1)

## DELBI domain 4: Clarity and design

<i>Item 15</i>	<i>Item 16</i>	<i>Item 17</i>	<i>Item 18</i>
Recommendations not specific and clear (1)	not different hand options are shown (1)	Recommendations throughout easily and clearly identifiable (4)	no additional materials of the instruments (1)

## DELBI domain 5: General applicability

<i>Item 19</i>	<i>Item 20</i>	<i>Item 21</i>
organizational barriers not discussed (1)	possible costs not discussed (1)	No metrics or criteria for monitoring defined (1)

## DELBI domain 6: Editorial independence

<i>Item 22</i>	<i>Item 23</i>
No declaration on financing (1)	No declaration regarding possible conflicts of interest (1)

## DELBI domain 7: Applicability in the German healthcare system

<i>Item 24</i>	<i>Item 25</i>	<i>Item 26</i>	<i>Item 27</i>	<i>Item 28</i>	<i>Item 29</i>	<i>Item 30</i>
no clear difference of the Supply areas (1)	No information on obsolete measure taken (1)	no illustration of the decision process (1)	no orientation on the development decision process recognizable (1)	Document online free of charge bar (3)	No concept for Implementation described (1)	no description of the methodical procedure (1)

## Norway 1: Helsedirektoratet

## Document:

Kjønnsinkongruens. Nasjonal faglig retningslinje (Gender incongruence. National professional guideline)

## Publishing institution:

Helsedirektoratet (Norway; public authority)

## DELBI domain 1: Scope and purpose

<i>Item 1</i>	<i>Item 2</i>	<i>Item 3</i>
Goal not specifically described (1)	Questions underlying the recommendations are only named selectively (2)	Simple naming of the target group without differentiating (2)

## DELBI domain 2: Stakeholder participation

<i>Item 4</i>	<i>Item 5</i>	<i>Item 6</i>	<i>Item 7</i>
Designation and participation of all relevant specialist groups; inclusion of other parties is not clear (3)	Direct participation of patients ent*innen; no explanation of the consequences of the decision (3)	Direct and indirect applications target group clearly named (4)	no pilot study (1)

## DELBI domain 3: Methodological accuracy of guideline development

<i>Item 8</i>	<i>Item 9</i>	<i>Item 10</i>	<i>Item 11</i>	<i>Item 12</i>	<i>Item 13</i>	<i>Item 14</i>
no systematic literature research (1)	no systematic literature selection (1)	No information on Methods for Formulation of the recommendations (1)	Not specified to secondary effects, benefits and risks Recommendations (1)	Partial connection of Emp-recommendations and Literature; none LoE or GoR indicated (2)	no previous Appraisal (1)	no update indicated (1)

## DELBI domain 4: Clarity and design

<i>Item 15</i>	<i>Item 16</i>	<i>Item 17</i>	<i>Item 18</i>
Recommendations partially specific and clear, but not predominant (2)	different options for action in some areas (2)	Key recommendations available but often not easily and clearly identifiable (4)	Reference to additional material or instruments; no summary or overview of recommendations (2)

## DELBI domain 5: General applicability

<i>Item 19</i>	<i>Item 20</i>	<i>Item 21</i>
organizational barriers not discussed (1)	possible costs not discussed (1)	No metrics or criteria for monitoring defined (1)

## DELBI domain 6: Editorial independence

<i>Item 22</i>	<i>Item 23</i>
No declaration on financing (1)	No declaration regarding possible conflicts of interest (1)

## DELBI domain 7: Applicability in the German healthcare system

<i>Item 24</i>	<i>Item 25</i>	<i>Item 26</i>	<i>Item 27</i>	<i>Item 28</i>	<i>Item 29</i>	<i>Item 30</i>
no clear difference of the Supply (1)	Some information to obsolete Measures, not Related to recommendations (2)	no illustration of the decision making process (1)	no orientation on the development decision process process recognizable (1)	Document online free of charge bar (3)	But more generally more unspecific Implementation plan (e.g. decentralization; 2)	no description of the methodical procedure (1)

## Norway 2: UKOM

## Document:

Pasientsikkerhet for barn og unge med kjønnsinkongruens (Patient safety for children and adolescents with gender incongruence)

## Publishing institution:

Statens undersøkelseskomisjon for helse-og omsorgstjenesten (UKOM; semi-governmental organization advising the government)

## DELBI domain 1: Scope and purpose

<i>Item 1</i>	<i>Item 2</i>	<i>Item 3</i>
General, but no specific objectives defined (2)	Questions underlying the recommendations are only named selectively (2)	Simple naming of the target group without differentiating (2)

## DELBI domain 2: Stakeholder participation

<i>Item 4</i>	<i>Item 5</i>	<i>Item 6</i>	<i>Item 7</i>
Authors not named (1)	Consultation, but no direct Patient participation (2)	General user target group defined, but not specific (2)	no pilot study (1)

## DELBI domain 3: Methodological accuracy of guideline development

<i>Item 8</i>	<i>Item 9</i>	<i>Item 10</i>	<i>Item 11</i>	<i>Item 12</i>	<i>Item 13</i>	<i>Item 14</i>
no systematic literature research (1)	no systematic literature selection (1)	No information on Methods for Formulation of the recommendations (1)	Not specified to secondary we effects, benefits and risks Recommendations (1)	Partial connection of Emp-recommendations and Literature; none LoE or GoR indicated (2)	no previous Appraisal (1)	no update ration indicated (1)

## DELBI domain 4: Clarity and design

<i>Item 15</i>	<i>Item 16</i>	<i>Item 17</i>	<i>Item 18</i>
Recommendations predominant specific and unambiguous, no presentation of uncertainties (3)	not different hand options are shown (1)	Recommendations throughout easily and clearly identifiable (4)	Reference to additional material without recommendation grades in short version (2)

## DELBI domain 5: General applicability

<i>Item 19</i>	<i>Item 20</i>	<i>Item 21</i>
organizational barriers not discussed (1)	possible costs not discussed (1)	No metrics or criteria for monitoring defined (1)

## DELBI domain 6: Editorial independence

<i>Item 22</i>	<i>Item 23</i>
No declaration on financing (1)	No declaration regarding possible conflicts of interest (1)

## DELBI domain 7: Applicability in the German healthcare system

<i>Item 24</i>	<i>Item 25</i>	<i>Item 26</i>	<i>Item 27</i>	<i>Item 28</i>	<i>Item 29</i>	<i>Item 30</i>
no clear difference of the Supply areas (1)	Information on ob-measures men without GoR (2)	no illustration of the decision process (1)	no orientation on the development decision process recognizable (1)	Document online free of charge bar (3)	No concept for Implementation described (e.g. for the implementation clinical studies; 1)	Very descrip of the methodical approach, but decision process is not apparent (1)



## Sweden: SBU &amp; Socialstyrelsen

## Document:

Hormonbehandling vid könsdysfori - barn och unga. En systematisk översikt och utvärdering av medicinska aspekter (Hormone therapy for gender dysphoria - children and adolescents. A systematic review and evaluation of the medical aspects) & Vård av barn och ungdomar med könsdysfori. Nationellt kunskapsstöd med rekommendationer till profession och beslutsfattare (Care of children and adolescents with gender dysphoria. National knowledge base with recommendations for professionals and decision makers)

## Publishing institution:

State Board for Medical and Social Welfare (SBU) & Socialstyrelsen

## DELBI domain 1: Scope and purpose

<i>Item 1</i>	<i>Item 2</i>	<i>Item 3</i>
General, but no specific targets defined (2)	Recommendations underlying questions are named throughout (4)	Simple naming of the target group without differentiation (2; e.g. early- vs. late-onset)

## DELBI domain 2: Stakeholder participation

<i>Item 4</i>	<i>Item 5</i>	<i>Item 6</i>	<i>Item 7</i>
all relevant medical specialties groups included, type of inclusion not specified (3)	Patients participate indirectly in involved, no direct participation (2)	User target group and indirect users named (4)	No pilot study evident (1)

## DELBI domain 3: Methodological accuracy of guideline development

<i>Item 8</i>	<i>Item 9</i>	<i>Item 10</i>	<i>Item 11</i>	<i>Item 12</i>	<i>Item 13</i>	<i>Item 14</i>
all relevant Factors of a systematic Literature search indicated (4)	individualized treatment naming of In and out Conclusion criteria (4)	Formal coordination mation methods used, each but no for-painting mation methods  <i>for recommendations</i> indicated (2)	Benefits, risks and ancillary work are partly with literature we prove this. Comparison with "natural"  Course or alternative pre hardly go placed (3)	Recommendations linked with Evidence and un-stating the Recommendation straight, but without Levels of evidence (3)	Review (not mandatory "wis-basis") was externally assessed under specification of name and  Specialization of the Experts but without Description of the Method (3)	no validity  Duration specified (1)

## DELBI domain 4: Clarity and design

<i>Item 15</i>	<i>Item 16</i>	<i>Item 17</i>	<i>Item 18</i>
Recommendations throughout spe- and the lack of a basis for other explicit recommendations. cited (4)	different options for action in some areas (2)	Key recommendations through easily and clearly identifiable (4)	Reference to additional material (from gender dysphoria register) without recommendation grades or abridged version (2)

## DELBI domain 5: General applicability

<i>Item 19</i>	<i>Item 20</i>	<i>Item 21</i>
organizational barriers not discussed (1)	No information on financial effects only reference to lack of evidence (1)	no definition of measured variables or Review criteria (1)

## DELBI domain 6: Editorial independence

<i>Item 22</i>	<i>Item 23</i>
Declaration by publisher as financier (2)	General declaration of absence of conflicts of interest of the persons involved (2)

## DELBI domain 7: Applicability in the German healthcare system

<i>Item 24</i>	<i>Item 25</i>	<i>Item 26</i>	<i>Item 27</i>	<i>Item 28</i>	<i>Item 29</i>
no clear difference the supply areas (1)	obsolete measures named and with literature research occupied (4)	Clinical procedure Decision-making presented without Diagram or similar (2)	Open call-off of the Guideline with additional materials, long fibers solution but only on  Sw iss available	general con- implementation concept described (2)	no general Representation of the me- thodic procedure methodology of the  Decision-making process

National treatment recommendations for gender dysphoria in KiJu - Tables for DELBI assessments

			bar (1)		process. written (1)
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## USA: American Academy of Pediatrics

## Document:

Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents

## Publishing institution:

American Academy of Pediatrics (USA; largest pediatric and adolescent medical society in the USA)

## DELBI domain 1: Scope and purpose

<i>Item 1</i>	<i>Item 2</i>	<i>Item 3</i>
General, but no specific targets defined (2)	Questions underlying the recommendations are only named selectively (2)	Simple naming of the target group without differentiating (2)

## DELBI domain 2: Stakeholder participation

<i>Item 4</i>	<i>Item 5</i>	<i>Item 6</i>	<i>Item 7</i>
Clear naming of Specialist groups, but presumably not all relevant specialist groups with decision-making rights involved in recommendations (2)	No mentioned participation of Patients (1)	User target group in the flow text indirectly defined, not clearly named (2)	no pilot study (1)

## DELBI domain 3: Methodological accuracy of guideline development

<i>Item 8</i>	<i>Item 9</i>	<i>Item 10</i>	<i>Item 11</i>	<i>Item 12</i>	<i>Item 13</i>	<i>Item 14</i>
no systematic literature research  che (1)	no systematic literature selection (1)	Probably none Consensus building, as first author as is declared responsible (1)	Benefits, risks and ancillary work effects are only sparsely discussed and only partly with literature evidence. (2)	no explicit Connection of Recommendations and literature (1)	no previous Appraisal (1)	Period of the Validity of  5 years no person as an employee. contact person named (2)

## DELBI domain 4: Clarity and design

<i>Item 15</i>	<i>Item 16</i>	<i>Item 17</i>	<i>Item 18</i>
Recommendations partially specific and clear, but not predominant (2)	not different hand options are shown (1)	Key recommendations in the flow text, but not easy to identify, summarized recommendations not congruent at the end (2)	no additional materials of the instruments (1)

## DELBI domain 5: General applicability

<i>Item 19</i>	<i>Item 20</i>	<i>Item 21</i>
organizational barriers not discussed (1)	possible costs not discussed (1)	No metrics or criteria for monitoring defined (1)

## DELBI domain 6: Editorial independence

<i>Item 22</i>	<i>Item 23</i>
Financing by issuing organization; type of financing not described (2)	general negative declaration regarding possible conflicts of interest. conflicts only for the main author; no declaration by other parties involved, No specific documentation (2)

## DELBI domain 7: Applicability in the German healthcare system

<i>Item 24</i>	<i>Item 25</i>	<i>Item 26</i>	<i>Item 27</i>	<i>Item 28</i>	<i>Item 29</i>	<i>Item 30</i>
no clear difference rency of the  Supply rich (1)	No information on obsolete measure taken (1)	no illustration of the decision ation process (1)	no orientation on the development decision process process recognizable (1)	Document online free of charge and as PDF available (3)	No concept for Implementation described (1)	no description of the methodical procedure hens (1)