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The Society for Evidence-Based Gender Medicine (SEGM) welcomes WPATH SOC8's acknowledgement of the profound shift in the incidence of gender dysphoria/gender incongruence and its presentation among youth, and the acknowledgement of the risk of inappropriate medical transition of youth. We also commend the increased focus on psychotherapy assessments, since gender incongruence in youth can arise from multiple causes and may have multiple paths to resolution.

At the same time, we are disappointed by the significant methodological limitations in the draft SOC8 guideline. These are most evident in the *reporting of the guideline recommendations*. The recommendation statements are not always clear and actionable. There is no strength of recommendation or certainty of evidence attached to them. There is no justification about the balance of desirable and undesirable consequences for each of the recommendations. There is no evidence synthesis attached to each of the recommendations. Values and preferences, which shape the recommendations, are not articulated. These reporting issues will make it difficult for clinicians to follow the recommendations, or to be confident that following them will result in more good than harm for any given patient.

We are also concerned about the *content accuracy* in key sections affecting care for children and young people, which omits or misrepresents important information. We briefly outline our concerns with the Child, Adolescent, and Assessments sections; however, the short timeline to comment precludes us from providing a detailed analysis of these sections, or any analysis of the remainder of the sections, many of which suffer from similar limitations. These gaps call into question the methodological rigor of the *guideline development process* itself, including the quality of the *evidence synthesis* underpinning the treatment recommendations.

Use of the term "Standards of Care" for WPATH's treatment guideline is misleading. A *standard of care* is a treatment approach that all reasonable providers would use in a particular clinical situation. For example, penicillin or amoxicillin are the antibiotics of choice to treat group A strep pharyngitis and as such, this treatment is a standard of care. No such consensus exists for how to care for the growing numbers of youth with increasingly varied gender identity presentations. In fact, leading health systems and hospitals worldwide, including those that pioneered the practice of pediatric medical transition, such as the Karolinska—the home of the Nobel Prize in Medicine—have revised, or are currently revising their treatment protocols because of concerns about very low-quality evidence for the medical and surgical gender dysphoria interventions and their potential for harm.

With 2%-10% of youth self-expressing gender variant identities that make them eligible for hormonal and surgical interventions, an evidence-based treatment guideline is urgently needed. Unfortunately, the draft SOC8 does not meet this need. SEGM welcomes the opportunity for a productive dialogue with WPATH about the draft SOC8 and the process used to create it. We would be happy to assist or collaborate in a process to enable the creation of a true evidence-based practice guideline.

Section Comments

A. Child

This section appropriately acknowledges that childhood gender nonconformity is common and is not necessarily indicative of a future transgender identification. However, the chapter's key recommendation to socially transition children who desire it, and the assertion that a strong recommendation can be made in the context of weak evidence, are misguided.

In addition, the reporting of the recommendations does not adhere to a high methodological standard: the lack of clear and actionable statements, evidence synthesis, and clear strength/certainty statements for each recommendation limit the guideline's utility.

The guideline would be improved if it more accurately reflected the following evidence:

- The single most likely outcome of childhood gender variance, even if strongly expressed, is desistance before adulthood (Steensma et al., 2013; Ristori & Steensma, 2016; Singh et al, 2021).
- A high degree of childhood gender-variance is associated with future gay/lesbian/bisexual orientation (Korte et al., 2008; Steensma et al., 2013).
- There is no test that can differentiate between the children who will have a remission of gender dysphoria later in life and those whose gender dysphoria will persist and who may wish to undergo medical transition later (Ristori & Steensma, 2016).
- Childhood gender incongruence may be a sign of healthy diversity or a symptom of trauma and adversity (Kozlowska et al., 2021a; Kozlowska et al., 20201b).
- While socially transitioned children may thrive in the short-term, little is known about the long-term effects. Existing studies have been unable to demonstrate a causative beneficial effect of social transition when controlling for general parental acceptance and strong peer-relations (Sievert et al., 2020; Wong et al., 2019).
- The risks of social transition are not fully known. They include the possibility of iatrogenic persistence of gender dysphoria (Hembree et al., 2017), as well as a need to initiate puberty blockers in the very early stages of puberty. This, in turn, prevents children from experiencing the early and mid-stages of natural puberty, which, when allowed to occur, lead to the resolution of gender dysphoria in the majority of cases of childhood-onset gender dysphoria (Ristori & Steensma, 2016).

References:

Hembree, W. C., Cohen-Kettenis, P. T., Gooren, L., Hannema, S. E., Meyer, W. J., Murad, M. H., Rosenthal, S. M., Safer, J. D., Tangpricha, V., & T'Sjoen, G. G. (2017). Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline. *The Journal of Clinical Endocrinology & Metabolism, 102*(11), 3869–3903. https://doi.org/10.1210/jc.2017-01658

Korte, A., Goecker, D., Krude, H., Lehmkuhl, U., Grüters-Kieslich, A., & Beier, K. M. (2008). Gender Identity Disorders in Childhood and Adolescence. *Deutsches Ärzteblatt International, 105*(48), 834–841. https://doi.org/10.3238/arztebl.2008.0834

Kozlowska, K., Chudleigh, C., McClure, G., Maguire, A. M., & Ambler, G. R. (2021a). Attachment Patterns in Children and Adolescents With Gender Dysphoria. *Frontiers in Psychology, 11*. https://doi.org/10.3389/fpsyg.2020.582688

Kozlowska, K., McClure, G., Chudleigh, C., Maguire, A. M., Gessler, D., Scher, S., & Ambler, G. R. (2021b). Australian children and adolescents with gender dysphoria: Clinical presentations and challenges experienced by a multidisciplinary team and gender service. *Human Systems: Therapy, Culture and Attachments, 1*(1), 70–95. https://doi.org/10.1177/26344041211010777

Ristori, J., & Steensma, T. D. (2016). Gender dysphoria in childhood. *International Review of Psychiatry, 28*(1), 13–20. https://doi.org/10.3109/09540261.2015.1115754

Sievert, E. D., Schweizer, K., Barkmann, C., Fahrenkrug, S., & Becker-Hebly, I. (2020). Not social transition status, but peer relations and family functioning predict psychological functioning in a German clinical sample of children with Gender Dysphoria. *Clinical Child Psychology and Psychiatry*, 135910452096453. https://doi.org/10.1177/1359104520964530

Singh, D., Bradley, S. J., & Zucker, K. J. (2021). A Follow-Up Study of Boys With Gender Identity Disorder. Frontiers in Psychiatry, 12. https://doi.org/10.3389/fpsyt.2021.632784

Steensma, T. D., van der Ende, J., Verhulst, F. C., & Cohen-Kettenis, P. T. (2013). Gender Variance in Childhood and Sexual Orientation in Adulthood: A Prospective Study. *The Journal of Sexual Medicine, 10*(11), 2723–2733. https://doi.org/10.1111/j.1743-6109.2012.02701.x

Wong, W. I., van der Miesen, A. I. R., Li, T. G. F., MacMullin, L. N., & VanderLaan, D. P. (2019). Childhood social gender transition and psychosocial well-being: A comparison to cisgender gender-variant children. *Clinical Practice in Pediatric Psychology, 7*(3), 241–253. https://doi.org/10.1037/cpp0000295

B. Adolescent

This section appropriately recognizes the poorly understood rapid rise in the number of adolescents presenting with gender dysphoria; the potential role of social influence on the rise of adolescent-onset transgender identity; and the profound lack of evidence specific to the novel population of gender dysphoric youth. The section also accurately observes that adolescents are still in the process of establishing their identities, and that adolescent development varies and often is not completed until the 20s. SEGM also concurs with SOC8's emphasis on extended psychological evaluations of youth and acknowledgement of the important role of parent reports in assessments.

However, the treatment recommendations in this section disregard these profound uncertainties and instead recommend lowering the age of eligibility for irreversible interventions. The age of eligibility for cross-sex hormones has been lowered to 14; mastectomy to 15; and the age for sterilizing procedures and most genital surgeries has been lowered to age 17. While the possibility of regret of medicalizing a transient transgender identity is acknowledged, clinicians using these recommendations will be unable to distinguish the patients who might benefit from the recommended interventions from those who would be harmed.

In addition, the reporting of the recommendations does not adhere to a high methodological standard: the lack of clear and actionable statements, evidence synthesis, and clear strength/certainty statements for each recommendation limit the guideline's utility.

To improve the Adolescent section SEGM advises:

- **Do not conflate gender diversity with the clinical diagnosis of gender dysphoria/gender incongruence.** SOC8 appears to have commingled a poorly defined concept of "gender diversity" with the clinical diagnoses of gender incongruence (ICD-11)/gender dysphoria (DSM-5). While the attempt to use inclusive language is well-meaning, the clinical implication of suggesting that youth who merely do not adhere to gender stereotypes are candidates for medical transition is dangerously misleading. Significant gender dysphoria or cross-sex identification in childhood is often a precursor to homosexual orientation. The guidelines should clearly describe how clinicians can minimize harm to pre-gay or gay youth.
- **Avoid non-standard terminology.** SOC8 appears to have created its own terminology for widely accepted clinical terms. For example, "persistence" and "desistance" are standard terms used in many peer-reviewed studies of gender identity. The alternative terms WPATH uses such as "*continuity and discontinuity of gender diversity*" and *"reduced or fully discontinued gender diversity"* are unnecessarily nonspecific and obscure the concept. SOC8 has also chosen to use terms such as "*knowing one's gender diversity earlier vs later*" rather than the well-established concepts of "pre-pubertal (early) onset" and "post-puberty (late) onset." Given that SOC8 will likely be translated in many languages, the risk of misinterpretation of these nonstandard terms will likely be amplified.
- **Present a more balanced overview of the Dutch studies, which are the landmark studies that served as the foundation of the practice of medical transition of minors.** The Dutch results (de Vries et al., 2011; de Vries et al., 2014) are widely recognized as the foundation for the practice of adolescent, as opposed to mature adult, gender transition. We applaud SOC8 for acknowledging that the Dutch protocol findings cannot be extrapolated

to cases with adolescent-onset gender dysphoria, since all the Dutch subjects had childhood-onset of gender dysphoria.

However, another important limitation of the Dutch study was not addressed, and in fact has been misrepresented in a problematic way. When describing the Dutch study results (de Vries, et al., 2014), SOC8 states: "*the findings demonstrate improved psychological functioning… this was the first study to show that gender affirming treatment enabled transgender adolescents to make age-appropriate developmental transitions while living as their affirmed gender, and with satisfactory objective and subjective outcomes in adulthood… These were convincing results.*" This is not an accurate report of the study findings:

- Contrary to the SOC8 assertion, *psychological function* failed to meaningfully improve. Of nearly 30 psychological measures taken before and after treatment, roughly half were not statistically significant, including the average sample scores for depression, anxiety, and anger. The half that was statistically significant was of marginal clinical significance. For example, the measure of global functioning, which delivered some of the biggest improvements - nearly 10 points on a 100-point scale, nonetheless remained in the same healthy range before and after the Dutch protocol interventions.
- There is also no mention of the fact that there was 1 death, 3 serious complications of obesity and diabetes that disqualified study subjects from further treatment, and 1 respondent who chose to discontinue treatment despite extensive evaluations. Given the small final sample size (n=55), and an even smaller number of cases that supplied psychological pre-and post-intervention scores (n=32), clinicians should be apprised of these 5 adverse outcomes, which were not accounted for in the reported psychological outcomes. Further, the study end-period was only 1.5 years post-surgery. The concerning lack of long-term outcomes of the Dutch cohort (in either the psychological or physical health domains) should also be highlighted.
- Further, the only attempt to replicate the first part of the Dutch Protocol outside the Dutch clinic failed, finding no improvements in any psychological measures (Carmichael et al., 2021). This lack of improvement may be attributable to the fact that at baseline all Dutch study subjects were already very high functioning with no significant depression or anxiety, as required for study participation. However, since the protocol is increasingly promoted as the solution to adolescents' distress, it is important to disclose that the Dutch protocol has not been tested in adolescents with significant mental health problems or functional impairment.

- **Differentiate between childhood and adolescent onset of gender dysphoria, specify whether they should be treated differently or similarly, and enumerate the conditions under which treatment varies.** We applaud WPATH for recognizing that "…*an increasing number of youth are coming to self-identify as gender diverse in later adolescence"* and that *"nothing is known about how their gender trajectories compare to those of youth who have come to know their gender diversity earlier*." We also welcome the explicit acknowledgement that adolescents should not be treated medically or surgically unless their gender incongruence has lasted for "*several years*."

  However, considering the knowledge gained from the Dutch Protocol, which explicitly disqualified adolescent-onset gender dysphoria cases, it is troubling that there is no recommendation to ascertain and document whether the gender incongruence began prior

to puberty (early-onset) or during or after puberty (late-onset). Nor is it clear how long "several years" is. This information is vital in order to counsel patients and families about the existing research, or lack of data, about potential desistance, persistence, and response to medical and surgical transition.

- **Provide a comprehensive review of detransition research.** While we applaud SOC8 for quoting a study on detransition by Vandenbussche, 2021, several key studies on detransition were omitted, including Littman, 2021 and Turban et al., 2021. The two studies came to different conclusions, likely because Littman, 2021, surveyed individuals who medically or surgically transitioned and then medically or surgically detransitioned regardless of current gender identification, while Turban et al., 2021 analyzed data about individuals who previously detransitioned but subsequently reidentified as transgender at the time of the study. Two additional detransition-related studies using clinic samples were published around the time of the draft release, Hall et al., 2021, and Boyd et al., 2022. Other important studies concerning detransition should also be considered for inclusion (Entwistle, 2020; Expósito-Campos, 2021).

- **Present a more even-handed discussion of the literature.** The current description of the literature betrays a strong bias toward studies promoting social and medical transition. For example, when discussing the childhood desistance literature, SOC8 cities Temple Newhook, 2018, who asserted that high desistance rates are based on flawed data, but fails to cite the response by Zucker, 2018, which addressed Newhook's concerns and provided a new analysis confirming the validity of the original claim of high rates of childhood desistance.

  Similarly, SOC8 notes the methodological limitation of Littman, 2018, which used parental reports to identify the role of social contagion/peer influence as the potential trigger for adolescent-onset gender dysphoria; however, it fails to note this same methodological limitation for Olson et al., 2016, which also used parental reports in their study that reports on the benefits of social transition (in the Child section).

  Of note, Littman's (2018) hypothesis that social factors may lead to the development of gender dysphoria, which originated from parental reports, has recently been strengthened by detransitioners' own accounts of how *"psychosocial factors (such as trauma, mental health conditions, maladaptive coping mechanisms, internalized homophobia, and social influence) can cause or contribute to the development of gender dysphoria"* (Littman, 2021).

- **Reconcile internal inconsistencies and contradictory assertions.** The Adolescent section acknowledges that "*stability versus instability of a particular young person's gender identity development"* is a key concept and that "*for a select subgroup of young people, in the context of exploration, social influence on gender may be a relevant issue and an important differential."* Yet paradoxically, this section also claims, *"however, probing the contribution of the environment on gender identity development is difficult and clinically irrelevant."* These statements are contradictory.

  Another inconsistency is, on the one hand, acknowledging that prior to undergoing transition, clinicians should "*mitigate threat or crisis such that there is sufficient time and stabilization for thoughtful gender-related assessment and decision making*," while in the same paragraph suggesting that adolescents can be safely transitioned while actively self-harming: "*safety-related interventions should not preclude starting gender affirming care.*" While WPATH is entitled to its position that self-harm, including suicidality, is not a barrier to an adolescent's medical transition, prospective users of the guideline must be given clear guidance about this important issue, rather than having to reconcile these seemingly contradictory directions.

References

Boyd, I., Hackett, T., & Bewley, S. (2022). Care of Transgender Patients: A General Practice Quality Improvement Approach. *Healthcare, 10*(1), 121. https://doi.org/10.3390/healthcare10010121

Carmichael, P., Butler, G., Masic, U., Cole, T. J., De Stavola, B. L., Davidson, S., Skageberg, E. M., Khadr, S., & Viner, R. M. (2021). Short-term outcomes of pubertal suppression in a selected cohort of 12- to 15-year-old young people with persistent gender dysphoria in the UK. *PLOS ONE*, *16*(2), e0243894. https://doi.org/10.1371/journal.pone.0243894

de Vries, A. L. C., McGuire, J. K., Steensma, T. D., Wagenaar, E. C. F., Doreleijers, T. A. H., & Cohen-Kettenis, P. T. (2014). Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment. *Pediatrics*, *134*(4), 696–704. https://doi.org/10.1542/peds.2013-2958

Entwistle, K. (2020). Debate: Reality check – Detransitioner's testimonies require us to rethink gender dysphoria. *Child and Adolescent Mental Health, camh*.12380. https://doi.org/10.1111/camh.12380

Expósito-Campos, P. (2021). A Typology of Gender Detransition and Its Implications for Healthcare Providers. *Journal of Sex & Marital Therapy*. https://www.tandfonline.com/doi/abs/10.1080/0092623X.2020.1869126

Hall, R., Mitchell, L., & Sachdeva, J. (2021). Access to care and frequency of detransition among a cohort discharged by a UK national adult gender identity clinic: Retrospective case-note review. *BJPsych Open*, 7(6), e184. https://doi.org/10.1192/bjo.2021.1022

Hutchinson, A., Midgen, M., & Spiliadis, A. (2019). In support of research into rapid-onset gender dysphoria [Letter to the Editor]. *Archives of Sexual Behavior*. https://doi.org/10.1007/s10508-019-01517-9.

Littman, L. (2018). Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. *PLoS ONE*. https://doi.org/10.1371/journal.pone.0202330.

Littman, L. (2020). The Use of Methodologies in Littman (2018) Is Consistent with the Use of Methodologies in Other Studies Contributing to the Field of Gender Dysphoria Research: Response to Restar (2019). *Archives of Sexual Behavior 49*, 67–77. https://doi.org/10.1007/s10508-020-01631-z

Littman, L. (2021). Individuals treated for gender dysphoria with medical and/or surgical transition who subsequently detransitioned: A survey of 100 detransitioners. *Archives of Sexual Behavior, 50*(8), 3353-3369.

Temple Newhook, J., Pyne, J., Winters, K., Feder, S., Holmes, C., Tosh, J., . . . Pickett, S. (2018). A critical commentary on follow-up studies and "desistance" theories about transgender and gender-nonconforming children. *International Journal of Transgenderism, 19*(2), 212-224.

Turban, J. L., Beckwith, N., Reisner, S. L., & Keuroghlian, A. S. (2020). Association Between Recalled Exposure to Gender Identity Conversion Efforts and Psychological Distress and Suicide Attempts Among Transgender Adults. *JAMA Psychiatry*, *77*(1), 68. https://doi.org/10.1001/jamapsychiatry.2019.2285

Turban, J. L., Loo, S. S., Almazan, A. N., & Keuroghlian, A. S. (2021). Factors Leading to "Detransition" Among Transgender and Gender Diverse People in the United States: A Mixed-Methods Analysis. *LGBT Health*, *8*(4), 273–280. https://doi.org/10.1089/lgbt.2020.0437

Vandenbussche, E. (2021). Detransition-Related Needs and Support: A Cross-Sectional Online Survey. *Journal of Homosexuality*, 20. https://doi.org/10.1080/00918369.2021.1919479

Zucker, K. J. (2018). The myth of persistence: Response to "A critical commentary on follow-up studies and 'desistance' theories about transgender and gender non-conforming children" by Temple Newhook et al. (2018). *Int. J. Transgenderism 19,* 231–245. https://doi.org/10.1080/15532739.2018.1468293

Zucker, K. J. (2019). Adolescents with gender dysphoria: Reflections on some contemporary clinical and research issues. *Archives of Sexual Behavior, 48*(7), 1983–1992. https://doi.org/10.1007/s10508-019-01518-8

C. Assessment

This section acknowledges the role of extensive psychological assessments for youth prior to undergoing gender-affirming medical interventions. It appropriately points out the need to identify co-occurring mental health conditions and distinguish between situations where gender incongruence is primary vs. secondary to other mental health conditions. We also appreciate the acknowledgement of the need to address fertility preservation prior to undergoing medical transition.

However, very little information is given about which assessments should be performed or when they should be completed. There is no recommendation about which tools or techniques should be utilized (e.g., interviews, psychological testing, chart review), or even the domains that should be included in the assessment. The recommendations are often contradictory and provide no real-world guidance for creating a meaningful assessment procedure, or how to identify youth who may be harmed by gender-affirmative care.

There is also a marked asymmetry in how the decision to transition and detransition are handled. According to the SOC8 draft Assessment section, individuals wishing to medically transition should be supported in their decisions to medicalize: *"Indeed, there should generally be an assumption to treat."* The Assessment section endorses a *"comparatively brief assessment process"* for individuals wishing to transition. However, when an individual wishes to detransition, clinicians are instructed to use an "*interdisciplinary team*" to "*thoroughly investigate the motivations for the original treatment and for the decision to retransition."* This markedly different treatment of the two situations betrays bias in favor of medical transition. We are also concerned by the assertion that individuals unable to provide meaningful consent should still be medically and surgically transitioned: "*However, limits to capacity to consent to treatment should not be an impediment to individuals receiving appropriate GAMST [gender affirmative medical and surgical treatments]*."

We call on the SOC8 Assessment workgroup to revisit this chapter so that it provides clear and practical guidance for mental health professionals about how to properly assess individuals and develop a treatment plan that prioritizes their long-term mental and physical health.