Recommendation of the Service Board

Medical treatments for dysphoria associated with gender identity variations in minors

Concepts

Inhibitor therapyInhibiting puberty	with GnRH analogues (gonadotropin-releasing hormone inhibitor) to prevent the development of secondary sexual characteristics consistent with biological sex
Cisgender/Cis personA person whose perceived gender corresponds to that of the person at birth	defined gender (identifies and is happy with their sex at birth and usually expresses their gender accordingly)
A person who does not perceive themselves as male or female, but as something in between, for	example, asexual, transgender, intersex, transsexual or intersex.
TransgenderA person	whose perceived gender does not correspond to the legal and biological sex assigned to them at birth, but to the opposite sex.

Table of contents

1. Criteria for making a recommendation

Palko decided to draw up a recommendation on medical treatments for dysphoria (anxiety) associated with gender identity variations in minors because of the increasing number of patients referred to the multidisciplinary outpatient clinics for the study and treatment of gender dysphoria at the Helsinki University Hospital (HUS) and Tampere University Hospital (TAYS), including minors. Gender identity variation refers to the positioning of gender identity anywhere on or outside the male-female dimension, not only the division between men and women. Only a proportion of people with gender identity variation experience significant distress and disability, and only a proportion wish to receive medical treatment.

This recommendation is based on the legislation in force at the time of its adoption, research evidence and the clinical experience of the multidisciplinary units of the Helsinki University Hospital (HUS) and Tampere University Hospital (TAYS) specialised in the study and treatment of dysphoria due to gender dysphoria. The evidence base for the recommendation is described in a separate preparatory memorandum and its annexes. These include a description of the organisation of care and the implementation of medical procedures, a literature review of medical treatments, a comprehensive ethical analysis and a meeting with patients and patient organisations.

Finnish legislation defines the conditions for transsexual gender affirmation (translaki 536/2002). The Decree (1053/2002) provides for more detailed rules on the implementation of gender reassignment research and treatment in the case of transgender gender confirmation.
The Trans Act and the related Decree apply to persons of legal age. There is no specific legislation on the need for and provision of care for transgender persons who are not of legal age, but the Health Care Act (1326/2010) applies, in particular Articles 7 (criteria for integrated care), 7a (criteria for the range of services), 8 (evidence-based, good practice, quality, safety and appropriateness) and 10 (criteria for centralisation), and the Constitution (11.6.1999/731) and Article 19 on the right to adequate social and health services. The Law on the Status and Rights of Patients (785/1992), in particular Articles 5, 6 and 7, should also be taken into account.

2. Target group of the recommendation

This recommendation applies to minors who seek medical assessment and treatment for gender identity variant dysphoria in a situation where the child or young person feels they are the opposite sex (transgender), completely genderless, both a girl and a boy, or something in between (intersex).

3. Method to be assessed

The recommendation covers medical treatments aimed at reducing the distress and disability associated with sexual anxiety in minors.

4. Current practice

The strong identification with the opposite sex that occurs in childhood usually disappears with puberty, but in a small number it can be strengthened. Gender anxiety may also emerge or intensify only at the onset of puberty. Individual variation in the timing of puberty is high for both sexes. The initial treatment for sexual anxiety is psychosocial support and, if necessary, psychotherapy, as well as appropriate treatment for any co-occurring psychiatric disorders.

Children (pre-pubertal) may be referred to the TAYS or HUS Minors Gender Identity Research Team for consultation if there is a need for counselling (for parents/carers) due to the child's identification with the opposite sex and/or gender anxiety, but any support or other psychiatric care needs will be provided by local services.

If a pre-adolescent has a clear pattern of gender dysphoria before the onset of puberty, which intensifies during puberty, he or she may be referred to TAYS or HUS for evaluation of treatment to slow down the progression of puberty in gender identity research teams. If no contraindications to early intervention are found, pubertal arrest with GnRH analogues (gonadotropin-releasing hormone inhibitors) may be considered to prevent the development of secondary sex characteristics consistent with biological sex.

Adolescents who have already gone through puberty, who are experiencing gender anxiety but do not have other concomitant symptoms requiring psychiatric treatment, and whose experience of transgenderism does not disappear with the opportunity to reflect on their identity, can be referred for gender identity research to the TAYS or HUS gender identity research team for minors. Conversion hormone therapy (testosterone/estrogen and antiandrogen) is started after diagnostic tests at the age of 16 years at the earliest. In addition, for those under 18 years of age, GnRH analogue therapy, which blocks the endocrine activity of the own gonads, is often started 3-6 months before the modifying hormone therapy. No sex reassignment surgery is performed on minors.

5. Effectiveness and safety and related uncertainties

The literature review found two studies with a total of 271 people with gender identity disorder and associated gender or body anxiety diagnosed in childhood and worsening during adolescence (Annex 1 of the preparatory memorandum, Tables 15 and 16, pages 46-48).

In a smaller study of 70 adolescents, puberty was interrupted by GnRH analogues at an average age of 14.8 years (range 12-18 years) and treatment continued for an average of 2 years. During treatment, the adolescents' mood improved and their risk of behavioural problems decreased, but there was no reduction in gender dysphoria or changes in body image. In a larger study of 201 adolescents, 101 patients started psychological supportive intervention at an average age of 15.5 years (range 12-18 years) for 18 months, and at 6 months pubertal development was arrested by starting a GnRH analogue. The other group of 100 subjects received only psychological supportive intervention for 18 months.
Both groups showed statistically significant improvements in overall functioning at 12 and 18 months, and those who received only psychological intervention showed statistically significant improvements already at the first 6 months. For both studies, long-term follow-up into adulthood is lacking.

The impact of adolescent-onset hormone therapy on functional ability, adolescent developmental progression and psychiatric symptoms has also been examined in one domestic study published after the completion of the literature review. Problems in these areas did not decrease during conversion hormone therapy.

The potential risks of GnRH treatment include impaired bone mineralisation and as yet unknown central nervous system effects. In transgender women, early pubertal retardation affects penile growth in such a way that other tissue grafts have to be used for possible subsequent vaginoplasty.
The effect of puberty suppression therapy and conversion hormones on fertility is not known.

6. Ethics review

The ethical analysis did not systematically address the specific issues of children and young people, but they were raised in several paragraphs (pages 52-62 of the preparatory memorandum and its annex 5).

According to the Health Care Act (8§), health care activities must be based on evidence and good treatment and operating practices. For minors, there are no research-based health care methods. On the other hand, it has been recognised that minors are increasingly experiencing gender identity conflict.
In this situation, the most important thing is that the child or young person is heard and given the opportunity to share their feelings. The opportunity to reflect on these experiences should be readily available in the health care system of the child's home environment (school or student health care, primary health care) and should not be immediately interpreted as requiring specialised health care or treatment.

For children and adolescents, ethical issues concern in particular the normal development of gender identity in adolescence and the effects of possible treatments on this. It has been suggested that hormone treatments

(e.g. pubertal retardation) alter the development of gender identity, i.e. in practice they can establish a gender identity that would have changed for some of those treated with pubertal development. Treatment studies without a comparable control group are highly unreliable and cannot be used to make decisions that could permanently alter the mental and physical development of a still-developing young person.

From the perspective of patient organisations, delaying puberty is seen as giving young people time to think about their gender identity, rather than confirming it. The idea is that permanent gender expression changes would not take time to develop, which is seen as socially facilitating and allowing time for diagnostic tests. In addition, the patient organisation suggests that early initiation of hormone therapy would in some cases allow for a better outcome if the person ends up with sex reassignment therapy. For their part, professionals stress the importance of ensuring that irreversible interventions, which can also be associated with significant adverse physical and psychological effects, are only carried out on people who are able to understand the permanent changes and potential harm associated with the treatment and who are unlikely to have regrets. It is also not known how the hormonal inhibition of the development of sexual characteristics affects the ability to reason and make decisions.

The Law on the Status and Rights of Patients (1992/785) states that patients must be informed about their state of health, the importance of treatment, the different treatment options and their effects, and other aspects of their care that are relevant to the decision on their treatment.
In a situation where a minor is diagnosed with long-term and severe dysphoric identification with the opposite sex, it is important to ensure that he or she understands the realistic potential of gender-affirming treatments to affect gender expression, the importance of lifelong adherence to medication, the permanence of effects, and the potential physical and psychological side effects of treatments. Although remorse is possible, there is no return to an untransformed body and functioning after body-interfering treatments. Brain development continues into early adulthood (around 25 years of age), which also affects young people's ability to assess the consequences of decisions for their future and the rest of their lives.

It is also damaging if the very common psychiatric co-morbidity of young people with gender problems is not recognised. Hormone medication or surgical treatments cannot reduce other psychiatric symptoms and should not be used to control the experience of sex. Young people need to have a stable identity and personality development in order to be able to genuinely confront and discuss their gender identity anxiety and to assess the meaning of their feelings and the need for different treatment options.

These factors are the main reasons for postponing treatment in children and adolescents until adulthood.

7. Conclusions

The initial treatment of gender identity variations in childhood and adolescence is psychosocial support and, if necessary, gender-sensitive therapy and treatment of any co-occurring psychiatric disorders. It should be possible to discuss gender identity ambiguity, according to the severity of the symptoms and the level of care needed, at school health services, student health services, primary health services in the municipality or specialised health services.

In adults, psychiatric morbidity and developmental difficulties may predispose to the experience of sexual dysphoria. These should be treated and the child/young person's mental state should be stable before gender identity is explored.

Clinical experience has shown that autism spectrum disorders are over-represented in the developmental population with gender anxiety, and rehabilitative interventions for autism spectrum disorders need to be provided appropriately, even if the developmental population is problematic about their gender.

In the light of the research evidence, conversion therapies initiated when a person is a minor are experimental. Studies in underage gender identity research groups suggest that it is possible to consider hormonal conversion therapies before adulthood if transgender identity is confirmed, but great caution should be exercised and irreversible treatments should not be initiated. Information on the potential harms of hormone therapy is slowly accumulating and is not systematically reported. Information on the benefits and harms of treatments must be obtained in reliable research settings.

A pre-pubertal consultation at TAYS would include at least a comprehensive assessment visit at a cost of €369. If necessary, an outpatient consultation day can also be arranged at a cost of €1408.

The cost of the adolescent gender identity research process at TAYS and HUS is around €4,300, with a minimum cost of €640 if the research process is found to be untimely. An initial assessment/consultation by telephone costs €100.

The cost of planning and monitoring the brake management is around €2,000 for the first year and around €1,200 for the following years. The planning and monitoring costs for hormone therapy will be at least €400 per year.

These costs do not take into account psychosocial support in the place of residence, the need for possible psychiatric treatment or the cost of hormone therapy medication.

8. Summary of the recommendation

Palko considers that

1. Psychosocial support should be provided in school and student health care and in primary health care for the treatment of dysphoria in minors due to gender identity variations, and there should be sufficient expertise in this area.
2. Consultation with a child or adolescent psychiatrist and any necessary psychiatric care and psychotherapy must be provided in accordance with a locally agreed tiering of care.
3. If a child or adolescent with gender anxiety has other psychiatric symptoms requiring specialist care at the same time, treatment appropriate to the nature and severity of the disorder must be provided by services in the area, as no conclusions can be drawn about the stability of gender identity during the period of disturbance caused by the psychiatric illness and symptoms affecting development.

Palko considers that the consultation, research sessions and treatments of the TAYS or HUS Gender Identity Research Team for minors should be carried out in accordance with the following principles.

1. Children who have not started puberty may be referred for a consultation at the TAYS or HUS Minors' Gender Identity Research Team for long-lasting and severe gender identity and/or gender conflict-related anxiety. Any need for support or other psychiatric care beyond the consultation visit should be addressed by local services, depending on the nature and severity of the problem.
2. If a child has a long-standing experience of identifying with the opposite sex and a pattern of gender anxiety that intensifies during puberty, he or she may be referred for pubertal retardation treatment at TAYS or HUS for evaluation in the underage gender identity research teams. Possible puberty braking treatment can be initiated on a case-by-case basis after careful consideration and appropriate diagnostic tests, if there are medical indications and no contraindications. Therapeutic amenorrhoea, i.e. the prevention of menstruation, is also possible.
3. An adolescent who has already gone through puberty may be referred to the Gender Identity Research Clinic for Minors at TAYS or HUS for comprehensive gender identity research, if the gender identity variation and the associated dysphoria are not described as a transient search for identity characteristic of the adolescent developmental stage and do not develop in a different direction when the adolescent has the opportunity to reflect on his or her identity, but the adolescent's identity and personality development appear stable.
4. On a case-by-case basis, the initiation of gender-altering hormonal interventions can only be considered before adulthood if the opposite sex identification can be confirmed as permanent and causing severe dysphoria and the young person is able to understand the implications of irreversible treatments and the potential benefits and harms of lifelong hormone therapy and no contraindications are identified.

5. If a young person experiencing gender anxiety has had or has a co-occurring psychiatric condition requiring specialist care, gender identity testing may be considered if the need for it continues after the psychiatric condition has resolved and the developmental tasks of adolescence have returned to normal. In this case, the adolescent may be referred for a comprehensive specialised gender identity examination by the adolescent psychiatric specialist hospital in his/her area to the TAYS or HUS Gender Identity Examination Team for Minors, where diagnostic examinations are initiated and the need for and timeliness of medically based treatment is assessed on an individual basis.

Surgical treatments that permanently alter the body are not included in the treatment of gender dysphoria in minors. The initiation and follow-up of hormone treatments for minors should be concentrated in the gender identity research clinics for minors at HUS and TAYS.

9. Gathering further evidence and monitoring the impact of the recommendations

The following data on patients diagnosed and treated in Finland are needed for the re-evaluation of the recommendation:

- referral rates for new patients
- numbers of patients entering the study period, new transgender F64.0 and asexual F64.8 diagnoses during the year
- do the diagnoses remain the same at follow-up or does the gender experience change?
- those who dropped out of the survey and the reasons for dropping out,
- treatment interruptions and reasons for interruption
- adverse effects of treatments (especially long-term effects and effects on fertility)
- the number of people refusing hormone treatments
- the effect of study cycles and treatments on the genealogy of cervical cancer (GCLS) scores,
- the impact of study periods and treatments on functional capacity and quality of life
- psychiatric comorbidities (including neuropsychiatric F80-F90) in those seeking/ diagnosed with these conditions and whether these comorbidities have an impact on the benefits of study periods and treatment interventions (reduction in sexually transmitted dysphoria)
- whether study periods and treatment interventions reduce suicide attempts
- whether research and treatment reduce depression and anxiety

10. Annexes

The working document and its annexes 1-5.