

Medical care for gender variant young people: Dealing with the practical problems

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Introduction

Cross-gender behaviour in children may be apparent from age two years[1]. In prepubertal children, it is not uncommon. Whereas, in adolescents, cross-gender expressions are far fewer[2]. It appears that most **gender variant** young people who are destined to be **transsexual** adults do not receive medical care for this condition. The great majority of adult transsexual people say they experienced the discomfort from the earliest years of life[3]. The National Health Service and private gender identity clinics in the UK receive about 1000 new “adult” cases per annum[4]. Yet, the UK’s sole specialist treatment centre for “children and adolescents” in London received only 64 new referrals in the year to April 2008[5].

Family responses

It seems that most parents with gender variant children do not seek specialist help. Some will not regard gender variance as a problem. Others may be deeply stressed and try to ignore it. Some may try to persuade their child that the feelings are wrong or not acceptable; parents may reward typical gender behaviour and punish cross-gender behaviour. When families reject a gender variant adolescent, the sex trade may offer a means of survival[6]. Often, the family is unaware of their child’s gender variance. Fear of bullying may inhibit a young person’s expression of gender variance. A survey of 872 **transgender** people in 2006 showed that more than half had experienced bullying at school. This included physical abuse and even unwanted sexual behaviour[7]. Also, young people may not reveal their gender feelings because they know that treatment is unavailable unless they travel abroad—for most, this is an unattainable ambition[8].

Families need to be aware of the risks that their gender variant children face as puberty approaches. In the London service, 23% of those aged 12 and over admitted to having engaged in self-harm[9]. The actual number may be far greater. During puberty, those who identify as boys, despite their female bodies, find periods and breast development disgusting. They sometimes become frustrated by their small stature. Those who identify as girls, in rapidly developing male bodies, are equally distressed as their voices deepen, as they grow facial hair and prominent Adam’s apples, as they experience erections and as they become taller than most other women. Some physical changes may be reversed but require painful and

costly surgical procedures. Other changes are irreversible and cause life-long disadvantage, often making it impossible to “pass” as a person of the opposite sex, resulting in prejudice, harassment, humiliation and even violence[10].

Establishing a reliable prognosis

No physical test is available for detecting **gender variance** that is likely to develop into adult **transsexualism** [15]. Hence, clinicians must rely on the young person’s own account of his or her feelings, on information from the parents about the way the child talks and behaves, and on psychological tests[16]. These tests will be undertaken in the specialist centres that exist in some countries. Guidance on assessment is contained in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders[17]. By adolescence, for the majority of both boys and girls (80-95%), the gender variance remits[15]. Prepubertal GID remits most frequently in adolescence and adulthood as homosexuality or bisexuality[11]. Whereas, in those who still experience gender discomfort in “adolescence”, there is a very high rate of persistence of GID into adulthood[12, 13, 14]. The adolescent experiences increasing disgust with phenotypic pubertal development, which is a significant indication that the condition will not remit. To provide a highly reliable prognosis, this is confirmed by careful psychological screening before any physical intervention is undertaken[18].

Offering early suspension of puberty

In carefully screened young people, hormone-blockers that suppress the release of gonadotrophins from the pituitary, may be administered to suspend further unwanted pubertal development[19]. This intervention relieves the young person’s acute stress and provides more time for decisions to be made about whether to live as a man or as a woman in adulthood. Treatment is monitored to ensure adequate bone development and mineralization, and proportionate growth of the trunk and the legs. In those with female phenotype who intend to live as men, suppression of endogenous oestrogen, combined with other medication, permits growth to continue so that a more typically male height may be achieved[19, 15] (limiting height in those with male phenotype is discussed below). Clinicians who are reluctant to offer early suspension of puberty argue that, before a GID can be regarded as unremitting, the brain must have been exposed

to the pubertal hormones that conform to the phenotype. There is, however, no evidence from brain research to support this argument[15]. Upon cessation of hormone-blocking medication, phenotypic puberty would be resumed without harm to the young person. However, none of the patients treated by the Dutch clinicians has decided to stop the hormone-blocking intervention and none has regretted it[19]. Because early hormone-blocking medication is not available to young people in the UK, some have travelled to the USA[20]. Their families have borne the cost of evaluation and medications. The Children's Hospital, Boston has seen four such cases[21].

Changing gender role

There is no absolute rule about the right time to start living in the opposite **gender role**. However, for children who are clearly prepubertal, it is strongly recommended that the change of gender role is delayed because in so many the **gender variance** will remit. It is difficult to overcome the social impact of a change of gender role, especially in school[18]. Nonetheless, the gender variance in some children is so severe that they insist on changing gender role at a very young age.

Offering cross-sex hormones

Once the young person has made a firm decision to remain permanently in the new gender role, cross-sex hormone medication may be offered. This is administered in a gradually increasing dosage that is ultimately adequate to masculinise or feminise the body in opposition to the genotype/phenotype[19]. However, it is not usually offered before age 16. In those with male phenotype who intend to live as women, oestrogens have the added benefit of restricting overall height so that it falls into the typical female range. The latter may be more beneficial if offered before age 16. The Children's Hospital, Boston is mentoring clinicians elsewhere in the use of cross-sex hormones, as well as hormone blocking, once the young person has been assessed by an experienced mental health professional. The techniques involved are not complicated, the medication is well known in treating other paediatric conditions such as central precocious puberty and delayed puberty, and the followup protocols are relatively simple[22]. The team in Amsterdam will also allow health professionals to visit and learn from their experience and expertise in this field. Physical changes induced by cross-sex hormone medication are initiated slowly, but some

are difficult or even impossible to reverse, including the effects on voice pitch and the growth of facial and body hair associated with masculinising hormones and, following feminising hormones, the development of breasts in those with male phenotype. Consequently, the decision to commence this medication is more critical than the previous decision to commence reversible hormone blocking medication.

Discussing gender confirmation surgery

Most **gender variant** adolescents seen by the specialised clinics have a straightforward wish for sex reassignment[23] and this may include surgery. It is important to begin discussion of surgery at an early stage with any adolescents who express determination to transition so that they understand its limitations[6, 24]. The international standards of care published by the World Professional Association for Transgender Health[25], state that any surgical intervention should not be carried out before the age of 18. Nonetheless, clinicians in Europe and North America need to be aware that it is possible, subject to stated safeguards, for a young person who is undergoing a male to female transition and aged at least 16, to obtain genital and gonadal surgery in Thailand, where one of the clinics states that it has a number of patients, from a variety of western countries, who underwent such surgery at age 16[26].

Informed consent

Properly informed consent to treatment is vital at each stage of intervention. In the UK, the young person must be competent to give informed consent to the physical interventions, even if, as with hormone blocking, they are entirely reversible. They must understand the risks and benefits of treatment, and the consequences of not having treatment[30]. After the sixteenth birthday, a young person is automatically deemed to be competent (Family Law Reform Act, 1969[27]). However, in most circumstances, the consent of parents (or others with Parental Responsibility) will be required as their support is a significant contributor to successful outcomes[28].

Advising on fertility options

Before consenting to any physical treatment, young people should be carefully informed about the possibility of future infertility. They may not have contemplated being parents themselves. However, cross-sex hormones do, at least temporarily, negate their reproductive capabilities. The cessation of the medication would permit the restoration of their fertility, provided that only a few years had elapsed since its commencement. Cryopreservation of sperm and, possibly in the future, of ova, may maintain that capability[31]. This might be undertaken before the start of or during a break from medication. For those whose gonads never developed beyond an early pubertal stage because of the early use of pubertal blocking drugs, it might require many years off all medications for sperm or ova to be retrieved. Ultimately, fertility will be lost. Unless there are further advances in reproductive medicine, surgery that involves the removal of gonads would result in the permanent loss of fertility.

Resolving ethical and legal issues

Clinicians may feel uncertain about treating **gender variant** young people because the evidence upon which treatment is based is incomplete[11]. However, no adverse long-term effects have yet emerged[19]. International guidelines[25], support early intervention and, in addition, a significant number of respected treatment centres, in Europe, North America and Australia, offer such treatment[29]. These factors would provide protection against a charge of negligence were any complaint made[32]. The guidelines that specifically prohibit early suspension of puberty in the UK are under review[33]. The failure to provide treatment early enough to block full pubertal development in response to a competent minor's request, risks being unethical [34].

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