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Special Report: Evolving Controversies in the Treatment of Gender Dysphoric/Incongruent Minors

Jack Drescher, M.D. | AUTHORS INFO & AFFILIATIONS

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As the nation marks LGBTQ+ Pride Month amid the wave of conservative politics and unanswered medical questions, the debate about whether to provide gender-affirming care to youth has heated up.

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As gender-affirming treatment has become more common in this country, it is not surprising that controversies have arisen around providing such care to youth. To oversimplify, in one corner are those who recognize that such treatment can alleviate mental suffering, improve lives, and sometimes even save lives; and in the opposite corner are those who are opposed to treatment for a variety of reasons, including the unknown long-term effects of hormonal and surgical treatments. What follows are some of my thoughts and opinions about the evolution of these controversies in the treatment of children and adolescents with a diagnosis of gender dysphoria (GD) in *DSM-5-TR* or gender incongruence (GI) in the ICD-11 (World Health Organization).

To begin, I am an adult psychiatrist and psychoanalyst and do not treat children and younger adolescents. However, I first became curious about child treatments during the *DSM-5* development process (2007-2013), and together with my colleague William Byne, M.D., Ph.D., began learning about some of the issues raised by these treatments. Little did we know that a relatively obscure, albeit sometimes sensationalized, clinical issue would later lead to major news stories in the popular media, lawsuits against the U.K.'s Tavistock Clinic leading

to the 2022 decision to close it, and, in the United States, legislation to prevent transition services for minors in a growing number of states.

History of Child and Adolescent Gender Diagnoses

Until the middle of the 20th century, the concepts of sexual orientation and gender identity were routinely conflated. Today, the concepts are often conflated in popular discourse and in legal documents as well. However, scientific approaches to these subjects distinguish between the two. Stated succinctly, whom one is attracted to (one's sexual orientation) is not necessarily an indicator of one's gender identity (whether one identifies as male, female, or some other gender).

Despite a growing scientific awareness of different gender identities from the 19th century on, neither the first nor second editions of APA's *Diagnostic and Statistical Manual of Mental Disorders* (1952, 1968) contained any gender diagnoses. In 1980, a newly reconceptualized *DSM-III* abandoned the psychodynamic formulations that informed the first two *DSM* editions and instead adopted a neo-Kraepelian, descriptive, symptom-based framework drawing upon contemporary research findings of the time. In making that shift, a growing body of research on child, adolescent, and adult gender identity variations found its way into the manual.

In *DSM-5* (2013) and more recently in *DSM-5-TR* (2022), the *DSM-IV* diagnosis of gender identity disorder in childhood was renamed *gender dysphoria in children*. Similarly, gender identity disorder in adolescence and adulthood was renamed *gender dysphoria in adolescents and adults*. In a parallel manner, the ICD-11 replaced the ICD-10 diagnosis of transsexualism with *gender incongruence of adolescence or adulthood*, and gender identity disorder of childhood was replaced by *gender incongruence of childhood*. Further, and most telling, these ICD diagnoses were moved out of the mental disorders section into a new chapter called "Conditions Related to Sexual Health." This means that today, a person diagnosed with gender incongruence in a country using ICD-11 is no longer considered to have a mental disorder for that condition but can still access care to treatment. However, the United States is still using ICD-10, which was first approved in 1990.

A Tale of Two Diagnoses

ICD Gender Identity Diagnoses

ICD Edition (Year)	Parent Category	Diagnosis Name
ICD-6 (1948)	N/A	N/A
ICD-7 (1955)	N/A	N/A
ICD-8 (1965)	Sexual deviations	Transvestitism
ICD-9 (1975)	Sexual deviations	Transvestism Transsexualism
ICD-10 (1990)	Gender identity disorders	Transsexualism Dual-role transvestism Gender identity disorder of childhood Other gender identity disorders Gender identity disorder, unspecified
ICD-11 (2019)	Conditions related to sexual health	Gender incongruence of adolescents and adults Gender incongruence of children

Source: Jack Drescher, M.D.

Table 1

Since the publication of *DSM-III* in 1980, there have been at least two distinct gender diagnoses—one for prepubescent children and one for adolescents/adults. Those distinctions persist in the current iterations of *DSM* and ICD. One reason for making this distinction was that children diagnosed with GD/GI were thought to be (and many still believe them to be) a clinical population different from adolescents and adults. One factor leading to making these distinctions was 11 studies done since the 1970s that prospectively followed prepubescent children presenting to specialized gender clinics with GD/GI: They showed that the majority of these children grew up to be gay and cisgender, not transgender (see a 2018 commentary by James Cantor, Ph.D.). In the language of that research, their GD/GI *desisted*. For the minority of prepubescent children in those research studies whose GD/GI did continue into adolescence and later, their GD/GI *persisted*.

DSM Gender Identity Diagnoses

DSM Edition (Year)	Parent Category	Diagnosis Name
DSM-I (1952)	N/A	N/A
DSM-II (1968)	Sexual deviations	Transvestitism
DSM-III (1980)	Psychosexual disorders	Transsexualism Gender identity disorder of childhood
DSM-III-R (1987)	Disorders usually first evident in infancy, childhood, or adolescence	Transsexualism Gender identity disorder of childhood Gender identity disorder of adolescence and adulthood, non-transsexual type
DSM-IV (1994)	Sexual and gender identity disorders	Gender identity disorder in adolescents or adults Gender identity disorder in children
DSM-IV-TR (2000)	Sexual and gender identity disorders	Gender identity disorder in adolescents or adults Gender identity disorder in children
DSM-5 (2013) *DSM-5-TR* (2022)	Gender dysphoria	Gender dysphoria in adolescents or adults Gender dysphoria in children

Source: Jack Drescher, M.D.

Table 2

In contrast, the GD/GI diagnosis for adolescents and adults was thought to have a different trajectory. For example, in most individuals (except children who had diagnosable GD/GI that persisted into adolescence) the onset of GD/GI in adolescence or adulthood was not preceded by childhood GD/GI. While many adolescents and adults diagnosed with GD/GI may retrospectively claim they had gender dysphoric/incongruent feelings in childhood, typically their feelings (and behavior) were not perceived to be of such magnitude to be brought to clinical attention.

In addition, although this has never been stated directly in either *DSM* or ICD, historically, GD/GI that emerged in adolescence or adulthood was, in most cases, usually thought to be permanent. However, concerns about the possibility of error or "regrets" related to gender transition led to the introduction of clinical safeguards. For example, starting with *DSM-III*, the manuals have offered differential diagnoses that might appear to the untrained clinician as GD/GI. These needed to be ruled out to make a diagnosis. In addition, the World Professional Association for Transgender Health, an international body of expert clinicians, recommends

diagnostic evaluations followed by a stepwise approach to providing transition (medical or surgical) services. Again, the wish to prevent regrets about transition seems paramount in these recommendations.

Controversies a Decade Ago

As noted earlier, Dr. Byne and I began studying the issue of children with GD/GI more than a decade ago. In 2008, Dr. Byne was appointed chair of the APA Task Force on Treatment of Gender Identity Disorder, as the diagnosis was referred to at that time, and the report of the task force's deliberations was published in 2012. The task force, however, was unable to reach consensus on the best approach to treating prepubescent children and outlined three approaches to treatment.

The first approach was to work with children and caregivers to try to lessen GD/GI and to decrease atypical gender behaviors and identifications. The assumption was that this approach decreased the likelihood that GD/GI would persist into adolescence and the need for medical or surgical transition services later in life. Some refer to this approach as "conversion therapy" or gender identity conversion efforts.

A second approach, often referred to as the Dutch approach as it was initiated in the Netherlands, made no direct effort to lessen GD/GI or gender atypical behaviors. This approach was premised on the research finding that GID diagnosed in childhood usually did not persist into adolescence and beyond and on the lack of reliable markers to predict in whom it would or would not persist. This approach was neutral with respect to a child's eventual gender identity and had no therapeutic target with respect to gender identity outcome.

The third and final approach outlined by the APA task force, sometimes referred to as the "gender-affirming" approach, argued for affirmation of a child's cross-gender identification by both mental health professionals and family members. In this approach, a prepubescent child was supported in transitioning to the desired gender role and expression, with the option of endocrine treatment to delay and even suspend puberty to suppress the development of any unwanted secondary sex characteristics if the GD/GI persisted into puberty.

To better understand these clinical approaches, Dr. Byne and I first invited clinicians to explicate their approaches in greater detail and later organized a scientific symposium at APA's 2014 Annual Meeting where they could explain their differences to a wider audience. Jack Pula, M.D., and I also weighed in on some of the ethical issues raised by the different approaches as well in a Hastings Center report.

From Clinical Controversy to Public Policies

The number of controversies generated by whether or how to treat children and adolescents with GD/GI could fill an entire volume. The controversies are, in part, fueled by a lack of definitive scientific evidence regarding the "causes" of GD/GI; what having GD/GI means to individuals who present this way; lack of clarity regarding differential diagnoses; and lack of clarity in determining who will and will not express regrets after transition, to name a few. Also, as the following illustrates, how to respond to minors with GD/GI has become a culture war issue.

Conversion Therapy Bans

Beginning with California in 2012, 20 states and the District of Columbia have passed legislation to make sexual orientation change efforts (SOCE) and gender identity change efforts (GICE) for minors under the age of 18 a

matter of unprofessional conduct. This meant that any licensed health care professional trying to change a minor's sexual orientation, gender identity, or gender expression could face professional censure by licensing bodies that might even include the loss of license to practice. In states without bans, many municipalities have passed local bans. Further, lawsuits to overturn state bans have not been successful. According to a 2020 United Nations report, similar bans have been passed and are being considered around the world.

Shortly after a ban on conversion therapy for minors was enacted in Ontario in 2015, the head of Toronto's CAMH gender clinic of many years was fired from his position, and the clinic closed. (CAMH stands for Centre for Addiction and Mental Health.) He subsequently sued CAMH and in 2018 received an apology, monetary damages, and legal fees from the institution for having misrepresented his behavior and his work in a public review three years earlier. Nevertheless, while CAMH offers treatment for adults with GD/GI, the child gender clinic remains closed.

Gender Transition Bans for Minors

While there has been a growing movement around the world to protect the rights of gender dysphoric or incongruent individuals to access care and receive respectful treatment, there has also been a recent and growing movement on the U.S. political right aimed at banning gender-affirming treatment of GD/GI in minors.

In 2021, Arkansas passed the Save Adolescents from Experimentation (SAFE) Act, making it the first state to introduce a ban on physicians giving hormones or puberty-delaying drugs to anyone with GD/GI under age 18. Physicians who provide such care can lose their professional licenses and be sued for medical malpractice. Although the state's governor vetoed the bill as an unnecessary intrusion into the doctor-patient relationship, the state's Republican-controlled legislature voted to override the veto. The law is being challenged in the courts by mainstream health and mental health organizations, including APA. Nevertheless, similar bills have been introduced into other state legislatures.

In 2022 in Texas, the Republican governor issued a directive to investigate parents who make gender-affirming care available to their transgender children. A number of families were placed under investigation for potential child abuse by the Texas Department of Family and Protective Services for seeking out and permitting gender-affirming care for their transgender children. This directive is also being challenged in the courts.

The U.K.'s Tavistock Clinic

In July 2022 The New York Times reported, "The [U.K.'s] National Health Service [NHS] is closing England's sole youth gender clinic, which had been criticized for long wait times and inadequate services." This announcement was the culmination of a series of events that began in 2019 when several former staffers publicly criticized the practices of the Tavistock Clinic's Gender Identity Development Service's (GIDS) in treating children presenting with GD/GI or other atypical gender presentations. This led, in 2020, to the NHS's launch of an independent review into Tavistock's gender identity services for children and young people.

Earlier that same year, in January, a 23-year-old former patient of the clinic who had "detransitioned" after receiving transition treatment sued the clinic and the NHS. Birth assigned as female, she had received puberty blockers at age 16, been prescribed masculinizing hormones at age 17, and had a double mastectomy at age

20. However, at age 22, her GD/GI had abated, and she returned to identifying and presenting as female in public.

A lower court was asked to determine whether a child was legally competent to give valid consent to treatment for gender transition. The court found that consent for treatment was possible only for adolescents aged 16 and over. However, that decision was overturned by the Court of Appeal, which concluded that "it was inappropriate for the Divisional [lower] Court to give the guidance concerning when a court application will be appropriate and to reach general age-related conclusions about the likelihood or probability of different cohorts of children being capable of giving consent."

Nevertheless, the review begun in 2020 chaired by Dr. Hillary Cass was issued in 2022, first with an interim report followed by a letter with "further advice" to the NHS. The report and follow-up recommended closing the Tavistock GICD service. "[I]n order to meet current demand and provide a more holistic and localised approach to care, gender identity services for children and young people need to move from a single national provider to a regional model," she wrote in the letter. This would involve creating "regional centres" and "designated local specialist services." The report made recommendations regarding the need for comprehensive evaluations for the wide range of patients who may seek services under the new system. It called for the establishment of "a formal national provider collaborative with an integral research network [to bring] together clinical and academic representatives from the regional centres."

The letter went on to warn about the use of puberty blockers: "We do not fully understand the role of adolescent sex hormones in driving the development of both sexuality and gender identity through the early teen years, so by extension we cannot be sure about the impact of stopping these hormone surges on psychosexual and gender maturation. We therefore have no way of knowing whether, rather than buying time to make a decision, puberty blockers may disrupt that decision-making process." The report then stated that "brain maturation may be temporarily or permanently disrupted by puberty blockers, which could have significant impact on the ability to make complex risk-laden decisions, as well as possible longer-term neuropsychological consequences. To date, there has been very limited research on the short-, medium-, or longer-term impact of puberty-blockers on neurocognitive development."

While the report called for further research in this area, given the research that has been done to date, the odds seem unlikely that long-term deleterious impacts on such cognitive functions would have gone unnoticed. All of this begs the question of whether funding for any of the report's recommendations will be made available.

Red Flags and Puberty Blockers?

There are a growing number of articles citing the risks and dangers of using puberty blockers for treating children and adolescents with GD/GI (see the following references for this article in its online version: Bell, 2020; Evans, 2021; Schwartz, 2021; Levine et al., 2022). And it is true, as Cass noted, that more research needs to be done in this area.

DSM-5: Gender Dysphoria Diagnoses and Codes

There is one overarching diagnosis with separate developmentally appropriate criteria sets for children and for adolescents and adults.

- Gender dysphoria in children 302.6
- Gender dysphoria in adolescents and adults 302.85
- Other specified gender dysphoria 302.89
- Unspecified gender dysphoria 302.6

ICD-11: Gender Incongruence Diagnoses and Codes

These diagnoses were moved out of the "Mental Disorders" section and into a new chapter, "Conditions Related to Sexual Health."

- HA60 Gender incongruence of adolescence or adulthood
- HA61 Gender incongruence of childhood
- HA6Z Gender incongruence, unspecified

Source: Jack Drescher, M.D.

However, in my efforts to better understand the panic surrounding the use of puberty blockers in children and adolescents with GD/GI, I found myself delving into the literature of another patient population for whom the use of puberty blockers is a rather uncontroversial standard of care: central precocious puberty.

In a 2019 paper in *Acta Biomedica*, Vincenzo De Sanctis, M.D., et al., wrote that since 1981 gonadotropin-releasing-hormone analogues have been the standard treatment for central precocious puberty. "This treatment is generally considered to be safe and well tolerated in children and adolescents. The most commonly reported drug reactions were pain, swelling, and urticaria at the injection site. Most events were mild, and there was no interruption in study procedures from these ADRs [adverse drug reactions]. Nevertheless, whatever is the frequency of these side effects, clinicians using these treatments should be aware of the possibility of significant local and general ADRs that can lead to treatment withdrawal in the most severe cases." Other recent publications have been equally sanguine about the use of puberty blockers over the last 40 years.

I do not presume to know the reasons why puberty suppression as a treatment for precocious puberty does not raise the same danger signals in the medical community as those being raised when the same medications are used for children and adolescents with GD/GI. Perhaps the belief is that because precocious puberty is a neuroendocrine condition, it should be treated with an endocrine intervention, and those who perceive gender dysphoria as a psychological issue may believe that it should be addressed with psychological interventions. However, since irrational responses of many people to the very existence of transgender identities is not unusual, this leads me to conclude that personal biases are playing a large role in efforts to legislate medical judgments involving GD/GI youth. Clearly, more research is needed.

The treatment of gender dysphoric youth is a complex clinical task. Based on what is known after more than 30 years of research, some young people will benefit from medical interventions; others, however, might not. When and how clinicians choose to intervene in such cases, ideally, should require a complex, individualized evaluative process. In the meantime, well-trained and experienced clinicians should not be hampered from

using their best judgment and working with parents to decide whether to provide gender-affirming care to youth who will benefit from such treatment. ■

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Biographies

Jack Drescher, M.D., is a clinical professor of psychiatry and a faculty member of the Division of Gender, Sexuality, and Health at Columbia University. He served on the working groups that revised *DSM-5* and ICD-11. Most recently, he was section editor of the *DSM-5-TR* chapter on gender dysphoria. He is the author of numerous publications including *Psychoanalytic Therapy and The Gay Man*. He is the recipient of the 2022 Sigourney Award for his work in gender and sexuality.

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