Managing Gender Dysphoria in Young People
The NAPP Guide

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

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

Specifically, this guide:

While respecting young people's views about their gender identity, it does so as part of the totality of their developmental and holistic clinical picture, and incorporates these into the clinical formulation. This approach requires that a comprehensive bio-psycho-social assessment of the young individual and their family be conducted before recommending specific treatment.

Acknowledges that childhood and adolescence is a time of rapid physical and psycho-social growth and profound personal development, during which young people may question their identity, sexual orientation and gender. As the child matures and progresses through puberty this questioning usually transforms and resolves, and the young person, in the majority of cases, accepts his/her biological sex and adult body [4, 5].

Understands that gender dysphoria/incongruence can be both a symptom and a syndrome. For a young person to have the syndrome of gender dysphoria/incongruence there must be a significant, established and prolonged pattern [2] of desire and behaviour that indicates the person insists they are a gender different to their biological sex and natal (birth assigned) gender.

Recognises that gender dysphoria/incongruence can often be a manifestation of complex pre-existing family, social, psychological, or psychiatric conditions or predisposing factors [6]. A holistic approach to assessment includes a comprehensive exploration for these potential conditions in order to more fully understand a child presenting with gender dysphoria/incongruence [7,8]. Where these conditions are presenting as gender dysphoria/incongruence, the treatment of the underlying condition is a priority.

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

Psychotherapy for gender dysphoria in children and adolescents is a respectful, supportive and exploratory process that does not seek any particular outcome in relation to gender identity or sexual orientation. It seeks to understand the nature and meaning of the young person's gender distress and the context in which it has arisen. Psychotherapy addresses the multiple factors that contribute to the young person's difficulties, helping to address issues that resolve distress and support ongoing development and maturation. Conversion therapies, on the other hand, aim to achieve a pre-determined outcome, such as gender normativity or heterosexual orientation. Psychotherapy for gender dysphoria must NOT be conflated with conversion therapies.

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

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

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

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

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

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

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

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

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

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