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SPECIAL ARTICLE

Position statement: Gender dysphoria in childhood and adolescence. Working Group on Gender Identity and Sexual Development of the Spanish Society of Endocrinology and Nutrition (GIDSEEN)☆

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Abstract Gender dysphoria (GD) in childhood and adolescence is a complex condition where early detection and comprehensive treatment are essential to improve quality of life, decrease mental comorbidity, and improve GD. In this position statement, the Working Group on Gender Identity and Sexual Development of the Spanish Society of Endocrinology and Nutrition (GIDSEEN), consisting of specialists in Endocrinology, Psychology, Psychiatry, Pediatrics and Sociology, sets out recommendations for evaluation and treatment of GD in children and adolescents. Interdisciplinary management of GD should be carried out at specialized units (UTIGs), considering that any clinical intervention should follow the principles of scientific rigor, experience, ethical and deontological principles, and the necessary caution in front of chronic, aggressive, and irreversible treatments.

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◊ See Appendix.

PALABRAS CLAVE
Disforia de género;
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Posicionamiento

Documento de posicionamiento: disforia de género en la infancia y la adolescencia. Grupo de Identidad y Diferenciación Sexual de la Sociedad Española de Endocrinología y Nutrición (GIDSEEN)

Resumen La disforia de género (DG) en la infancia y adolescencia es una condición compleja, siendo importante la detección precoz y el tratamiento integral, ya que con ello se mejora la calidad de vida, disminuye la comorbilidad mental y la propia DG. En este documento de posicionamiento, el Grupo de Identidad y Diferenciación Sexual de la Sociedad Española de Endocrinología y Nutrición (GIDSEEN), integrado por especialistas de Endocrinología, Psicología, Psiquiatría, Pediatría y Sociología, establece unas recomendaciones sobre la evaluación y tratamiento de la DG en niños y adolescentes. El manejo interdisciplinar de la DG debe llevarse a cabo en unidades con equipos especializados (UTIG) y considerando que cualquier intervención sanitaria debe seguir los principios del rigor científico, la experiencia acumulada, los principios éticos y deontológicos y la prudencia necesaria ante tratamientos crónicos, agresivos e irreversibles.

Introduction

Disagreement between, on the one hand, experienced gender and, on the other hand, assigned gender and gender rearing causes a dysphoric feeling that may manifest itself with different degrees of intensity in each person and at each stage of life.[1] Gender dysphoria (GD) in childhood and adolescence is a complex condition which is associated with strong discomfort. The early detection and comprehensive management of GD are therefore extremely important for improving quality of life and for decreasing mental comorbidity and GD itself.[2,3]

An increasing number of children and adolescents identified as ''transgender'' (transient or persistent incongruity with biological sex) are looking for medical counseling and care to achieve the development of physical characteristics consistent with their expressed gender as soon as possible.[4]

The Working Group on Gender Identity and Sexual Development of the Spanish Society of Endocrinology and Nutrition (GIDSEEN), comprising specialists in Endocrinology, Psychology, Psychiatry, Pediatrics, and Sociology, has since 2010 been engaged in multidisciplinary work around GD and sexual differentiation.[5] One of the leading objectives of this group has been to agree on an evaluation and intervention protocol for minors with GD based on international guidelines and adapted to the actual situation in Spain, as has been done in other countries.[6–11]

Specialized interdisciplinary units

This document explains the position of the GIDSEEN on specialized health care in transsexualism, and emphasizes the need for caution in the management of GD in children and adolescents. Care for transsexualism and gender identity is currently considered to be an interdisciplinary activity within specialized units (UTIGs) which have been working in national public health care and in close contact with the school, family, and legal environments for more than 10–15 years.[12–15] These units accept the international consensuses and have been accredited and evaluated using institutional care quality criteria.

The GIDSEEN has found, however, that ''non-official pseudo-units'' providing care for transsexualism have proliferated in Spain in recent years in both the public and private health care sectors. Many such units, largely unregulated, are treating boys and girls who have been sent there by parents who are themselves usually quite misinformed as to what would be the most adequate treatment model for their children.

In this regard, most professionals working at the UTIGs want to provide their continued reflection and experience to ensure and regulate care to minors with GD. This may prevent future psychological and physical changes in adolescence and adult life in those who are today receiving early and/or inadequate management.

Such ''new'' units need to have a staff of professionals who are duly accredited both by official health care bodies and by professional associations in each specialty involved. This would prevent people without adequate basic training from being in a position to take part in activities for which they are not authorized (e.g. merely by claiming that they have received postgraduate training).

Gender identity in childhood and adolescence

Gender identity is considered to be shaped at some period between the first and fourth years of life, depending on the author. However, this does not mean that identity, either general or sexual, is necessarily closed and complete.[16–18] Identity evolves throughout life, depending on the social experiences of the person, and gender identity evolves similarly. Gender identity is not considered to be more stable until 6–7 years of life, and is based on three components: ''gender label'' (the reality of being a boy or a girl), ''gender stability'' (the feeling that one's gender will not change with time), and ''gender consistency'' (the feeling

of stability regardless of physical appearance). Gender identity will become increasingly established if this process occurs adequately and is highly related at all times to the affective environment and self-esteem of the minor.

It should be noted that ''cross-gender behavior'' (sometimes known as ''gender role'') is not equivalent to GD; in fact, most minors with gender discordant behavior do not eventually have a transgender identity.[4,19]

Adolescence starts with puberty and with all resultant changes in the body. It is a process of endocrine and psychological development that goes beyond body changes. This period is often associated with some instability, caused by the suddenness of the changes and the adaptation they require. The so-called ''crisis of adolescence'' is therefore not strange. Quite to the contrary, an easy adolescence is much stranger.

For those who are not prepared for such body changes, however, their imminent appearance will cause much uncertainty. What changes will there be? With what intensity will they occur? At what pace? What will the outcome be?

As previously discussed, adolescents do not only experience physical changes. A great intellectual development also occurs, including the development of symbolic thought at the stage of formal operations and self-consciousness (never before 12 years of age and sometimes much later).

The persistence of GD is another factor that should be taken into account. Different studies have reported disparate results, but there is a common denominator: its persistence is considerably lower in children as compared to adults. The data on persistence suggest that the vast majority (80–95%) of prepubertal children who say that they feel they belong to the sex opposite to that assigned at birth will not continue to experience GD after puberty,[20–22] which makes it difficult to make a final diagnosis in adolescence.[23]

By contrast, it is known that if cross-identity continues after the start of puberty, GD will usually continue in adulthood.[8,19] Psychological evaluations should therefore be even more careful in children than in adults, should be performed by staff specialized in GD, and should avoid harmful or irreversible medical interventions, if at all possible.[16,24–26]

Management of gender dysphoria in children and adolescents

Because of the partially or totally irreversible consequences of hormone therapies, careful diagnosis and comprehensive individual evaluation at UTIGs are absolutely essential.[15,27] It should be noted that sex and gender identity is part of one's personality, and that this is a dynamic process that develops in a reciprocal relationship with the environment and simultaneously includes dispositional, cultural, social, and historical factors.[28] The professional making the diagnosis should therefore have received adequate training in developmental psychopathology in childhood and adolescence, and be competent in the diagnosis and treatment of mental problems. A wide understanding of GD is also required.[3]

Once GD persistence has been shown using an adequate psychological evaluation, and the start of puberty has been verified through endocrine assessment, a therapy that decreases sex steroid levels and the appearance of secondary sexual characteristics may be considered. These objectives may be achieved through pubertal blockade using GnRH analogs. The two requirements currently made before this treatment can be prescribed are age older than 12 years and Tanner stage II or later of puberty. Cross-sex hormone therapy is added from 16 years of age. It is mandatory that minors and their guardians be informed about the effects of these treatments on fertility and psychoemotional maturation, and also about the complexity of and limitations on future reconstructive genital surgery.[15,20,27]

Because of the few long-term efficacy and safety data available concerning treatment in minors, close evaluation by groups experienced in GD is required, as clinical trials are considered unethical.

Based on the foregoing, care for GD should be preceded by a diagnosis, with adequate monitoring, in the setting of a multidisciplinary team and following a specific protocol recorded by the competent bodies.

Any health care intervention should follow the principles of scientific rigor, cumulative experience, ethical and deontological principles, and the necessary caution when chronic, aggressive, and irreversible treatments are administered. The use of these treatments in minors also has the added problem that they are not covered by explicit legal regulations.

As a specialized working group that represents most professional workers in Spanish UTIGs, we call attention to this situation and urge the relevant bodies to take fast and effective action to define both care regulation and the legal framework for minors with GD and/or gender diversity.

Conflicts of interest

The authors state that they have no conflicts of interest.

Appendix. The GIDSEEN Group (Group on Gender Identity and Sexual Differentiation of SEEN)

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