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Gender variance, medical treatment and our responsibility

OPINIONS

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We need to work together to build a society where children and adolescents freely can express their gender identity. As doctors working with children and adolescents with gender incongruence, we often face challenging situations, not least because of the dearth of research-based knowledge on gender-affirming treatment.

We wish to laud the Journal of the Norwegian Medical Association for having addressed the issue of gender incongruence during the last year (1). In this article, we wish to share our experience from meeting children and adolescents who live with gender incongruence, to help elucidate some of the complexities involved in assessment and treatment.

In the recently revised diagnostic manual from the World Health Organization, ICD-11, the diagnosis of transsexualism has been removed and replaced by gender incongruence. In ICD-10, the medical diagnosis of transsexualism describes a situation in which a person perceives him- or herself to have a gender identity which does not conform to the sex that person was assigned at birth, i.e. the perception of being either a boy/man or a girl/woman. A condition for this diagnosis is the perception of gender dysphoria, i.e. a clear discomfort experienced as a result of the non-conformity between the sex assigned at birth and the person's perception of his/her gender identity.

In ICD-11, the diagnosis of gender incongruence has been placed in a new chapter on sexual health, in contrast to transsexualism, which was a psychiatric diagnosis (1). In this new diagnosis, the perception of gender dysphoria is not a requirement, but the person in question needs to have a strong desire to remove some or all primary or secondary gender characteristics. The diagnosis also allows for fluid gender identities and includes those who have a non-binary gender identity, i.e. those who define themselves neither as boys/men, nor as girls/women. This diagnostic change strengthens the need for intensified care for these children and adults, at all levels from the primary to the specialist health services.

Increase in referrals

Both adults and young people with gender incongruence increasingly seek out clinics worldwide (2–5). The reason is unknown, but there are speculations that this might stem from better access to treatment, better knowledge obtained through the internet, a generally higher level of openness and awareness of different gender identities and expressions in society, less stigmatisation, or the fact that identity development today also includes a greater degree of exploration of gender identities (6).

The National Treatment Service for Transsexualism for Children and Adolescents (NBTS – children and adolescents) receives all those who experience gender identity challenges, gender incongruence and gender dysphoria, but the service has traditionally treated patients who fulfil the diagnosis of transsexualism. In recent years there has been a strong increase in the number of referrals: in the early 2000s only a handful of children and adolescents came, while in 2018 we received well over 200 referrals. The increase consists primarily of teenagers with female gender assigned at birth. In 2017, this group accounted for nearly 70 % of all referrals, in 2012 approximately 35 % (our figures, unpublished).

Our experience is that a large proportion of the adolescents have serious psychiatric symptoms. These can include severe depression, social phobia and anxiety, substance abuse, autism-spectrum disorders, self-harming, suicidal thoughts and acts, psychotic symptoms, eating disorders, or exposure to serious trauma during their upbringing. Many of them have had previous contact with the paediatric psychiatry service for reasons other than gender incongruence. These difficulties or concerns can be significant sources of great

discomfort, and in our experience, if these are left untreated, they may complicate the process of exploring gender identity and identifying solutions for gender incongruence. Close collaboration with the local outpatient clinic for child and adolescent psychiatry is absolutely crucial to ensure professional care for these children and adolescents in parallel with the assessment by the therapeutic services. Our clinical experience indicates that not all mental difficulties in this group will necessarily be attributable to gender incongruence; therefore not all their afflictions can be solved by gender-affirming treatment. This is not an argument against gender-affirming treatment, but underscores the need for safe care overall.

Dearth of research

The new diagnosis may result in a further increase in the number of individuals seeking treatment. So far, research on gender-affirming treatment has focused on those who experience gender incongruence at a very young age and those who have been diagnosed with transsexualism and wish to live as the opposite gender to the one they were assigned at birth. We know far less about young people who experience their first signs of gender incongruence during adolescence, and no longitudinal data are available. Recent developments have given rise to a strong need for prospective studies regarding both the substantially growing number of non-binary gender adolescents, and patients assigned with female gender at birth.

We receive referrals from adolescents who feel that they are neither boys, nor girls, or both boys and girls to varying degrees simultaneously, or who do not identify themselves by gender at all. We are increasingly confronted with demands articulated by the media and organisations engaged in gender identities for a recognition of individually specific gender identities and concomitant requests for correspondingly specific individual treatments. Health workers are thereby asked to support individual requests that may include medical treatment. As health workers, we are first and foremost obligated not to cause any harm. This is made even more relevant by the increasing number of adolescents who are currently seeking treatment. Our obligation not to cause any harm is further put to the test by the new diagnosis of gender incongruence: the patient group becomes even more heterogeneous, and there is a worrisome lack of clinical treatment protocols and evidence-based research on patients with non-binary gender identities. What will constitute safe treatment for each individual? To what extent should clinical discretion and the patient's own knowledge determine what kind of treatment should be provided?

In conclusion, we wish to affirm and underscore our commitment towards a shared responsibility to work for a society where children and adolescents with gender variation may safely express themselves, and thereby develop a secure identity with or without the need for medical treatment.

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