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AWMF Guideline

(German Association of Scientific Medical Societies)

Gender Incongruence and Gender Dysphoria in Childhood and Adolescence - Diagnosis and Treatment

(S2k) AWMF Registry No. 028 - 014

Trans-Kinder-Netz e.V.

Version: 24.06.2025

Leading professional association

German Society for Child and Adolescent Psychiatry, Psychosomatics and Psychotherapy (DGKJP)

Other AWMF specialist societies involved

Academy for Ethics in Medicine (AEM)

German Medical Association for Behavioural Therapy (DÄVT)

German Society for Endocrinology (DGE)

German Society for Gynaecology and Obstetrics (DGGG)

German Society for Paediatrics and Adolescent Medicine (DGKJ)

German Society for Paediatric and Adolescent Endocrinology and Diabetology (DGPAED)

German Society for Medical Psychology (DGMP)

German Society for Psychiatry and Psychotherapy, Psychosomatics and Neurology (DGPPN)

German Society for Psychoanalysis, Psychotherapy, Psychosomatics and Psychodynamic Psychology (DGPT)

German Society for Sexual Research (DGfS)

German College of Psychosomatic Medicine (DKPM)

Other specialist organisations involved:

Federal Association for Child and Adolescent Psychotherapy (bkj)

Professional Association of German Psychologists (BDP)

Professional Association for Child and Adolescent Psychiatry, Psychosomatics and Psychotherapy (BKJPP)

Federal Working Group of Chief Clinicians for Child and Adolescent Psychiatry, Psychosomatics and Psychotherapy (BAG)

Federal Chamber of Psychotherapists (BPtK)

German Psychoanalytical Society (DPG)

German Society for Systemic Therapy, Counselling and Family Therapy (DGSF)

Society for Sexology (GSW)

Child and adolescent psychotherapy - behavioural therapy (KJPVT)

Austrian Society for Child and Adolescent Psychiatry (ÖGKJP)

Swiss Society for Child and Adolescent Psychiatry and Psychotherapy

Association for lesbian, gay, bisexual, trans*, intersex and queer people in psychology (VLSP)

Association of Analytic Child and Adolescent Psychotherapists in Germany (VAKJP)

Participating representative organisations of treatment seekers:

Federal Association Trans* (BVT*)

Trans* Children's Network (TraKiNe)

Specialist societies that were not involved in the process of drawing up the guideline, but were involved in the commenting phase and also approved the final version of the guideline:

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Introduction

1. The development of this guideline in the context of current debates

This AWMF guideline is intended to provide guidance for all healthcare professionals who deal with young transgender and non-binary people. This guidance for professional care shall be optimally informed and based on the best available current state of medical knowledge. Twenty-six medical and psychotherapeutic societies as well as two self-advocacy organisations were involved in drawing up and agreeing on the guideline. This broad participation ensures that the recommendations in this guideline are based on a representative and broadly legitimised opinion of the medical and psychotherapeutic community.

Despite the high level of media attention given to the topic of treating adolescents with gender dysphoria, it should be noted that the number of young people with gender incongruence receiving medical treatment is very low in absolute terms. However, the relative increase in treatment figures correlates with society's increasing openness to transgender life paths and the improvement of access to specialised health services. Increasing treatment figures are not a special phenomenon in adolescence. They can be observed in similar proportions in adulthood. According to a recent extrapolation based on anonymised insurance data from the BARMER health insurance company[1], the numbers of hormonal treatments started by young people with gender incongruence under the age of 18 increased by a factor of 3.2 across Germany between 2014 and 2019 (from approx. 330 to approx. 1,060) and 3.5-fold for adults aged between 18 and 30 in the same period (from approx. 510 to approx. 1,800).

Medical care for transgender people is a multifaceted challenge. Due to the methodological limitations of previous studies the evidence base for body-altering medical interventions is uncertain, particularly in adolescence. As there is no proven effective alternative treatment for persistent gender incongruence with gender dysphoric distress that works without body-altering medical interventions, the feasibility of controlled clinical trials is also severely limited for ethical reasons. This means that the available evidence is mainly based on clinical observational studies (the state of evidence is reviewed in Chapter VII → "*Variant developmental trajectories (persistence, desistance and detransition)*"). There is some controversy among experts as to what conclusions should be drawn from this uncertain evidence base for clinical recommendations. For example, current international recommendations differ in some cases, each of which refers to the same reviewed state of evidence,

[1] The release of these figures was authorised by BARMER.

which is agreed to be uncertain. One of the decisive factors here is the extent to which the best available evidence has been evaluated from the perspective of clinical expertise. Current guidelines published by medical societies are primarily developed by acknowledged clinical experts for this field and are thus based on an integrated synthesis of the evaluation of available evidence and the broadest possible expert consensus as well as on the underlying clinical experience.

This integration of scientific evidence and clinical expertise corresponds to the requirements for the creation of S3 guidelines in accordance with the AWMF regulations. It is also required in the same way by the Executive Board of the German Medical Association. In its position statement "*Scientificity as a constitutional element of the medical profession"*, it says:

> "Scientific medicine is not the same as evidence-based medicine. Evidence-based medicine is the conscientious, explicit and judicious use of current best external scientific evidence to inform decisions in the medical care of individual patients. The practice of evidence-based medicine is the integration of individual clinical expertise with the best available external evidence from systematic research. Evidence-based medicine is based on three pillars: individual clinical experience, the values and wishes of the patient and the current state of research." (German Medical Association, 2020, p. A1-A20)[2]

Some national health authorities' guidelines, such as the Cass Review for NHS England and Wales (Cass, 2024), recommend a comparatively more restrictive approach to adolescents' access to body-altering interventions on the grounds that the evidence base is uncertain. The involvement of clinical experts in the preparation of these recommendations is not assured or at least not transparent or questionable (see explanations in the appendix → *"Deviating recommendations in other countries*"). For the preparation of this guideline experts with many years of experience in the development and treatment of young patients with gender incongruence were delegated by the participating specialist organisations to a large extent. Some of the challenges faced during the development of this guideline and the procedures followed are explained below.

1.1 Depathologisation in the ICD-11 of the World Health Organisation

Over the past two decades, there has been a paradigm shift in the understanding of non-conforming gender identities in the medical world in the sense of their depathologisation. This

[2] Bek_BAEK_Wissenschaftlichkeit_Online (bundesaerztekammer.de

depathologisation is comparable to the change in dealing with homosexuality, which was removed from the ICD-10 catalogue of psychiatric diagnoses by the WHO in 1992. Accordingly, there are no longer any so-called *gender identity disorders* (F64) in the sense of mental illnesses in the ICD-11. Instead, the diagnosis of *gender incongruence* (HA60) was newly introduced under the new heading of *conditions related to sexual health* (WHO, 2022). This anchoring of a medical diagnosis in the ICD-11 was necessary - in contrast to homosexuality - because if it is present, there may be a medically justified need for treatment. *Gender incongruence (GI)* is therefore not considered a disease by itself, but nevertheless is a health-relevant condition that may require medical treatment in order to avert or reduce a specific condition known as *gender dysphoria (GD).* The terms *gender identity disorder* and *transsexualism* are considered obsolete and are not used in this guideline, as is already the case in the S3 guideline for adulthood *Gender incongruence, gender dysphoria and trans health* (DGfS, 2018). This new conceptualisation of non-conforming gender identities and their terminology in the ICD-11 thus represents a relevant advance in the globally recognised state of medical knowledge. These are significantly relevant for this guideline, even though, during the current transition period until ICD-11 is fully implemented, medical diagnoses will still be coded using ICD-10.

1.2 Medical-ethical considerations when making treatment decisions in adolescence

When adolescents are diagnosed with persistent gender incongruence before they have fully completed their biological maturation, any treatment decision in favour of or against body-altering interventions are generally subject to a great burden of ethical justification and thus require careful consideration in each individual case. On the one hand, the irreversible consequences of a treatment decision in favour of hormone treatment must be considered. On the other hand, postponing such treatment due to the equally irreversible progression of the development of male or female physical characteristics can lead to an aggravation of gender dysphoric distress and thus to the worsening and chronification of gender dysphoria. This in turn can be associated with an increased risk of impaired long-term mental health. In this context, balanced ethical considerations must be made between the principles of protecting minors from potentially premature decisions that could later be regretted and respecting young people's self-determination over their gender identity and body (Hädicke et al., 2023).

One-sided ethical positions ("In adolescence, such far-reaching decisions are generally not justifiable" versus "Adolescents should always decide for themselves and have a right to make mistakes") do not do justice to the complexity of the ethical considerations to be made. They result in equally one-sided and polarising expert opinions, which can also be found occasionally in the current

medical debate. The active involvement of the *Academy of Ethics in Medicine (AEM*) as the AWMF's specialist society for medical ethics in the development of the guideline and the ongoing collaboration of its delegated expert in the steering group was a valuable support for the balanced reception of the relevant discourse in medical ethics. In addition, the German Ethics Council held a bioethics forum during the guideline development phase in February 2020, at which different ethical viewpoints, as were represented within the guideline commission, were openly discussed. The subsequently published recommendation paper *Trans Identity in Children and Adolescents Therapeutic Controversies - Ethical Orientations* (German Ethics Council, 2020) was incorporated into the guideline.[3] The high requirements associated with these issues for determining the capacity to consent in underage patients are addressed in a separate chapter on ethical and legal requirements (see Chapter X → *"Annotations on the legal basis and ethical standards for the treatment of minors with gender incongruence*"). Particularly noteworthy is the German Ethics Council's call for an individualized risk-benefit assessment with regard to the irreversible consequences of both treatment and non-treatment, which should precede any recommendation for body-altering medical interventions (see Chapter VII → *"Guidance for recommending body-altering medical interventions*"). The requirement that the ethical principles of *benefit and non-harm* in this treatment context applies to both active medical action and non-action was also specifically included in the *preamble to the guideline* (see Chapter I → *"Preamble to the guideline*").

1.3 Dealing with the transgender debate in society and aspects of discrimination

During the preparation of the guideline, there was repeated and intensive media coverage of the *transgender* topic. The task of the guideline commission, however, was to develop a medical guideline, the primary focus of which should not be the political concerns and interests of the LGBTQI community. Nevertheless, when drawing up a medical guideline, it is important to seek a respectful dialogue with patients and their relatives on an equal footing. Transgender people were pathologised in medicine for decades. Empirical studies have shown that discrimination of trans persons in the healthcare system is still widespread today. Two self-advocacy organisations (Bundesvereinigung trans* e.V./ BVT and Trans-Kinder Netz e.V./ TraKiNe) participated in the development of the guideline with voting rights in accordance with AWMF regulations. The endeavour to ensure discrimination-

[3] In December 2024, the Swiss National Ethics Commission for Human Medicine (NEK) published a comprehensive position paper, whose recommendations are in line with the balanced ethical approach of this guideline as well. Link: [New CNE opinion paper on the medical treatment for minors with gender dysphoria] National Advisory Commission on Biomedical Ethics NCE

sensitive treatment of trans people in the healthcare sector is reflected in a separate chapter (see Chapter IX → "*Professional interaction and discrimination-sensitive conduct with gender-nonconforming children and young people*") as well as in an appropriate terminology, which is presented in the → *Glossary*.

1.4 Integrating controversy and dealing with dissent

The broad participation of 26 specialist organisations and two patient advocacy organisations in the development of the guideline as well as the involvement of the leading specialized treatment centres in child and adolescent psychiatry (Frankfurt, Hamburg, Munich, Münster, Zurich) representing many years of experience in the steering group ensured that the composition of the guideline commission reflected a representative overall picture of expert opinion. As expected, controversial discussions were held within the guideline commission. In some cases, fundamental lines of disagreement on ethical and therapeutic principles could not be bridged and endured after clarification and decisions in consensus conferences. In order to provide a transparent and focussed presentation of what the guideline commission considers to be fundamental ethical and therapeutic attitudes, the guideline is preceded by a preamble, which was adopted with a strong consensus (>95% agreement) (see Chapter I → *"Preamble to the guideline"* and section on *"Dealing with dissent"* in the Methods Report).

1.5 Setting up recommendations when the evidence base is uncertain

In developing the guideline, two main quality objectives were pursued by adhering to the AWMF regulations, in accordance with the S3 guideline level[4] originally intended at the time of registration:

1. The aim of providing *the best possible information on the current state of knowledge* was realised through the systematic review and discussion of the literature as well as its transparent evaluation.
2. The goal of *the best possible accordance with the current expert consent on best practice* was realised through externally moderated consensus with the maximum achievable consensus strength (>95% across almost all recommendations).

[4] Translator's note: According to the AWMF regulations, the S3 levels the highest standard level for medical guidelines. This level requires that recommendations are both evidence-based as well as consensus-based, and that a minimum of 50% of its recommendations have to be based on scientific evidence.

Due to a lack of controlled proof of effectiveness and an overall uncertain state of evidence based on uncontrolled observational and case-cohort studies, it was ultimately not possible to set up evidence-based recommendations in this guideline. Instead, all recommendations were set up on the basis of consensus, while also taking in to account the best available evidence. In agreement with the AWMF, this led to the decision to publish the guideline as an S2k guideline, even though the methodological structure of its preparation, in particular the systematic literature review, followed the regulations of a S3 guideline.

How are guideline recommendations justified when the evidence is uncertain?

Guideline recommendations recognised by the medical community for which there is only uncertain or very uncertain evidence are widespread in medicine. This is particularly true for paediatric medicine. According to a recent meta-analysis, 82% of all treatment recommendations in medical guidelines for off-label prescriptions in paediatric medicine are based on uncertain to very uncertain evidence (Meng et al., 2022). If one considers that in paediatric medicine up to 65% of all medications prescribed in the inpatient sector and up to 31% of all medications prescribed in the outpatient sector are only available in off-label use (Kimland & Odlind, 2012), one can estimate the scale of established guideline recommendations for children and adolescents that are based on uncertain to very uncertain evidence only. In such cases, until research gaps are closed by further studies, consensus-based guideline recommendations—aligned with recognized best clinical practice—are generally justified in pediatric medicine if, alongside positive clinical experience, the following conditions are fully or partially met (Meng et al., 2022):

- There is sufficient evidence in favour of treatment for adults,
- the medical mechanism of action of a particular drug is considered to be fully known, and sufficient patient safety in children and adolescents has been proven for another area of application,
- there is no other justifiable and tested alternative treatment available,
- non-treatment is ethically unacceptable.

The consensus-based recommendations in this guideline on the use of body-altering medical interventions in adolescents with persistent gender incongruence are also based on these generally recognised and common considerations and procedures in paediatric medicine.

How should evidence-based medicine deal with existing uncertainties?

In the interests of continuous medical and scientific progress, a medical guideline must endeavour to be able to close existing gaps in the evidence base of its recommendations in the foreseeable future. The *Cass Interim Report* for NHS England and Wales calls for the following three tasks to be fulfilled when dealing with existing uncertainties, as is customary in other areas of medicine (Cass, 2022):

- Clinical care services must be designed to be as safe and effective as possible within the limits of the current state of knowledge. This includes the careful consideration of treatment options in individual cases, as well as the development of the best possible informed treatment decisions in participatory dialogue with patients and their guardians as *shared decision making* (see Chapter 1 → "*Preamble to the guideline*").
- As long as there is no immediate prospect of closing research gaps, consensus-based recommendations should be available that are supported by patient participation (see above endeavour for strong consensus, i.e. > 95% across almost all recommendations of this guideline).
- Clinical care providers should support the collection of follow-up data so that medicine functions as a learning system (see corresponding recommendation in Chapter VII → "*Guidance for recommending body-altering medical interventions").*

2. The epidemiology of gender incongruence

2.1 Frequency in adults and minors

Over the past 15 years, estimates based on scientific studies on the proportion of gender-nonconforming people in the overall population have changed. The new international guideline *Standards of Care - Version 8* of the World Professional Association for Transgender Health (Coleman et al., 2022) states in an overview chapter that improved empirical studies on the frequency of *transgender and gender diverse persons (TGD*) in the general population have been published over the past ten years. More recent reviews summarise the available findings (Arcelus et al., 2015; Collin et al., 2016; Goodman et al., 2019; Meier & Labuski, 2013; Zhang et al., 2020). For epidemiological data on the *TGD population*, it is recommended to avoid the terms *incidence* and *prevalence* if the data do not refer exclusively to medical diagnoses or treatments, but to self-reported data. This is also to avoid pathologising of gender-nonconforming individuals (Adams et al., 2017; Bouman et al., 2017).

Instead, the *Standards of Care* (Coleman et al., 2022) recommend using the terms *number* and *proportion* to denote the absolute and relative size of the so-called *TGD population*. When evaluating study findings, it is important to pay attention to the methodology of the surveys, in particular the chosen approach to recruiting respondents and the chosen case definitions. For example, frequency data diverge considerably depending on whether the data refers to people who have sought medical treatment in the healthcare system due to a diagnosis of gender incongruence or gender dysphoria (Collin et al., 2016; Meier & Labuski, 2013) or to people who have reported a non-conforming gender identity in a population-based survey. Such population-based surveys are based on a broader definition of self-reported gender identities and therefore result in significantly higher case numbers.

The majority of studies published more than a decade ago had calculated the number of patients treated in a particular clinical centre and extrapolated it to an estimated population size of the catchment area of the clinical centre in question. This may have led to a significant underestimation of the proportion. For these reasons, only studies that have been published since 2009 and whose methodology provides a clear definition of TGD status as well as a precisely defined reference population were included in the review of the *Standards of Care* (Coleman et al., 2022). These are categorised as follows:

- Studies reporting the proportion of gender-nonconforming people in the context of the utilisation of healthcare services;
- Studies based on population-based surveys with predominantly adult participants; and
- Studies based on surveys of young people in schools.

A total of six US studies analysed data from *the Veterans Health Affairs System*, a health insurance system that covers more than nine million people. The proportion of transgender people in the total number of people insured in this system was determined to range between 0.02% and 0.08% based on service data and diagnostic codes (Blosnich et al., 2013; Dragon et al., 2017; Ewald et al., 2019; Jasuja et al., 2020; Kauth et al., 2014; Quinn et al., 2017). An important limitation of these studies was that people aged 65 and over tended to be overrepresented in the reference population.

In contrast*, population-representative studies* based on self-reported transgender status found significantly higher numbers of cases: Two American studies used the *Behavioural Risk Factor Surveillance Study (BRFSS)*, an annual telephone survey conducted in all 50 US states (Conron et al., 2012; Crissman et al., 2017). Based on different annual surveys, both studies consistently report that around 0.5% of participants aged 18 and over answered *"yes"* to the question "*Do you consider yourself*

transgender?". In an internet-based survey conducted on a representative sample of the Dutch population aged 15 to 70, 1.1% of people assigned male at birth and 0.8% of people assigned female at birth stated that they tended to identify with the other gender (Kuyper & Wijsen, 2014).

In a methodologically similar study in Belgium, which was conducted on a sample drawn from the country's population register, the proportion of people identifying as gender non-conforming according to self-report was 0.7% for persons assigned male at birth and 0.6% for persons assigned female at birth (Van Caenegem et al., 2015). In a study of approximately 50,000 population-representative adult residents of the Stockholm region, the proportion of gender-nonconforming individuals was investigated with differentiated questions on perceived gender identity, including the desire for body-altering medical treatments (Åhs et al., 2018). A *"strong desire"* for hormone therapy or gender-affirming surgery was reported by 0.2% of respondents from both natal sexes. In contrast, questions on the experience of a nonconforming gender identity and the wish for a social transition ("*I feel like someone of a different gender*" and "*I would like to live and be treated as someone of a different gender*") were positively confirmed by 0.8% to 1.2% of respondents. This should be interpreted as an indication that estimated proportional frequencies of people with a transgender or non-binary self-description are not to be equated with estimated frequencies of people with a desire for body-altering medical interventions. A representative survey of 6,000 adults in Brazil (Spizzirri et al., 2021) revealed a proportion of 1.9% gender-nonconforming people, of whom 0.7% described themselves as transgender and 1.2% as non-binary.

There are several school-based survey studies on the proportion of *gender non-conforming young people* under the age of 19. In a national cross-sectional survey of high schools in New Zealand (*n* = 8,000), 1.2% of respondents stated that they identified as *transgender* or *gender diverse*, while a further 2.5% stated that they were unsure (Clark et al., 2014). In a survey of 14- to 18-year-old students in the US state of Minnesota (*N* = 81,000), 2.7% of respondents stated that they were *transgender* or *gender-diverse* (Eisenberg et al., 2017). The the *Youth Risk Behaviour Survey (YRBS)* is conducted nationwide every two years in the USA with high school students in grades nine to twelve (age range 13-19). In the survey of 2017 1.8% of the almost 120,000 participants in 19 urban regions survey confirmed the statement *"Yes, I am transgender"* and 1.6% confirmed the statement *"I am not sure if I am transgender* " (Johns et al., 2019). Only one study investigated the proportion of children describing themselves as transgender in a younger age group. In the 2011 survey of *N* = 2,700 students in grades six to eight (age range 11-13) at public middle schools in San Francisco (Shields et al., 2013),

1.2% of respondents self-identified as *transgender* when asked "*What is your gender*?", with the answer options being *"female, male or transgender"*.

In summary, the reported data show that in studies in which transgender status was determined on the basis of self-reporting, the percentage was between 0.3% and 0.5% for adults and between 1.2% and 2.7% for adolescents. If the definition was expanded to include a broader spectrum of gender non-conforming manifestations, such as uncertain or ambivalent gender identity, the corresponding percentages were higher: 0.5% to 4.5% for adults and 2.5% to 8.4% for adolescents. This indicates a broad and fluid spectrum of non-conforming or *"queer"* self-descriptions in adolescence, which cannot be equated with a medical diagnosis of GI, but requires internal differentiation.

In studies conducted in the health care system that are based on diagnostic codes or other information documented in medical records, the percentages of identified transgender-related diagnoses ranged from 0.02% to 0.08%, which is less than one-tenth of the frequencies found in population-based representative surveys (see Table 1).

Table 1

Proportion of TGD people in the total population estimated according to studies (figures from Coleman et al., 2022)*

	Transgender	All TGD
Health system-based data (F64 diagnoses)	0,02-0,1 %	-
Representative surveys of adults	0,3-0,5 %	0,3-4,5 %
Representative surveys of young people	1,2-2,7 %	2,5 - 8,4 %

Note. TGD: transgender and gender diverse.

2.2 Explanations for the increase in case numbers

In addition to the aforementioned differences in the frequency figures between health care-based and population-based surveys, another observation is the steady increase in the proportion of gender-nonconforming and trans people estimated on the basis of study findings over the past two decades. This steady increase is reflected in the same way health care-based and population-based surveys, as well in the data on legal name and civil status changes (legal transition). Over the past ten

years, the number of young people seeking specialised healthcare for issues related to the *transgender* phenomenon has steadily increased across many countries (Kaltiala et al., 2020). The number of medical transition treatments for adult trans people has also risen sharply. According to the Federal Statistical Office of Germany, the number of gender-affriming surgeries for adults in Germany tripled overall between 2012 and 2020, with a steady upward trend (Statistisches Bundesamt, 2023). In the *Cass Review* for NHS England and Wales (Cass, 2024), the increase in referrals to the Clinical Gender Service for adolescents, which is centrally available for the whole of England and Wales, is described several times by the author as *"exponential"*. This is statistically incorrect and has been criticised in two comprehensive critical reviews of the methodology underlying the Cass Review (McNamara et al., 2024; Noone et al., 2024).

If the reported figures from the Cass Review are taken into account, according to which only 27% of the cases referred nationwide to the Clinical Gender Services of NHS England for diagnosis in the study period from 2018-2022 (n = 3466) were subsequently referred to the Endocrinological Service after multiple consultations (Cass, 2024, Appendix 8, p. 7), and of these, only 81.5% started puberty-blocking treatment, the reported figures are primarily relativised in that they reflect an overall increase in the utilisation behaviour of adolescent patients with gender-related issues in a specific care context. This, however, cannot be equated with an increase in the prevalence of gender incongruence requiring treatment. In particular, prevalence figures based on the use of special health services are not to be equated with treatment figures for hormonal interventions (in the current Cass Review figures (2024), this only concerned 22% of the cases initially referred to specialised gender services).

According to the authors of the *Standards of Care of the WPATH* [5] (Coleman et al., 2022) and other authors, the general trend towards increasing proportions of transgender or gender non-conforming people, which has been repeatedly documented in the recent literature, can be explained most likely by socio-political changes, such as increasing tolerance and destigmatisation as well as improvements in access to qualified healthcare. The further trend that this increase is more evident in younger people than in older people, appears to be explained at least in large part by the fact that the mentioned societal aspects have different effects across generations (Ashley, 2019; Pang et al., 2020; Zhang et al., 2020). In this context, the results of the last census in Canada, in which all people in the country's total population aged 16 and above were explicitly asked about their gender identity, provide evidence of a generational effect in the sense of age kinetics that is reflected over the entire lifespan

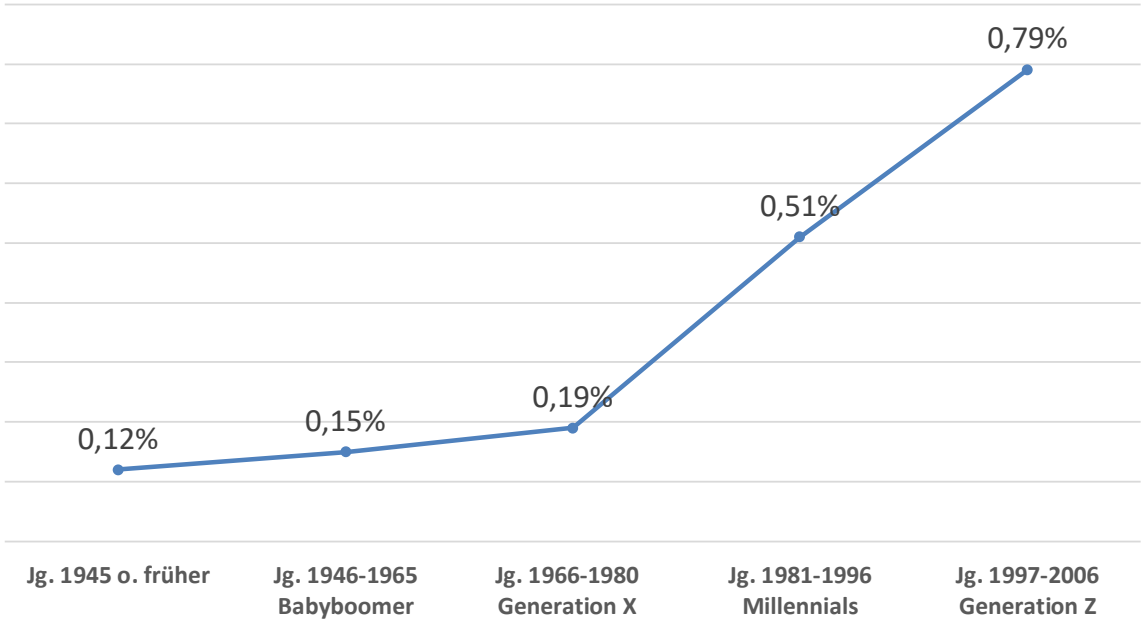
[5] WPATH - World Professional Association for Transgender Health

and does not appear to be specific to adolescence. In addition to *"male"* and *"female"*, *"transgender", "non-binary or "unsure"* and *"no response"* were also explicitly offered as possible answers (Statistics Canada, 2022).

Based on these census data, 100,815 of Canada's 30.5 million inhabitants defined themselves as transgender or non-binary; this corresponds to 0.33% of the population of all age groups up from 16 years. A separate analysis by birth cohorts showed that the trend towards higher proportions of trans people in younger age groups is not a special phenomenon of adolescence, but rather a largely linear age kinetic over the adult life span from around the 1966-1980 birth cohorts (the so-called "Generation X") over the birth cohorts of subsequent decades (see Figure 1 below). Although these data were collected on a broad epidemiological basis, one limitation is that it remains unclear for the time being whether and how the population proportions reported in Canada can be compared with those in other countries. This generational effect, which is evident throughout adulthood, indicates that the trend whereby younger people describe themselves as *trans* more frequently than older people *cannot* be explained solely by the developmental issues that are characteristic of adolescence only, as this trend is also evident in the same way in younger age groups throughout adulthood.

Figure 1

Frequency distribution of transgender identity by age group in Canada.



Note. Total population aged 16 and over, figures from Statistics Canada (2022)

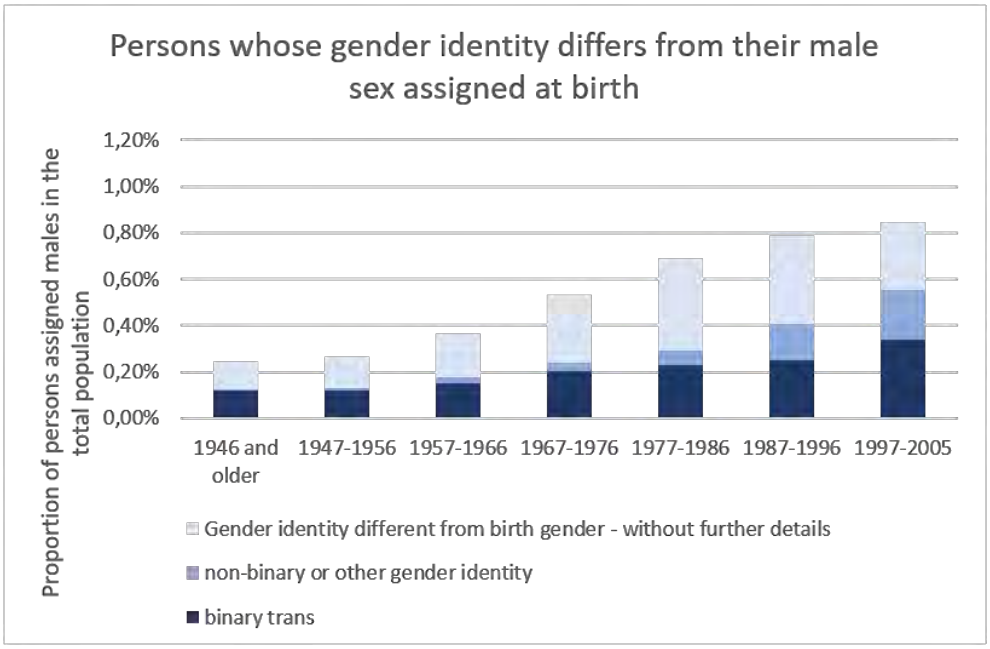
Similar age kinetics can also be seen in the 2021 census data from England and Wales, which was also available to the *Cass Review*, in which, for the first time, the gender identity of all residents aged 16 and above was asked for (Office for National Statistics, 2023a). The question asked was whether the gender the person identifies with matches the gender assigned at birth ("*Is the gender you identify with the same as your sex registered at birth?*"). The question could be answered with "*Yes"* or "*No"* and the perceived gender could then be specified in free text. The response rate for the question on gender identity was 94% of the total population of over 48.5 million respondents. The percentages given below refer to the extrapolated population. A total of 0.54% of respondents stated that their gender identity differed from their birth gender. Just a little less than half of these (0.24%) did not provide any further details about their gender identity. In each case, 0.1% of the total population stated that they identify as trans male or trans female, which corresponds to 18.5% of the subpopulation with a gender-nonconforming gender identity.

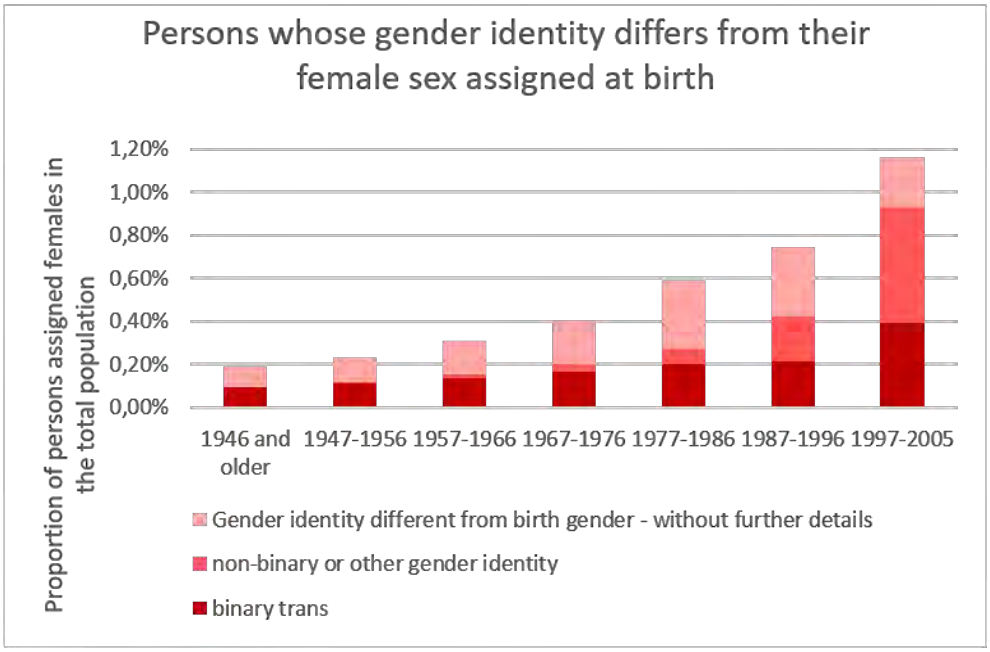
The proportion of the total population that identified as non-binary is 0.06%, which corresponds to 11.1% of the subpopulation with a gender-nonconforming gender identity. A proportion of 0.04% of respondents stated a different gender identity, corresponding to 3.4% of the subpopulation with a gender-nonconforming gender identity. From the datasets available on the *Office for National Statistics* website, the data can be accessed separately for age groups and sex at birth (Office for National Statistics, 2023b, 2023c). In terms of age, the proportion of people with a non-conforming gender identity is highest in the 16-24 age cohort at 1%. As the age of the cohorts increases, the proportion falls steadily and is 0.22% in the over-75 age group.

In particular, the proportion of people who identify as non-binary is higher in the 16-24 and 25-34 age cohorts (0.26% and 0.11% respectively) than in the older cohorts. With regard to the sex ratios, there are only slight differences across all subgroups. Across all age cohorts, the proportion with an incongruence between gender identity and natal sex is 0.52% for natal females and 0.56% for natal males, which corresponds to a sex ratio of 52:48 in favour of natal females. In the cohort of 16-24-year-olds, the proportion of natal females with a non-conforming gender identity is slightly higher at 1.16% than the corresponding proportion of natal males at 0.84%, corresponding to a sex ratio of 58:42. In all other age cohorts, the proportion of natally male individuals with a non-conforming identity is slightly higher than the proportion of natally female individuals (Office for National Statistics, 2023b, 2023c, 2023a). Figure 2 shows the relative proportions of age kinetics of non-conforming gender identities by sex assigned at birth.

Figure 2

Proportion of non-conforming gender identity as a percentage of the total population of England and Wales by natal sex and age cohort





Note. Taken from Office for National Statistics (2023a, 2023b, 2023c).

2.3 Unequal sex ratio in the utilisation of healthcare services

A much-discussed observation for adolescence is the increasing change in the reported relative frequency distribution between the sexes (sex ratio) over the past ten years. When it comes to the use of health services (e.g. referral figures for specialised gender services), this is in favour of the proportion of adolescents assigned female at birth. Here, several studies consistently report a sex ratio around 80:20 (Aitken et al., 2015; De Graaf, Carmichael, et al., 2018; De Graaf, Giovanardi, et al., 2018; Steensma et al., 2018; Zhang et al., 2021). Such an unequal sex ratio is not found in population-based surveys of young people on self-perceived non-conforming gender identity (see previous section 2.2), which suggests that there is no gender-specific "trans hype" among youths, or particularly among natal girls. The discrepancy in the sex ratios between representative self-reports of gender-nonconforming young people and selective utilisation figures for health services rather indicates gender-related differences in the threshold for using health services among gender-nonconforming people. Nevertheless, the above-mentioned observation has led to a controversy as to whether persistent gender incongruence can be diagnosed with sufficient validity, especially in adolescents whose sex was assigned female at birth, and how a possible risk of overdiagnosis in this group can be countered. The deviating recommendations of health authorities in some other countries (Sweden, Finland, England) listed in the appendix emphasise this concern, among others. For example, the statements of the Swedish health authority *Socialstyrelsen* and the *Cass Review* for *NHS England and Wales* refer, among other things, to what the authors consider to be the allegedly insufficiently clarified observation of this strongly shifted sex ratio among adolescents seeking treatment, without referring to the known sex ratio that is not shifted accordingly in population-representative surveys (Cass, 2024; Socialstyrelsen, 2022).

Even if the currently unequal sex ratio of adolescents presenting at special centres for GD has not yet been conclusively clarified, the following three findings appear noteworthy for hypotheses to be discussed. However, they do not allow any generalizable statements to be made and require further empirical investigation:

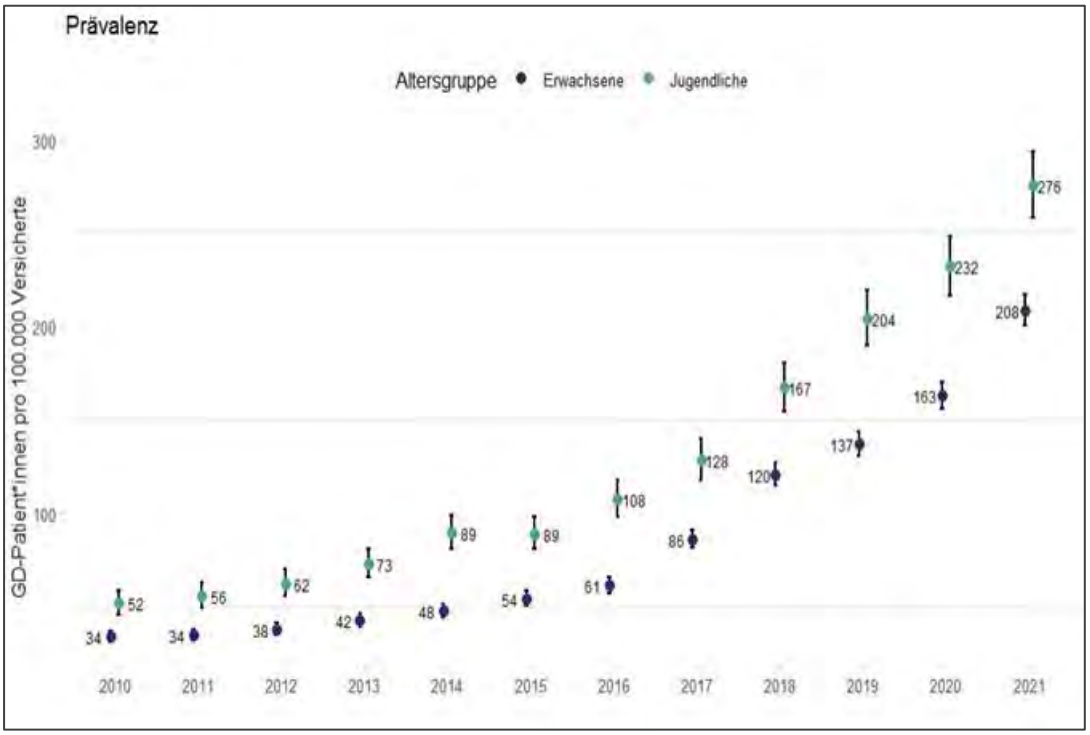
- In an analysis of *N* = 420 cumulatively collected assessments of persons up to the age of 19 who had applied for a change of name and civil status under the German Transsexuals Act (TSG) and who were almost without exception granted a positive decision, a sex ratio of 80:20 was found for this age group in favour of applicants with a sex assigned to female at birth (Meyenburg et al., 2021). In this context, it is important to be aware of the requirements for such an assessment under the German TSG: This must be carried out by *two independent psychiatric or psychological*

experts who must have relevant expertise in the diagnostic assessment of this target group. Their expert mandate is to examine in detail whether the applicant *has been experiencing a persistent and pronounced affiliation with the opposite sex* over a period of *at least three years* ("inner compulsion") and whether, after a diagnostic assessment based on the current state of scientific knowledge, *it can be assumed* with a *very high degree of probability that this will not change any more*. Due to these assessment criteria, which are designed for maximum specificity (= prevention of false positive classification), it would be expected that adolescents who, for example, are in unease with their gender role due to a temporary identity crisis, would not receive positive confirmatory assessments. Accordingly, the reported unequal sex ratio in the cohort of this study *cannot be* plausibly explained by a *selective female-specific tendency* towards false positive cases due to a surplus of girls with uncertainty around their during puberty.

- There are indications that currently in Germany, the step of a social transition for trans females takes place on average around 10 years later than for trans males. This could explain why social transitions and thus also requests for medical treatment by trans women are significantly rarer before the age of 20. This observation is reflected in the Germany-wide figures determined by the German Society for Transidentity and Intersexuality (dgti e.V.) on the frequency of so-called *supplementary identity cards* applied for by age and gender in the period 1999-2016, which are an indicator of the kinetics of social transitions over time (dgti e.V., Schaaf, 2019). This supplementary identity card is a low-threshold document that can be issued on request, with which trans people who are already living a social transition in everyday life but have not yet completed a legal change of name and civil status can easily identify themselves in everyday situations in conjunction with their official identity documents (dgti.org). This observation of different age frequencies requires further empirical examination in future studies, as long as no published peer-reviewed studies are available.
- A recent epidemiological study based on nationwide billing data collected by the health insurance company BARMER throughout Germany examined the increases in the use of healthcare services among adolescents (13-17 years) with diagnosed gender dysphoria in comparison with adults (18-30 years) (Nettermann et al., 2025), this was done for the first time on a largely representative basis. The findings show that the trends over a 12-year period (2010-2021) for adults were similar to those for adolescents (see Figures 3 and 4 below) in terms of both the relative increase in cases overall and the shift in sex ratios towards natal females. This speaks against the hypothesis that these increases and shifted sex ratios can be explained as an adolescent-specific phenomenon (e.g. as an expression of increased psychosexual identity conflicts during female puberty or similar).

Figure 3

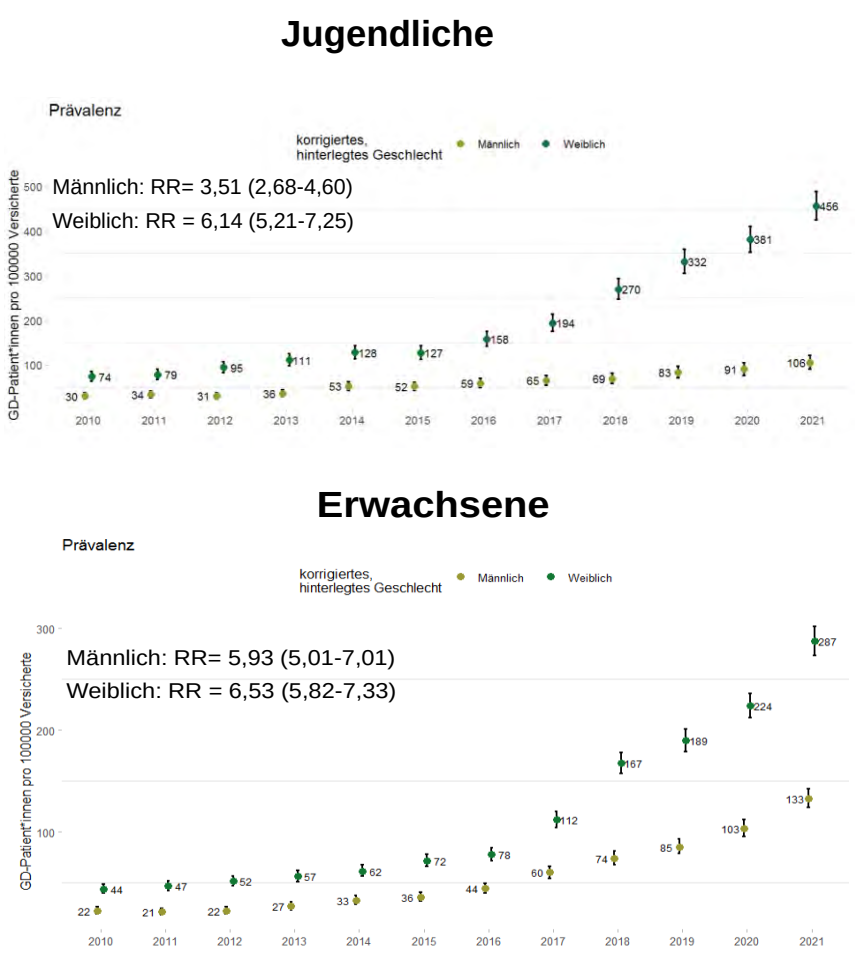
Increase in treatment cases with a gender dysphoria diagnosis in the healthcare system throughout Germany calculated per 100,000 insured persons in a comparison of adolescents vs. adults



Note. *(N = 7377;* Nettermann et al., 2024).

Figure 4

Treatment cases with a diagnosis of GD per 100,000 insured persons in Germany, broken down by sex assigned at birth in comparison between adolescents and adults



Note. (*N* = 7377; Nettermann et al., 2024).

3. How does non-conforming gender identity develop?

The answer to the question of how non-conforming gender identity forms and develops has not been conclusively clarified. A multifactorial genesis is suspected, in which biological, social and psychological factors interact. The specific aetiological mechanisms and reciprocal interactions are not yet well understood. At this point, we will merely provide a brief outline of current scientific findings that can be used for multifactorial models.

Traditional models of gender identity development in children and adolescents assume that biological and psychological processes determine the development of gender identity in a way that typically corresponds to the sex assigned at birth (Martin et al., 2002; Stoller, 2020). According to these models, the variability of typical and atypical forms of the lived *gender role* unfolds normatively within a *gender identity that conforms* to the sex assigned at birth. If the development of gender identity remains congruent with the assigned sex in this sense, a person's *social gender role behaviour* may therefore correspond more or less typically to the perceived sociocultural expectations. In the course of their development, adolescent (cis) girls can identify as more or less "typically female" to varying degrees without fundamentally questioning their self-perception as a female person. Similarly, (cis) boys can identify as more or less "typically male" in the course of their development without fundamentally questioning their self-perception as a male person.

In the case of persistent gender incongruence or gender dysphoria according to the diagnostic criteria of ICD-11 or DSM-5, a pronounced, persistent and profound experience according to which a person's perceived gender identity cannot be reconciled with the physical characteristics of the sex assigned at birth clearly goes beyond discomfort with a social gender role or a "struggle" with perceived socio-cultural expectations of a female or male role in the sense of *gender uncontentedness*. This distinction is supported by the clinical observation that gender dysphoric distress associated with a persistent gender incongruence cannot be resolved solely through living in a socially accepted atypical or non-conforming social gender role, e.g. as a masculine-typed female person (so-called "tomboy") or feminine-typed male person. Accordingly, adolescents with a diagnosed gender incongruence typically continue to experience persistent gender dysphoria with regard to their own physical appearance after a completed social role change in all areas of life, even if this consistently goes along with experienced social acceptance.

For the published state of knowledge on the question of which genetic, hormonal, neuronal and psychological factors are involved in the development of non-conforming gender identities,

reference is made here to the available reviews (Ettner, 2020; Korpaisarn & Safer, 2019; Saleem & Rizvi, 2017; Skordis et al., 2020). In earlier decades, concepts on psychosocial models of development dominated. What these hypotheses for gender-nonconforming developments (L. M. Diamond & Butterworth, 2008; Martin et al., 2002; Stoller, 2020) have in common is that they do not differentiate between developments of children and adolescents with atypical role behaviour and developments with persistent gender incongruence in the sense of transgender identities. This can be seen as a weakness of these concepts.

Since the 1990s, biological models have been increasingly discussed, and there is some evidence from genetic, endocrinological and neuroscientific studies for their relevance in the context of an assumed multifactorial genesis. The findings are not unambiguous and must be considered preliminary. The assumption *of genetic influences* was substantiated by observations of familial clusters of transgender individuals (Gomez-Gil et al., 2010; Green, 2000), as well as by the observation of an increased concordance rate of transgenderism in twin studies (Diamond, 2013). In one study, this was 39% for monozygotic twins compared to less than 1% for dizygotic twins (Heylens et al., 2012). In contrast, in a Swedish population-based registry study of 67 twin pairs with at least one twin with a GD diagnosis, the concordance of the GD diagnosis was only increased in mixed-sex (i.e. always bizygotic) twin pairs (*37%*), while it was 0% in same-sex twin pairs (which can be monozygotic or bizygotic) (Karamanis et al, 2022), which relativises the assumption of direct genetic determinism, although this result has not yet been replicated. Furthermore, molecular genetic findings on polymorphisms in oestrogen and androgen receptor genes associated with transgender identities have been reported (Bentz et al., 2008; Fernández et al., 2014b, 2014a, 2018; Hare et al., 2009; Henningsson et al., 2005).

There are some studies that suggest possible *prenatal influences of hormones* on the development of gender identity (Meyer-Bahlburg et al., 2008; Schneider et al., 2016). It is worth noting that there is no evidence to date that deviating steroid hormone levels can still influence gender identity at a later stage of development, particularly after the onset of puberty. Hormonal influences on the expression of gender-typical role behaviour in pubertal gender-conforming adolescents are well known, but there is no evidence to date that the influence of pubertal steroid hormone levels can change a sense of belonging to a gender that is already differentiated after the onset of puberty. For example, there are no known increased rates of gender incongruence (female to male) among women with post-pubertal hyperandrogenism (e.g. polycystic ovary syndrome as its most common cause).

Neuronal correlates of transgender identities in the sense of brain structural findings that can be used to differentiate cisgender from transgender individuals are discussed on the basis of brain anatomical autopsy studies (Garcia-Falgueras & Swaab, 2008; Kruijver et al., 2000; Taziaux et al., 2012; Zhou et al., 1995). Structural MRI studies on the phenotypic differentiation of brain structural patterns of trans and cis individuals across both natal sex groups are also a currently growing branch of research, in which indications are reported that transgender individuals could represent a separate entity whose typical brain structural characteristics differ significantly from those of both cis-female and cis-male individuals (Flint et al., 2020; Mueller et al, 2021; Rametti, Carrillo, Gómez-Gil, Junque, Segovia, et al, 2011; Rametti, Carrillo, Gómez-Gil, Junque, Zubiarre-Elorza, et al, 2011; Savic & Arver, 2011; Zubiaurre-Elorza et al, 2013). As both the brain anatomy and MRI studies mentioned are cross-sectional findings in adults, no causal relationships can be derived from them to date.

In summary, current knowledge indicates that genetic, hormonal, neurobiological and psychosocial factors appear to be involved in the development of GI in the sense of a multifactorial aetiology (Ettner, 2020; Korpaisarn & Safer, 2019; Saleem & Rizvi, 2017; Skordis et al., 2020). However, the specific etiological mechanisms and reciprocal interactions are not yet well understood.

Glossary of important terms used in the guideline

Term	Explanations
Treatment seekers, **people seeking tretament**	The term "treatment seeker" or „people seeking treatment“ is used in the text of the guideline to emphasise that, in this context, it refers to underage patients together with their custodial relatives.
Caregivers	The term "caregivers" refers to all carers of children and young people, regardless of whether they are legally entitled to custody.
cis, cisgender	Term used in the running text as adjectives in contrast to the terms trans or transgender for all persons whose gender identity corresponds to the gender assigned at birth on the basis of biological and anatomical characteristics.
Coming out	The term "coming out" is used in the guideline text to differentiate from the term → "social role change" to describe the entire process of increasingly "showing oneself" to one's social environment in a non-conforming gender role that corresponds to one's currently perceived gender identity. Such a process often takes place in several steps and involves an increasing social radius.
Desistance, desisters	The term ‘desisters’ refers to children with temporary gender-nonconfromiforming identification who, during adolescence, do not develop persistent gender dysphoria with a desire for transiton (see Chapter II → "*Variant developmental trajectories (persistence, desistence and detransition)*"). In the research literature and in the guideline, the term is thus used exclusively for developmental trajectories from childhood to adolescence.

Detransition	In the guideline text, the term "detransition" is used for the step of turning away from gender-affirming medical interventions in the context of an initiated or completed transition. It is therefore only used if such a gender-affirming intervention (e.g. hormone treatment) has already been carried out. This includes a variety of trajectories, including those in which gender incongruence still persists or a non-binary identity is reported. Outside of the guideline text, the term is sometimes used more broadly, for example to refer to the reversal of a social role change before the start of medical interventions.
Capacity to consent[1]	Term for the ability of minors to give informed consent to a medical intervention (see Chapter X → *"Ethics and law"*).
Specialist	Term used in the guideline text for members of defined healthcare professions involved in diagnosis and treatment, e.g. doctors, psychologists or psychotherapists.
gender-nonconforming	The term gender-nonconforming is used here to generally describe children and adolescents whose observable behaviour or experienced identity does not correspond to the gender assigned at birth. The term is therefore used regardless of whether a medical diagnosis of persistent gender incongruence has (already) been made. The spectrum includes all children and adolescents with a corresponding identification, including open-ended or fluid trajectories (see Chapter V → "*Psychotherapy and psychosocial interventions*"). We use the term "gender-nonconforming" as a general descriptive term corresponding to the terms "gender-diverse" and "gender-variant" commonly used in English literature in order to avoid confusion with the term "diverse" used elsewhere in Germany for the third legal

[1] Translator's note: In the German speaking region the legal terms for a minor's capacity to consent to medical treatment are synonymous but named different in each country: Germany – *Einwilligungsfähigkeit (engl. capacity to consent)*; Austria – *Entscheidungsfähigkeit (engl. capacity of decision-making*; Switzerland – *Urteilsfähigkeit (engl. capacity of judgement)*. In the English translation only the term *capacity to consent* is used.

	gender entry (e.g. for non-binary persons) as well as with the term *variants of sex development, which is* designated in the discourse on *Differences in Sexual Development* (DSD, intersexual conditions).
Gender uncontendness	The term "gender-uncontentedness" refers to a spectrum of largely unspecific statements or self-descriptions that are accompanied by a subjective feeling of discomfort or distress in relation to gender-related role expectations or the anticipation of an adult gender role. This can include the wishful fantasy of preferring to belong to a different gender (e.g. "I would sometimes prefer to be a boy/girl"). Gender uncontentedness is a widespread fluid phenomenon in adolescence that is more common in young people with mental health problems than in non-clinical populations and does not usually persist into adulthood. It should be distinguished from gender incongruence and gender dysphoria.
Gender dysphoria (GD)	The term gender dysphoria is understood in the sense of the DSM-5 diagnosis of the same name (APA 2013) (see Chapter I → "*Preamble to the guideline*"). It describes a state of discomfort, distress or suffering that occurs because a person's gender identity differs from the sex assigned at birth. Not all trans and non-binary people suffer from gender dysphoria. In order to distinguish precisely in the text of the guideline whether the term gender dysphoria (GD) refers to a diagnosis or a condition leading to a diagnosis, this is specified in the description, e.g. with the addition "adolescents with diagnosed GI or GD" or "adolescents with gender dysphoric complaints/symptoms".
Gender incongruence (GI)	The term gender incongruence (GI) is understood in the sense of the ICD-11 diagnoses HA60 and HA61 (see chapter I → "*Preamble to the guideline*"). It describes the pronounced and persistent experience of a person that their gender identity does not match the gender assigned to them

	at birth. In order to be able to distinguish precisely in the text of the guideline whether a diagnosis or a condition leading to a diagnosis is meant, the addition "adolescents with diagnosed GI" or "adolescents with gender-nonconforming self-description" is used, for example.
Informed	In the context of medical treatment, "informed consent" refers to the patient's consent to a medical procedure based on sufficiently comprehensive information and education as well as a reflected understanding based on this.
Non-binary gender identity	A non-binary gender identity is located in a person's subjective perception of their *gender* beyond the binary gender binary of male and female. In the guideline text, we use the term as an umbrella term for various non-binary identifications, e.g. between male and female, beyond gender or gender identities that become fluid over the course of a person's life.

Non-binary understanding of roles	The term "non-binary role understanding" is used in the guideline text in differentiation to the term "non-binary gender identity" to describe a person's reflected understanding of their own gender role, which is not rooted in heteronormative ideas of "male" or "female", but defines their own role beyond social role expectations (see Chapters I and V → "*Preamble to the guideline*" and "*Psychotherapy and psychosocial interventions*").
Patient	In the text of the guideline, the term patient is used in its socio-legal meaning for the persons for whom a medical service to be provided in the healthcare system (including diagnostics and counselling) is defined ad personam (see Chapter I → "*Preamble to the guideline*"). In places in the text where medical services are not the focus, the term is deliberately omitted in the interests of depathologisation.
Persistence, persistent	The term persistence is used to describe the persistence of gender incongruence after the onset of puberty into adolescence (see Chapter VII → Recommendations for body-modifying measures).
Psychotherapeutic process support	The term psychotherapeutic process support is not meant here in the narrower sense of the defined guideline psychotherapy, but includes all forms of psychosocial support provided by psychotherapeutically trained professional helpers with the aim of maintaining or improving the mental health of children and adolescents with GI/GD (see Chapter V → "*Psychotherapy and psychosocial interventions*").
Custodian	The term "custodian" is used in the guideline text in accordance with the legal definition in the respective national legislation (D/A/CH).

Social role change, **social transition**	In the guideline text, the terms "social role change" and "social transition" are used synonymously and in distinction to medical transition measures. This refers to the decision not only to dress and behave according to one's own wishes in some or all areas of life, for example, but also to be consistently addressed and respected according to one's perceived gender identity (see also Chapter III → "Social role change in childhood").
trans, transgender	Synonymous adjectives that refer to the **self-description** or expressed affiliation to a spectrum of non-conforming gender identities (independent of a diagnosis), non-binary trans identities are included here.
Assigned gender, **sex assigned at birth**	The "sex assigned at birth" refers to a person's status as male, female or intersex based on physical characteristics - usually based on the appearance of the external genitalia - at the time after birth*, according to the terminology of ICD-11*. As the term "assigned sex" refers to this specific point in time, it always remains clearly defined over the course of a person's life, regardless of any medical transition treatments that may have been carried out.

Chapter I

Preamble to the guideline

1. **Why a preamble?**
2. **Text of the preamble**

1. Why a preamble?

This guideline provides medical recommendations in a field in which the international medical community has undergone a paradigm shift over the past two decades. In 2015, the World Medical Association called for the recognition of non-conforming gender identities as non-pathological norm variants of human development and their consistent depathologisation in all areas of medicine (World Medical Association, 2015) . The previously held view that transgenderism was a psychopathological aberration of gender identity has proven to be scientifically untenable - similar to homosexuality, which used to be also considered a disorder until 1977. Accordingly, in the WHO's ICD-11 (2022) , the diagnostic category of so-called *gender identity disorders*, which was still defined as such in the ICD-10 (WHO, 2019) , and thus also the former psychiatric diagnosis of what was previously known as *transsexualism*, were removed from the catalogue of mental disorders.

The disorder concepts behind these diagnostic terms are considered obsolete, even if diagnoses are still to be coded according to the old ICD-10 (WHO, 2019) for the time being. Instead, in the ICD-11 (WHO, 2022) , the new diagnosis of *gender incongruence* has been redefined outside the catalogue of mental disorders under a new heading *of conditions related to sexual health*. This has implications for the professional attitude towards people with non-conforming gender identities for healthcare professionals. Recommendations in this regard are detailed in Chapter IX → *"Professional interaction and discrimination-sensitive treatment of gender-nonconforming children and adolescents*". Current guidelines authorized by medical societies have already completed this paradigm shift towards consistent depathologisation and extensive individualisation of treatment paths, including the S3 guideline of the AWMF (Association of the Scientific Medical Societies in Germany) for adulthood *Gender incongruence, gender dysphoria and trans health* (DGfS, 2018)

German legislation has also followed this new direction with the law banning conversion treatments, which explicitly protects children and adolescents with an experienced non-conforming gender identity from attempts at therapy that are considered unethical. The recommendation of the German Ethics Council (2020) also emphasises the need to protect the right to self-determination of children and adolescents with regard to their gender identity and calls for careful consideration of the benefits and risks of *both* the contemplated treatment *and* the decision not to undergo such treatment when making medical treatment decisions in adolescence. Here, the participation and self-determination of minors must be taken into account just as appropriately as the protection against premature treatment decisions with possible harmful consequences in the event that gender incongruence does not persist. It should be emphasised here that, as in other areas of medicine, even optimal medical care can never guarantee absolute certainty that treatment decisions will not be

regretted at a later date (see section on *detransition* in Chapter II → *"Variant developmental trajectories").*

These challenges lead to controversies of a fundamental nature, which are also being conducted in society and politics far beyond medicine. Controversial discussions also took place within the guideline commission from the outset. In the interests of a goal-oriented, transparent and constructive process, the Guideline Commission has adopted the following approach to dealing with the fundamental issues mentioned:

- In internal discussions on consensus-based recommendations, the maximum possible consensus basis within the commission should be explored with the aim of providing future users of the guideline with a professional orientation based on the *strongest* possible *expert consensus* (i.e. > *95%*).
- In addition, the preamble presented below was agreed by *a strong consensus* (> *95%*) with the aim of prefacing the guideline text with a number of key principles that the Commission considers to be essential and that shall take appropriate and balanced account of the current medical, ethical and legal discourse.

2. Text of the preamble

Consented with strong consensus (> 95%)

1. The guideline is based on the ethical principles of respect for the dignity and self-determination of the person as well as beneficence and non-harm and aims to realise these principles in the treatment setting.

2. The overarching aim of the guideline is to improve access for children and adolescents with gender incongruence[1] and/or gender dysphoria[2] to professional information and treatment based on scientifically and ethically recognised standards, thereby enabling them to achieve the best possible health development.

3. Respecting the dignity of those seeking treatment, the guideline supports the elimination of discrimination and the depathologisation of people whose gender identity does not correspond to their anatomical sex or sex assigned at birth. This is reflected, among other things, in the terminology used. The term "*gender identity disorder"* from the ICD-10 (WHO, 2019) is therefore no longer used. Instead, the terms *"gender incongruence"* and *"gender dysphoria"* are used according to ICD-11 (WHO, 2022) and DSM-5 (APA, 2013) .

4. Patients[3] with gender incongruence and/or gender dysphoria have diverse individual developmental trajectories. Counselling and treatment should therefore be tailored to individuals and their needs. The guideline is intended to provide professional orientation for the best possible individual treatment decisions.

5. In the process of its development, the guideline is committed to the idea of participation of all parties involved, including transgender people and their relatives. The evaluation of previous experiences of people seeking treatment[4] in the healthcare system is incorporated into the new version of the guideline, in particular to improve the standards of available care and to avoid discrimination.

6. A person's gender identity is of a highly personal nature. Promoting self-determination and - where necessary - the ability to self-determine is therefore a key concern in the treatment

[1] The term gender incongruence is understood in the sense of the ICD-11 diagnoses HA60 and HA61 (see glossary of terms).
[2] The term gender dysphoria is understood in the sense of the DSM-5 diagnoses F64.0 and F64.2 (APA 2013) (see glossary of terms).
[3] The term patient is used in the text of the guideline in its social law meaning for the persons for whom a medical service to be provided in the healthcare system (including diagnostics and counselling) is defined ad personam.
[4] The term "treatment seeker" is used in the text of the guideline when it should be emphasised that in this context it refers to underage patients together with their custodial relatives (see glossary of terms).

setting with underage patients. Therapy approaches that are implicitly or explicitly based on the treatment goal of steering a person's sense of belonging to a particular gender in a certain direction are considered unethical.

7. Psychotherapeutic support[5] should be offered and made available at a low threshold to those seeking treatment, e.g. to support open self-discovery, to strengthen self-confidence, to overcome experiences of discrimination or for psychological preparation and follow-up of steps in the transition process. An obligation to undergo psychotherapy as a precondition for access to medical treatment is not ethically justified for reasons of respect for the dignity and self-determination of the person.

8. Decisions in favour of medical measures that intervene into not completed biological maturation imply a particular challenge and ethical responsibility for all those involved. On the one hand, the potential open-endedness of psychosexual and identity development to be assumed in individual cases and, on the other hand, the ever-increasing irreversibility of somatosexual maturity development and the possibly resulting increased risks to mental health must be taken into account. When deciding on medical treatment steps for puberty interruption or gender-affirming measures in adolescence, the expected benefits and risks must therefore be carefully weighed up. The possible consequential health risks of a decision in favour of medical treatment that is subsequently regretted by those affected or treatment that turns out to be misguided for other reasons must therefore be weighed against the health risks that may arise if medical treatment is postponed or not initiated.

9. The guideline is intended to serve as a professional basis for responsible medical treatment decisions, which are to be made jointly by health professionals, minor patients and their legal guardians in the sense of *shared decision making*. The guideline is intended to provide orientation in this regard, particularly with regard to the requirements for sufficient information and counselling to enable those seeking treatment to understand the nature, significance and scope of the respective treatment options and to decide on them.

[5] The term psychotherapeutic support is not meant here in the narrow sense of defined guideline psychotherapy for mental disorders, but includes all forms of psychosocial support provided by health professionals with a certified psychotherapeutic qualification (see explanations in Chapter V → *"Psychotherapy and psychosocial interventions"*).

Special vote of the German Society for Psychiatry, Psychotherapy, Psychosomatics and Neurology (DGPPN):

The Board of the DGPPN, whose elected representative consented the preamble, announced in its vote on the final version of the guideline that it does not support the preamble in the above-mentioned text version.

Justification see appendix (or *here)*.

Chapter II

Variant developmental trajectories (persistence, desistance and detransition)

1. Introduction and key questions

The observation that there are diverse developmental trajectories of gender-variant experience and behaviour in childhood and adolescence raises the question of predictors for a persistent transgender identity beyond puberty into adulthood. This is particularly important if a diagnosis of gender incongruence (GI) with gender dysphoria (GD) in early adolescence raises the question of whether hormonal puberty suppression is recommended and if there are indicators from the course of development to date that the persistence of transgender development can be predicted with a sufficiently high degree of probability. The assumption of a permanent persistence of gender incongruence is a decisive factor in the individual assessment of the benefits and risks that a decision in favour of or against medical interventions in physical maturation may entail. Developmental trajectories in childhood and adolescence exhibit a high degree of variance, particularly with regard to identity development, and can be fluid. The question of the assessability or *detectability* of persistent gender incongruence in children and adolescents is therefore at the centre of ethical debates on medical treatment options for adolescents with gender dysphoria who wish to undergo puberty blockade or gender affirming hormone treatment. The German Ethics Council addressed this topic in a bioethics forum in 2020 and subsequently adopted a recommendation. It outlines the ethical issues as follows[1]:

"With regard to children and adolescents, who are in any case a particularly vulnerable group, the therapeutic measures considered in the context of transgender identity require special ethical consideration. Tension arises from the fact that, on the one hand, the capacities of reflection and decision- making are still developing in adolescents and, on the other hand, the physical changes taking place in puberty create time pressure. In this situation, both treatment options considered and refraining from using them can have serious and sometimes irreversible consequences. The adults involved – the parents who have custody and the specialists in charge of treatment – are faced with the task of taking the minors' views and wishes into account while also safeguarding their well-being. The ethical challenge is to support minors on their way to their own gender identity and, at the same time, to protect them from – at times irreversible – harm.“" (German Ethics Council, 2020).

Considering that, within the known spectrum of developmental trajectories, there are both very clear trajectories of permanently persistent gender incongruence recognisable early in the course

[1] In December 2024, The Swiss National Ethics Committee for Human Medicine (NEK) published a comprehensive ethical opinion paper on the same issue: Medical treatment for minors with gender dysphoria – Ethical and legal considerations [New CNE opinion paper on the medical treatment for minors with gender dysphoria] National Advisory Commission on Biomedical Ethics NCE

of development, as well as known trajectories in which gender identity remains fluid over a longer period of time and so-called desistance (non-persistence of gender incongruence) occurs, in which gender identity in adolescence remains fluid over a longer period of time and so-called *desistance* (= *non-persistence*) of gender-incongruent feelings occurs, there is widespread international agreement among medical experts that adolescents with diagnostically confirmed gender incongruence should not be excluded from access to medical interventions as a matter of principle. The current national recommendations in Sweden, Finland and the NHS (National Health Service) England (excluding Scotland, Wales and Northern Ireland), which are more restrictive than the guidelines of international medical societies and this guideline, also contain suggestions for the recommendation of puberty blockers and gender-affirming hormone treatment in adolescence. They only define stricter criteria for their recommendation and access to tretament (see chapter in the appendix → "*Divergent treatment recommendations in other countries for children and adolescents with gender incongruence*")

Our guideline follows the recommendations of the German Ethics Council (2020) and the Swiss National Ethics Commission for Human Medicine (2024) in that professional and ethically justifiable treatment decisions in adolescence can only be made on the basis of a comprehensive assessment of the individual case and an individual risk-benefit analysis. To this end, it is essential to have sufficient knowledge of the variance in the developmental trajectories of gender-nonconforming children and adolescents, which is presented in the following chapter. Finally, consensus-based recommendations are derived from this. With regard to the high clinical relevance of the diagnostic assessment of persiting gender incongruence in terms of a persistent phenomenon, we refer to Chapter VII → "*Guidance for recommending body-altering medical interventions*".

Key questions of this chapter:

- What findings have been reported on the spectrum of variant developmental trajectories of children and adolescents with gender-nonconforming behaviour and on children and adolescents with clinical signs of gender incongruence?
- Is there evidence for prognostically relevant characteristics in children and adolescents with signs of gender incongruence or gender dysphoria that can be used to distinguish *desisters* from *persisters* in the future?

2. State of research

Firstly, it is necessary to clarify how persistence and non-persistence (hereinafter referred to as *desistance* in the Anglo-American literature) are to be defined. To avoid unintended connotations, the historical origin of these terms should be critically mentioned. The term persistence was initially used in psychological literature for disorder-relevant problem behaviour (including conduct disorders), from which the meaning of desistance could be derived as a "return to normal healthy behaviour" (Temple Newhook et al., 2018). In the context of research on variant developmental trajectories of gender diversity from childhood to adolescence, these terms are established in a purely descriptive sense. A connotation in the sense of problem behaviour or a turning away from it is not intended. In the present empirical studies, a distinction is made between two groups of children from clinical populations of service users who presented clinically *before* the onset of puberty:

- The term *persisters* is used to describe the group of children who showed a persistent gender incongruence with gender dysphoria through the course of puberty and usually continued on the path of transition, which was usually associated with medical treatment steps for puberty suppression and/or gender-affirming hormone treatment *in adolescence*.
- The term *desisters* is used to summarise the group of those *children* for whom no corresponding persistence of gender dysphoria with a desire to transition was reported *during adolescence*.

However, this does not allow any general conclusions to be drawn about the frequency with which these *desisters* permanently identified congruently with their gender assigned at birth - or were still in a fluid and therefore open-ended process of developing their adult gender identity at the time of the study survey (Steensma & Cohen-Kettenis, 2018; Temple Newhook et al., 2018). The two terms *persisters* and *desisters* were introduced into the discussion for this context by the authors of the Dutch working group led by Cohen-Kettenis and Steensma. Their specialised treatment centre in Utrecht and later Amsterdam was the first in the world to carry out puberty-suppressing and gender-affirming hormone treatments for adolescents with gender dysphoria on a case-by-case basis and to publish follow-up studies on this (Cohen-Kettenis & van Goozen, 1997; de Vries et al., 2011). In a published discussion article, Steensma and Cohen-Kettenis (2018) retrospectively emphasise that their follow-up studies are *not* suitable for deriving generalisable prevalence rates for *persisters* (so-called *persistence rates*) due to their partly selective case composition. This was also not the aim of their follow-up studies. The primary aim of these studies was to demonstrate the range of variation in developmental trajectories and to identify *possible early recognisable characteristics* of persistent gender dysphoria with a desire for treatment in adolescence (Steensma & Cohen-Kettenis, 2018). This should help to

increase decision-making certainty for upcoming recommendations for hormone treatment in minors (Steensma & Cohen-Kettenis, 2018).

The phenomenological diversity of gender-nonconforming gender expression in children necessitates a conceptual sharpening for the description of developmental trajectories as well as a clear definition of the cohorts initially investigated in childhood. In fact, previous studies have taken different approaches depending on the different questions asked. For example, earlier longitudinal studies in the 1960s to 1980s, which were based on a broad spectrum of children with gender-atypical behaviour (predominantly natal boys who exhibited feminine behaviour at an early age), reported high rates of later homosexual outcomes in adolescence. In contrast, more recent studies from 2008 onwards have looked more specifically at the developmental trajectories of children from clinical populations attending specialised gender clinics who were suspected or diagnosed with "gender identity disorder" (according to the earlier ICD 10 and DSM III-R or IV criteria). It is important to note that the diagnostic criteria for *childhood gender dysphoria* in the *DSM-5* diagnostic system (American Psychiatric Association, 2013) have been further narrowed in comparison to the older criteria for a so-called gender identity disorder in childhood according to ICD-10, DSM III-R or IV in that the diagnosis according to DSM-5 can no longer be given if the focus is exclusively on gender-nonconforming role behaviour. In order meet the diagnostic criteria according to DSM-5, however, it is required that, among other things, there is a strong explicit positive identification with a gender other than the gender assigned at birth (i.e. demanding to belong to this gender instead of only showing role-typical behaviour) and/or a pronounced body-related gender dysphoric distress (expressed discomfort with one‘s genitals. In order to match the diagnostic criteria according to DSM-5 (American Psychiatric Association, 2013), at least one of the following gender dysphoric symptoms must be present in childhood:

- A strong desire to be of the other gender or an insistence that one is the other gender
- A strong dislike of one's sexual anatomy
- A strong desire for the physical sex characteristics that match one's experienced gender“

As the DSM-5 (American Psychiatric Association, 2013) was not yet available at the time the children in the present studies were diagnosed, there are no valid data on the subsequent persistence rates of prepubertal children diagnosed with gender dysphoria according to the narrower DSM-5 criteria.

In the present follow-up studies with clinical cohorts on the persistence or desistance of gender dysphoria in childhood and adolescence, only children who had already sought health services at a prepubertal age due to their gender-nonconforming experience and behaviour were examined. Accordingly, persistence was defined as the fact that the children in question showed persistent gender dysphoria after *the onset of puberty* and accordingly completed a transition, including the desire for gender-affirming hormone treatment. Based on their gender-nonconforming behaviour in childhood, these adolescents are then considered *persisters*. In this respect, with regard to the limited evidence available, it must be noted that the available data on developmental trajectories are not representative of all children and adolescents with gender incongruence. Rather, these data were obtained on the basis of observations of a selective subgroup of these children, namely those who presented to a specialised institution (gender clinic) before puberty. This means that neither adolescents in whom gender dysphoria occurred for the first time after puberty, nor adolescents with gender dysphoria in whom gender-nonconforming behaviour was reported retrospectively from childhood but who were not presented for a specialised diagnosis before puberty, e.g. because gender-nonconforming behaviour was not seen as a problem, were included in these studies. In addition, the reported persistence and desistance rates from childhood onwards say nothing about how frequently or likely it is that gender dysphoria persists in adolescents who have gender dysphoria after the onset of puberty.

2.1 Early longitudinal studies (1960s to 1980s)

A look at previous research shows the influence of the historical context on the respective approaches. The older follow-up studies, which were published between 1968 and 1987 and were previously used to estimate the so-called persistence rates of gender-nonconforming behaviour in childhood (Bakwin, 1968; Davenport, 1986; Green, 1979, 1987; Kosky, 1987; Lebovitz, 1972; Money & Russo, 1979; Zuger, 1978, 1984), have some special features that distinguish them from the more recent studies from 2008 onwards. In some of these publications, the connection between gender-nonconforming behaviour in boys in childhood and a later homosexual sexual orientation plays a major role. The titles of some of these publications[2] already show the strong focus on homosexual developmental trajectories and gender-variant expressions. They have sometimes been accused of being characterized by efforts to prevent homosexual development (Bakwin, 1968; Kosky, 1987). Another limitation of the studies is the often small sample size, which limits the comparability of

[2] For example Zuger (1984): "Early Effeminate Behaviour in Boys. Outcome and Significance for Homosexuality" and Green (1987) "The 'sissy boy syndrome' and the development of homosexuality"

subgroups (Zucker, 2005). The results of these studies are therefore not suitable for deriving an estimate of a general persistence rate for children with gender-nonconforming behaviour. At best, they provide mpsys of the entire range of developmental trajectories without allowing quantitative statements to be derived from them.

2.2 More recent studies (since 2008)

No follow-up studies were published between 1987 and 2008. There were only provisionally reported data (Bradley & Zucker, 1990; Cohen-Kettenis, 2001), which were included in later publications (Ristori & Steensma, 2016).

From 2008 onwards, four studies can be identified which, in the form of quantitative follow-up studies, primarily dealt with the course of a "gender identity disorder" with onset in childhood operationalised according to DSM-5 or ICD-10. It should be noted that two studies were conducted by the specialised clinic in Toronto and two studies by the specialised clinic in Utrecht/Amsterdam. One qualitative follow-up study by Steensma et al. (2011) should also be taken into account. The descriptive data of a sample from the Frankfurt specialised outpatient clinic, which is presented in the monograph by Meyenburg(2020), was also included in this review.

2.2.1 Quantitative studies

The study by Wallien and Cohen Kettenis (2008) reports on the trajectories of 77 Dutch children (*N* = 59 natal males; *N* = 18 natal females), who were on average 8.37 years old at the time of initial presentation at the Dutch *Gender Clinic* and on average 19.24 years old at the time of follow-up. The entire study period covered the years 1989 to 2005. 75.3% of the children had a diagnosis of "gender identity disorder" (GID) according to DSM III-R at the time of initial presentation.

The study by Drummond et al.(2008) was also published in 2008, reporting on 25 natally female children from Canada who presented at the *Gender Clinic* in Toronto. Here, the mean age at the time of the childhood survey was 8.88 years and 23.24 years at the time of the respective follow-up. The time period considered covers the years from 1975 to 2004. 60% *of* the children in this sample were diagnosed with GID (according to the former DSM versions III, III-R and IV).

The sample of the second Canadian study (Singh, 2012) comprises 139 natally male children with a mean age of 7.49 years at first presentation and 20.58 years at follow-up. The corresponding data were collected between 1975 and 2009. The GID diagnosis (according to DSM versions III, III-R and IV) was made in 63.3% of the children.

The second Dutch study (Steensma et al., 2013) includes the cases of 127 children in total (*N* = 48 natal females and *N* = 79 natal males). The average age at the initial survey was 9.15 years and 16.14 years at follow-up. Data were collected between the years 2000 and 2008. 63% of the children were diagnosed with GID (according to DSM-IV).

The studies mentioned differ from each other in some respects, both in terms of their methodological approaches and the results reported.

2.2.2 Qualitative study by Steensma et al. (2011)

The aim of this analysis of 25 biographical interviews was to identify qualitative characteristics that differentiated the developmental trajectories of later *persisters* from those of later *desisters*. One of the key findings reported was that the age range between 10 and 13 was considered by both *persisters* and *desisters* to be critical or largely decisive for the later course of development. In this context, the physical changes in the course after the onset of puberty, the accompanying changes in the social environment and experiences with falling in love appeared to be particularly significant for the adolescents.

Furthermore, it was found that later *desisters* were more likely to have expressed *a desire* to belong to a different gender in childhood, while it was more typical for later *persisters* to insist that they already actually belonged to the opposite gender (e.g. "I am a girl" vs. "I would rather be a girl").

2.2.3 Data from the Frankfurt specialised outpatient clinic

The descriptive data of the clinical sample described by Meyenburg(2020) (*N* = 46 at follow-up) show a large difference in the persistence rate depending on age at first presentation. A persistent outcome was significantly less common in children who were presented for the first time before the age of 12. Here, the proportion of *persisters* was 33%. In comparison, 88% of those who presented after the age of 13 - i.e. under the influence of pubertal development - showed an outcome of persistent gender dysphoria. This corresponds to the clinical experience of relevant treatment centres and underlines the fact that gender dysphoria that (continues to) exist after the onset of puberty is much more likely to persist, whereas in comparison, signs of gender incongruence or gender dysphoria in childhood are much more likely to desist later.

2.2.4 Methodological differences in the definition of persistence and desistance

Singh (2012) defines *persisters* as those participants who fulfil at least one of the following three criteria in the follow-up survey: (1) A mean score on the *Gender Identity/Gender Dysphoria Questionnaire for Adolescents* (Deogracias et al., 2007) of three or lower, (2) the presence of two or more items in the *Gender Dysphoria Questionnaire* (Zucker et al., 1996*)*, (3) the presence of strong

indications of gender dysphoria from the interviews conducted. In Drummond et al.(2008) persistence was assumed if either the diagnosis of GID (according to DSM-IV) was present at follow-up or if there were strong indications of this from the interviews conducted.

In the Dutch studies (Steensma et al., 2013; Wallien & Cohen-Kettenis, 2008) it is noticeable that the group of *desisters* does not only include those young people (or adults) who were identified as *desisters* as part of their personal participation in the follow-up surveys. Instead, all *non-responders* (those participants who were not reached for a follow-up survey) are also categorised as *desisters*. The background to this is that the Amsterdam clinic was the only clinic in the Netherlands offering a special clinical service for adolescents with gender dysphoria. This led the authors to assume that all former patients who no longer attended the clinic at a later date could be classified as *desisters*. As there can be many reasons for non-participation or withdrawal from the study, it was critically questioned to what extent it is justified to include *non-responders* among the *desisters* (Temple Newhook et al., 2018).

As Steensma and Cohen-Kettenis (2018) explain in a later discussion paper on their studies, this approach was guided, among other things, by the operationalisation of persistence, which primarily included the persistent desire to start gender-affirming hormone treatment *in adolescence*, whereas desistance was equated with non-persistence according to this operationalisation. Accordingly, desistance in this definition is not to be equated with a permanent *reconciliation* with the physical sex assigned at birth, but can also include fluid developmental trajectories that remain open into adulthood with regard to gender identity (Steensma & Cohen-Kettenis, 2018). Furthermore, cases were included in which only parents were able to provide information.

2.2.5 Longitudinal studies of children with social transition before puberty

Children who undergo a complete social role change before puberty are to be regarded as a highly selective subgroup within the spectrum of gender-nonconforming children, in which the persistence of gender incongruence into adolescence is described much more frequently. The studies on this subgroup are presented separately in Chapter III → *"Social transition in childhood".*

2.3 Findings of recent studies

2.3.1 Persistence rates

Due to the differences described with regard to the definition of persistence and desistance between the studies, it makes sense to present a differentiated presentation of the persistence rates and to carry out re-analyses (Nonhoff, 2018), which are illustrated in the following table.

Table 2

Determined persistence rates of non-conforming gender identity in childhood depending on defined inclusion criteria

	Drummond et al., 2008	Singh, 2012	Wallien & Cohen-Kettenis, 2008	Steensma et al., 2013
N to baseline	25	139	77	127
Age range at baseline	3-12	3-12	5-12	6-12
Mean ages at baseline	8.9	7.5	8.4	9.2
Age range for follow-up	15-36	13-39	16-28	15-19
Mean age at follow-up	23.2	20.6	18.9	16.1
Persistence rates in %				
total as reported	12.0	12.2	27.3	37.0
total without nonresponders[a]	12.0	12.2	39.0	47.5
female[b]	12.0	-	50.0	50.0
male[b]	-	12.2	20.3	29.1
with GID diagnosis[c]	13.3	13.6	36.2	55.0
with GID diagnosis without nonresponder[d]	13.3	13.6	50.0	63.8
without GID diagnosis[e]	10.0	9.8	0.0	6.4

[a] Study participants who did not report back or who were not available for a follow-up are not taken into account here.

[b] "Female" or "male" refers to the sex assigned at birth, if rates where reported for one sex subgroup

[c] Reported rates if only cases diagnosed with *Gender identity disorder in childhood* are taken into account.

[d] Reported rates if only those cases are taken into account in which the participants both had a GID diagnosis in childhood and took part in the follow-up.

[e] Reported rates if no GID diagnosis was given in childhood.

As expected, the results presented in Table 2 show that the respective persistence rates determined vary considerably depending on the inclusion criteria applied (diagnosis of "gender identity disorder" fulfilled in childhood?, non-responders counted as desisters?). In addition to the selectivity of the samples, this severely limits the generalisability of the persistence rates reported in the studies reviewed with regard to probability of occurrence. In particular, generalised statements taken out of context without a precise definition of the initial criteria (age, GD diagnosis), such as the figures frequently used by popular media according to which allegedly 80% of gender dysphoric adolescents would not develop a permanent transgender identity, cannot be supported by evidence. At best, the statement that a high to very high proportion of children with gender-nonconforming role behaviour who *do not* meet the diagnostic criteria for gender dysphoria do not develop persistent gender dysphoria in adolescence can be supported by evidence. Furthermore, a strong centre effect is noticeable. The persistence rates determined in Toronto were significantly lower than those in the Dutch studies. The underlying treatment concepts, which diverged considerably between the two centres, must be viewed critically here. In Toronto, it was part of the explicit concept to recommend treatment for children with the aim of reducing the probability of persistence of transsexualism (Zucker et al., 2012).

From today's perspective, such an approach to treatment would not only be unethical, but would even be prohibited in Germany under the law passed in May 2020 to protect against conversion treatments. Taking into account the treatment approach of the Gender Clinic in Toronto at the time, there are at least two possible biases to consider (Temple Newhook et al., 2018): Firstly, the aforementioned context of service utilization means that prepubescent children presented there were overrepresented, whose parents saw gender-nonconforming behaviour as problematic combined with the desire to "avert" a possible later transsexualism of their child. Secondly, since the basic professional attitude of the practitioners at this clinic was along the noted lines, it would be expected that children who continued to exhibit gender dysphoric feelings or behaviour as adolescents would be underrepresented in a sample examined there. In a clinic in which a persistent course of children with gender incongruence was regarded as an unfavourable outcome and in which therapeutic efforts were undertaken with the declared intention of making this outcome more unlikely if possible, it can be assumed that at least some of the children with a persistent transgender identity treated there were inhibited in unfolding their identity.

In the Amsterdam clinic, on the other hand, it was part of the explicit concept to approach all potential developmental trajectories of gender variant children with an open and accepting attitude. This was combined with the offer to support a social transition with puberty-suppressing and gender-

affirming hormone treatment in the event of persistent gender dysphoria, without connoting this as a favourable or unfavourable outcome (Steensma & Cohen-Kettenis, 2018). The authors themselves also emphasise that the aim of the Dutch studies was not to determine a representative persistence rate, but to illustrate the range of variation in developmental trajectories and to identify discriminatory predictors that facilitate the diagnostic assessment of persistent outcomes, particularly in early adolescence (Steensma & Cohen-Kettenis, 2018).

2.3.2 Predictors

In addition to the assessment of how likely or how frequent a persistent outcome is in general, the question of possible factors that allow a prediction in individual cases (predictors) is of particular interest. The following predictors were analysed:

Presence of a GID diagnosis[3] *already in childhood* (Singh, 2012; Steensma et al., 2013; Wallien & Cohen-Kettenis, 2008)

- There were significantly higher persistence rates if a GID diagnosis was made in childhood compared to cases of service users in which the (former) criteria for a GID diagnosis in childhood were not met.
- Wallien et al. (2008) point out that in their study a significant correlation between GID diagnosis in childhood and persistence was only found for natal boys and not for natal girls.
- Steensma et al. (2013), on the other hand, report a significant effect of a GID diagnosis in childhood on the probability of persistence, regardless of gender.

Sex assigned at birth (Steensma et al., 2013; Wallien & Cohen-Kettenis, 2008)

- Both Dutch studies report a higher probability of persistence of gender dysphoria in natal girls (i.e. trans boys).

Age at the time of first presentation in childhood (Singh, 2012; Steensma et al., 2013; Wallien & Cohen-Kettenis, 2008)

- Wallien et al.(2008) cannot report any age influence on the probability of persistence.
- The differentiated analysis by Steensma et al. (2013) generally suggests that the probability of persistence is lower in children who were younger at first presentation. However, due to the

[3] GID - Gender Identity Disorder of Childhood according to ICD-10, DSM-III-R or DSM-IV

smaller subsample of natal girls, this influence only proved to be significant for natal boys if age was analysed separately by gender as a predictor.

- Singh(2012) showed a similar correlation: children who were older at the time of their first presentation in childhood were more likely to be later *persisters.*

The expression of gender-incongruent behaviour (Drummond et al., 2008; Singh, 2012; Steensma et al., 2013; Wallien & Cohen-Kettenis, 2008)

- Drummond et al. (2008) and Singh (2012) point to a significant influence of gender-variant behaviour in childhood on the probability of persistence.
- Wallien et al. (2008) report that the extent of gender variant behaviour in childhood is a significant predictor for natal boys but not for natal girls.
- According to Steensma et al. (2013), bivariate analyses showed that that a high level of gender-incongruent behaviour predicted a higher likelihood of persistence across all measures examined.

Completed early social transition (Steensma et al., 2013)

- Generally speaking, an early social transition proved to be a significant predictor of persistent outcomes (although causalities cannot be inferred here). Separated by gender and within the framework of multivariate analyses, however, a significant influence was only found for natal boys.

2.3.3 Epidemiological data on the course of gender incontentedness in adolescence

In a current longitudinal study with a representative cohort of 2772 adolescents (53% male/ 47% female) from the *Tracking Adolescents' Individual Lives Survey* and a clinical comparison cohort, the development of gender-specific incontentedness, i.e. dissatisfaction with the gender corresponding to one's own sex assigend at birth, was investigated from early adolescence to young adulthood (age 11-26 years) at six measurement points (Rawee et al., 2024). In addition, the relationship between subjective gender incontentedness and self-concept, behavioural and emotional problems and sexual orientation in adulthood was investigated. Gender-specific incontentedness was measured at all six survey waves using the item "I wish I belonged to the opposite sex" from the *Youth and Adult Self-Report* (YSR/ASR). Behavioural and emotional problems were measured using the total scores of these scales at all six waves. Sexual orientation was determined by self-report at the age of 22.

At the beginning of puberty (11 years), 10% of participants stated that they were "sometimes" dissatisfied with their gender, 2% stated that this was "often" the case. The prevalence decreased with increasing age and was 2% for "sometimes" and 1% for "often" at the age of 26. Three types of developmental trajectories of gender incontentedness were identified: Consistently no gender incontentedness was found in 78% of respondents, decreasing gender incontentedness in 19% and increasing gender incontentedness over time in 2% of respondents. People with increasing gender incontentedness were more frequently assigend female at birth. Irrespective of an increasing or decreasing course, gender incontentedness in adolescence were associated with lower self-esteem, more behavioural and emotional problems and a non-heterosexual orientation in adulthood. Compared to the normative cohort, the frequency of gender incontentedness in the clinical comparison cohort was consistently 2-4% higher up from the second measurement at the age of 13-14 years, whereby this was mainly due to the weaker expression ("sometimes"). A more pronounced gender incontentedness ("often") was affirmed by 2% of respondents in both the normative cohort and the clinical cohort in the first survey at the age of eleven. In the age groups between 13 and 24, the frequency of higher incontendedness was only between 0.01% and 0.05%, rising to 1% at the age of 26.

When interpreting these findings, it is important to note that the phenomenon of "gender incontentedness" as investigated here, which was operationalised solely on the basis of the answer "sometimes" or "often" to the questionnaire item "I wish I belonged to the opposite sex", cannot be equated with the phenomenon of gender incongruence or gender dysphoria. Particularly among the young people who answered to this item with "sometimes" at the age of 11-14, this rather vague or diffuse self-disclosure predominantly declined during the course of further development.

It can be concluded from the data that a temporary *gender incontentedness* is a widespread phenomenon in adolescence, which occurs more frequently in adolescents presenting with clinical problems than in the average population. No conclusions can be drawn from the data of this study regarding the frequency of gender incongruence or gender dysphoria in adolescence or its persistence over the course of development. It can only be assumed that the prevalence of gender incongruence or gender dysphoria in adolescence is likely to be in the range of a small fraction of the reported frequencies of *gender incontentedness*.

3. Summary of the empirical evidence

Based on the current state of knowledge, some predictors can be derived in prepubertal childhood that are associated with a higher probability of persistent gender dysphoria in adolescence

and adulthood. However, these predictors only have a *relative predictive value*. To date, *there is no confirmed feature* that allows to predict a persistent outcome into adolescence in the case of assumed gender incongruence or gender dysphoria *in childhood*.

The following empirically confirmed statements can be summarised:

3.1 Persistence rates reported in previous studies

- For children who can be diagnosed with "childhood gender dysphoria" before the onset of puberty according to the narrower criteria of the DSM-5 (American Psychiatric Association, 2013), *no* persistence or desistance rates for gender dysphoria in adolescence have been reported to date.
- For children who were diagnosed with "childhood gender identity disorder" (according to earlier ICD-10 and DSM-III-R or DSM-IV criteria) before the onset of puberty, widely diverging persistence rates for gender dysphoria in adolescence ranging from 13% to 63% were reported as heterogeneous findings based on populations of service users of two treatment centres. Due to methodological limitations, representative statements are not possible here either.

3.1.1 Predictor: Gender

- Natally female children with signs of gender dysphoria were more likely to report persistent developmental trajectories of gender dysphoria in adolescence as compared to natally male children (Steensma et al., 2013; Wallien & Cohen-Kettenis, 2008).

3.1.2 Predictor: level of gender-incongruent behaviour and completed social transition

- A high level of reported gender-incongruent experience and behaviour or gender dysphoric symptoms in childhood and a social transition already completed in childhood are associated with a higher probability of persistence of gender dysphoria in adolescence (Drummond et al., 2008; Singh, 2012; Steensma et al., 2013; Wallien & Cohen-Kettenis, 2008).

In this context, no statement can be derived from the reported data regarding its direction of effect. In other words, no statement can be made as to whether a social role change that takes place in childhood before the onset of puberty has an effect per se on the probability of a persistent outcome. A possible selection effect must be taken into account: Children with highly pronounced gender incongruence before puberty and therefore more probably showing later persistence are also more likely to perform a social transition in childhood (see Chapter III → "*Social transition in childhood*").

3.1.3 Predictor: Age

- The younger a child was before puberty at the time of a presentation for clinical assessment, the less predictable was the probability of persistent gender dysphoria in adolescence within a wide range of developmental trajectories (Singh, 2012; Steensma et al., 2013).
- For the developmental trajectories of children in whom there are already clear indications of childhood gender dysphoria before the onset of puberty, the age range of 10 to 13 years can be assumed to be the critical phase in which it typically becomes clear whether gender dysphoria persists or not.

As the reported studies relate exclusively to the developmental trajectories of adolescents who were referred to a specialised health service (gender clinic/special consultation service) in childhood due to their gender-nonconforming behaviour, the reported data also do not allow any statement to be made about the prognostic probability of persistent gender dysphoria if *gender dysphoric symptoms first become* apparent to the social environment *after the onset of puberty*. Gender dysphoric symptoms can appear for the first time at any age. In particular, an apparently gender-conforming development in childhood as reported by parents does not per se indicate a low probability of persistence, if gender dysphoria is presented by a teenager.

When providing professional counselling and support for prepubertal children with clinical signs of gender incongruence or gender dysphoria, the uncertainty of predicting the future course of development, in particular the fact that there is currently no criterion that can be used to predict the later persistence or desistance of gender dysphoria in adolescence *before the onset of puberty*, must be given appropriate consideration.

3.2 Conclusions

To summarise, the following empirically supported conclusions can be drawn from the current state of knowledge on variant developmental trajectories of children with signs of gender incongruence and/or gender dysphoria:

- Subjective dissatisfaction with the gender role corresponding to one's sex assigned at birth (*gender incontentedness*) is a frequent phenomenon in early adolescence (up to 11%), especially in a weak form of expression ("sometimes"), which is predominantly to be categorised as a temporary developmental phenomenon and does not allow any statement to be made about the presence or absence of gender incongruence or gender dysphoria.
- The evidence to date does not allow any generalisable assumptions about the persistence rates of gender incongruence from childhood to adolescence.

- Children who show gender-nonconforming behaviours before puberty often *do not* develop persistent gender dysphoria during puberty.
- Children before the onset of puberty who show more pronounced signs of gender incongruence or gender dysphoria are more likely show persistent gender incongruence in later life, especially if a diagnosis of gender incongruence/ gender dysphoria is present already in childhood.
- However, even if there are clear signs of gender incongruence before the onset of puberty, it is not possible to reliably predict its persistence.
- In children in whom there are clear indications of gender incongruence before puberty, it typically becomes clear by the age of 13 whether gender incongruence persists under the influence of pubertal maturation.

This has the following implications for healthcare practice:

- In a child before the onset of puberty, it is not yet possible to predict *persistent gender incongruence in adolescence*, even if there are clear signs of gender incongruence in childhood (see recommendation II.K.3 at the end of this chapter).
- Recommendations for any medical interventions to support a transition are therefore obsolete before the onset of puberty (see recommendations in Chapter VII → "*Guidance for recommending body-altering medical interventions"*).
- A diagnosis of *gender* incongruence *in childhood* (ICD-11: HA61) made before the onset of puberty can therefore not justify a need for medical action, but at best has the value of a documented early onset of the reported signs of gender incongruence with regard to any later assessment or recommendation for medical interventions. (see recommendations in Chapter VII → "*Guidance for recommending body-altering medical interventions"*).

4. Trajectories with the outcome of later detransition

As mentioned above, the research literature refers to adolescents as *desisters* (as opposed to *persisters*) if gender incongruence, which was already present *in childhood*, was not consistently present in adolescence (Steensma & Cohen-Kettenis, 2018; Temple Newhook et al., 2018). It is therefore a construct derived from observational studies on clinical populations of service users that were conducted in earlier decades. The findings of these studies are only transferable to today's social context to a very limited extent, partly because gender-nonconforming behaviour in childhood is increasingly less problematised by today's society and therefore the use of professional healthcare services for prepubertal children presenting with gender-nonconforming behaviours is increasingly seen as less necessary.

In recent publications, the term "detransitioners" has been introduced but inconsistently used (Expósito-Campos, 2021): Basically, this refers to persons who break off or (partially) reverse a transition that has already begun, which can include steps completed in the past in a social, legal and/or medical transition. The reasons for this can vary. This can refer to individuals who, after a period of experienced transgender identity and a completed social transition, identify again with their gender assigned at birth or as non-binary and therefore cancel a transition that has already begun. However, it can also refer to individuals who cancel or reverse a transition for external reasons (social pressure, medical reasons, etc.) but whose experienced transgender identity nevertheless persists.

The desired discontinuation of gender-affirming medical treatment is of particular importance for patient safety issues and should therefore be considered here. In widespread views, detransition after gender-affriming medical treatment is seen as a negative outcome (Cohn, 2023; Entwistle, 2021). Nevertheless, detransition should not be equated with *regret* (= regretting a previous wrong decision). In a meta-analysis, Bustos et al. (2021) estimate the frequency of *regret* after gender reassignment surgery in adults at less than 1% to 2% of those who have undergone surgery. However, patients do not necessarily regret a gender-affirming treatment when they decide to discontinue it, however, they sometimes state that it was a positive step for them at the time of starting this treatment. It also happens that a detransition is temporary and that, for example, gender-affriming hormone treatment is resumed later (Littman, 2021; Turban et al., 2021). Detransition is therefore not necessarily to be understood as the final endpoint of a gender dysphoric trajectory, but can be temporary. To date, the phenomenon of detransition has been little researched (Butler & Hutchinson, 2020). The following original publications were identified for a review of empirical findings on detransition following gender-affirming medical treatment on the basis of our systematic literature research and additional communication among the members of guideline steering group:

In an English study (Boyd et al., 2022), a retrospective chart review of 41 patients who were treated with gender-affirming hormones was conducted in one general practioneer’s practice. Gender-affirming treatment began in almost all cases during adulthood. It was found that out of the 41 patients mentioned, 4 trans men (10%) discontinued the hormone treatment, i.e. they detransitioned. These 4 persons had been taking androgens for an average of 18 months and had not undergone gender-affirming surgery. No trans woman or non-binary person reported detransition. The authors report that 32% of the patients were not treated by a specialist for endocrinology. In addition, 62% were not treated in accordance with (inter-)national treatment standards, although this mainly relates to medical aspects and not to the standards for determining recommendations for the beginning of gender affirming treatments.

In another retrospective chart review from a specialised gender service for adults in England, Hall et al. (2021) analyzed the clinical records of 175 patients. Additional reports of psychiatric or psychotherapeutic treatment outside the treatment centre were also included. Of the 175 persons, 156 (89%) started gender-affirming hormone treatment. 61% of the patients were assigned male at birth and 39% were assigned female. Patients had to be at least 17 years old when they first presented to the treatment centre and the median age at first presentation was 25 years. In 12 patients (7% of 175), detransition occurred after the initiation of hormone treatment. Of these, eight were natal males and four were natal females, which roughly corresponds to the general gender distribution in the sample. In other six cases some signs similar to detransition were reported, however, in these cases continuous hormone treatment had not been undertaken before.

In a community-based study, Littman (2021) surveyed 100 selected individuals with a reported experience of detransition. 93% of them discontinued a gender-affirming treatment or had it reversed. 7% of the respondents discontinued a puberty blockade. Participants were recruited via detransitioner groups on internet websites as well as mailing lists of specialised practitioners. Of the participants, 68% were assigned female at birth and 32% were assigned male. The participants were on average 22 years old (*SD* = 6) when they first sought out a practitioner for gender-affirming treatment. It is therefore highly likely that only a small minority of respondents were under the age of 18 at the start of their medical transition. No specific analysis is available for this subgroup. On average, an interval of three years was reported between starting and stopping hormone treatment. 50% of respondents reported strong or very strong regret about their former transition. The reasons for detransition were categorised by the author as non-exclusive to one another in the following proportions: Recognition that experienced gender dysphoria was due to another mental disorder or trauma (58%); social pressure for original transition (20%); original transition was due to internalised misogyny (7%); social pressure (stigma etc.) to detransition (29%); identification as non-binary (16%). 55% of respondents reported that they had been diagnosed with a mental disorder before the onset of gender dysphoria. 57% of respondents felt that the diagnosis before starting treatment was inadequate and at least 46% of respondents felt that they had not received sufficient information.

Turban et al. (2021) analysed a comprehensive survey of trans people in the USA with regard to (past) detransitions. The sample therefore only includes people who identified (again or still) as trans at the time of the survey. 13% of respondents who had ever transitioned stated that they had (temporarily) detransitioned in the past. However, this does not necessarily refer to gender affirming treatment. In the group of respondents with detransition experiences, persons assigned male or female at birth were represented in roughly equal numbers (51% vs. 49%). The authors categorised

the reasons for (temporary) detransition into *external* (e.g. social pressure) and *internal* (e.g. lack of clarity regarding gender identity). There is no specific analysis of reasons for the subgroup of respondents who had transitioned before the age of 18. Of the respondents who had detransitioned in the past, 83% reported at least one external reason and 16% at least one internal reason.

In a community-based study, Vandenbussche (2021) interviewed 237 selected people who described themselves as detransitioners. The participants were recruited via detransitioner groups on internet websites. Of the participants, 92% were assigend female at birth and 8% were asigend male, possibly due to selective recruitment. Of all respondents, approximately 64% reported prior gender affriming hormone treatment and 30% reported (possibly additional) gender affirming surgery. 25% began their medical transition before the age of 18. No specific analysis is available for this subgroup. On average, an interval of 2 years was stated between the start of treatment and detransition. Of all respondents, 60% expressed regret regarding the transition and/or the medical treatment. The following reasons for detransition were mentioned most frequently:

- "realised that my gender dysphoria was related to other issues" (70%),
- "health concerns" (62%) and
- "transition did not help for my dysphoria" (50%).

A clear majority of respondents stated that they had been diagnosed with one or more mental disorders and 54% reported at least three co-occurring mental disorders. In addition, 78% of respondents stated that, in retrospect, they did not feel sufficiently informed or only partially informed about the treatments and interventions they had received.

In the clinical follow-up study by de Vries et al. (2014), the long-term courses of *N* = 55 persons were analysed who, as adolescents, after careful assessment and with assured ongoing professional support, first received puberty blockade, then affirming hormone treatment and then underwent gender affirming surgery. On average, the time between the start of gender affirming hormone treatment and the interview was four years. Of the 55 people reported, no case of regret and/or detransition was reported. However, it should be noted that the sample analysed is ideally selective in several respects. However, the results suggest that in order to reduce the outcome risk of later detransition when treatment decisions are made in adolescence, it makes sense to define professional standards for quality assurance in the determination of clinical recommendations and professional support.

To summarise, only cautious statements can be made given the sparse research on detransition with very selective samples. It should also be emphasised that in most of the reviewed studies detransition was reported mainly in persons who began their medical transition as adults.

In clinical chart reviews based on adult samples the frequency of detransition was reported between 7% and 10%. Turban et al. (2021) stated that 13% of those surveyed had detransitioned only temporarily in the past. In the clinical study by de Vries et al. (2014), there were no incident detransitions in the small sample. Given the background of stricter requirements in international guidelines for recommendations of of body-altering medical interventions for adolescents as compared to adults (Coleman et al., 2022), it can be assumed that the detransition rate is lower in persons who started their treatment as adolescents than in the reported chart reviews on adults. Robert et al. (2022) provide an indication of this: in a selective sample, it was shown that at least 74% of the persons who had started affriming hormone treatment as minors were still continuing it after four years. In contrast, at least 64% of those who had started hormone treatment as adults continued it after the same time interval, which represents a statistically significant lower continuation rate. However, this study should be interpreted with caution, as only the positively documented continuation of hormone treatment was analysed. The reasons for undocumented continuation of treatment were not reported, meaning that for these cases detransition cannot be reliably assumed. Nevertheless, the data does not indicate a higher detransition rate for persons who started gender affriming medical treatment in adolescence compared to adulthood, but rather the opposite.

The findings regarding the sex assigned at birth and the (previous) gender identity of detransitioned persons are inconsistent. While in some studies *detransitioners* assigned female at birth are overrepresented (Boyd et al., 2022; Littman, 2021; Vandenbussche, 2021), in another study *detransitioners* assigend male at birth are overrepresented (Turban et al., 2021) or the gender ratio of *detransitioners* corresponds to the ratio in the overall sample (Hall et al., 2021). These variations are presumably due to the strongly divergent sampling between the studies. The mean duration from the start of gender affirming treatment to detransition is reported to be relatively similar in the range of one and a half years (Boyd et al., 2022) to three years (Littman, 2021) and thus is significantly shorter than a follow-up period of eight years as recommended by Cohn (2023).

While Littman (2021) and Vandenbussche (2021) mainly report intrinsic factors for detransition and a subsequent renunciation of transgender identification, Turban et al. (2021) mainly report extrinsic reasons while transgender identification was persisting at the time of the survey. The frequency of *regret* among *detransitioners* is only surveyed in the two community-based studies (Littman, 2021; Vandenbussche, 2021) and was reported at 50% and 60% respectively. In these two

studies, 46% and 78% respectively also felt that they had not received sufficient information about the medical treatment they had started. From a clinical point of view, the chart review by Boyd et al. (2022) also provides evidence of treatments that were not in line with specialist and guideline-based requirements. It can be concluded that the risk of detransition is higher if medical transition treatments are not recommended and carried out in accordance with professional guidelines or quality standards.

Accordingly, the Standards of Care of the WPATH (Coleman et al., 2022) formulate the following recommendation for the adequate treatment of adolescents diagnosed with gender incongruence, pointing out that detransition is a rare phenomenon:

"[...] detransitioning may occur in young transgender adolescents and health care professionals should be aware of this." (Coleman et al., 2022, p. 547).

5. Recommendations for professional counselling in the healthcare setting

Consensus-based recommendation:

II.K1.	When providing professional counselling to children and adolescents with signs of gender incongruence/gender dysphoria (GI/GD) and their guardians and, if applicable, other caregivers, professionals should have comprehensive knowledge of the range of variations in possible gender-diverse developmental trajectories in childhood and adolescence.

Consensus strength: strong consensus (> 95%)

Consensus-based recommendation:

II.K2.	If counselling takes place in connection with a desired or already initiated social role change, the child or young person, their guardians and, if applicable, other caregivers should be informed about the variety of developmental trajectories, including the possibility of later detransition

Consensus strength: strong consensus (> 95%)

Consensus-based recommendation:

II.K3.	In children before the onset of puberty who show signs of childhood gender incongruence (according to ICD-11 HA61)[4], health professionals should assume that it is not possible to predict *persistent* gender incongruence in adolescence until the onset of puberty.

Consensus strength: strong consensus (> 95%)

[4] For the diagnostic criteria for childhood gender incongruence (HA61), see Chapter VII → "*Guidance for recommending body-altering medical interventions*".

Chapter III

Social transition in childhood

1. Introduction and key questions

2. Legal and ethical requirements

3. The state of empirical knowledge

3.1. Summary of the empirical state of knowledge

4. Recommendations for professional counselling

4.1. Recommendation of other guidelines

4.2. Consensus-based recommendations

1. Introduction and key questions

The question of whether and to what extent gender-nonconforming children should be supported in achieving a complete social transition *before* puberty, i.e. to dress, behave and be addressed according to their own wishes in all areas of life, is the subject of controversial debate among experts. There are children who demand this persistently and with great vigour. In individual cases, an educational approach that is primarily orientated towards the child's well-being and their unimpaired socio-emotional development is required, which basically is the responsibility and discretion of the legal guardians and does not require a medically justified decision or any medical action. However, children with signs of gender incongruence (GI) or gender dysphoria (GD) are presented in medical and psychotherapeutic treatment contexts at any developmental age with the request for professional advice. Such professional counselling should then be informed by the available evidence to date and made accessible to those seeking advice. It is also not uncommon for educational institutions (daycare centres and primary schools) to request medical or psychological opinions in order to provide professional support for an educational approach or procedure that is oriented towards the child's welfare. As the earlier S1 guideline on "Gender identity disorders in childhood and adolescence" was also used as a professional frame of reference for educational or family psychology issues in the past, despite its intention to focus on the medical treatment context, the authors of the guideline consider it important to present the current state of knowledge and recommendations that could be derived from it, while exercising due restraint in educational matters.

Key questions for the guideline:

- What implications for further development can result from a social transition in childhood?
- What findings are there with regard to a possible accompanying social determination to a gender role in adolescence?
- What findings are there with regard to the possible favourable or unfavourable effects of a social transition in childhood on the child's psychosocial and health outcome?

2. Legal and ethical requirements

In principle, the right to develop one's own personality is a right of a child that is protected by both the German Basic Law and the UN Convention on the Rights of the Child as a human right. In the case of gender-nonconforming children, the potential openness of the later course of development from the onset of puberty in terms of the child's right to an open future (Feinberg, 1992) must also be considered with regard to personality development, as it is known that the later course of development of gender identity in adolescence is subject to great variance (see Chapter II → "*Variant developmental trajectories (persistence, desistance and detransition*)").

The recommendation of the German Ethics Council on the professional support and treatment of children and adolescents with signs of transgender development states, among other things (www.ethikrat.org):

- " In German law, the general right of personality includes the right to lead a life in accordance with one's own subjectively perceived gender identity and the right to recognition of this identity.
- In all decision-making processes, minors must be heard and their views and wishes must be taken into account according to age and maturity. In the present context, this rule is all the more important as it relates to questions of personal identity, on which ultimately the person concerned has to decide."

In a current treatise on the ethical discourse on social role transition in childhood and adolescence by Ashley (2019), it is emphasised that the decision for such a role transition, regardless of the age of the child, cannot be made as the result of a previously complete intrapsychic clarification of one's own gender identity. Rather, social role-testing in the self-perceived gender role is embedded in the process of self-exploration in constant interaction with the social environment, even if this process can still be regarded as open-ended (Ashley, 2019).

Generalised directive recommendations beyond the encouragement of an educational attitude that both accepts the child's personality and remains open to a potentially fluid course of gender identity development cannot yet be substantiated by empirical evidence. It should also be borne in mind that a social role changes in childhood, which may take place in all areas of life, are sometimes already a fact at the time of initial presentation in medical or psychotherapeutic services, which must be met with a non-judgemental, non-discriminatory attitude (see Chapter IX → "*Professional interaction and discrimination-sensitive conduct with gender-nonconforming children and young people*").

3. The state of empirical knowledge

To date, there have only been a few empirical studies from the North American cultural area in which children who had completed a social transition the onset of puberty were systematically analysed. If one examines the results of these studies to see what effects a social transition can have on the mental health development of a gender-nonconforming child, it must be emphasised in advance that only limited statements can be made in this regard. The reasons for this are:

- In terms of their intention and design, the studies mostly investigated other issues.
- The children who had undergone a role change were selectively chosen and were more likely to have particularly pronounced signs of gender incongruence in childhood, combined with high self-confidence and a high level of support from their family environment. Therefore, in addition to a particularly strong expression of characteristics with regard to their gender-nonconforming behaviour, these children had a high level of generally protective resources.
- To date, there are few reliable findings on the later outcome of these children after the onset of puberty. Only in a recent follow-up study with an observation period of five years after the start of a social role change in childhood (*N* = 237) was a subgroup (*N* = 70) 14 years or older at the time of the survey (Olson et al., 2022).
- In particular, apart from anecdotal reports of individual cases, there are no follow-up data available on how and under what circumstances a later retransition to the gender role assigned at birth during adolescence occurred and was coped with.

Previously *investigated questions* include gender-role-related cognitions and characteristics of mental health in gender-nonconforming children after a completed social transition compared to gender-conforming peers (Durwood et al., 2017; Olson et al., 2015; Fast & Olson, 2017). In a post-analysis of available cross-sectional study data, characteristics of mental health and their predictors were also compared between children with pronounced gender-nonconforming behaviour after transitioning and gender-nonconforming children without having transitioned (Wong et al., 2019). One study retrospectively investigated the differential step-by-step course of social transition processes in childhood (Kuper et al., 2019). In addition, the experiences and reports of families who accompanied a child's transition were analysed qualitatively (Kuvalanka et al., 2014; Olson et al., 2019). In the largest follow-up study to date, the trajectories of gender identity development in a group of *N* = 237 children five years after a complete social transition in childhood was investigated (Olson et al., 2022).

The following empirical results in this context have been documented by individual studies:

- 4- to 8-year-old children with strong indications of GI in childhood (inclusion criterion was, among other things, that the children affirmed that they are boys or girls and did not just want to be) who had completed a social transition in all areas of everyday life with the support of their parents (*N* = 36; *n* = 28 m→ w, *n* = 8 w→ m) did not differ in their gender-related cognitions compared to siblings and control children comparable in age and birth gender. These included attributions of their own gender role in relation to their perceived gender, ideas about gender-typical behaviour and gender consistency about situations (Fast & Olson, 2017). They were all aware of their birth gender, which was contrary to their sense of belonging. The only difference in their gender-related cognitions was that they saw gender as a less stable construct over longer periods of time than other children, which can be plausibly explained by their own transition experience (Fast & Olson, 2017).
- In a group of 5- to 12-year-old gender-nonconforming children who had completed a social transition with the support of their parents (*N* = 32; *n* = 20 m→ w, *n* = 12 w→ m), the study group did not differ in the coherence and stringency of their gender-related cognitions (peer preference, object preference, gender identity, both implicit and explicit) from either their siblings or external control children. The cognitions consistently and stringently corresponded to the perceived trans gender accepted by the social environment (Olson et al., 2015).
- In a group of 6- to 8-year-old gender-nonconforming children who had completed a social transition with the support of their parents (*N* = 46; *n* = 14 w→ m, *n* = 42 m→ w), they were comparatively less prone to gender stereotyping and were more open and accepting of gender nonconformity than children in a control group (Olson & Enright, 2017).
- In a group of 6- to 14-year-old gender-nonconforming children who had completed a social transition with the support of their parents (*N* = 116), they showed no differences in self-esteem compared to control children (*N* = 122) and siblings (*N* = 72, Durwood et al., 2017).
- In a group of 3- to 12-year-old gender-nonconforming children who had completed a social transition with the support of their parents (*N* = 73, *n* = 22 w→ m; *n* = 51 m→ w; 3-12J), there were no significant differences in the analysed outcome parameters for mental health, such as depression and anxiety compared to siblings and control children. There were also no differences in the outcome with regard to depression as compared to the normal population. There were only slightly higher values for anxiety compared to the normal population, although this difference was not significant (Olson et al., 2016).

- In a group of 9- to 14-year-old gender-nonconforming children who had completed a social transition with the support of their parents (*N* = 63), they were not more depressed than comparable control children and siblings, but tended to be slightly more anxious (Durwood et al., 2017).
- In a case study of five families with children who underwent a transition (m→ w) between the ages of 7 and 10, it was reported that, from the parents' perspective, the children primarily took the initiative for this step and that the parents were largely uninformed about the topic of gender non-conformity at the beginning. Nevertheless, in retrospect, very early gender-nonconforming behaviour was reported (from the first or second year of life), which was initially classified differently by the parents. In the perception of the parents, the supported transition predominantly led to positive psychological changes in the child (blossoming, self-confidence, etc.). Only in one case was a crisis-like development with suicidal tendencies reported as a reaction to the trans hostility experienced in the social environment and society (Kuvalanka et al., 2014). The parents also reported widespread lack of information and sometimes unethical attitudes and statements by professionals in healthcare and schools, and the associated need to become experts on their own concerns (Kuvalanka et al., 2014).
- In an analysis of cross-sectional data from 6- to 12-year-old gender-nonconforming children, which were combined from three previous studies, there were no significant differences in mental health scores between children with and without a completed transition, although the two groups differed significantly in the extent of signs of GI or GD (Wong et al., 2019). Social integration in peer relationships was consistently shown to be the most important predictor of mental health across both groups, although the generalisability of this statement is limited due to methodological limitations (Wong et al., 2019).
- In a retrospective follow-up study of gender-nonconforming children and adolescents with completed or desired transition (*N* = 224; age 6-17 years, 60% f→ m; 40% m→ w), 98% of whom received a DSM 5 diagnosis of GD, a wide range of variation in developmental trajectories before the onset of puberty and gender differences were found. In the natal male children, binary transgender role identification as a girl was already more common before puberty, whereas natal female children showed mixed or non-binary gender expressions more frequently before puberty. In addition, the sequence of steps in social outings (messages to the social environment) and lived transition (clothing, haircut, names and pronouns, official transition at school, etc.) as well as their gradual or non-gradual progression varied considerably (Kuper et al., 2019).
- In a comparative study, the parents of two stratified subgroups of children of both natal sexes with non-conforming gender expression with and without a completed social transition (*n* = 60 each)

were asked about the decision-making processes in favour of or against a completed social transition. In 83% of the children with a social transition, the parents stated that the decision was very clearly initiated by the child. In 75% of the cases in which a social transition had not (yet) taken place, the possibility of such a transition was openly discussed between parents and child. In only 10% of the children who had not (yet) socially transitioned did the parents state that they were largely responsible for this wait-and-see attitude (Olson et al., 2019). In an internet-based survey of parents whose children socially transitioned to their perceived gender (*N* = 266, 92% of whom transitioned before puberty), 68% stated that they had openly discussed the possibility of a later retransition in adolescence with their children (Olson et al., 2019) in order to maintain the openness of later trajectories in the child's imagination. Only a small proportion of parents of transitioned children (13%) expressed the fear that discussing the open option of later retransition could be interpreted by the child as non-acceptance of their subjective gender identity.

- There is little empirical data on developmental trajectories with a return to the gender role assigned at birth in adolescence. Such a course is reported in two individual cases in the Dutch studies on persistence and desistance (Steensma et al., 2013). These two natal girls, who had already (partially) transitioned to the role of a boy, reported considerable difficulties in returning to the female role, without describing any other accompanying psychosocial circumstances (Steensma et al., 2011).
- Only in a more recent follow-up study on *N* = 317 children with gender-nonconforming gender identity at an average age of eight years who had completed a complete social transition with the support of their families before the onset of puberty trajectories into adolescence (*N* = 70) were reported proportionally (Olson et al., 2022). In this study, 94% of the children remained in the transitioned gender after five years. 7.3% had retransitioned at least once, of which 1.3% changed back again to their transgender role after a phase of clarifying trial. Retransitions occurred more frequently if the first transition had already taken place before the age of six and were more often completed before the age of ten. At the time of the 5-year follow-up, *N* = 70 adolescents had reached the age of 14, of whom only one person (1.7%) had retransitioned to their gender assigned at birth. The study shows that the vast majority of children who initiate a transition before puberty with the support of their parents remain in transition in the long term. On the other hand, the study also shows that retransitions in this group of children occur in rare cases (7%), which is an important information in counselling in order to prepare children and parents for this possible trajectory.

3.1 Summary of the empirical state of knowledge

The following statements and conclusions on the option of a social transition in childhood can be derived from the empirical state of knowledge, which can serve as orientation for professional counselling:

- There was no evidence of increased psychosexual confusion, uncertainty around identity or otherwise conspicuous gender-related cognitions in previously studied gender-nonconforming children who had completed a social transition with the support of their parents. The latter predominantly corresponded stringently to their perceived gender. Accordingly, there are children with strongly pronounced characteristics of gender incongruence in childhood in whom transgender role identification is consistently coherent and is *not* an expression of general psychosexual irritation or uncertainty of identity.
- There is evidence that a social transition supported by the child's social environment can have a favourable effect on social integration and the child's self-confidence through the development of the child's personality in the course of prepubertal development.
- There is evidence that a role change supported by the child's social environment before the onset of puberty can have a favourable effect on socio-emotional development.
- Social integration that is as unimpaired as possible and experienced acceptance in peer relationships are primarily important factors for the positive socio-emotional outcome of gender-nonconforming children who have undergone a social transition.
- To date, *there is no reliable empirical* evidence on how the affirmative support of a gender-nonconforming child by their attachment figures in their perceived gender identity affects the future openness of gender identity development in puberty. Although the rate of persistence of a perceived transgender identity is very high, this can be explained by the selection of particularly clear developmental trajectories, which is typical for the proactive demand for a role change on the part of the child. Retransitions following a completed transition in childhood were described in rare cases (7% of cases in one study), although these occurred more frequently before puberty.
- To date, *there is no reliable empirical* evidence as to how a restrictive approach by parents/guardians to the social expression of a gender-nonconforming role identification in children affects the child's later self-discovery of their identity and, if applicable, GI or GD.
- To date, *there is no empirical* evidence on the psychosocial circumstances under which retransitioning to one’s gender role according to one’s sex assigned at birth is made more difficult or easier after the experience of a complete social transition in childhood.

4. Recommendations for professional counselling

4.1 Recommendations of other guidelines

Specific recommendations as to whether and to what extent carers should or should not support a gender-nonconforming child's desire for a social transition are contained in the *Standards of Care Version 8 of the WPATH*[1] (Coleman et al., 2022) and in the *Cass Review* (Cass, 2024). It is noteworthy that both guidelines do not deviate significantly from the conclusions presented in the previous section 3.1. in their summary of the empirical state of knowledge, but nevertheless derive partially different recommendations from the associated uncertainties in the state of knowledge, with both guidelines emphasising the importance of the child's development remaining open in the case of a transition considered before puberty.

In *the WPATH's Standards of Care*, it is recommended, among other things, that healthcare professionals should have qualified expertise (p. 69):

- "...that parents/caregivers and health care professionals respond supportively to children who desire to be acknowledged as the gender that matches their internal sense of gender identity."
- "...support children to continue to explore their gender throughout the pre-pubescent years, regardless of social transition."
- "...discuss the potential benefits and risks of a social transition with families who are considering it."

The *Cass Review* (Cass, 2024) also states that the state of knowledge does not allow any conclusion to be drawn that a social transition in childhood restricts the openness of later development: "In particular, it is unclear whether it alters the trajectory of gender development, and what short- and longer-term impact this may have on mental health." (S. 163). The recommendations remain correspondingly cautious. The only recommendation (Recommendation 4) on this topic in the Cass Review is (p. 165):

"When families/carers are making decisions about social transition of pre-pubertal children, services should ensure that they can be seen as early as possible by a clinical professional with relevant experience."

[1] WPATH - World Professional Association for Transgender Health

The explanatory text also suggests that a decision on this should not be made too early if possible, and that gradual or partial role testing of the child should be considered as a possibility, which could favour a development that remains flexible (p. 165):

"The clinician should help families to recognise normal developmental variation in gender role behaviour and expression. Avoiding premature decisions and considering partial rather than full transitioning can be a way of ensuring flexibility and keeping options open until the developmental trajectory becomes clearer..."

This guideline takes the view that any decision as to how, when, at what pace and in what steps a gender-nonconforming child's wish to be recognised in the gender that corresponds to their perceived gender identity should be met is not a medical decision, but an educational one that is the responsibility of the legal guardians who are responsible for the welfare of their child. Seeking professional counselling from health services can be useful and helpful, but is at the voluntary discretion of the legal guardians.

4.2 Consensus-based recommendations

Consensus-based recommendation:

III.K1.	When counselling children with gender incongruence or gender dysphoria who are considering a social transition before the onset of puberty and their guardians and possibly other caregivers, professionals should respect the child's right to free development of their personality.

Consensus strength: strong consensus (> 95%)

Consensus-based recommendation:

III.K2.	When counselling children with gender incongruence or gender dysphoria who are considering a social transition before the onset of puberty and their legal guardians and, if applicable, other caregivers, professionals should try to sensitise the legal guardians to

	an attitude that enables the child to explore and develop their gender identity and social gender role in a self-determined way.

Consensus strength: strong consensus (> 95%)

Consensus-based recommendation:

III.K3.	In counselling children with gender incongruence or gender dysphoria who are considering a social transition before the onset of puberty and their guardians and, if applicable, other caregivers, a (possible) social transition should be seen as a process that is to be shaped according to the needs of the child. The steps considered for testing the transition should be tailored to the individual life situation.

Consensus strength: strong consensus (> 95%)

Consensus-based recommendation:

III.K4.	When counselling children with gender incongruence or gender dysphoria who are considering a social transition before the onset of puberty and their guardians and, if applicable, other caregivers, professionals should offer their support to protect the child and/or their caregivers from stigmatisation and discrimination, regardless of the individual decision and life path of those affected.

Consensus strength: strong consensus (> 95%)

Special vote of the German Society for Psychiatry, Psychotherapy, Psychosomatics and Neurology (DGPPN):

The DGPPN is in favour of a stronger level of recommendation regarding professional support to protect children who are considering a change of social role from stigmatisation and discrimination and proposes the following amended wording:

In a counselling session for children with gender incongruence or gender dysphoria who are considering a social transition before the onset of puberty and their guardians and, if applicable, other caregivers, professionals **shall** provide professional support to protect the person concerned from stigmatisation and discrimination of the child and/or their caregivers.

Justification see appendix.

Chapter IV

Associated mental health difficulties in children and adolescents with gender incongruence and gender dysphoria

1. Introduction and key questions

2. State of research on mental disorders associated with gender dysphoria

2.1 Clinical interview and file studies

2.2 Clinical questionnaire studies with children and adolescents at the start of or before treatment

2.3 Non-clinical surveys of children and adolescents

2.4 Eating disorders/ body image

2.5 Abnormalities in the autism spectrum *(neurodiversity)*

2.6 Associated mental health difficulties after social transition in childhood

2.7 Associated mental health difficulties after social transition and after body-altering medical interventions in adolescence

2.8 Findings from current register studies

2.9 Explanatory approaches for the development of mental health difficulties in children and adolescents with gender incongruence or gender dysphoria

3. Statements and recommendations

3.1 Statements on scientific findings

3.2 Recommendations

4. Summary: Diagnostic procedure when there are indicators of gender incongruence, taking into account possible concomitant psychiatric diagnoses

1. Introduction and key questions

Based on the widely documented findings showing that there is an increased and multiform psychiatric morbidity among persons who self-identify as transgender (hereinafter referred to as trans persons), it is essential for practitioners to have knowledge of the spectrum of common mental health problems in trans persons and their relevance for the clinical approach to the diagnosis and treatment of gender incongruence (GI) and gender dysphoria (GD) in childhood and adolescence. In particular, the recent increasingly reported overlap of gender dysphoric symptomatology with symptoms from the autism spectrum raises questions in this regard.

Before a diagnosis of *persistent gender incongruence or gender dysphoria* in childhood and adolescence can be made with sufficient diagnostic clarity on the basis of existing symptoms and findings and a comprehensive consideration of the course of development in the individual case, any associated or coinciding mental health difficulty must be diagnosed professionally and evaluated with regard to their possible interference with the gender dysphoric symptoms.

In particular, a careful assessment must be made as to whether and to what extent co-occurring mental health problems interfere with diagnostic clarity when determining *stable/persistent gender incongruence or gender dysphoria* or with the recommendation or planning of certain treatment measures (see Chapter V → "*Psychotherapy and psychosocial interventions*" and Chapter VII → "*Recommendations for body-altering medical interventions*"). For an unbiased diagnostic approach and a valid understanding of the disorder in individual cases, it is essential that in the case of coincident mental health problems, no primarily theory-based assumptions are made about possible (co-)aetiological causes (see below consensus recommendations in this chapter).

Mental health problems in trans persons can occur both reactively as a variety of adjustment problems to an existing gender incongruence, as well as existing or having arisen independently of this. In terms of differential diagnosis, the possibility must also be considered that, especially as long as a diagnosis of *stable/persistent gender incongruence or gender dysphoria* cannot yet be made with sufficient certainty in a young person, other psychological problems can lead to temporary *gender dissatisfaction* with gender dysphoric symptoms. In this respect, every psychopathological condition associated with *gender dissatisfaction* must be assessed in terms of the extent to which it interferes with diagnostic clarity with regard to the presence of gender incongruence.

By no means all young persons who present themselves as belonging to a queer or trans spectrum have or will develop a *stable/persistent gender incongruence or gender dysphoria* (see Chapter II → "*Variant developmental trajectories*"). On the other hand, serious mental disorders that

can significantly impair diagnostic clarity (such as psychoses or complex personality disorders with pronounced identity diffusion) are not per se evidence that *stable/persistent gender incongruence or gender dysphoria* does not exist, just as a person's non-heterosexual orientation would not be regarded as fundamentally unlikely or less credible in the presence of such a serious disorder.

The term *comorbidity* is deliberately not used in this chapter, as *gender incongruence (GI)* is not considered a disorder in the ICD-11 and in the DSM-5 the GI underlying *gender dysphoria* per se has no disease value (Skagerberg, Davidson, et al., 2013; Skagerberg, Parkinson, et al., 2013).

For the following chapter on the diagnosis and differential diagnosis of associated mental health problems in children and adolescents who present to health services with the question of whether there may be *gender incongruence or gender dysphoria* requiring treatment, the following key questions were formulated a priori for this guideline (see Methods Report).

Key questions for the guideline:

- Which psychopathological problem areas beyond gender incongruence or gender dysphoria in childhood and adolescence should be given particular attention by practitioners?
- What influence do associated mental health problems have on treatment?
- What are the implications of a coincident autism spectrum disorder in minor patients with gender incongruence or gender dysphoria for the diagnostic and treatment process?
- What is the recommended diagnostic procedure for indications of gender incongruence, taking into account possible concomitant psychiatric or psychosomatic diagnoses that need to be considered?

2. State of research on mental disorders associated with gender dysphoria

In children and adolescents who present to the healthcare system with gender incongruence (GI) or gender dysphoria (GD), previous studies have shown that in the majority of cases, *GI/GD* was not preceded by any other underlying psychiatric disorder (Meyer-Bahlburg, 2010; Steensma et al., 2011). Nevertheless, studies have often shown a high prevalence and range of accompanying psychopathological abnormalities and disorders in young patients who present to a specialised clinical facility for diagnosis and treatment. These are significantly more common in adolescents, i.e. from the onset of puberty, than in children. The most frequently described accompanying mental health difficulties in adolescents with GI/GD are *depressive disorders, anxiety disorders, syndromes of self-*

injurious behaviour and suicidal tendencies. Irrespective of aetiological issues that consider this symptoms to be either reactive, pre-existing or a contributory factor of gender related distress, a diagnostic assessment of existing psychopathological symptoms is therefore necessary, as these can interfere with GI/GD and the potential treatment process.

The state of research on mental health difficulties in GI/GD in childhood and adolescence is presented below. A distinction is made between clinical file studies (chart reviews) and interview studies (with reported clinical diagnoses), clinical questionnaire studies (primarily: Child Behaviour Checklist/ Youth Self-Report; Achenbach & Rescorla, 2001) and population-representative studies. Almost all of the data were collected cross-sectionally and at the time of initial presentation or at the start of treatment (usually before starting with gender-affirming hormonal or surgical interventions). In addition, study results in childhood (usually < 12 years) and adolescence (≥ 12 years) are considered separately where possible, as gender dysphoric distress usually increases from the onset of puberty due to the onset of irreversible maturation processes in the body and the resulting increase in body dysphoria (Russell, 2003; Skagerberg, Davidson, et al., 2013; Skagerberg, Parkinson, et al., 2013; Steensma et al., 2011, 2014).

2.1 Clinical interview and file studies

Around half of the children and adolescents who took part in the existing *clinical interview or file studies* received at least *one psychiatric diagnosis* in addition to a diagnosis of gender incongruence or gender dysphoria (Becker et al., 2014; D. Chen et al., 2017; M. Chen et al., 2016; Chodzen et al., 2018; Di Ceglie et al., 2002; Hewitt et al., 2012; Holt et al., 2016; Kaltiala-Heino et al., 2015; Khatchadourian et al., 2014; Nahata et al., 2017; Spack et al., 2012).

For example, D. Chen et al. (2017) report at least one previous or current psychiatric diagnosis in 71% of the children they studied and Kaltiala-Heino et al. (2015) in 75% of the adolescents they studied. The reported co-occurring diagnoses consistently ranked first: *affective disorders (i.e. depression) and anxiety disorders* in 32 to 78% (Becker et al., 2014; D. Chen et al., 2017; M. Chen et al., 2016; Chodzen et al., 2018; Di Ceglie et al., 2002; Holt et al., 2016; Kaltiala-Heino et al., 2015; Khatchadourian et al., 2014; Nahata et al., 2017; Olson et al., 2015; Peterson et al., 2017; Skagerberg, Parkinson, et al., 2013; Spack et al., 2012). One of the studies even reported anxiety and depression in 100% of the clinical population, but did not further differentiate the diagnoses (Hewitt et al., 2012). Increased prevalences are also reported for *(non-suicidal) self-harming behaviour, suicidal thoughts or suicidal tendencies* in adolescents: Here, the figures for a previous suicide attempt (over the life span to date) range between 9 and 52% (Becker et al., 2014; M. Chen et al., 2016; Holt et al., 2016; Khatchadourian et al., 2014; Nahata et al., 2017; Peterson et al., 2017; Spack et al., 2012). Suicidality,

not further differentiated, e.g. in the form of suicidal thoughts (over the previous lifespan), and self-injurious behaviour,not further differentiated are reported for 13% to 75% (Becker et al., 2014; M. Chen et al., 2016; Di Ceglie et al., 2002; Holt et al., 2016; Kaltiala-Heino et al., 2015; Nahata et al., 2017; Olson et al., 2015; Skagerberg, Parkinson, et al., 2013; Spack et al., 2012).

In the present investigations based on the file studies, it must be taken into account that in most cases no differentiation was made between children and adolescents and therefore the reported prevalence of mental health difficulties in childhood may have been overestimated and in adolescence underestimated. In addition, some of the adolescents included in the studies had already started body-altering medical treatment and were at different stages of their transition process at the time of the evaluation.

2.2 Clinical questionnaire studies with children and adolescents at the start of or before treatment

The results of clinical questionnaire studies also show that children and adolescents with diagnosed gender incongruence or gender dysphoria exhibit an increased level of mental health difficulties at the start of treatment in a specialised clinical service. Although the results on this are inconsistent, children with GI/GD appear to be generally less distressed than patients in adolescence, especially when looking at the scale values on the *CBCL (Child Behaviour Checklist,* Achenbach & Ruffle, 2000). Compared to the norm population measured using the CBCL scales, children showed more frequent mental health difficulties both in emotional experience and at the behavioural level and also differed from their siblings in this respect (Aitken et al., 2016; Cohen-Kettenis et al., 2003; Sievert et al., 2021; Steensma et al., 2014; Zucker et al., 1997). The T-norm values reported in the available studies are in the clinically abnormal range in up to 62% of cases in childhood (above the 90th percentile; Aitken et al., 2016; Cohen-Kettenis et al., 2003; Steensma et al., 2014; Zucker et al., 1997, 2002).

Similarly, numerous questionnaire studies with samples of adolescents with GI/GD who had contacted a specialised clinical service for GI/GD show increased levels of mental health difficulties in a pathological range (de Graaf et al., 2018; de Vries et al., 2016; Levitan et al., 2019; Shiffman et al., 2016; Skagerberg, Davidson, et al., 2013; Skagerberg, Parkinson, et al., 2013; Zucker et al., 2002, 2012): 45-82% of adolescents showed externalising abnormalities such as social conduct and impulse control disorders and/or internalising symptoms such as anxious-depressive moods, somatisation tendencies and social withdrawal behaviour.

A similar pattern of symptoms can be seen across different countries: both in childhood and adolescence, internalising problems are more frequently reported using the CBCL compared to externalising problems (Cohen-Kettenis et al., 2003; de Graaf et al., 2018; de Vries et al., 2016; Levitan et al., 2019; Röder et al., 2018; Sievert et al., 2021; Skagerberg, Davidson, et al., 2013; Skagerberg et al., 2015; Steensma et al., 2014; Zucker et al., 1997, 2012). This means that in this population *higher levels of anxiety, depression and psychosomatic symptoms* and, in comparison, *relatively fewer aggressive or externalising behavioural problems are reported.*

If *disorder-specific diagnostic test inventories* such as the BDI (*Beck Depression Inventory*, Beck et al., 2011) or *standardised clinical interviews* are used instead of screening instruments such as the CBCL, the results from the screening studies are confirmed: In the clinical interview with parents of children with GI/GD, Wallien et al. (2007) record an additional psychiatric diagnosis for 52%, with internalising disorders (at 37%) occurring more frequently than externalising disorders (at 23%). In the study by Kolbuck et al. (2019), at least 37% of 3- to 11-year-olds received one psychiatric diagnosis in addition to the diagnosis of GI/GD.

Interview and questionnaire studies have also shown that affective disorders (anxiety and depression in up to 48% of cases) are particularly common in adolescents (Chodzen et al., 2018; de Vries et al., 2011). Olson et al. (2015) report depressive symptoms, measured using the BDI, for a total of 35% of adolescents, suicidal thoughts in 51% and suicide attempts in 30% *(over the lifespan).*

(Non-suicidal) self-injurious behaviour and suicidality are also reported just as frequently in the mentioned clinical questionnaire studies as in clinical file studies (see Surace et al., 2020 for a meta-analysis of clinical studies; Aitken et al., 2016; Arcelus et al., 2016; Fisher et al., 2017): In a meta-analysis by Surace et al. (2020), self-injurious behaviour is reported on average for 28% of all clinically presenting children, adolescents and young adults diagnosed with GI/GD, suicidal thoughts in 28% and suicide attempts in 15% of the cases (over the lifespan).

For their clinical sample of *children* diagnosed with GI/GD, Aitken et al. (2016) report self-harming behaviour/suicidal attempts in 19% of cases and suicidal thoughts also in 19%. This means that the number of self-harm behaviours and suicidal symptoms in children with GI/GD is still lower than in adolescents, but significantly higher than in the non-clinical population. For *adolescents* with GI/GD, Arcelus et al (2016) even report 46% non-suicidal self-injurious behaviour (over the lifespan).

2.3 Non-clinical surveys of children and adolescents

Naturalistic surveys based on samples of adolescent trans persons from youth welfare facilities (outside of a clinical context) report similar results to those reported on the basis of clinical samples:

These studies also indicate a *generally increased risk of mental health problems, depression, self-injurious behaviour and suicidality* (Becerra-Culqui et al., 2018; Clark et al., 2014; Grossman & D'Augelli, 2007; Katz-Wise et al., 2018; MacMullin et al., 2020; Nahata et al., 2017; Perez-Brumer et al., 2017; Peterson et al., 2017; Reisner et al., 2015; Taliaferro et al., 2018; van Beijsterveldt et al., 2006; Veale et al., 2017). It should be noted here that these populations had generally *not* received *a clinical diagnosis of GI/GD*, but were identified by less specific self-descriptions ("trans" "transgender" or similar).

Depression and suicidal behaviour are also among the most frequently reported mental health problems in these studies (Becerra-Culqui et al., 2018; Clark et al., 2014; Reisner et al., 2015). The highest prevalence of depressive symptoms is reported for 41% of the teenage transgender highschool students surveyed (Clark et al., 2014) and for 51% in a self-help facility (Reisner et al., 2015). Some authors such as Becerra-Culqui et al. (2018) also report increased prevalence of ADHD.

Percentages between 9.1% (suicide attempt or self-harm) and 6.8% (suicidal thoughts) are reported for children in a Canadian self-help facility who exhibit "*gender-nonconforming experiences and behaviour"*, similar to the results from clinical studies of GI and GD in childhood (MacMullin et al., 2020).

For the period of the past 12 months repeated (non-suicidal) self-harming behaviour is reported between 2% and 75% and *suicidal ideation* between 5% and 65% of trans adolescents surveyed from population-based samples (Becerra-Culqui et al., 2018; Gower et al., 2018; Perez-Brumer et al., 2017; Taliaferro et al., 2018; Veale et al., 2017) and between 12% and 49% (self-injurious behaviour) and between 25% and 84% (suicidal ideation) of adolescents recruited in youth services (for the past 12 months; Grossman & D'Augelli, 2007; Katz-Wise et al., 2018; Kuper et al., 2018; Reisner et al., 2015; Ross-Reed et al., 2019).

2.4 Eating disorders/ body image

Eating disorders or body image disorders, are rarely investigated or named in the mentioned studies (13% eating problems at Holt et al., 2016, and 2% eating disorders at Kaltiala-Heino et al., 2015), although a negative body image has been reported for adolescent samples with GI/GD in studies on eating behaviour and/or body image (Becker et al., 2018; McGuire et al., 2016). In addition, body image has an potentional influence on quality of life, especially in young persons with GI/GD (Peterson et al., 2017; Röder et al., 2018). For example, Guss et al. (2017) reported an increased risk of unhealthy behaviour with regard to body weight modification for adolescent trans persons.

2.5 Abnormalities in the autism spectrum *(neurodiversity)*

Around 25 quantitative studies from the last 10 years indicate that GI and GD are more likely to overlap with abnormalities from the autism spectrum. This has been described predominantly for children and adolescents, but occasionally also for adults (Herrmann et al., 2021). The frequent occurrence of ASD symptoms in persons with GI/GD is described as well as in the reverse constellation (bidirectional coincidence). In Anglo-American literature, this symptomatic overlap with autism-typical symptoms is discussed, among other things, under the English term *neurodiversity*, which is introduced in relevant scientific publications on this topic (Strang et al., 2019; Van Vlerken et al., 2020) and is also used in the corresponding chapter of the international guideline of the WPATH[1] (Coleman et al. 2022). As the term *neurodiversity* is not commonly used in the German literature with regard to autism spectrum disorders, it is not used in this guideline in this context.

According to DSM-5, the diagnostic criteria for autism spectrum disorder (ASD) include: persistent consistent deficits in social communication and interaction (A criterion)**,** restricted and repetitive patterns of behaviour, interests or activities (B criterion), the presence of symptoms since early childhood (C criterion), and suffering or impairment in several areas of functioning (D criterion). The earlier distinction between different subgroups of autistic disorders (e.g. Asperger's syndrome, infantile autism) was first abandoned in the US classification system (DSM-5) and then internationally (ICD-11 of the WHO) and replaced by the concept of autism spectrum disorder.

In the vast majority of publications to date, however, only *subclinical manifestations* of one of the two phenomena (ASD or GI/GD) have been investigated in a clinical population of the respective other diagnosis group. For example, the frequency of *gender-nonconforming experiences or gender variance (GV)* in clinical samples with ASD diagnoses and of so-called *autistic traits* in children and adolescents with GI/GD diagnoses has been investigated.

2.5.1 Gender dysphoric symptoms in ASD patients

Methodologically, a few individual items were often used in parent questionnaires (mostly CBCL) identify abnormalities in gender experience in children and adolescents with ASD (May et al., 2017; Strang et al., 2014; van der Miesen et al., 2018). There was an increased prevalence of 4-6.5% for *gender-nonconforming experiences* in children and adolescents with an ASD diagnosis. However, it is possible that developmental disorders and mental disorders generally have an increased prevalence

[1] WPATH: World Professional Association for Transgender Health

of gender-nonconforming behaviour (May et al., 2017), which has also been reported for ADHD (Strang et al., 2014; Thrower et al., 2020).

2.5.2 ASD symptoms in patients with gender incongruence or gender dysphoria

Five empirical studies showed that 4.7-13.3% of all children and adolescents who presented to specialist consultations due to suspected GI/GD also received an ASD diagnosis, with the majority of patient records analysed retrospectively (Herrmann et al., 2020).

When ASD screening instruments are applied to children and adolescents with GI/GD, 14.5-68.0% of children and adolescents achieved cut-off values above the threshold. This is by no means to be equated with an ASD diagnosis, but merely describes an increased perception of autistic traits by the parents of children and adolescents with GD, which can also occur in the context of other psychiatric diagnoses (e.g. social interaction difficulties in the case of social phobia). Due to the low specificity, the use of ASD screening questionnaires is currently only explicitly recommended if there are clinical indications for the possible presence of an ASD diagnosis (AWMF S3 guideline on the diagnosis of ASD).

2.5.3 Coincident ASD and diagnosed gender incongruence or gender dysphoria

To date, three quantitative studies have actually investigated the coincident presence of both diagnoses. The frequency of confirmed ASD diagnoses in children and adolescents with diagnosed GD was reported to be between 5.2% and 7.8% in each case (de Vries et al., 2010; Nahata et al., 2017; Spack et al., 2012). Since patients with both diagnoses presumably present clinically with increased urgency due to a variety of psychosocial problems (especially at the specialised services for GI/GD examined here), a so-called *presentation bias* was discussed as a limitation of the representativeness of the reported frequencies.

2.5.4 Differential diagnosis versus coincidence

The literature to date shows an increased prevalence of both *autistic traits* in children and adolescents with GI/GD as well as gender variance or gender-nonconforming experiences in children and adolescents with ASD (bi-directional overlap of the phenomena of gender-nonconforming behaviour and autism spectrum). Such a correlation is also reported for an overlap of confirmed diagnoses of ASD and GI/GD, albeit with a lower frequency (overview in Van Der Miesen et al., 2016).

Deficits in social integration are evident in both ASD and GI/GD. Psychosexual development is impaired, particularly in adolescence, and rigid thinking and excessive preoccupation with specific topics can characterise the clinical picture in both cases. Described *"autistic traits"* in subclinical form (i.e. without the presence of ASD, e.g. in the form of communication and interaction difficulties in

patients with GI/GD) could therefore also indicate impaired social integration or a social phobia. In addition to autism-related difficulties and delays in psychosexual development, a possible explanation for frequent *gender-nonconforming behaviour* of a subclinical nature, i.e. without the presence of GI/GD, is a low general role conformity typical of autistic individuals and an associated low level of psychosocial differences in gender role behaviour in patients with ASD (Wattel et al., 2022).

In a register study with 641,860 participants, in which five independently recruited data sets were analysed together and separately, it was shown that, regardless of age and educational level, the probability of autism was 3.03-6.36 higher for trans and gender-diverse persons than for cis persons. It also showed that undiagnosed autism could possibly be present to a greater extent in trans persons than in a cis comparison group. All these data and results relate to self-assessments by individuals, not to clinically established diagnoses (Warrier et al., 2020).

This study in particular was cited in the Cass Review for the NHS England and Wales as justification for a general recommendation to carry out clinical screenings for autism when patients present with GI/GD at clinical services (Cass, 2024). The Cass review also explicitly points out the risk that girls with autism spectrum disorder in particular may not be not adequately diagnosed, and that young persons with ASD may have particular difficulties in social communication and peer relationships, which can make it difficult for them to feel that they belong to a a peer group. ASD-related deficits in interoception and alexithymia may also make it difficult for them to express their inner feelings and gender identity (Cass, 2024).

The current state of evidence, including the current study by Warrier et al. (2020) and the comments on this in the Cass review (Cass, 2024), support the recommendation of the German guideline commission that autism-typical symptoms require careful attention in children and adolescents who present to the healthcare system due to the possible presence of gender incongruence or gender dysphoria. However, the recommendation for a general autism screening for all children and adolescents who present for GI/GD at health services is not appropriate in our opinion. If there are no clinical signs of autism-typical symptoms from the overall developmental history and the current clinical assessment, screening for autism is not necessary in accordance with the evidence-based German guideline *Autism Spectrum Disorders in Childhood and Adolescence, Part 1: Diagnostics* (DGKJP, 2016) (see consensus-based recommendations at the end of this chapter).

In clinical care, however, there is a subgroup of patients who persistently and permanently exhibit the full diagnostic picture of both gender incongruence and ASD. There is a risk of underdiagnosis and non-treatment or incorrect treatment for both diagnoses if symptoms that persist for too long are wrongly attributed to a phenomenon that was diagnosed first. This subgroup of

individauls with dual diagnoses of ASD and GI/GD must considered particularly vulnerable - not least due to the risk of social isolation, which can be significantly exacerbated by both phenomena. The increased risk of a more difficult access to specialist treatment should also be mentioned, which is associated on the one hand with the aforementioned risk of protracted misrecognition or non-recognition of the existence of a coincident dual diagnosis by treating professionals, and on the other hand with the possible need to integrate the clinical expertise for both diagnoses into a treatment plan (see recommendations below).

2.6 Associated mental health difficulties after social transition in childhood

In some studies, children with GI/GD were examined who had already completed a complete social role change in all areas of everyday life with the support of their carers before the onset of puberty. These children were not found to have a significantly higher incidence of mental health problems compared to the average normal population (see Chapter III → "*Social transition in childhood*").

2.7 Associated mental health difficulties after social transition and after body-altering medical interventions in adolescence

The few long-term follow-up studies to date with transitioned trans persons who received staged body-altering medical interventions starting in adolescence (puberty blockade, gender reassignment hormone treatment and surgery) have provided consistent evidence of a favourable course of mental health and quality of life, although the study results are inconsistent with regard to the extent of persistent psychopathological abnormalities in adulthood (Cohen-Kettenis & van Goozen, 1997; de Vries et al., 2011; de Vries et al., 2014, see detailed description of the study situation in Chapter VII → "*Guidance for recommending body-altering medical interventions*").

2.8 Findings from current register studies

Two recent registry studies from Finland were published during the consultation phase of this German guideline and are discussed below due to their relevance in this topic. The special feature of both studies lies in the nature of the health data registers of some northern European countries, which enable the linking of health information at individual level with prescription data or cause of death registers.

The first study (Ruuska et al., 2024) compared all young persons under 23 who presented to a specialised gender outpatient clinic between 1996 and 2019 (*N* = 2083) with a matched control group from the general population. The authors report that the overall mortality of young persons with

gender incongruence did not differ from that of the control group, but that completed suicides were more frequent in the group with gender incongruence (0.3% vs. 0.1%). This difference was highly confounded with mental disorders. When adjusted for these, the difference between the two groups in completed suicides disappeared. Furthermore, this study showed no difference between treated or untreated young persons with gender dysphoria in terms of completed suicides or overall mortality. The authors interpret the findings to mean that gender dysphoria per se does not lead to an increased risk of suicide, but that the extent of the associated psychopathology was responsible for this.

The fact that young persons with gender dysphoria who received hormone treatments showed neither increased mortality nor reduced suicidality was interpreted by the authors in two ways. On the one hand, hormone treatment appeared to be sufficiently medically safe in the long term, as they did not lead to increased overall mortality. On the other hand, hormone treatment also showed no protective effect with regard to completed suicides. This is justified by the fact that somatic therapies alone did not lead to a significant reduction in suicidality in the case of severe associated psychopathology. An increased risk of suicide in the case of gender dysphoria can therefore only be assumed if a psychiatric illness such as depression is also present. However, adolescents with gender incongruence have a significantly higher rate of these disorders and therefore the vulnerability of this group to psychiatric morbidity should be emphasised, which in turn explains the increased risk of suicide. In this respect, it seems questionable what statement can be derived from the adjustment of the group comparison according to concomitant psychiatric diagnoses, except that those adolescents with gender dysphoria who do not suffer from psychiatric illnesses do not have a statistically increased risk of suicide.

Another Finnish register study (Kaltiala et al., 2023) showed, in line with other studies, a sharp increase in the number of referrals to specialised facilities among Finnish young persons since the 1990s. Furthermore, the authors were able to show that the extent of associated psychopathology rose sharply during the observation period, regardless of whether body-altering medical interventions had already been taken. In line with the first study, this work also emphasises the importance of co-occurring mental illness in young persons with gender dysphoria.

Overall, the data from both register studies point to the outstanding importance of associated psychopathology in young persons with gender dysphoria and the need to diagnose and treat it professionally.

2.9 Explanatory approaches for the development of mental health difficulties in children and adolescents with gender incongruence or gender dysphoria

From the predominantly cross-sectional study results on the prevalence and severity of accompanying mental disorders in adolescents with GI/GD, no statement can be made about the extent to which the associated psychopathology is a consequence of the stress associated with gender dysphoric distress, is involved in the development of gender dysphoria or may have developed independently of GI/GD. Furthermore, it is not possible to determine the extent to which reactive mental disorders as a result of GD are caused by aversive environmental experiences in the sense of inadequately experienced social acceptance of transgender identity (so-called *minority stress*, see below) and/or by body-related dysphoria from the onset of puberty.

Some of the studies summarised here report correlations between an increased level of mental health problems and possible predictors and have statistically investigated these as possible explanatory approaches: A number of studies refer to the correlation of generally increased mental health problems with experiences of discrimination based on one's own gender identity or external appearance (DGfS, 2018). This is explained by the *Minority Stress Model* (Meyer, 1995, 2003, 2015), which basically describes how psychological stress can develop from a variety of interpersonal and/or social circumstances. According to this model, the stress that minorities in particular experience (e.g. persons who belong to the LGBTIQ spectrum) results from stress and conflicts that these persons experience with their environment (Arcelus et al., 2016). Social or cultural intolerance towards gender-diverse persons favours experiences of discrimination or victimisation among transgender persons (for more information on the study situation, see Chapter IX → "*Professional interaction and discrimination-sensitive conduct with gender-nonconforming children and young people*"). As children and adolescents with persistent GI/GD represent the end of the spectrum of gender diversity, it can be assumed that they are at an increased risk of making correspondingly aversive experiences with their social environment (Van Der Miesen et al., 2016) (see explanations in Chapter IX → *"Professional interaction and discrimination-sensitive conduct with gender-nonconforming children and young people"* and Chapter V → *"Psychotherapy and psychosocial interventions*").

Such a connection has been analysed in studies primarily using a so-called *Poor Peer Relations Index:* In the studies on this reported below, negative experiences in peer relationships were the most important predictor in the prediction of mental health problems in both children and adolescents with GI/GD (Aitken et al., 2016; de Graaf et al., 2018; de Vries et al., 2016; Levitan et al., 2019; Sievert et al., 2021; Steensma et al., 2014). Shiffman et al. (2016) also found three other statistically significant

correlates of general emotional and behavioural problems in adolescents with GI/GD: 1. experiences of social exclusion due to transgender, 2. other experiences of exclusion, and 3. fewer friendships.

Although victimisation is reported more frequently in adolescent trans persons than in affected children, these aversive experiences sometimes occur in childhood, which may increase the risk of negative mental health outcomes in the long term (Katz-Wise et al., 2018; Ross-Reed et al., 2019; Steensma et al., 2014). For example, the studies by Kuper et al. (2018) and Perez-Brumer et al. (2017) consistently report that experiences of victimisation and depressive symptoms were the strongest predictive factors for suicidal thoughts in transgender adolescents.

Young persons with a GI/GD diagnosis and non-suicidal self-injurious behaviour also exhibit general psychological problems and lower self-esteem at (Arcelus et al., 2016). The majority of these adolescents (with self-injurious behaviour) report having suffered more from discrimination or personal interpersonal problems in the past than those without self-injurious behaviour.

However, the studies on peer relationships in childhood and adolescence by Aitken et al. (2016), de Vries et al. (2016), MacMullin et al. (2020), Steensma et al. (2014) and Zucker et al. (1997) also point out that poor peer relationships can also be an expression of greater psychosocial problems in general and, as a consequence, increased mental health difficulties. For example, some authors point out that during childhood the experience of marginalisation and the presence of negative experiences with the environment are not sufficient as only explanation for the development of mental health difficulties, but that the experience of GI /GD by itself can be a strong long-term stressor (Aitken et al., 2016; Bockting, 2016; Grossman & D'Augelli, 2007; MacMullin et al., 2020; Zucker et al., 2012). Aitken et al. (2016) and MacMullin et al. (2020) also find a link between generally increased emotional and behavioural problems and the presence of suicidality, which attenuated the influence of peer relationships when both factors were considered simultaneously. The authors conclude that the experience of GI/GD in itself can already represent a high level of stress for young persons.

Furthermore, *minority stress* can also be experienced within one's own family, as the study by Grossman et al. (2005) has shown. Here, young persons reported that between 53% and 63% of their parents reacted negatively to their gender-nonconforming experiences and behaviour. Here too, the authors conclude that there is a connection between psychological well-being and the experience of stress due to negative reactions in the family environment. This result was replicated on the basis of more recent studies on the importance of one's own family (Kolbuck et al., 2019; Levitan et al., 2019; Sievert et al., 2021; Simons et al., 2013) and is considered in a separate chapter of this guideline (see Chapter VI → "*Inclusion of the family relationship environment and family dynamics*"). Kolbuck et al.

(2019) also point out that parents of children with GI/GD can also be exposed to *minority stress* themselves.

The protective role of teachers and schools should be mentioned here, too: While transgender adolescents often report victimisation, problems or reduced quality of life in the school context (Röder et al., 2018; Shiffman et al., 2016; Toomey et al., 2010), the experience of school support appears to be associated with a lower frequency of reported victimisation and self-harming behaviour (Ross-Reed et al., 2019).

Overall, the exact causes and correlates of mental health difficulties and their interdependent interaction in children and adolescents with GI/GD have not yet been sufficiently researched. Authors such as Bockting (2016), de Vries et al. (2016) and Smith et al. (2001) emphasise that the lasting experience of incongruence between the perceived gender identity and the external appearance characterised by physical sexual characteristics (body-related gender dysphoria) already acts as a strong, persistent stressor in affected young persons. In addition, Röder et al. (2018) point out the connection between satisfaction with one's own body and quality of life in adolescents with GI/ GD.

In summary, the findings from emorical studies to date do not allow any generalisable conclusion with regard to causal relationships. This means that no general statement can be made about the extent to which the mental health problems frequently occurring in young transgender people with and without diagnosed GI/GD can be regarded as a consequence of predominantly reactive stress, or how often they represent a primary mental health problem that has developed independently of GI/GD and in the course of which temporary gender dysphoric symptoms may occur that do not lead to persistent GI/GD.

3. Statements and recommendations

3.1 Statements on scientific findings

On the basis of the systematic literature review presented in the previous sections, the guideline commission agreed on the following two statements on the current state of knowledge:

Statements:

IV.E1.	There is evidence from cross-sectional studies that clinically relevant mental health difficulties occur frequently among gender dysphoric children and adolescents who present to health services, which go beyond the reported gender dysphoria.

The evidence for this statement is well documented. More than 20 conclusive studies with a sufficient number of cases and methodological quality are available (Aitken et al., 2016; Arcelus et al., 2016; Becker et al., 2014; D. Chen et al., 2017; M. Chen et al., 2016; Chodzen et al., 2018; de Graaf et al., 2018; de Vries et al., 2011; Di Ceglie et al., 2002; Fisher et al., 2017; Hewitt et al., 2012; Holt et al., 2016; Kaltiala-Heino et al., 2015; Khatchadourian et al., 2014; Nahata et al., 2017; Olson et al., 2015; Peterson et al., 2017; Shiffman et al., 2016; Skagerberg, Davidson, et al., 2013; Skagerberg, Parkinson, et al., 2013; Spack et al., 2012; Surace et al., 2020; Zucker et al., 2002, 2012).

Consensus strength: strong consensus (> 95%)

IV.E2.	There is evidence that clinically relevant mental health dificulties associated with gender incongruence or gender dysphoria in childhood and adolescence, which go beyond reported gender dysphoric distress, are more common in adolescents after the onset of puberty than in prepubertal children.

The evidence for this statement is supported by more than 10 studies with a sufficient number of cases and methodological quality (Aitken et al., 2016; Arcelus et al., 2016; Cohen-Kettenis et al., 2003; de Graaf et al., 2018; de Vries et al., 2016; Kolbuck et al., 2019; Shiffman et al., 2016; Skagerberg, Parkinson, et al., 2013; Steensma et al., 2014; Wallien et al., 2007; Zucker et al., 1997, 2002).

Consensus strength: strong consensus (> 95%)

Note: In the case of persistent GI, affected adolescents often report a sharp increase in body-related gender dysphoric distress from the onset of puberty, which leads to a pronounced and persistent stress load. This body-related distress often plays little or no role in gender-nonconforming children before puberty, especially if they feel socially accepted in their perceived gender affiliation. This can be seen as an important factor in the significantly increased risk of mental illness among gender dysphoric adolescents.

It should be put into perspective that psychopathological symptoms are generally more common in adolescence (with or without GI/GD) than in childhood, which is explained by the particular vulnerability of this age group in connection with coping with the psychosocial and psychosexual developmental tasks of puberty.

3.2 Recommendations

3.2.1 General recommendations

Based on the knowledge presented in the previous sections and the clinical observations and treatment experiences of the experts involved in the guideline development, we provide the following *consensus-based recommendations* for the diagnostic and therapeutic approach to children and adolescents who present to the health care context because of a potentially existing or developing GI/GD.

Consensus-based recommendation:

IV.K1.	Children and adolescents who present for assessment and/or treatment of gender incongruence or gender dysphoria (GI/GD) should undergo a comprehensive mental health assessment if there are any indications of clinically relevant mental health difficulties. The history of the reported abnormalities and their possible interactions with GI/GD should be carefully recorded.

Consensus strength: strong consensus (> 95%)

Explanation: If there are no indications of clinically relevant mental health difficulties and no psychotherapeutic treatment is desired, a comprehensive menatl health assessment is not necessarily required initially. For example, general developmentally oriented counselling support in preparation for social role testing does not require any prior psychological assessment. However, this only applies as long as there is no desire for body-altering medical treatment. A comprehensive diagnostic *assessment* is an absolute prerequisite for any recommnedation for medical interventions (e.g. puberty blockade or gender-affriming hormone treatment), even in the current absence of psychopathological symptoms: this is necessary both for sufficient diagnostic certainty in terms of persistent gender incongruence as well as for detecting whether another mental health difficulty is present and needs to be addressed. This diagnostic assessment is also mandatory to determine the

capacity for informed consent (see Chapter VII → "*Guidance for recommending body-altering medical interventions*").

Special vote of the German Society for Psychiatry, Psychotherapy, Psychosomatics and Neurology (DGPPN):

The DGPPN is in favour of a stronger level of recommendation and the deletion of the condition of indications of psychopathological abnormalities as a prerequisite for a comprehensive assessment and proposes the following amended wording:

Children and adolescents who present for assessment and/or treatment of gender incongruence or gender dysphoria (GI/GD) **shall** undergo a comprehensive mental health assessment. The history of the reported abnormalities and their possible interactions with GI/GD **shall** be be carefully recorded.

Justification see appendix.

Special vote of the Swiss Society for Child and Adolescent Psychiatry and Psychotherapy (SGKJPP):

The SGKJPP favours that the recommendation made elsewhere in the guideline, namely that a comprehensive mental health assessment is particularly required before any body-altering medical interventions are recommended (see summary of this chapter p.99, as well as recommendations VII.K1, VII.K3, VII.k12 and VII.K14 in → *Chapter VII on recommendations for medical interventions*) is to be emphasised in this recommendation as follows:

In the case of children and adolescents who present for assessment and/or treatment of gender incongruence or gender dysphoria (GI/GD) **and for whom medical measures are to be initiated, a comprehensive mental health assessment is essential.** The history of the reported abnormalities and their possible interactions with GI or GD should be carefully recorded.

Justification see appendix.

Consensus-based recommendation:

V.K2.	If a professional mental health assessment is carried out on children and adolescents with gender incongruence or gender dysphoria, their developmental history to date should be taken, on the basis of which the onset and progression of gender-incongruent self-perceptions and any associated gender dysphoric symptoms are carefully traced.

Consensus strength: strong consensus (> 95%)

Explanation: This recommendation applies regardless of the reason for and objective of the mental health assessment (diagnostic clarification of psychopathological symptoms, recommendation for psychotherapy or recommendation for medical interventions).

Consensus-based recommendation:

IV.K3.	In a professional mental health assessment of children and adolescents with gender incongruence or gender dysphoria, specific attention should be paid to the possible presence of depression, anxiety disorder, self-injurious behaviour and suicidal tendencies that require treatment.

Consensus strength: strong consensus (> 95%)

Special vote of the German Society for Psychiatry, Psychotherapy, Psychosomatics and Neurology (DGPPN):

The DGPPN is in favour of a stronger level of recommendation for the clarification of comorbid mental disorders and proposes the following amended wording:

In a professional mental health assessment of children and adolescents with gender incongruence or gender dysphoria, specific attention **shall** be paid to the possible presence of depression, anxiety disorder, self-harming behaviour and suicidal tendencies that require treatment.

Justification see appendix.

Consensus-based recommendation:

IV.K4.	If a mental disorder associated with gender incongruence or gender dysphoria (GI/GD) in childhood or adolescence is diagnosed that requires treatment, adequate treatment in line with professional standards should be offered. This should be individually designed as part of a comprehensive treatment plan including any recommended interventions that are specifically addressing gender incongruence or gender dysphoria.

Consensus strength: strong consensus (> 95%)

Explanation: The treatment of a diagnosed mental disorder should be specific to the disorder in accordance with relevant guideline standards. However, this usually cannot be done separated from the psychological distress caused by persistent gender dysphoria. Such gender dysphoric distress is to be understood as a permanent and aetiologically significant stressor within the framework of a clinical explanatory model to be individually developed. If this is not adequately adressed in a comprehensive treatment plan, sole psychotherapeutic or pharmacotherapeutic interventions, which, for example, are geared to reduce anxious or depressive symptoms, often are not sufficiently effective according to the predominant clinical experience of the experts involved in the development of the guideline.

Special vote of the German Society for Psychiatry, Psychotherapy, Psychosomatics and Neurology (DGPPN):

The DGPPN is in favour of a stronger level of recommendation for the professional treatment of comorbid mental disorders and their consideration in an individual treatment plan and proposes the following amended wording:

If a mental disorder associated with gender incongruence or gender dysphoria (GI/GD) in childhood or adolescence is diagnosed that requires treatment, adequate treatment in line with professional standards **shall** be offered. This **shall** be individually designed as part of a comprehensive treatment plan including any recommended interventions that are specifically addressing gender incongruence or gender dysphoria.

Justification see appendix.

Consensus-based recommendation:

IV.K5.	In a diagnostic assessment of psychopathological symptoms or mental disorders that are associated with gender incongruence or gender dysphoria (GI/GD), clinicians should avoid making generalised assumptions about causal relationships. Instead, in an open dialogue with their patients, an attempt should be made to develop an individualised clinical explanatory model with regard to symptoms and complaints. (see Chapter V → *"Psychotherapy and psychosocial interventions*")

Consensus strength: strong consensus (> 95%)

Explanation: If there is a confirmed diagnosis of gender incongruence, the assumption that the resulting gender dysphoric distress in combination with aversive social experiences *(minority stress)* can be aetiologically significant stressors is obvious, but must be checked in each individual case during the diagnostic process. Psychopathological symptoms may also have arisen independently of an existing GI/GD or may have already existed prior to the realisation of gender-incongruent feelings. Similarly, some psychological disorders, even if they are also caused by gender dysphoric distress, can develop a self-perpetuating dynamic, such as in addiction disorders, eating disorders or pronounced social phobias with school absenteeism. Furthermore, the possibility that a primary mental disorder associated with pronounced uncertainty around one's identity and/or identity diffusion may lead to temporary gender dysphoric symptoms which do not persist in the further course of development should be considered as well, and, if necessary, carefully examined in the diagnostic process. If, for example, a personality disorder with pronounced identity diffusion is present in an individual case, this can make a diagnostic assessment considerably more difficult and require a longer diagnostic process. Nevertheless, an *automatic* assumption that there is no persistent GI in such a case is equally unjustified and may need to be critically reviewed in the further course.

Special vote of the German Society for Psychiatry, Psychotherapy, Psychosomatics and Neurology (DGPPN):

The DGPPN is in favour of a stronger level of recommendation for the development of an individual case-related disorder model and proposes the following amended wording:

In a diagnostic assessment of psychopathological symptoms or mental disorders that are associated with gender incongruence or gender dysphoria (GI/GD), making generalised assumptions about causal relationships **shall** be avoided. Instead, in an open dialogue with their patients, an attempt should be made to develop an individualised clinical explanatory model with regard to symptoms and complaints (see Chapter V → *"Psychotherapy"*)

Justification see appendix.

3.2.2 Special recommendations when there are indicators of coincident autism spectrum disorder (ASD)

When there are indicators of a coincident dual diagnosis of ASD and GI/GD, clinical assessment and professional support usually becomes complex and time-consuming. Autism-related traits can considerably complicate and delay the differential diagnosis, support and treatment of adolescents who present with syptoms of GI/GD. If a professional diagnosis of GI/GD has been confirmed, however, a coinciding diagnosis of ASD does not justify the delay or reluctance to recommend desired body-altering medical interventions to support a social transition.

Consensus-based recommendation:

IV.K6.	In children and adolescents who present with gender dysphoric symptoms, attention should be paid to the possible presence of an autism spectrum disorder. If an autism spectrum disorder is suspected, the diagnostic procedures according to the S3 guideline *Autism Spectrum Disorders in Childhood and Adolescence*, Part 1: Diagnostics (DGKJP, 2016) should be followed.

Consensus strength: strong consensus (> 95%)

Explanation: Although diagnostic overlap between ASD and GI/GD occurs disproportionately often, it is rare in absolute terms. A general autism screening is therefore unnecessary if there are no clinical indications of the possible presence of ASD from the overall medical history and the current clinical picture. However, if there are clinical indications of the possible presence of ASD, further diagnostic procedures for autism according to professional guidelines should be initiated. In most cases, depending on the clinical picture, it is generally recommended that a standardized autism screening is carried out first and, if there are substantial indicators of an ASD, a standardised assessment battery for autism should be administered.

Special vote of the German Society for Psychiatry, Psychotherapy, Psychosomatics and Neurology (DGPPN):

The DGPPN is in favour of a stronger level of recommendation for the clarification of an autism spectrum disorder (ASD) and proposes the following amended wording:

In children and adolescents who present with gender dysphoric symptoms, attention **shall** be paid to the possible presence of an autism spectrum disorder. If an autism spectrum disorder is suspected, the diagnostic procedures according to the S3 guideline *Autism Spectrum Disorders in Childhood and Adolescence*, Part 1: Diagnostics (DGKJP, 2016) **shall** be followed.

Justification see appendix.

Consensus-based recommendation:

IV.K7.	If children and adolescents with gender incongruence or gender dysphoria also have a diagnosed autism spectrum disorder, the expertise of both areas should be included when providing professional support.

Consensus strength: strong consensus (> 95%)

Explanation: In the case of a dual diagnosis, the specific characteristics of both areas must be taken into account for professional further treatment planning in the medium and long term. This means that autism-specific clinical expertise is indispensable for understanding and treating GI and GD cases and vice versa.

Special vote of the German Society for Psychiatry, Psychotherapy, Psychosomatics and Neurology (DGPPN):

The DGPPN is in favour of a stronger level of recommendation with regard to professional support in the case of a dual diagnosis of ASD and GI/GD and proposes the following amended wording:

If children and adolescents with gender incongruence or gender dysphoria also have a diagnosed autism spectrum disorder, the expertise of both areas shall be included when providing professional support.

Justification see appendix.

4. Summary: Diagnostic procedure when there are indicators of gender incongruence, taking into account possible concomitant psychiatric diagnoses

When gender incongruence (GI) is diagnosed, it should be noted that it is not defined as a mental disorder according to ICD-11. The diagnosis is therefore made according to the ICD-11 in the sense of a health-relevant *condition*. The patient's reflected and authentic self-disclosure of their non-conforming gender identity and its persistence in adolescence after the onset of puberty are key to the diagnosis. If mental disorders that are frequently associated with GI, are considered in the differential diagnosis, these are not to be understood as *exclusion diagnoses* - neither in the sense that the presence of such a diagnosis is an argument against the assumption of GI, nor that they must be excluded before a diagnosis of GI can be made. In the case of mental disorders that are accompanied by symptoms of body dissatisfaction, identity diffusion or social anxiety, for example, adolescents may temporarily identify as gender-nonconforming without a persistent GI. Such a temporary *gender uncontentedness*, which may be accompanied by *gender-related distress*, may possibly lead to a temporary self-description of young persons as *trans* in conjunction with other psychopathological abnormalities and influences from peer groups or social media. This must be differentiated from the specific and much rarer condition of persistent gender incongruence with gender dysphoric distress, as operationalised by ICD-11 and DSM-5:

Diagnostic criteria for gender incongruence in adolescence and adulthood according to ICD-11 (HA60; WHO, 2022).

Gender incongruence in adolescence and adulthood is characterised by

- a *marked and [persistent] incongruence* between a person's perceived gender and their assigned gender, often leading to a *desire to "transition" in order to live and be accepted as a person of the experienced gender*, through hormone treatment, surgery or other health services, in order to conform the person's body as *closely as possible and desired to the experienced gender*.

The diagnosis cannot be made before the onset of puberty.

Gender variant behaviours and preferences alone are not a basis for assigning the diagnosis.

Diagnostic criteria for gender dysphoria in adolescence and adulthood according to DSM 5 (APA, 2013, p. 621)

A. A pronounced discrepancy between gender and gender of assignment *that has existed for at least 6 months*, whereby *at least two of the following criteria* must be fulfilled:

1. Pronounced discrepancy between gender and the primary and/or secondary sexual characteristics (or, in the case of adolescents, the expected secondary sexual characteristics).
2. Pronounced desire to get rid of one's own primary and/or secondary sexual characteristics (or, in adolescents, the desire to prevent the development of the expected secondary sexual characteristics).
3. Pronounced desire for the primary and/or secondary sexual characteristics of the opposite sex.
4. Pronounced desire to belong to the opposite sex (or an alternative gender that differs from the assigned sex).
5. A strong desire to be treated as the opposite sex (or as an alternative gender that is different from the assigned sex).
6. Pronounced conviction to exhibit the typical feelings and reactions of the other gender (or those of an alternative gender that differs from the assigned gender).

B. Clinically relevant suffering or impairment in social, educational or other important areas of functioning.

Only through a careful assessment that takes into account the individual developmental history an *alternative hypothesis* ("Could gender-related distress be better explained by other disorders?") can be ruled out. It should be noted that there is no mental disorder that produces the specific clinical picture of persistent GI/GD.

Persistent GI can cause uncertainty round one's identity, body dissatisfaction, anxiety symptoms and other secondary symptoms over time. In individual cases, the diagnostic assessment must therefore be made carefully on the basis of the entire clinical picture and the developmental course of symptoms. As GI is not defined as a mental disorder (see above), this guideline does not use the term *comorbid disorder*, but rather the terms *coincident disorder* or *disorder associated with GI* are used throughout.

Differential diagnostic considerations in the sense of a differentiated assessment of associated mental health difficulties in the suspected presence of GI are important because these may interfere with several aspects that are important for treatment decisions, including:

- diagnostic clarity regarding nonconforming gender identity (e.g. in the case of severe depressive symptoms with identity diffusion),
- diagnostic clarity regarding expressed body dissatisfaction (e.g. in eating disorders),
- stability of gender identity over time (e.g. in the case of emotionally unstable personality disorders),
- capacity to consent (e.g. in the case of mental disorders with cognitive constriction or pronounced emotional instability),
- medical contraindications for hormonal treatments (e.g. anorexia with severe underweight or mental disorders with pronounced emotional instability and/or impulsivity).

The recommended procedures for determining professional recommendations for body-altering medical interventions in the case of a diagnosed persistent GI are described in Chapter VII →*"Guidance for recommending body-altering medical interventions".* In many cases, this is preceded by an in-depth mental health assessment due to associated mental health problems. The important principles and steps for a comprehensive diagnostic procedure described in the previous chapter are summarised here:

1. If gender incongruence is suspected, this alone does not justify the need for a professional menatl health assessemnet in the absence of psychopathological symptoms. In particular, no differential or exclusion diagnosis is required in the absence of psychopathological symptoms.

2. However, a comprehensive child and adolescent mental health assessement is always necessary in cases of suspected gender incongruence *if one of the following three reasons* applies:
    a. There are indicators of a mental disorder requiring treatment in the history and clinical findings, which may need to be considered in interaction with the gender incongruence *(→ see recommendation IV. K1 above)*. In this case, the diagnostic procedure follows the respective guideline standard of the mental disorder under consideration (e.g. depression, anxiety disorder, eating disorder or autism spectrum disorder). An individualised clinical explanatory model should be developed with the patient, which takes into account various possibilities of causal as well as reactive relationships between psychopathological symptoms on the one hand and gender dysphoric distress on the other *(→ see recommendation IV. K5 above).* Frequent and thus significant co-occurring mental disorders to be considered are listed in Table 3 below.
    b. There is a desire for psychotherapeutic support. In this case, the diagnostic procedure follows the usual principles of psychotherapists for a professional recommendation and goal formulation (see explanations in Chapter V → *"Psychotherapy and psychosocial interventions*").
    c. There is a desire for body-altering medical interventions or such a recommendation is considered. In this case, a comprehensive mental health assessment, in which possible associated mental health difficulties are carefully considered and addressed, is essential before a professional recommendation can be made (see explanations in Chapter VII → "*Guidance for recommending body-altering medical interventions*").

Table 3

Differential diagnoses and common co-occurring disorders in gender incongruence

Depressive disorders
Social phobias
Personality disorders with identity diffusion
Eating disorders
Suicidal syndromes
Syndromes of self-harming behaviour
Autism spectrum disorders

3. There are *no standardised diagnostic tools* for the clinical diagnosis of persistent gender incongruence as a health-relevant *condition,* which according to ICD-11, is not pathological. The diagnosis is primarily based on the narrative exploration of the patient's self-experience over longer periods of time. Health professionals can be guided by the diagnostic criteria according to ICD-11 (see above), according to which there is a *pronounced and persistent incongruence* between the perceived gender of a person and the assigned gender, which justifies the reflected desire for a permanent and socially accepted transition. If body-altering medical interventions are considered in connection with such a desire for transition, the persistence of this pronounced experience must be explored comprehensively with the person seeking treatment regarding the background of their previous developmental history, taking into account the perspective of the custodians, before an recommendation is made (see Chapter VII → "*Guidance for recommending body-altering medical interventions*", *Recommendation VII. K3).* In doing so, mental health professionals must have comprehensive knowledge of the range of variations in the developmental trajectories of gender-nonconforming children and adolescents. This includes knowledge of forms of development that are associated with desistance or detransition (see Chapter II → "*Variant developmental trajectories (persistence, desistance and detransition)*" *and recommendations II. K1 and II K2*).
4. The diagnostic criteria for *gender dysphoria in adolescence and adulthood according to the DSM-5 (see above)* can also be used for a standardised diagnostic assessment of the degree of gender dysphoric distress in GI. In addition, four English questionnaire instruments validated for adolescence have been established internationally for the assessment of gender dysphoric symptoms, two of which have been validated in a German translation (see Table 4 below).

Such symptom questionnaires are dispensable for clinical diagnosis because they have no added value compared to the clinical DSM-5 criteria in individual cases. To date, they have mainly been used in cohort studies to record symptom manifestations and their course over time.

Table 4

Validated questionnaire instruments for recording gender dysphoric symptoms (after Bloom et al., 2021; Bowman et al., 2022).

Instrument	Authors	Year	Country	Perspective	German validation
Gender Diversity Questionnaire *(GDQ)*	Twist & de Graaf	2019	UK	Self-report	No
Gender Identitiy Questionnaire for Children *(GIQ)*	Johnson et al.	2004	Canada	External report by parents	No
Gender Identity/Gender Dysphoria Questionnaire for Adolescents and Adults *(GI/GDQ-AA)*	Deogracias et al.	2007	Canada	Self-report	Yes*
Utrecht Gender Dysphoria Scale *(UGDS)*	Steensma et al.	2013	The Netherlands	Self-report	Yes*

*Note. * Schneider et al., 2016*

The diagnosis of a co-occurring mental disorder may interfere with diagnostic clarity in the assessment of GI, however, it does not by itself rule out the presence of GI, nor does it justify a contraindication for body-altering medical interventions. Possible interferences between GI/GDs and a co-occurring mental disorder can be manifold and must be assessed on a case-by-case basis. This can sometimes make a longer diagnostic process necessary to clarify the adequate clinical management. Here are two illustrative case examples that show how complex diagnostic processes can be. Of course, in clinical practice similar case constellations may also take completely different courses.

Case 1: Brian 16-21 years,

Autism spectrum disorder and gender incongruence

Brian is a 16-year-old adolescent with transgender self-perception (female to male) who, when he initialy presented at a specialized clinical gender service, was still socially living in the role of a girl. Brian communicates very sparsely with the clinician, maintaining eye contact. His language appears simple. He clearly communicates that he feels like being a boy, but has no idea how this can be realised in everyday life. He wants to maintain his female first name for the time being, as he has had it for "so long" and it suits for him. However, the fact that those around him do not recognise him as a boy under his girl's name, causes great distress. The body-related dysphoria is very pronounced. He wishes he had a deep voice, male hair, a beard and more muscles in his upper arms and upper body. He also reports great distress from menstruation and from the appearance of his female breasts. He had been socially isolated since childhood and had always had major problems with school performance, particularly in the language subjects. The developmental history taken with Brian and his parents reveals a picture of a male gender identity that has been stable since early childhood, but so far without a clearly expressed desire to transition.

This is followed by a one-year phase of psychotherapeutic counselling. A large discrepancy between a high level of gender dysphoric distress on the one hand and a great fear of change on the other becomes apparent. Brian and the family are advised to take themselves time for the process of decision-making. He is supported in well preparing any steps he wants to take. Brian finally decides to adopt the desired male name in everyday life. A comprehensive diagnostic assessment revealed the following diagnoses: 1. *persistent gender incongruence*; 2. *autism spectrum disorder;* 3. *average level of intelligence*.

In the therapeutic process, it seems important to elaborate Brian’s understanding to what extent his ambivalence towards transitioning, which was enduring for several years, could have to do with his uncertainty regarding his gender identity or rather with a fear of change and social anxiety as his

autistic traits. At the age of just under 18, Brian decides to start with testosterone treatment, for which a professional recommendation is confirmed. He also urgently wishes a mastectomy. He often cries in despair during therapy sessions, but cannot decide in favour of this surgery for over two years as he is very afraid of this step. He is again supported in taking himself time to make the decision.

In retrospect, Brian has never questioned his gender identity. He had been clear about being a male person since his early childhood. He needed open-ended mental health support over a period of years in order to get it clear which interventions were the right ones for him. He signs up for a pre-mastectomy consultation and then cancels it, only to sign up again a year later. At the age of 20, he has the mastectomy performed following a psychiatric assessment. The follow-up at the age of 21 shows a high level of satisfaction with the gender-affirming interventions of hormone treatment and mastectomy. Brian is now living in a partner relationship with a young man.

Case 2: Nick, 15-20 years old,
Anorexia and gender incongruence

15-year-old Nick, who already lives in the male gender, presents at a specialized gender service in a hospital for a child and adolescent psychiatry due to his chronic restrictive anorexia nervosa, which has led to several hospitalisations since the age of 12. Nick, whose assigned gender at birth was female, explained that he felt like a boy. However, he had never expressed this during his previous hospital stays. From his developmental history, he reports typical boyish behaviour and preferences in childhood, although he had never explicitly expressed a desire to take steps to transition. It was not until puberty that a pronounced body dysphoria developed with regard to all female secondary sex characteristics. In a longer process of psychotherapy, the development of his gender identity in the course of his life and the background of his body-related dysphoria are reflected upon. The extent to which his eating disorder is to be understood as a reaction to gender dysphoria is explored, or whether, conversely, his rejection of assuming a female gender role could be understood as an expression of a possible conflict around psychosexual maturation in the context of his eating disorder. It is becoming more and more clear to him that his male gender identity has been persisting since childhood and that it therefore was not possible for Nick to experience female physical maturation as congruent with his identity. On the one hand, Nick can describe the development of the eating disorder in connection with his gender identity, but on the other hand, he can also clearly recognise that the eating disorder has developed a self-perpetuating dynamic. He differentiates his body dissatisfaction according to different body characteristics: The stomach feels "too fat", the breasts as "fundamentally wrong and inappropriate". After one year of psychotherapy, starting with puberty supression is recommended

following Nick's wish. As a result, weight gain occurs very quickly after Nick is given the prospect of a physically masculine development that is congruent with his identity. After four years of the eating disorder, Nick can manage to gain weight stably up to the 25th BMI percentile. At the age of 17, he starts with testosterone treatment and undergoes mastectomy at the age of 18 while maintaining a stable normal weight. In the follow-up at the age of 20, a stable male identity, a high level of satisfaction with the gender affirming interventions and a complete remission of the eating disorder are evident.

Chapter V

Psychotherapy and psychosocial interventions

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1. Introduction and key questions

There is no causal psychotherapeutic treatment for gender dysphoria. Psychotherapy in the presence of gender incongruence (GI) or gender dysphoria (GD) can only be a process-oriented and/or supportive accompany or associated mental health difficulties can be treated by it. The relevant procedures and meaningful therapeutic goals are described in this chapter. Psychotherapy is always preceded by a professional diagnosis, differential diagnosis, patient information and recommendation by a psychotherapeutic specialist. The basis for this is the professional duty of care as described in the professional codes of conduct of the psychotherapeutic professions and in statutory regulations. As part of this diagnostic process, the presence of gender incongruence (GI) or gender dysphoria (GD) as well as diagnoses of any associated mental illnesses can usually be confirmed or ruled out. The recommendation for psychotherapy can also be established during the diagnostic process. Admission to psychotherapeutic treatment remains voluntary and self-determined. If the presence of persistent gender incongruence (GI) or gender dysphoria (GD) in a minor person cannot be determined with sufficient reliability, no recommendation for body-altering medical interventions can be given at this stage. In this case, a longer-term process and follow-up assessment as part of an accompanying psychotherapeutic treatment may be recommended. On the other hand, the diagnosis of gender incongruence is by no means to be equated with the recommendation for the start of a desired body-altering medical intervention. The additional prerequisites required for this and the rules of care to be observed are described in detail in Chapter VII → *"Guidance for recommending body-altering medical interventions".*

In previous professional recommendations on psychotherapeutic interventions for children and adolescents who present to professional services with signs of possible gender incongruence (GI) or gender dysphoria (GD), a remarkable discrepancy is noticeable. On the one hand, there is broad agreement that it is very important to offer psychotherapeutic support. In treatment recommendations of earlier decades, undergoing psychotherapy for trans persons was even defined as a mandatory prerequisite for access to body-altering medical interventions.[1] On the other hand, in previous relevant recommendations, there has been little or no definition of what kind of interventions psychotherapy for trans people should include or which therapeutic goals are useful or not useful. In

[1] In the review directive published in 2020 by the Medical Service of the National Association of Statutory Health Insurance Funds (BGA-MDS; Medizinischer Dienst des Spitzenverbandes Bund der Krankenkassen e.V., 2020), whose authorship is not transparent. This outdated view is still held, although it is not compatible with the current state of scientific knowledge presented in the current S3 guideline *on gender incongruence, gender dysphoria and trans* health* for adulthood (DGfS, 2018) nor with the professional ethics of psychotherapists.

other words, psychotherapy is often recommended, but usually remains a "black box" in the recommendations.

The diagnosis of GI according to ICD-11 (World Health Organisation, 2022) alone does not justify the recommendation for psychotherapeutic interventions. Offering psychotherapy in the narrower sense of the German Psychotherapy Guideline[2] therefore requires a separate determination of the recommendation in individual cases, which has to be justified by the presence of a mental disorder (see below). However, psychotherapeutic counselling to support young persons in their gender identity development and its successful integration into their overall personality often appears to be helpful. Accordingly, it is often requested and utilised by those seeking treatment. The diversity and complexity of developmental issues in childhood and adolescence, which usually go far beyond the gender issue, must be taken into account appropriately, especially with regard to the entire scope of identity development in adolescence (Seiffge-Krenke, 2021).

The primary aim of the structure and content of this chapter is to provide mental health professionals with a broad basis for professional orientation from the specialised literature reviewed, without regulating a specific approach. Accordingly, the explanations focus on *professional attitudes* to be reflected upon, as well as on useful *possible goals of psychotherapeutic interventions*, which are the directive forms, the basis for the provision of psychotherapy within the framework of statutory health insurance. It regulates in detail, in particular, the forms of psychotherapeutic treatment and application that can be provided on an outpatient basis at the expense of statutory health insurance or be worked out with patients or clients and their relatives on a case-by-case basis. In this chapter, just a few concrete guiding recommendations are included, that were emphasised by the guideline commission.

[2] Translator's note: The German Psychotherapy Guideline [*German: Psychotherapierichtlinie]* is an offical directive that defines the basis for the provision of psychotherapy within the framework of statutory health insurance. It regulates in detail, in particular, the forms of psychotherapeutic treatment and application that can be provided on an outpatient basis at the expense of statutory health insurance.

Key questions for the guideline:

- How binding can/should psychotherapy be recommended to those seeking professional support?
- What can guideline-compliant professional support be defined for patients who do not want or need psychotherapy?
- What meaningful goals can be identified for psychotherapeutic interventions for adolescents with gender incongruence or gender dysphoria?
- Which goals of psychotherapeutic interventions are obsolete in this context?

2. General conditions for psychotherapeutic services and recommendations for psychotherapy

In healthcare practice, psychotherapeutic services for gender-nonconforming children and adolescents are not limited to psychotherapy as defined by the German Psychotherapy Guidline[3], but encompass a broader spectrum of interventions. In order to differentiate appropriately qualified psychotherapeutic services from other *psychosocial counselling* services for trans people, we define them as follows in this chapter:

Definition:

Psychotherapeutic support for children and adolescents who present with signs of GI or GD is understood to encompass all professional services provided by licenced specialists with proven psychotherapeutic qualifications with the aim of maintaining or improving mental health.

In particular, this also includes low-frequency mental health counselling services that are offered by licensed psychotherapeutically trained specialists as part of professional guidance to support a social transition and/or to accompany medical transition steps. In individual cases, the *recommendation* for psychotherapy in the narrower sense of the German Psychotherapy Guideline[4] is based on existing symptoms, the associated psychosocial impairment, the subjective level of distress and the desire for psychotherapeutic support. Since the presence of gender incongruence according to ICD-11 (World Health Organisation, 2022) does not constitute a mental disorder by itself, an independent diagnosis of a mental disorder should always be made, if necessary, which guides the

[3] Translator's note: see explanation above in footnote 2

[4] See above

recommendation for therapy and in which an existing gender dysphoric condition can also be reflected, e.g. depressive disorder, anxiety disorder, social phobia, F54[5] etc..

This procedure is also recommended for the remaining transition period during which diagnoses are still coded according to ICD-10 (World Health Organisation, 2019) in healthcare practice. This takes into account the fact that the change over to ICD-11 in coding practice is expected to take place within the period of validity of this guideline. It should be noted that the disorder concepts on which the F64 diagnoses of ICD-10 (so-called "gender identity disorders") were based are obsolete.

A regular *obligation* to undergo psychotherapy for those seeking treatment, e.g. as a precondition for access to body-altering interventions for gender reassignment, is unethical and also obsolete. The AWMF's S3 guideline for adulthood makes the following consensus-based recommendation in this regard:

"Psychotherapy should not be used without a specific recommendation and under no circumstances as a prerequisite for body-altering treatments. The recommendation must be provided in accordance with the requirements of the [German] Psychotherapy Guideline[6]." (DGfS, 2018, p. 45).

In a statement by various medical associations and the Federal Chamber of Psychotherapists, the current review directive for the statuary health insurance on the obligation to undergo psychotherapy as a prerequisite for gender-affirming surgery are commented on as follows: "Demanding psychotherapeutic interventions on a mandatory, general and a priori basis presupposes an untherapeutic attitude - such forced conversations are not psychotherapy. Psychotherapy is an appropriate measure in individual cases and, as an essentially emancipatory process, presupposes willingness and voluntariness. Anyone who abandons this prerequisite for psychotherapy a priori denies people with GI/GD seeking treatment the ability to reflexively self-assess and perpetuates the discriminatory view of trans* people." (BPtK, 2021, "Psychotherapieverständnis", section 1). The international guideline *Standards of Care, Version 8* of the World Professional Association for Transgender Health (2022) formulates the following recommendation in this regard:

"We recommend health care professionals should not make it mandatory for transgender and gender diverse people to undergo psychotherapy prior to the initiation of gender-affirming treatment, while acknowledging psychotherapy may be helpful for some transgender and gender diverse people.“ (p. 177).

[5] F54: psychological factors in diseases classified elsewhere
[6] See footnotes 2-4 above

Consensus-based recommendation (from the preamble of the guideline):

V.K1.	Psychotherapeutic support should be offered and made easily accessable to those seeking treatment, e.g. to support open self-discovery, to strengthen self-confidence, to overcome experiences of discrimination or for psychological preparation and follow-up of steps in the transition process. An obligation to undergo psychotherapy as a precondition for access to medical treatment is not ethically justified for reasons of respect for the dignity and self-determination of the person.

Special vote of the German Society for Psychiatry, Psychotherapy, Psychosomatics and Neurology (DGPPN):

The DGPPN is in favour of deleting the reference that there should be no obligation to undergo psychotherapy for ethical reasons of respect for dignity and self-determination and proposes the following amended wording:

> Psychotherapeutic support should be offered and made available to those seeking treatment as support and guidance, e.g. for open-ended self-discovery, to strengthen self-confidence, to cope with experiences of discrimination or for psychological preparation and follow-up of steps in the process of transition, **as well as for the treatment of comorbid mental disorders**. A general commitment to psychotherapy as a condition for access to body-altering treatment is not necessary.

Justification see appendix.

There are some specific aspects in the professional support of self-discovery and transition processes of children and adolescents with GI or GD which, depending on the individual case, may justify the offer of psychotherapeutic support if desired due to an increased mental health risk:

- As puberty progresses, irreversible body changes and the resulting exacerbation of gender dysphoric distress can result in time pressure for treatment decisions on body-altering interventions. Psychotherapeutically supported clarification processes may be necessary for the psychological preparation and medical recommendation for body-altering interventionss (e.g. in the case of still open or fluid identity-finding processes in adolescence or to support the development of sufficient capacity for consent).

- The mental health prognosis for GI or GD depends crucially on the experience of emotional support from the family. If a child's GI leads to conflicts in the parent-child relationship, this is a lasting burden for those affected and may make psychotherapeutic support necessary.
- The mental health prognosis depends decisively on the experience of social support and acceptance in the living environment, for which a self-confident social outing ("no longer hiding") is usually necessary, for the successful preparation of which psychotherapeutic support is often required.
- As members of a gender minority, people with GI often experience minority stress in their living environment in connection with experiences of discrimination (see Chapter IX → "*Professional interaction and discrimination-sensitive conduct with gender-nonconforming children and young people*"), which cause an increased risk of mental health problems and often require psychotherapeutic support to cope with them
- A social transition in conjunction with any body-altering interventions in adolescence takes place in several stages over a number of years. These must be psychologically prepared and processed in interaction with the social environment in order to be integrated into psychosexual and psychosocial identity development. This can often be better achieved with psychotherapeutic support. The success of this psychological integration, in turn, appears suitable for minimising the risk of later feelings of disturbance ("A part of me is somehow missing"), as is sometimes reported in later detransition wishes of adult trans people (Littman, 2021; Vandenbussche, 2021).
- It seems sensible to promote stability and coherence in one's own gender perception, especially in cases of uncertainty related to the tension between inner conviction and the ability to live in the social context of relationships.

Günther, Teren & Wolf (2021) explain: "The gender-variant or trans*gender experience of children and adolescents alone does not indicate a need for psychotherapy. However, psychotherapy [in the extended sense mentioned above] can be useful to support them in overcoming specific challenges that these children and adolescents face in family, school and other social contexts" (p. 254).

Dietrich (2021) explains this form of supportive, development-orientated process support, which can also include psychoeducational elements:

"In the psychotherapeutic accompaniment of adolescent transitions, a process-orientated approach that is responsive to the individual and changing needs of those seeking treatment is also required. [...] we cannot [...] prescribe a strict treatment plan or a fixed goal, but must work this out together with the adolescent. The adolescent should be thoroughly and comprehensively informed

about all steps [...] Such an approach also means that the therapists are able to accept the processual nature of development as such." (p. 19-20).

Beyond the unspecific recommendation for psychotherapeutic support, there is only scant information in the relevant specialist literature on how to address the *specific aspects* mentioned above that may be relevant in the psychotherapeutic support of children and adolescents with GI or GD and how to implement them in psychotherapeutic interventions. There are no evidence-based recommendations to date. The approach in individual cases must therefore be developed and designed on an individualised and needs-oriented basis with the person seeking treatment. On the basis of a comprehensive review of previous guideline recommendations, study results and other relevant literature, we have extracted some important aspects for the application and design of psychotherapeutic interventions for this guideline in the sense of a current *state of the art*, which can serve as orientation and inspiration for psychotherapeutic professionals. As no specific recommendations for concrete interventions or therapeutic procedures or methods can be derived from the entire scientific literature to date, we will concentrate in the following sections on important aspects of a *psychotherapeutic attitude* and on *definable goals* of psychotherapeutic interventions that are relevant in this field.

Consensus-based recommendation:

V.K2.	When gender-nonconforming adolescents seek psychotherapeutic support, the format (setting, frequency, etc.) and goals should be based on individual needs. Goals should be discussed transparently between the psychotherapist and the person seeking treatment and mutually agreed upon.

Consensus strength: strong consensus (> 95%)

3. Excursus: Historical development of basic psychotherapeutic attitudes and concepts:

Various narrative reviews from earlier decades describe three partly contradictory concepts in the treatment of children and adolescents with gender dysphoria, each of which was based on a specifically defined attitude (Korte et al., 2016; Leibowitz & Telingator, 2012; Menvielle & Gomez-Lobo, 2011; Olson et al., 2011; Spivey & Edwards-Leeper, 2019; Vance et al., 2014). These three concepts represent a historical development of prototypical *pure forms*, which were based on various theoretical assumptions on the basis of which the respective attitude was founded:

1. The *Live in your own skin model* by Zucker et al. (2012) was based on the assumption of a still malleable *gender brain* in children, with the main aim that the child could still learn to accept its birth gender in order to protect itself from later stigmatisation and rejection. The psychotherapy programme was therefore aimed at the parents and the child, with recommendations to remove and replace gender-typical toys, change the choice of playmates and increase contact with the parent of the same sex. This was associated with a reduction in contact with the other parent. This model is considered historically outdated and obsolete, both in terms of its aetiological assumptions and its recommended therapeutic goals and interventions. From today's perspective, such an approach by therapists would not only be considered unethical, but would even be a criminal offence in Germany if it were applied with the intention of changing a child's sense of belonging to one gender in a defined direction.[7]
2. The *watchful waiting model* – was developed by the Dutch team led by Cohen-Kettenis (1994). Essentially, this model envisaged a sufficiently long phase of support for a child or adolescent during which an *open-ended self-exploration* with regard to gender identity was to be supported. The child should be encouraged to try things out in order to find the path that is most consistent with their inner experience of identity. In this concept, it was recommended that children who already showed a GI before puberty should at least experience the beginnings of puberty in order to find out for themselves under the impression of a pubertal development that has begun, how the identity experience develops, i.e. whether the GI persists in the sense of a stable, solidifying trans identity or not. This is a kind of *observation over time* combined with the advice that the child does not yet commit to a gender role in all areas of life in relation to the outside world. The psychotherapy offer also provided for the creation of safe niches in the child's private space in which the child could partially live out trans-gender role behaviour. The recommendation inherent in this approach to avoid a potentially premature commitment to a transgender role identification, especially in childhood, was based on the assumption that a later return to the social gender role assigned at birth (*retransition*) may be difficult to cope with psychologically in the event of a later desistance of the GI. However, there is no empirical evidence for this assumption, only reports of corresponding clinical observations in a few individual cases from earlier decades, in which such a retransition in adolescence was accompanied by psychopathological abnormalities (Steensma et al., 2013). In these reported cases, however, it remained unclear which accompanying family or social factors could have contributed to this.

[7] The "Act on the Prohibition of Conversion Treatments" passed by the German Parliament in 2020 prohibits, among other things, all therapeutic offers to persons under the age of 18 that are "aimed at changing or suppressing sexual orientation or self-perceived gender identity" (§1, Federal Law Gazette I p. 1285)

There are now follow-up studies with larger numbers of cases of children who have already undergone a complete social role change before puberty (see Chapter III → "*Social transition in childhood"*). Their results - also on the courses with a retransition - argue against these fundamental reservations about social transitions in childhood (Olson et al., 2022).

3. The so-called *gender affirmative model*, which also includes various psychosocial interventions, recommends validating a child's self-identified sense of gender affiliation and meeting them with an affirmative attitude (Ehrensaft, 2017; Olson et al., 2011; Spivey & Edwards-Leeper, 2019). If desired, the child and parents may also be supported before puberty to complete the child's social transition in all areas of life, including daycare and school. This model emphasises the individualisation of care and the avoidance of rigid therapy patterns.

Depending on the individual clinical situation on the path to self-discovery through to accompanying a social outing, most current recommendations and approaches refer implicitly or explicitly to aspects of the *watchful* waiting and gender-affirmative therapy model.

The opinion of Korte et al. (2016) is an exception in the evaluation of the psychotherapy models mentioned. The authors consider the affirmative approach to be unfavourable because it allegedly proceeds from empirically unproven basic assumptions and consolidates rather than helps to resolve the identity conflicts of those affected. The result of this is that premature support for a social transition may make a later return to the *original gender* more difficult due to years of experienced affirmative validation of the transition. The authors do not report any experiences from therapeutically supported processes in this regard. In the literature, there is only a reference in the persistence/desistance studies by Steensma et al. (2011 & 2013) to two individual cases of birth-gender girls who had already (partially) changed into the role of a boy as children before puberty, in which considerable difficulties were reported in returning to the birth-gender role in the course of a desistance of gender dysphoria in adolescence. No further details are provided on other accompanying circumstances such as psychotherapeutic counselling (Steensma et al., 2011; see Chapter II → "*Social transition in childhood*").

4. Observational studies on psychotherapeutic interventions

In the few observational studies on psychotherapeutic interventions with gender dysphoric children and adolescents to date, the number of cases is usually small, which relativises their informative value, and there is also a large variance with regard to the outcome parameters. Austin et al. (2018) accompanied eight people between the ages of 16 and 18 by supporting them with coping strategies for rejection and bullying. As a result, depression levels were reduced. However, the previous coping strategies remained unchanged.

Di Ceglie and Thümmel (2006) report on their work with ten parents of trans children in six thematic sessions as part of a cross-sectional study. The parents felt less isolated afterwards, discovered similarities with other parents, appreciated the contact with the specialists and the children also benefited from the work with the parents.

The investigation of social support was at the centre of the study by Levitan et al. (2019). In 146 trans boys and 34 trans girls, it was shown that the social transition proceeds significantly better if the children are not left alone with their problems, but receive sufficient social support from parents, other caregivers and specialists.

In an evaluation study by Menvielle (2012) on a group intervention for families, it was reported that the moderated exchange between parents (42 parents with 31 trans children) in a group setting on site and via an internet platform helped to overcome the feeling of social exclusion. The children stated that the intervention helped them to deal more with questions about their future active lifestyle (*empowerment*).

A pre-post study on open groups for adolescents aged 15 and over with gender dysphoria came to the following conclusions (Davidson et al., 2019): The openly expressed desire to transition was stronger or more frequent after this intervention than before. Respondents reported more social support and less social isolation after the group discussions. They still experienced rejection and negative judgements, but were able to deal with them better. This emphasises the psychotherapeutic benefits of an affirmative group experience in terms of empowerment.

5. Professional attitude in the psychotherapeutic counselling of gender-nonconforming, gender-incongruent and gender-dysphoric adolescents

In the following sections, some important aspects of an appropriate therapeutic attitude are presented in condensed form from previous guidelines and from current contributions by individual authors, as discussed and recommended for psychotherapeutic process counselling in this field. These

aspects are intended to serve as orientation for users of the guideline and encourage them to continuously reflect on their own attitude. We have refrained from making consensus-based concrete recommendations on the basic therapeutic attitude, as this is ultimately the reflective responsibility of each psychotherapeutic professional and cannot and should not be regulated by a guideline.

5.1 Non-binary understanding of gender

It is considered an important prerequisite for an appropriate professional attitude towards trans people that professional helpers have a reflected theoretical understanding of the development of gender identities. This should not be rooted in outdated assumptions of an exclusively binary gender or in cis and heteronormative ideas, but should also recognise non-binary gender identities and gender identities that become fluid over the course of a person's life (Ehrensaft, 2016; Quindeau, 2014a, 2014b).

The S3 guideline *on gender incongruence, gender dysphoria and trans* health* for adulthood explains this in the explanatory text (DGfS, 2018, p.16) :

"The assumptions to be questioned [by practitioners] include, for example, that one's own gender permanently corresponds to the physical sex characteristics and that gender identity is unchangeable in the course of a biography. Thus, encounters with trans people can confront those providing treatment with their own gender identity, gender-related development and role perceptions as well as conflicts between acceptance and non-acceptance of their own body. If left unreflected, such a confrontation can lead to defence and avoidance as well as projective psychopathologisation, which can jeopardise the development of a sustainable relationship (Güldenring, 2015)."

The *Guidelines for Psychological Practice with Transgender and Gender Nonconforming (TGNC) People* of the American Psychological Association (2015) contains the first of 16 professional statements on this subject:

"Psychologists understand that gender is a nonbinary construct that allows for a range of gender identities and that a person's gender identity may not align with sex assigned at birth" (cited in APA, 2015, p. 834).

In the monographic practical handbooks on gender dysphoria in childhood and adolescence by Dietrich (2021) and Meyenburg (2020), the following recommendations are formulated:

- "It is important to abandon the deceptive notion of the possibility of a clear gender categorisation, which is based on the system of a hetero- and cisnormative concept of binary gender. This notion does not reflect the reality of the lives of the people we encounter nor the

reality of the lives of the practitioners" (Dietrich, 2021, p. 64). And further: "Only if we take the concept of an open-ended approach serious and recognise the changeable nature of human identity and the experience of gender identity, we as therapists can signal verbally and non-verbally from the very beginning of our support that everything that the client feels should have its place in the therapy." (Dietrich, 2021, p. 65).

- "Practitioners should not express a binary view of gender. They should give great freedom to explore different possibilities of gender expression." (Meyenburg, 2020, p. 12).

5.2 Accepting and open-minded attitude

Accepting the experience of being trans by no means as an equal and non-pathological variant of gender diversity is an elementary prerequisite for a trans-sensitive attitude (Wiesendanger, 2002). Thus an unconditionally accepting attitude towards the current gender-related sense of belonging expressed in each case is an important prerequisite for a therapeutic relationship. Any confusion and uncertainty that (possibly) arises ("trans or not trans?") may need to be endured in the therapeutic relationship (Romer & Möller, 2020). It is recommended, especially from the first contact, to use first names and pronouns in the personal form of address in accordance with the wishes and self-ascription of the person seeking treatment and to clarify this at the beginning of the conversation ("How would you like to be named by me during our conversation?").

Regardless of the therapy goals to be formulated in each case (see next section below), which are based on the individual needs of those seeking treatment and therefore vary greatly in terms of *the specific support* provided *for individual transition steps* (from waiting to encouraging), depending on where the individual person currently stands in the process, a trans-sensitive professional attitude includes an affirmative basic attitude. This should be based on the previously described unbiased and unconditional acceptance of gender-nonconforming identities and encourage every person seeking treatment to engage in open and fear-free self-exploration in lively interaction with social role-testing. Such self-exploration also includes the space for expressing and reflecting on uncertainties and doubts on the part of the person seeking treatment. Children and adolescents who want to try out gender non-conformity, come out as trans or may wish to undergo a social transition may encounter real or expected adversities in their social and institutional environment. This is important to recognise, together with the resulting specific need for social and professional support. When adopting such an affirmative attitude, the basic rules of therapeutic abstinence is to be observed at the same time, e.g. in order not to give a person seeking treatment the feeling of pleasing or disappointing the therapist if, for example, a certain step of a transition is taken or not (yet) taken.

This accepting, affirmative and open-minded basic attitude in the context of the duty of care of a medical profession does not contradict the knowledge of a wide range of developmental trajectories in childhood and adolescence that is indispensable for health professionals (see Chapter II → "*Variant developmental trajectories (persistence, desistance and detransition)*"). These can include, in particular, fluid trajectories of identity formation in adolescence. Not all adolescents who feel that they belong to a spectrum of *queer* forms of expressing their gender diversity and thus describe themselves as *trans* develop a permanently persistent gender incongruence.

Rauchfleisch (2021) has formulated this as follows: "We must make it clear to the children and young people that coming out requires a lot of strength and it is therefore important for us to be precisely informed about their state of health so that we can work with them to stabilise their personality and thus enable them to successfully manage their transition (p. 192)."

In the *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People* (APA, 2015) the following professional statements are relevant in this regard:

"4. Psychologists are aware of how their attitudes about and knowledge of gender identity and gender expression may affect the quality of care they provide to TGNC clients and their families." (p. 837)

"6. Psychologists strive to recognize the influence of institutional barriers on the lives of TGNC people and to assist in developing TGNC-affirmative environments." (p. 840)

"7. Psychologists understand the need to promote social change that reduces the negative effects of stigma on the health and well-being of TGNC people." (p. 841)

"8. Psychologists working with gender-questioning and TGNC youth understand the different developmental needs of children and adolescents, and that not all youth will persist in a TGNC identity in adulthood." (p. 841)

"11. Psychologists recognize that TGNC clients are more likely to experience positive life outcomes when they receive social support or trans-affirmative care." (p. 846)

5.3 Rejection of "reparative" therapy goals and legal punishability of conversion therapies

"Treatment methods that are based on the assumption of a psychopathological maldevelopment and thus aim to change gender identity and gender-typical behaviour so that they are more in line with the gender assigned at birth have been tried without success. Today, such treatment methods are considered ethically unacceptable" (Meyenburg, 2020, p. 12). In Germany, attempts to treat minors with such *reparative* intentions (so-called „conversion treatments“ to change sexual orientation or gender identity) are legally punishable since 2020 (Law for the Protection against

Conversion Treatments, Bundesgesetzblatt I, p. 1285). Therefore, there is no need for a specific consensus-based recommendation in this guideline.

5.4 Knowledge of or enquiry about trans-specific experiences

For an empathic understanding of the individual experiences of trans people, it is important to specifically ask about trans-specific life realities and socialisations (Günther et al., 2021). This includes, among other things

- experiences with minority stress and discrimination (see Chapter IX → "*Professional interaction and discrimination-sensitive conduct with gender-nonconforming children and young people*"),
- the possible associated processing and coping with internalised transnegative parts in the self-reference of those affected (Günther et al., 2021),
- subjective relations between sexual orientation and gender identity,
- specific impacts of being trans on romantic and sexual relationships,
- overlaps between gender-nonconforming identity and other culturally characterised identities in the subjective experience of those affected.

In the *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People* (APA, 2015) the following four of 16 professional statements are formulated:

"2. Psychologists understand gender identity and sexual orientation are distinct but interrelated constructs." (p. 835)

"3. Psychologists seek to understand how gender identity intersects with the other cultural identities of TGNC people." (p. 836)

"5. Psychologists recognize how stigma, prejudice, discrimination, and violence affect the health and well-being of TGNC people." (p. 838)

"12. Psychologists strive to understand the effects that changes in gender identity and gender expression have on the romantic and sexual relationships of TGNC people." (p. 847)

5.5 Reflection on the therapeutic role and self-awareness

When shaping a psychotherapeutic relationship, it is important to reflect critically and openly on aspects of a possible gap of power and dependency. A real imbalance in this regard arises, for example, when psychotherapeutic practitioners themselves prepare recommendations and expert opinions for body-altering interventions and thus formally assume a professional *gatekeeping function*

for access to medical transition treatments. Such a structural imbalance of power arises regardless of how accepting and respectfully this role is performed. For psychotherapeutic practitioners, it is important to recognise the history of a health and legal system that used to be restrictive towards trans people, which extends far into the current reality of care. This included, among other things, the fact that trans people had to undergo detailed assessments by two independent psychological or psychiatric experts in order for their gender identity to be legally recognised under the *German Transsexuals Act (Transsexuellengesetz, TSG),* which was still in force until October 2024.

Furthermore the review directive for statutory health insurance published in 2020[8] whose authorship and associated scientific legitimacy are not transparent, stipulate that a trans person who wishes to undergo gender-affirming surgery must first have undergone psychotherapy in accordance with the German Psychotherapy Guideline[9] in order to prove that this *means of treatment* for alleviating the existing gender dysphoria *has been exhausted.* This documentation of an ineffective attempt to treat by means of psychotherapy as a prerequisite for the statutory health insurance to cover the costs of gender-affirming surgery is postulated irrespective of the fact that this surgery has been recommended in accordance with professional guideline standards.

This requirement is thus in open contradiction to the current evidence-based S3 guideline published two years earlier (!) by the AWMF *„Gender Incongruence, Gender Dysphoria and Trans* Health"* for adulthood (DGfS, 2018). Based on the recognised state of scientific knowledge, the professional associations involved in this guideline expressly stated that the requirement of mandatory psychotherapy as a prerequisite for access to gender affirming surgery is "neither compatible with current specialist knowledge nor with professional ethical principles" (BPtK, 2021, p. 7).

This outlined history of the instrumentalisation of psychotherapy as a restrictive barrier towards trans people in the healthcare system can also cause a subjectively perceived power imbalance in the psychotherapeutic relationship in the sense of latent mutual expectations and role attributions, even when the relationship is structured on an equal footing. It is important to reflect on this carefully and critically.

Furthermore, for the self-reflection of psychotherapeutic practitioners, it is recommended that they have critically examined various aspects of their own gender and its development as part of

[8] This directive was published by the Medical Service of the Federal Association of Health Insurance Funds (Medizinischer Dienst des Spitzenverbandes der Krankenkassen e.V.)
[9] See footnotes 2ff

their professional self-awareness in order to avoid latent defensive attitudes towards gender-nonconforming forms of expression and life.

The AWMF S3 guideline *on gender incongruence, gender dysphoria and trans* health* for adulthood (DGfS, 2018) provides the following consensus-based recommendation:

"Clinicians should have critically reflected on their own gender-related development and their relationship to physical sex characteristics, if possible in the context of professional self-encounter**.** Self-reflection should include dealing with the confusion that can be caused by the contradiction between one's own perception and the self-representation or self-description of the person seeking treatment with regard to gender." (p. 16)

6. Tasks and objectives of psychotherapeutic interventions for gender-nonconforming, gender-incongruent and gender-dysphoric adolescents

Based on the S3 guideline *Gender incongruence, gender dysphoria and trans health* for adulthood (DGfS, 2018) and the *Standards of Care 8* of the WPATH (Coleman et al., 2022), the following possible goals of psychotherapeutic interventions for gender-nonconforming adolescents and adolescents with gender incongruence or gender dysphoria are summarised for orientation purposes and should be considered when planning interventions based on the needs of the individual case:

Possible goals and topics to be addressed in the psychotherapeutic counselling of gender-nonconforming[10] adolescents:

- Support with self-exploration and finding one's identity
- Promotion of self-acceptance, self-esteem and self-confidence
- Coping with feelings of shame and guilt as well as internalised trans negativity
- Supporting the coming out process
- Supporting communication within the family in the event of family acceptance problems
- Support in trying out social roles and reflecting on the experiences made with this
- Dealing with aversive experiences of discrimination, transphobia or hostility
- Talking about love, partnership and sexuality
- Talking about body image and body reference

[10] The term gender-nonconforming is used here as a generic term, even if it is intended to include adolescents who have not (yet) been diagnosed with persistent/persistent GI, i.e. the question of gender identity is still considered to be open.

– Support in preparing decisions on body-altering treatments (including obtaining full capacity to consent) – Support with the psychosexual integration of body changes after body-altering treatments – Support in coping with negative feelings and stress in cases of persistent gender dysphoria

6.1 Involvement of parents and other family caregivers

Successful psychosocial coping with a transition in adolescence depends crucially on support from the family environment of those affected (cf. Romer & Möller, 2020; see Chapter VI → "*Inclusion of the family environment and family dynamics*"). Therefore, "the importance of the close involvement of parents and other close family caregivers in the entire transition process and their professional support [...] cannot be emphasised enough" (Romer & Möller, 2020, p. 92). Here, the psychotherapeutic professional has the task of "accepting the patient's endeavours in full on the one hand and, on the other hand, acknowledging the [possibly existing] concerns and worries of the parents and, in the case of existing aetiological assumptions, informing them according to current specialist knowledge. The offer of a relationship with the adolescents and a working alliance with the parents also represent [...] [sometimes] a major challenge"(Dietrich, 2021, pp. 10-11). Further details on this can be found in Chapter VI → "*Inclusion of the family environment and family dynamicsdynamics*" of this guideline.

6.2 Support for self-exploration and self-discovery of gender-nonconforming young people

If young people who currently describe themselves as gender non-conforming and who are still in a rather fluid process of self-discovery or appear uncertain about their experienced trans identity seek psychotherapeutic support, an important goal to be clarified in advance can be to accompany a process of self-exploration in constant interaction with social role-testing, without suggesting any commitments for the future regarding a permanent desire to transition.

Ashley (2019) writes: "Exploration is not a step that precedes a [social] transition, but a process that runs through a transition. It is impossible to imagine a level of exploration [without social role testing] that makes us confident that a transition is appropriate for future identity development. Instead of [merely] questioning the young people, professional helpers should play a supporting role [here]" (p. 233).

Preuss (2021) writes accordingly, "The most important overriding treatment goal in the treatment of gender dysphoric children and adolescents, in whom it is not yet [...] [foreseeable] whether [a persistent gender incongruence is present or not], is the resolution of inner confusion and

the promotion of the ability to trust one's own sense of gender identity and to express oneself with it" (p. 180).

Romer and Möller (2020) formulate this as follows: "A psychotherapeutic programme is thus understood as a developmentally oriented accompaniment. In the process of self-discovery with regard to a persistent [or non-persistent] trans* identity, the focus is on supporting introspective and socially interactive self-exploration" (p. 91).

An important goal here can be to support gender-nonconforming young people in further developing the degree of certainty about their own gender identity through dialogue ("It's not about convincing others, it's about being sure of yourself"). Encouragement to question exclusively binary gender role expectations in the process of self-discovery and to reflect on non-binary role ideas and perspectives and explore them through everyday social experiences can be particularly useful in view of the likelihood of later detransition. For example, retrospective interviews with people who have experienced detransition have reported cases in which a non-binary gender identity was reported at the time of detransition, which had not yet been consciously felt at the time of the previous transition (Littman, 2021).

Consensus-based recommendation:

V.K3.	Adolescents with a gender-nonconforming self-description who seek psychotherapeutic support when their gender identity is still uncertain should be informed that exploratory social role testing is important to support a process of introspection and self-reflection in connection with socially interactive experiences through dialogue. Protection against discrimination should be taken into account. In this process, young people should be encouraged to question gender stereotypes of role expectations and to reflect on the possibility of a non-binary understanding of gender roles.

Consensus strength: strong consensus (> 95%)

Special vote of the German Society for Psychiatry, Psychotherapy, Psychosomatics and Neurology (DGPPN):

The DGPPN is in favour of deleting the reference to the possibility of a non-binary understanding of gender roles for its redundancy. Furthermore, the DGPPN is in favour of a stronger level of recommendation for the reflection of gender-stereotypical role expectations and proposes the following amended wording:

Adolescents with a gender-nonconforming self-description who seek psychotherapeutic support when their gender identity is still uncertain should be informed that exploratory social role testing is important to support a process of introspection and self-reflection in connection with socially interactive experiences through dialogue. Protection against discrimination should be taken into account. In this process, young people shall be encouraged to question gender stereotypes of role expectations.

Justification see appendix.

6.3 Self-acceptance and processing internalised trans-negativity

A negative inner attitude towards being trans (internalised trans negativity) can arise from anticipated or already suffered experiences of discrimination. Social prejudices and a rejection of homosexual people and/or trans people that is characterised by cultural ideas in the family and social environment can contribute to young people experiencing themselves as *deficient, not right and a disappointment for their relatives*. This can be associated with severe self-esteem problems (Dietrich, 2021). Accordingly, better and more conflict-free self-acceptance is often a sensible goal in the psychotherapeutic support of gender dysphoric adolescents. Romer and Möller (2020) write in this regard, "For psychotherapy with gender dysphoric adolescents, supporting the integration of gender-incongruent self-experience into a coherent self-image and its acceptance is an important goal" (p. 89).

In the psychotherapeutic treatment of internalised transnegativity, it is important to embed it in real experiences with trans hostility in a social or medical context, as internalised trans hostility is often shameful for those affected (Günther et al., 2021). According to the Minority Stress Model, specific rules of silence and other experiences of trans hostility should therefore be considered as significant factors in the psychotherapeutic treatment of internalised trans negativity. Not talking about personally important internal processes, non-conforming gender identities and experiences of violence can serve to protect against further stigmatisation, but can also hinder the activation and development of resources that are necessary for mobilising self-empowerment and support options (Günther et al., 2021). Reducing internalised trans-negativity can make a significant contribution to strengthening the self-esteem and self-confidence of gender dysphoric adolescents and thus their resilience (*empowerment*). This in turn can be suitable for reducing the likelihood of bullying experiences, for example. The degree of self-confidence and (gender) conviction can be seen as protective for psychosocial stabilisation, peer group acceptance and successful social relationships.

6.4 Psychotherapeutic support for role testing and role changes

The open-ended and clarifying accompaniment of self-exploration processes in gender-nonconforming young people and affirmative support for exploratory role-testing complement each other (see above). Early encouragement to try out gender-nonconforming roles in the sense of trying them out with as little fear as possible (see above) counteracts the conditions for the emergence of internalised transnegativity described in the previous section and also opens up inner spaces for experiencing social gender diversity beyond persistent gender incongruence (e.g. as a "tom-boy"), including non-binary role models. A perceived *binary role fulfilment pressure* shaped by assumed social expectations was found to be a significant factor in surveys of formerly transitioned persons who later

detransitioned after irreversible medical interventions (so-called *detransitioners*) (Littman, 2021; Turban et al., 2021; Vandenbussche, 2021). However, when gender-diverse young persons are encouraged to explore social roles as openly as possible and experience an accepting attitude towards gender diversity, this can counteract the perceived notion that one has no choice but to be 'binary trans'. In individual cases, such self-determination can sometimes also mean a subjectively firm desire for gender-affirming hormone treatment, which may later prove premature when the young person realises that they have not yet sufficiently explored a non-binary self-positioning for themselves.

Therefore, an *ethics of gender exploration* that encourages gender-diverse children and adolescents to try out social roles at an early stage (Ashley, 2019; see above) is also justified with regard to the prevention of later detransitions that occur after medical transition treatments, which are then regretted (so-called *regrets*). In this sense, encouraging children and adolescents to try out gender-nonconforming roles to support open-ended self-exploration makes sense. In the case of young people who have not yet legally changed their name and marital status, it is sometimes important for psychotherapeutic specialists to provide expert opinions in order to support such role-testing in schools and training institutions.

As psychotherapeutic support is not usually required in connection with social role testing in childhood beyond an accepting educational approach, the relevant recommendations are explained in a separate chapter III → "*Social transition in childhood*".

If young people with gender incongruence or gender dysphoria wish to undergo a social transition, the focus of psychotherapeutic support is usually on the affirmative accompaniment of all upcoming steps and their preparation, as well as the dialogue-based processing of the personal experiences made. Particularly in light of the historical background of earlier treatment guidelines, in which, for decades, a psychotherapeutically accompanied complete role change was recommended as a *mandatory* requirement e.g. for the medical recommendation for gender affirming hormone treatment, it is advisable to convey to those seeking treatment that ongoing biographical reflection on the experiences associated with a social transition is a supportive psychotherapeutic offer and not an *obstacle*.

Consensus-based recommendation:

V.K4.	Children and adolescents with gender incongruence or gender dysphoria who have begun a social transition or are aiming to do so can be offered psychotherapeutic support to prepare for individual decisions and to reflect on the associated experiences.

Consensus strength: strong consensus (> 95%)

Special vote of the German Society for Psychiatry, Psychotherapy, Psychosomatics and Neurology (DGPPN):

The DGPPN is in favour of a stronger level of recommendation for psychotherapeutic process support in social transition and proposes the following amended wording:

Children and adolescents with gender incongruence or gender dysphoria who have begun a social transition or are aiming to do so **shall be** offered psychotherapeutic support to prepare for individual decisions and to reflect on the associated experiences.

Justification see appendix.

Low-frequency appointments (e.g. 1-3 appointments per quarter), which can take place as part of psychiatric or psychosomatic counselling, are often sufficient for such support of these processes - especially if there is no coinciding mental disorder requiring treatment (e.g. depression or social anxiety). Direct or indirect support from therapeutic professionals in dialogue with institutions (school, training place, employer) can also be helpful or necessary.

6.5 Openness to doubts, desistent trajectories and the possibility of later detransition

Encouraging gender-nonconforming young people to openly explore their roles in their social environment implies that young people who describe themselves as trans may not remain with this self-description in the long term. This also includes the option of retracting an already completed social outing (social detransition). This possibility should be mentioned from the outset when encouraging young people to explore their social roles and kept in mind in dialogue with them, for which the mental space should remain open. In particular, young persons wit lacking self-confidence may tend to develop fears that they could *disappoint* other people when such doubts arise. This can lead to an inner inhibition to address their own doubts about the persistence of their own trans identity within

the psychotherapeutic relationship. In order to counteract such fears and inhibitions, it is advisable to explicitly dispel any potential misunderstandings in this regard, e.g. the affirmative attitude of the psychotherapeutic professional ("be the person you are and don't necessarily follow an image that others have made of you").

Consensus-based recommendation:

V.K5.	Psychotherapeutic professionals who accompany gender-nonconforming adolescents in the process of social role exploration or social transition should convey that they are open to any doubts and uncertainties that may arise with regard to transition and to thoughts of desistance or detransition.

Consensus strength: strong consensus (> 95%)

Special vote of the German Society for Psychiatry, Psychotherapy, Psychosomatics and Neurology (DGPPN):

The DGPPN is in favour of a stronger level of recommendation on the openness of psychotherapeutic professionals with regard to desistance/detransition and proposes the following amended wording:

Psychotherapeutic professionals who accompany gender-nonconforming adolescents in the process of social role exploration or social transition **shall** convey that they are open to any doubts and uncertainties that may arise with regard to transition and to thoughts of desistance or detransition.

Justification see appendix.

6.6 Working on topics relating to body image and body reference

In gender dysphoric adolescents, negative body feelings, needs and emotions such as disgust, shame, envy, anger and self-hatred are often very present as a result of body-related dysphoria and may require psychotherapeutic support with the aim of promoting the psychosexual integration of their own body image. It is advisable for gender dysphoric adolescents to critically examine normative body images and the limits of realising body ideals, even as a topic wich is not trans-specific. It is also important to explore and, if necessary, to deal with psychosexual maturation conflicts, which can also occur in *cis* adolescents and which are therefore not automatically to be understood in the specific

context of gender dysphoria. Careful monitoring of the integration of body image in the course of the physical changes brought about by body-altering interventions, their psychological anticipation and internal processing should not be forgotten either. This can be an important aspect of psychotherapeutic support in process.

6.7 Love, partnership and sexuality

Adolescents with gender incongruence or gender dysphoria who seek psychotherapeutic support can be expected to have a wide range of previous experiences, wishes and possibly associated insecurities in the areas of love, partnership and sexuality. Some adolescents already have sexual experience and/or are in a romantic relationship, others cannot even imagine this for themselves and still others state that they cannot imagine having their own sexual relationships until they have undergone gender affirming surgery at the earliest - and of course there is everything in between. Similarly, some young people are very well informed about the diversity of sexual lifestyles and their realisation through networking with the LBGTQ community (their level of information on these issues is often more comprehensive than those of many psychotherapeutic professionals) and thus demonstrate a self-confident approach, while others can appear very insecure in dealing with this issue.

In terms of sexual orientation, it can be assumed that trans people as a whole are significantly more diverse than the average population. For example, in a survey of adult trans people (*N* = 6368), only 22% of respondents stated a *heterosexual* orientation (*straight*) from the perspective of the trans gender (i.e. trans men, for example, stated that they were predominantly attracted to the female sex), while 74% of respondents stated other orientations from the *queer* spectrum (e.g. bisexual, homosexual from the perspective of the trans gender, *queer* or *other*) (Herman, 2016). Therefore, when asking young people about this topic, psychotherapeutic professionals should be as open and unbiased as possible towards gender diversity and as free as possible from heteronormative ideas. In particular, if they have already had longer experiences with a lived social transition in all areas of life, young people can often differentiate very clearly in their self-description between their perceived gender identity and their sexual orientation. For other adolescents who are in the process of open self-discovery in this regard, it can be helpful if this can also be explored in dialogue and without fear as part of psychotherapeutic support. On the part of the psychotherapeutic professional, it is primarily a matter of signalling that this topic can be discussed openly and impartially and is not avoided or tabooed. To this end, it is often necessary to address the topic of sexuality openly, whereby this should be done with appropriate sensitivity. However, it is up to the young person to decide to what extent they want to address this topic and talk about it. In particular, mental health professionals should be

sensitive to the fact that in the collective perception of trans people there may be narratives, according to which mental health professionals in the past forced explorations of the topic of sexuality, which was sometimes experienced as very intrusive, e.g. when explicit descriptions of masturbation practices and associated fantasies were explored in the context of assessments required for a change of civil status under the previous German Transsexuals Act (TSG).

6.8 Coping with negative feelings in the case of persistent gender dysphoria

Even if there is no causal psychotherapeutic treatment for persistent gender dysphoria, because by definition it is based on gender incongruence, which in turn is a permanent internal disposition of a person that cannot be influenced by psychosocial interventions, psychotherapeutic interventions can be helpful in better coping with the negative emotions and distress associated with gender dysphoria. This can in no way replace the primary and only permanently effective intervention that can lead to a lasting improvement in the mental health prognosis - namely supporting the development of the personality in harmony with the perceived gender and its social acceptance - possibly in conjunction with medically recommended body-altering interventions. This is contradicted by the defined requirement in the current review directive of the Medical Service of the National Association of Statutory Health Insurance Funds (2020), according to which, before the coverage of costs for a gender-affirming surgery, which has been recommended according to guideline standards, is approved, it must be proven in each individual case by means of an *unsuccessful* psychotherapy that the GD could not have been treated effectively by psychotherapeutic means alone. This defined requierement is not compatible with the current state of scientific knowledge and it is unethical and questionable in terms of its conformity with social law. It imposes on those affected the undergoing of a costly and, according to current knowledge, ineffective therapy (psychotherapy for healing gender dysphoria) as a prerequisite for the coverage of costs for guideline-compliant medical treatments.

If the social transition of gender dysphoric adolescents is accompanied by psychotherapy (possibly in parallel with body-altering interventions), general treatment techniques for coping with negative feelings and stress states, such as those commonly used in the treatment of depressive and anxiety disorders and trauma-related disorders, can be used. In this case, it may be necessary to check whether the extent of the burden or impairment caused by negative feelings and stress states justifies the assignment of a coincident psychiatric diagnosis and the associated determination of the need for psychotherapeutic treatment within the defined framework of the German psychotherapy guideline.

6.9 Support in the development of full capacity to consent to body-altering interventions

While adults are generally considered capable of giving consent, even for complex medical interventions, a special feature of the treatment of minors with gender incongruence or gender dysphoria is that their capacity to give consent must be confirmed in each individual case and specifically for each medical intervention considered as part of the professional recommendation (see Chapter X → "*Annotations on the legal basis and ethical standards for the treatment of minors with gender incongruence*" and Chapter VII → "*Guidance for recommending body-altering medical interventions* "). The capacity to consent to a specific medical or psychotherapeutic intervention also depends on the complexity of the decision to be made (see Chapter X → *"Annotations on the legal basis and ethical standards for the treatment of minors with gender incongruence"*).

Professional support for the reflection processes of adolescents with gender incongruence or gender dysphoria in order to achieve full capacity to consent given the complexity of a desired medical intervention can be an important part of psychotherapeutic support, especially if comprehensive reflections on the far-reaching consequences of treatment and its irreversibility are pending. Questions such as what influence medical transition treatment will have on one's own relationships, life and family planning and possible infertility, or whether or not precautionary cryopreservation to preserve fertility makes sense for the individual, can touch on very personal issues that cannot be adequately addressed with the help of medical information alone, but rather require in-depth and recurring reflection in order to be sustainably integrated into one's own consciousness and psychosexual self-concept.

Chapter VI

Inclusion of the family environment and family dynamics

1. Introduction and key question

When children and adolescents show symptoms of gender incongruence or gender dysphoria (GI/GD), this usually has a profound impact on their family environment. For parents and siblings (but also for family members outside the nuclear family), this means an adjustment that in many cases is initially accompanied by a high level of uncertainty. As a result, relationships within the family may change negatively and can make necessary educational interventions more difficult (e.g. because parents do not pay adequate or too much attention to the symptoms of GI/GD). Family members sometimes have enduring troubles with accepting the expressed gender identity or they may show a simplistic acceptance which does not address the complexity of the phenomenon adequately.

In the case of persistent trajectories in adolescence, parents are increasingly confronted with decisions regarding medical transition (puberty blockade, hormone therapy, surgical interventions), which may trigger understandable fears and worries. On the other hand, there is often a vehement desire on the part of the adolescents concerned to start body-altering medical interventions timely. This may lead to polarising conflicts in families, which put a strain on the parent-child relationship. Health professionals may easily be drawn into these conflicts and then run the risk of no longer being able to provide adequate *family-based* counselling and support, as is usually adequate in the field of child and adolescent mental health care.

However, for gender-nonconforming children and adolescents feeling accepted by their families is an essential prerequisite for exploring their gender through role testing in everyday life and also appears to be an important factor for their mental health outcome in the long term. Therefore, the involvement of the family environment, especially if there are reservations, rejections or fears about the topic of GI/GD, is very important in the counselling process. In rare cases, there may be a risk to the child's well-being, which must then be identified and dealt with accordingly.

Key question to the guideline:

Which family constellations and influencing factors are particularly important to consider with regard to the need for their exploration and any resulting action to take?

Gender-nonconforming children and adolescents have particular needs and have to make decisions that also affect other family members and their environment. They are dependent on the support of their family in their identity development, especially when making decisions about transitioning. Family dynamics play a significant role in these processes, as is generally well-known for vulnerable children and adolescents in the fields of child and adolescent psychiatry, youth welfare and family therapy - both in terms of family stress factors and protective resources. There is no doubt that children and adolescents with GI and/or GD belong to such a vulnerable group, as the increased rates of suicidality and self-harm described in the previous chapter clearly demonstrate (Eisenberg et al., 2017; Strauss et al., 2017; Travers et al., 2012; Veale et al., 2017, and many more, see Chapter IV → *"Associated mental health difficulties in children and adolescents with gender incongruence and gender dysphoria*"). This guideline therefore dedicates a separate chapter to the topic of family dynamics.

Unfortunately, in the entire breadth of research in the field of GI and GD, there are only a few studies that have - at least implicitly - also investigated issues relating to specific family dynamics. The literature reviewed for this chapter therefore largely overlaps with the literature reviewed in other chapters of the guideline. This includes original studies, review articles, existing guidelines and published treatment approaches, in which the issue of family dynamics is addressed in at least one question, conclusion or practical recommendation.

When looking at the issue of family dynamics, the possibly different interests and intentions of those involved should also be recognised and taken into account. Children and young people often have to rely on decisions made by their parents on their behalf. It is likely that parents assume the goals that correspond to their own views on the best interests of the child to be in the best interests of their child as well and therefore will most likely seek out care and treatment services that reflect their own views and attitudes (Byne et al., 2012). In the best-case scenario, the views of the children and parents coincide or are at least close to each other. Such families are often already very well informed about gender diversity and have networked with other families. Several studies have reported that this form of networking in the sense of peer support is associated with positive life satisfaction, low sexual risk behaviour and a low level of depressive symptoms in children and adolescents (Johns et al., 2018; Travers et al., 2012; Veale et al., 2017, and many more). Children and adolescents in these families often showed no or only very minor mental health problems (e.g. Dierckx et al., 2016; Kaltiala-Heino et al., 2018). These families may therefore often need no or only selective professional support from psychotherapists.

There are also families in which there are conflicts around the issue of their child's about the GI/GD. There are reports of negative reactions and even rejection by the parents. Reasons for this can include shame or fear of stigmatisation. Parents' fear of not doing the *right* thing and a lack of support and adequate information from the side of professional services are also reported (Dierckx et al., 2016). Professionals who are well informed and have an accepting and supportive attitude were perceived as positive and helpful in developing appropriate strategies for dealing with the child's GI/GD by the parents surveyed (Sharek et al., 2018).

Particular attention must be paid when gender-nonconforming children and adolescents experience rejection by their own family, including aggressive behaviour, especially if this is accompanied by specific authoritarian parenting methods and punitive sanctions by the parents (Adelson, 2012). The values and norms of the individual ethnic group or religious community can play a major role in this (Gartner & Sterzing, 2018). Several authors point out that negative reactions, comments and marginalisation by peers or family represent a particular developmental and health risk for the child. Examples cited include the weakening of protective factors against suicidal behaviour and dysfunctional coping strategies such as running away or prostitution (Strauss et al., 2017; Travers et al., 2012). It should be noted here that negatively burdened family and peer relationships can also be regarded as a non-specific risk factor for mental health problems. Furthermore, no reliable statements can be made about causal relationships, as interferences (in the sense that mental health problems can also be a stressor on relationships) must also be taken into account.

Acceptance and support from one's own family is a significant protective factor for the mental health of children and adolescents with GI/GD. This emphasises how important the involvement of parents/family is for the mental health of children and adolescents. However, it also shows the need for support for parents so that they are able to accompany their children appropriately. Supporting non-binary children and adolescents, who are at a particularly high risk of developing internalising mental health symptoms, is additionally challenging (Kuvalanka et al., 2017).

2. Statements and recommendations

2.1 Statements on scientific findings

VI.E1.	There is evidence that for children and adolescents with gender incongruence or gender dysphoria, a family environment that accepts and supports their perceived gender identity is a significant protective factor for their mental health.

The evidence for this statement is well documented. There are more than 10 studies with similar results (Aramburu Alegría, 2018; Catalpa & McGuire, 2018; Gray et al., 2016; Katz-Wise et al., 2017, 2018; Kolbuck et al., 2019; Kuvalanka et al., 2014; Levitan et al., 2019; McConnell et al., 2016; Pariseau et al., 2019; Ryan et al., 2010; Veale et al., 2017; Wilson et al., 2016).

Consensus strength: strong consensus (> 95%)

VI.E2.	There is evidence that children and adolescents with gender incongruence or gender dysphoria who *experience a low or lack of acceptance* of their perceived gender identity in their family environment have an increased risk of depressive disorders and suicidal tendencies as well as self-harming risk behaviour [(1)].

The evidence for this statement is uncertain. There are five studies with similar results (Aramburu Alegría, 2018; McConnell et al., 2016; Pariseau et al., 2019; Simons et al., 2013; Travers et al., 2012).

Consensus strength: strong consensus (> 95%)

2.2 Recommendations

Consensus-based recommendation:

VI.K1.	Custodians and carers should be informed that any attempted therapy aimed at changing the child's sense of belonging to a gender contrary to their expressed own experience are harmful and unethical.

Consensus strength: strong consensus (> 95%)

Explanation: The term *child* is not used here to refer to an age group, but to the social and legal relationship with custodians and carers. It therefore also refers to adolescents. The term "expressed own experience" does not exclusively include explicitly verbal expressions, but can also include behavioural expressions, provided that these clearly express the child's sense of belonging to a gender.

At this point, the following statement from the preamble (*Chapter I → "Preamble to the guideline"*) is emphasised once again:

"A person's gender identity is of a highly personal nature. Promoting self-determination and - where necessary - the ability to self-determine is therefore a key concern in the treatment setting with underage patients. Therapy approaches that are implicitly or explicitly based on the treatment goal of steering a person's sense of belonging to a particular gender in a certain direction are considered unethical."

Special vote of the German Society for Psychiatry, Psychotherapy, Psychosomatics and Neurology (DGPPN):

The DGPPN is in favour of a stronger level of recommendation for informing guardians about the harmfulness of attempts to influence the child's sense of gender affiliation and proposes the following amended wording:

Custodians and carers **shall be** informed that any attempted therapy aimed at changing the child's sense of belonging to a gender contrary to their expressed own experience **can be** harmful.

Justification see appendix.

Consensus-based recommendation:

VI.K2.	Custodians and carers should be informed that for children and adolescents with gender incongruence or gender dysphoria, the safe and constant experience of being accepted and supported by their own family is essential for the process of self-discovery, and, depending on its trajectory, also for a social coming out, role exploration and transition, and thus for a favourable mental health outcome.

Consensus strength: strong consensus (> 95%)

Explanation: In this context, the term *transition* can refer to social, legal and/or medical transition, depending on the situation. The term *social coming out* refers to the entire process of increasingly *coming out* to one's social environment in the gender role that corresponds to one's currently perceived gender identity. Such a process often involves several steps (see glossary).

Special vote of the German Society for Psychiatry, Psychotherapy, Psychosomatics and Neurology (DGPPN):

The DGPPN is in favour of a stronger level of recommendation for informing guardians about the importance of acceptance and proposes the following amended wording:

Custodians and carers **shall be** informed that for children and adolescents with gender incongruence or gender dysphoria, the safe and constant experience of being accepted and supported by their own family is essential for the process of self-discovery, and, depending on its trajectory, also for a social coming out, role exploration and transition, and thus for a favourable mental health outcome.

Justification see appendix.

Consensus-based recommendation:

VI.K3.	Custodians and carers should be advised to support a safe social space for exploring gender roles in all developmental processes of gender-nonconforming children and adolescents and, depending on their trajectory, also a safe social space for the possible later change of an expressed gender role.

Consensus strength: strong consensus (> 95%)

Explanation: Last but not least, in order to increase the certainty of decision-making in the event of gender-affirming medical interventions that may have to be examined at a later date, open-ended social role testing should serve, among other things, to explore the long-term coherence and viability of the desired gender role in the context of social experiences. This implies that, for example, when advising for social role explorations, the option of later withdrawing a trans outing should be explicitly addressed and, if necessary, supported.

Consensus-based recommendation:

VI.K4.	Custodians and carers of gender-nonconforming children and adolescents should be informed about the services offered by parent groups of self-advocacy organisations as an opportunity for networking and mutual support.

Consensus strength: strong consensus (> 95%)

Consensus-based recommendation:

VI.K5.	Custodians and carers who present with their child because of the possible presence of gender incongruence or gender dysphoria should be offered psychological support with the aim of helping the child, together with their family, to explore their own gender identity and to overcome psychosocial difficulties that may be associated with gender incongruence or gender dysphoria.

Consensus strength: strong consensus (> 95%)

Consensus-based recommendation:

VI.K6.	If the ideas and wishes of minors and their legal guardians with regard to how the family should deal with the child's non-conforming gender identity are not compatible, professional support for the family system by a specialist with expertise in family therapy should be recommended, with the aim of promoting an accepting and supportive attitude towards the child's gender identity. Such professional support is only recommended if no harmful effects on the child's health are to be expected.

Consensus strength: strong consensus (> 95%)

Explanation: The term "expertise in family therapy" in this recommendation *does not* refer to a formal certificate of a specific qualification in this field, but to the professional skills and experience of the specialist concerned.

Chapter VII

Guidance for recommending body-altering medical interventions

6. Requirements of recommendations for body-altering medical interventions

6.1 Fundamentals

6.2 Puberty suppression

6.3 Gender-affirming hormone treatment (GAH)

6.4 Gender-affirming surgery in adolescence

6.5 Recommended contents in a clinical recommendation letter

1. Introduction and key questions

Body-altering medical interventions for people with gender incongruence (GI) aim to prevent or reduce persistent body-related gender dysphoric distress by temporarily halting pubertal maturation or harmonising physical appearance. There is a consensus in current guidelines that it is important for a lasting positive effect on mental health that such medical interventions are embedded in a social transition associated with self- and social acceptance (DGfS, 2018; Coleman et al., 2022a). Making clinical recommendations for these interventions is complex and professionally challenging, especially in adolescence. This chapter sets out the professional competencies, skills and knowledge required when making a multi-disciplinary recommendation. It should be emphasised in advance that, in addition to formal requirements regarding the professional qualifications of the specialists involved, specific specialist knowledge and previous clinical experience in transgender health care are essential.

Consensus-based recommendation:

VII.K0a.	Specialist knowledge and several years of experience in the counselling and treatment of adolescents with gender incongruence are required for a professional treatment recommendation. Professionals without sufficient specialist knowledge and experience in this area should consult a sufficiently experienced professional or a specialist outpatient clinic or treatment centre for professional safeguarding before a recommendation is made.

Consensus strength: strong consensus (> 95%)

Explanation: This involvement of proven expertise is not formally defined and is based on the individual circumstances within a care and training landscape that is constantly evolving as a learning system. This can, for example, take the form of an independent medical second opinion, a consultative co-assessment, peer supervision, or multi-disciplinary meeting in quality assurance rounds.

Special vote of the German Society for Psychiatry, Psychotherapy, Psychosomatics and Neurology (DGPPN):

The DGPPN is in favour of a stronger level of recommendation and proposes the following amended wording:

Specialist knowledge and several years of experience in the counselling and treatment of adolescents with gender incongruence are required for a professional recommendation. Professionals without sufficient specialist knowledge and experience in this area **shall** consult a sufficiently experienced professional or a specialist outpatient clinic or treatment centre as an extra professional safeguardbefore recommendation is made.

Justification see appendix.

Key questions:

- What specialist expertise should be assumed for the professional recommendation of body-altering medical interventions in cases of gender incongruence in adolescence?
- What should be considered when diagnosing gender incongruence or gender dysphoria in adolescence with regard to the recommendation for body-altering medical interventions?
- What needs to be considered when diagnosing and treating associated mental disorders with regard to the recommendation for medical interventions?
- What development-related diagnostic considerations should be taken into account when determining the recommendations for medical interventions?
- What recommendations can be made for the gradation and sequence various medical treatment steps?
- At what age or maturity stage of pubertal development can which medical treatment steps generally be recommended?
- What requirements must be met for the informed consent of underage patients and their legal guardians before a recommendation for body-altering interventions is given?

2. Limitations of research evidence

The literature review conducted as part of the guideline development on the recommendation of puberty-delaying and gender-affirming interventions in children and adolescents with gender incongruence or gender dysphoria revealed only a small number of relevant original studies in which the outcome of these interventions was examined in a follow-up design. Studies with a higher level of evidence were particularly lacking (Mahfoudaet al., 2019; Taylor, Mitchell, Hall, Heathcote et al., 2024; Taylor, Mitchell, Hall, Langton et al., 2024). In addition to the small number of published studies, the limited evidence base is also due to methodological limitations with regard to the level of evidence of the studies in this context. Conducting randomised controlled and blinded studies in which one group of gender-incongruent or gender-dysphoric children and adolescents receives puberty-delaying or gender-affirming interventions and the other does not, does not appear to be ethically justifiable in principle. In principle, blinding is not possible with hormonal interventions. It is difficult to justify withholding effective puberty-delaying or gender-affirming interventions in the course of randomisation for study purposes if there is a desire for such an intervention on the part of those affected and their guardians and if there is a corresponding level of suffering on the part of those affected. This would presumably lead to a very low willingness to participate in such a study.

The systematically reviewed literature therefore mainly refers to clinical follow-up cohort studies. These studies examined adolescents with diagnosed gender incongruence or gender dysphoria who received puberty-delaying or gender-affirming treatment recommended by practitioners and the corresponding wishes of those affected and their guardians. In some cases, the clinical course of children and adolescents with gender incongruence or gender dysphoria for whom no recommendation for these treatments was given or for whom there was (still) no desire on the part of the affected person or their legal guardians was also reported for comparison. This results in correspondingly large group differences between the sub-cohorts compared. It can be assumed that groups who were recommended for medical interventions versus those who were not presented with different degrees of severity of mental health problems or differences in the extent of gender dysphoria and the associated psychological distress. There are no comparative studies between groups of treated adolescents in which different criteria for professional recommendations were applied.

Against the background of the limited research evidence outlined above, conclusions on the effects of puberty-delaying and gender-affirming treatments on the health outcomes of minors can only

be drawn from the follow-up data on mental and physical health and the social functioning. In the available follow-up studies, various medical interventions had been carried out at the time of the follow-up survey, mostly in combination with psychotherapeutic interventions (Becker-Hebly et al., 2021; Chen et al., 2023; Costa et al., 2015; de Vries et al., 2014; Grannis et al., 2023; Klink et al., 2015; Tordoff et al., 2022; Vlot et al., 2017). For methodological reasons, the outcomes measured in these longitudinal study results cannot usually be attributed to a single intervention, but only allow statements to be made about the outcome of adolescents with gender dysphoria after accessing an "overall package", which includes both psychosocially and medically supported transition with careful clinical recommendations and professional support throughout the process.

3. Outcome studies on mental health, life satisfaction, body satisfaction and gender dysphoria after body-altering interventions

A longitudinal study from the Netherlands with a sample of 70 gender-incongruent adolescents (47.1% trans female and 52.9% trans male) with an average age of 13.65 years (range: 11.1-17.0) found a significant reduction in emotional symptoms and behavioural problems after almost two years of puberty suppression with GnRH analogues (de Vries et al., 2011). Before starting treatment, 44.4% of participants showed emotional or behavioural problems in the clinically relevant range. After treatment, this proportion fell to 22.2%. In particular, there was a significant reduction in depression with a reduction in the raw score of the Beck Depression Inventory (BDI) from 8.31 (cut-off for depression at 14) before treatment to a score of 4.95 at the time of the follow-up. In addition, there was a statistically significant improvement in the global level of functioning from an average of 70.24 (upper range of some mild psychiatric symptoms) to 73.90 (range of transient symptoms). As expected, however, there was no significant change in the extent of dissatisfaction with one's own body after puberty suppression alone (de Vries et al., 2011). The sample consisted of adolescents with persistent gender dysphoria carefully diagnosed according to defined criteria after the onset of puberty. All adolescents in this study continued the puberty suppression over the course of the study and subsequently began gender-affirming hormone treatment.

In a further follow-up to a subsample of the previous study, 55 young adults (40.0% trans female and 60.0% trans males) who had undergone a staged medical transition which began in adolescence, initially with puberty suppression and subsequent gender-affirming hormone administration and gender-affirming surgery, were examined after an average observation period of seven years (de Vries et al.,

2014). Over the course of the study, statistically significant and clinically relevant improvements were found in the areas of psychological functioning, reduction of psychopathological symptoms, extent of behavioural problems, health-related quality of life and subjective well-being, as well as a statistically significant decrease in body dissatisfaction. While the initial scores for psychopathological symptoms and health-related quality of life before the start of puberty suppression were largely in the clinical range, the average scores for health-related quality of life, general life satisfaction and the extent of psychopathological symptoms after complete body-altering treatments were in the reference range of population-representative standardisation samples. In this study, participants accessed body-altering medical treatment in adolescence according to defined strict criteria. Only adolescents with a binary transgender identity and without co-occuring psychiatric diagnoses that could interfere with the diagnosis or treatment of gender dysphoria were included. In addition, all included adolescents received professional support from the treatment centre throughout all medical transition stages (Cohen-Kettenis et al., 2008).

In a study from the UK (Costa et al., 2015), 201 adolescents aged 15.52 years on average (range: 12-17) initially received psychological support over several months. Of these, 121 adolescents (38.5% trans female and 61.5% trans male) were recommended for puberty suppression 6 months after the baseline survey. Of these, 60 were immediately treated with puberty suppression (group 1). For the remaining 61, the decision to start puberty suppression was postponed due to various uncertainties (group 2). This was mostly due to the presence of increased and more complex psychological diffciulties. Group 2 continued to receive only unspecified psychological support during the data collection for this study. The groups of this study are therefore not comparable because they differed systematically from the baseline survey in their clinical presentations. They should therefore only be considered as separate follow-up cohorts. Both groups showed a statistically significant improvement in global functional level during the follow-up. A specific add-on effect of pubertal blockade cannot be derived from the reported data. The results underline the heterogeneity of the patient group with regard to accompanying psychopathological difficulties.

In a Dutch cross-sectional study, van der Miesen et al. (2020) compared 178 adolescents with gender incongruence after treatment with puberty suppression with 272 adolescents who had been newly referred to the Amsterdam Gender Centre but had not yet received medical treatment, as well as with a non-clinical control group of 651 adolescents from the general population. The gender-incongruent adolescents without medical treatment had significantly higher scores for self-harm and suicidality and

poorer peer relationships than their peers in the general population. The adolescents after medical treatment with puberty suppression showed significantly lower scores in emotional or behavioural problems than the adolescents before treatment and the same or lower scores than the adolescents from the general population. This study is categorised as the only study of high methodological quality in a current systematic review by Taylor and colleagues on the outcomes of puberty suppression alone (Taylor, Mitchell, Hall, Heathcote et al., 2024).

In a larger follow-up study of 148 US adolescents by Kuper et al. (2020), these were only treated with puberty suppression (*N* = 25, mean age of 13.7 years with a range of 9.8-14.9) or with feminising or masculinising hormone treatment (*N* = 123, mean age of 16.2 years with a range of 13.2-18.6). After an average follow-up period of 14.9 months, the adolescents' self-reported mean values showed a clear decrease in gender dysphoria with an improvement in their body satisfaction, slight to moderate improvements in depressive symptoms and an equally slight improvement in anxiety symptoms. These changes were statistically significant.

A follow-up study from Germany (Becker-Hebly et al., 2021) predominantly after treatment with puberty suppression, gender-affirming hormones or surgery comes to similar conclusions. Data from 75 individuals (14.7% trans female and 85.3% trans male) with an average age at baseline measurement of 15.56 years (range 11-18) were reported. There were slight to moderate descriptive improvements in psychopathology after an average survey period of two years. Inferential statistical significance was not tested.

A follow-up study with preliminary results from Switzerland (Pauli et al., 2020) of 51 adolescents (23.9% trans female and 76.1% trans male; average age at baseline 16.3 years, range 13-19), most of whom were treated by puberty suppression or with gender-affirming hormones, showed similar results over an average survey period of two years at. Only the trans female adolescents showed a reduction in the overall psychopathological score. However, this change was not inferentially significant due to the small number of cases (*N* = 12) and could not be shown for the trans male adolescents. A completed social transition proved to be a positive predictive factor for aspects of life satisfaction.

An English follow-up study of 44 adolescents under puberty suppression, most after one to two years, showed no change in psychopathological difficulties measured with the Youth Self Report (YSR) (Carmichael et al., 2021). In a study with a very short follow-up of only four months on average, there was no improvement in terms of anxiety, depression and suicidality regardless of the initialisation of hormone

therapy. The authors conclude that the follow-up time is too short to show an improvement (Cantu et al., 2020). A retrospective study of medical histories of members of professional soldiers from the USA showed a reduction in the number of visits to the psychiatric healthcare system but no overall reduction in the use of psychiatric healthcare systems after the administration of gender-affirming hormones. It should be noted that this study involved adolescents and young adults with an average age of 18;2 years at baseline and that the follow-up time was only up to 1.5 years (Hisle-Gorman et al., 2021). A Finnish study examined 52 adolescents who were under 18 years of age at enrolment and on average 18;2 years of age at diagnosis. They received gender-affirming hormone treatment after coming of age. It was found that those who already had concomitant psychiatric disorders before diagnosis also required psychiatric treatment after the initiation of hormone therapy. Those who had good psychosocial and academic/occupational functioning also showed this after hormone treatment. The authors conclude that medical treatment alone is not sufficient to meet the needs of young adults with gender incongruence. The follow-up time in this study was also only one year (Kaltiala et al., 2020). In contrast, another follow-up study from the USA with 115 adolescents one year after starting gender-affirming hormone treatment showed a strong reduction in body dissatisfaction as well as anxiety and depression, but also victimisation over the course of the treatment period and an improvement in life satisfaction (Chelliah et al., 2024).

In ten of the eleven follow-up studies reported above, it should be noted that the follow-up data was collected after 4-24 months compared to the long-term follow-up interval of seven years in one of the two Dutch studies (de Vries et al., 2014). It should also be noted that in some of the follow-up studies mentioned, not all adolescents initially received puberty suppression, but in three studies some of the sample received gender-affirming hormone treatment directly due to their advanced age at the start of treatment.

In a further naturalistic follow-up study over a total period of 12 months (Tordoff et al., 2022), 104 US adolescents and young adults who attended a specialised treatment centre were examined (26.0% trans female, 60.6% trans male, 13.4% non-binary or unknown). Their average age at the start of the study was 15.8 years (range: 13-20). It was found that the frequency of self-harming behaviour or suicidal thoughts in the group of previously untreated adolescents at the baseline measurement was 45%. After 12 months, it was 37% in the adolescents who had been treated with puberty suppression or gender-affirming hormones. However, the reported data from this study do not allow any statement to be made about the extent to which this moderate decrease is attributable to a treatment effect or not, as the reported control group of non-treated persons (*N* = 6) is too small and cannot be considered comparable

due to the assumed group differences. In an American study, 315 adolescents with gender dysphoria were examined before and two years after gender-affirming hormone therapy. It was found that the trans male adolescents had lower levels of anxiety and depression two years after the start of treatment than at the start of treatment and that the overall group had lower gender dysphoria and higher life satisfaction after treatment (Chen et al., 2023). Another study showed that gender-incongruent adolescents with gender-affirming hormone treatments had lower anxiety and depression scores and higher body satisfaction than adolescents who had not received these treatments (Grannis et al., 2023). A retrospective comparative study (Turban et al., 2020) from the U.S. Transgender Survey, which included over 27,000 adult trans individuals (26.2% trans female, 29.6% trans male and 44.2% non-binary or other gender identity), examined the subgroups of those who were treated intermittently with puberty blockers during adolescence (*N* = 89) and those who desired but did not receive them. Those who had received puberty suppression according to their wishes showed a statistically significantly lower lifetime prevalence of suicidality compared to those who had not received it despite their wishes.

In a secondary analysis of the data, the relationship between gender-affirming hormone therapy and outcome measures for mental health (current psychosocial stress and suicidal thoughts in the last 12 months) was examined retrospectively (Turban et al., 2022). The subgroups were differentiated according to whether such hormone treatment was started in adolescence (14-17 years; *N* = 481) or only after the age of 18 (*N* = 12,257). A further subgroup was defined as those who stated that they had never received hormone treatment despite an expressed desire for it (*N* = 8860). After statistically controlling for various potentially confounding variables, there was a statistically significant lower level of both outcome parameters (suicidal thoughts and current psychosocial distress) in the group treated in adolescence compared to those treated in adulthood. As expected, the outcome values for mental health were again significantly worse for those who were not treated despite their wish than for those treated from adulthood onwards. The authors see this as an indication of a favourable effect on long-term mental health of hormone treatment starting in adolescence in the case of persistent gender incongruence.

For the latter two studies, however, possible biases due to retrospective surveys must be considered as a limitation. For example, it is conceivable that people with better baseline mental health scores may have earlier access to gender-affirming treatment, which could overestimate the positive effect of starting the intervention earlier. The high number of cases and nationwide recruitment are strengths of this study, but possible selection effects in the overall sample due to recruitment via *trans community* organisations limit the transferability to other samples, which is why the study was criticised

(D'Angelo et al., 2021). Another retrospective study examined a group of 438 adolescents who accessed a diagnostic assessment for the treatment with gender-affirming hormones. Those who had previously received puberty suppression at Tanner stage 2-3 showed significantly lower scores in depression, anxiety and other psychological difficulties as well as stress and suicidality compared to those who had not received puberty suppression. However, the comparability of the groups was limited, as the group with puberty suppression was significantly younger and a larger number were assigned male at birth. However, after adjustment for age and gender, the differences between the groups remained apart from suicidality (McGregor et al., 2024).

3.1 Comparison with the reviewed evidence in adulthood

The evidence for a favourable health outcome following gender-affirming medical interventions in adult patients with gender dysphoria is much more comprehensive. This must be taken into account when assessing the expected effectiveness of these treatments in adolescents. In a meta-analysis, *N* = 28 studies with a total of *N* = 1833 patients were evaluated (*N* = 1093 trans female, *N* = 801 trans male) who underwent gender-affirming medical treatments, which included hormone therapy (Murad et al., 2010). Overall, 80% of those treated reported a significant improvement in gender dysphoria (95% CI = 68-89%*;* 8 studies; I^2 = 82%); 78% reported a significant improvement in psychological symptoms (95% CI = 56-94%*;* 7 studies; I^2 = 86%); 80% reported a significant improvement in quality of life (95% CI = 72-88%; 16 studies; I^2 = 78%); and 72% reported a significant improvement in sexual function (95% CI = 60-81%; 15 studies; I^2 = 78%). However, as these were predominantly non-controlled observational studies, the level of evidence is also categorised as low here despite the high number of cases.

3.2 Outcome studies on possible physical and cognitive effects of medical interventions in adolescence

The evidence base regarding physical and cognitive effects of medical interventions in gender-incongruent minors is still uncertain (Taylor, Mitchell, Hall, Heathcote et al., 2024; Taylor, Mitchell, Hall, Langton et al., 2024). The following studies on physical and cognitive outcomes have been published to date:

A study (Staphorsius et al., 2015) with adolescents diagnosed with what was then still called *"gender identity disorder*" (GIS) according to the diagnostic criteria of the DSM-IV (American Psychiatric Association, 2000) investigated the influence of pubertal blockade on executive functions, here in the sense of the ability to plan and operationalised with the "Tower of London Task" (ToL) and using fMRI

scans. The underlying question was whether a temporary pubertal blockade in adolescence could lead to maturational deficits in the prefrontal cortex. Twenty adolescents undergoing puberty suppression (40% trans female, 60% trans male) and 20 adolescents without medical treatment (50% trans male and 50% trans female) took part. Their average age was 15.4 years (min. 12 years). The participants in the intervention group had been treated with puberty suppression for an average of 1.6 years (*SD* = 1.0). Apart from lower accuracy in the ToL tasks by trans girls treated with puberty suppression compared with the control group, there were no statistically significant negative effects of puberty suppression on the executive functions investigated. In a further study, the executive functions of trans adolescents were analysed. It was found that treatment with puberty suppression lasting less than one year had no effect on executive functions, while treatment lasting more than one year was associated with slightly lower executive functions. Treatment with gender-affirming hormones, on the other hand, was associated with better executive functioning compared to no treatment (Strang et al., 2022). Another study (Arnoldussen et al., 2022) was able to show that in 72 participants (27 trans female and 45 trans male) after an almost 8-year follow-up interval following puberty suppression and subsequent gender-affirming hormone treatment, the educational level and career success in relation to the IQ measured before treatment was within the range of the educational level and career success expected from data from the normal population.

In four studies (Joseph et al., 2019; Klink et al., 2015; Schagen et al., 2020; Vlot et al., 2017) on physical parameters, bone density was examined after puberty suppression and subsequent gender-affirming hormone administration, among other things. What the studies have in common is that a statistically significant decrease in absolute bone density was observed during puberty suppression. This was predominantly restored to normal bone density values under subsequent gender-affirming hormone treatment, although the results are partly inconsistent in that in two individual studies this re-normalisation of bone density did not occur completely in one subgroup of each sex.

In one study (Vlot et al., 2017), the bone density of trans women normalised, whereas the bone density of trans men remained on average below the normal values for cis women of the same age. In another study (Schagen et al., 2020), the bone density of trans men normalised completely, whereas only in trans women the reduced bone density could not be completely renormalised under gender-affirming hormone treatment. The study results are presented in detail in Chapter VIII → *"Somatic aspects of hormonal interventions".*

In summary, it can be said that the research evidence on treatment with puberty blockers is still very uncertain, particularly with regard to the long-term effects of puberty suppression alone on mental health, cognitive development and physical health. Further studies are urgently required (Taylor, Mitchell, Hall, Heathcote et al., 2024; Taylor, Mitchell, Hall, Langton et al., 2024). The three current systematic reviews on the evidence of intended and undesired effects of puberty suppression alone (National Institute for Health and Care Excellence (NICE), 2020a; Taylor, Mitchell, Hall, Heathcote et al., 2024; Zepf et al., 2024) therefore largely agree that, due to the inconsistency of the study results to date, *no generally positive benefit-risk assessment* of puberty suppression for the treatment of persistent gender incongruence in adolescence can currently be made. It should be critically considered here that in a considerable number of the studies reviewed, treatment with puberty blockers took place at an age of 15-17 years[1]. Among other things, this corresponds to a practice that was mandatory in NHS England until April 2024, which is considered outdated. According to the previous NHS protocol every adolescent with gender dysphoria who was eligible for gender-affirming hormone treatment had to undergo puberty suppression for at least one year before starting gender-affirming treatment, regardless of age, which, in conjunction with the sometimes very long waiting times of two years or more, has regularly led to the treatment of 16-17 year old patients with puberty blockers. In this age range, pubertal development is usually already so far advanced that no sufficient benefit can be expected from puberty suppression, whereas negative effects predominate, particularly due to menopausal symptoms and unfavourable effects on bone metabolism (O'Connell et al., 2022). The risk-benefit assessment therefore becomes increasingly negative with increasing age at the start of treatment. According to the guidelines of the German Ethics Council (2022), a recommendation for the use of puberty blockers should therefore only be made on the basis of clinical experience and a *careful individualised risk-benefit assessment* (see consensus recommendations in this chapter below). In addition, long-term clinical observations must be ensured by appropriate follow-ups and, as far as possible, the conditions must be created to enable patients to participate in follow-up studies and clinical observational studies (see recommendations in this chapter below). This is also called for in a recent statement by the European Society for Child and Adolescent Psychiatry (ESCAP) (Drobnič Radobuljac et al., 2024). In order to minimise potential physical side effects, special requirements must be placed on professional endocrinological implementation when making recommendations for puberty suppression with possible subsequent gender-affirming hormone administration. In particular, a time limit for puberty suppression from a physiological point of view

[1] See a tabular list in the appendix of the method report.

appears important in order to minimise potential physiological risks (see recommendations in Chapter VIII → "*Somatic aspects of hormonal interventions*").

Further considerations of the physical effects of hormone treatments, including the possible effects of early pubertal blockade on the necessity, feasibility or non-necessity of later gender-affirming surgery (e.g. non-necessity of a later mastectomy in trans boys or effects on surgical procedures in the case of a later desire for genital reassignment in trans girls) are also reported and discussed in Chapter VIII → "*Somatic aspects of hormonal interventions*".

3.3 Follow-up studies on the trajectories of gender incongruence after the start of medical treatments (including desistance)

In the first Dutch follow-up study reported above by De Vries et al.(2011), all adolescents without exception who had started treatment with puberty blockers later also started gender-affirming hormone treatment. A more recent retrospective study from the same treatment centre partially relativised this result. Of 143 adolescents who were treated with puberty blockers between 2010 and 2018, 125 (87%) subsequently continued treatment with gender-affirming hormones. On average, this happened after twelve months for the trans girls and after ten months for the trans boys (Brik et al., 2020). Five adolescents were still too young to start gender-affirming hormone treatment at the time of the study, in five adolescents the gender dysphoria had not persisted over the course of the treatment and four adolescents did not continue the puberty suppression for other reasons (e.g. undesirable side effects).

In a Canadian study of 27 gender dysphoric adolescents who were treated with puberty suppression, 19 (70.4%) were followed by gender-affirming hormone treatment (Khatchadourian et al., 2014). Only one trans girl was reported as not wanting to continue the transition. The others discontinued the puberty suppression for other reasons (e.g. undesirable side effects).

To summarise, it can be said that in the available studies, the vast majority of adolescents who receive puberty suppression later continue their transition with gender-affirming hormone treatment. Only a minority decide in the course of the puberty suppression to detransition combined with discontinuation of the medical treatments. Adolescents and their legal guardians should be made aware of this fact before puberty suppression begins (see recommendations below).

3.4 Follow-up studies on gender-affirming surgery

There is little literature available on gender-affirming surgery in minors. According to the current international guideline recommendations of the WPATH (Coleman et al., 2022a), a mastectomy after gender-affirming hormone treatment may be recommended in adolescent trans boys with persistent gender incongruence and high gender dysphoric distress in relation to female breasts. Studies of trans male adolescents with a desire for mastectomy have shown that breast dysphoria was associated with greatly increased rates of anxiety, depression and stress and can lead to functional limitations, such as avoidance of sports or swimming activities (Mehringer et al., 2021; Olson-Kennedy et al., 2018; Sood et al., 2021). Follow-up studies of adolescents who had a mastectomy to reduce breast dysphoria showed good surgical outcomes, satisfaction with the results and minimal regret during the study follow-up period (Marinkovic & Newfield, 2017; Olson-Kennedy et al., 2018). One study reported that dysphoria related to female breasts can progressively increase in trans male adolescents after starting testosterone prior to a mastectomy (Olson-Kennedy et al., 2018).

3.5 Surveys on fertility and criteria for clinical recommendations

One study showed that there is a discrepancy between the (still) low utilisation for fertility preservation (cryopreservation) by young people who start body alterating treatments due to gender incongruence or gender dysphoria, and a higher number of people who express a desire to have children after having undergone body altering treatments in the past (De Roo et al., 2016). This indicates that the importance of a potential desire to have children later in life in young trans people has so far been underestimated by healthcare professionals. Medical information and counselling on medical options for fertility preservation must therefore take place before the recommendation for body-altering interventions is made (see recommendations below).

A qualitative survey of 13 Dutch adolescents with gender dysphoria who had started their first medical transition treatment at an average age of 16 years and 11 months showed that most of them considered the setting of a minimum age limit for the recommendation of puberty suppression to be problematic and an individual developmental approach to be more appropriate. With regard to the known lack of studies on possible long-term physical consequences of puberty suppression, the adolescents stated that although they would like to see more data on this, they would not question the treatment recommendation for themselves due to their high level of suffering without any other treatment alternative (Vrouenraets et al., 2016).

Apparently, the concrete, foreseeable consequences of an increasingly irreversible progression of the development of secondary sexual characteristics in the event of non-treatment outweighed the uncertainty of the data on possible long-term consequences of treatment for the respondents. In another study with a qualitative survey of 15 trans adolescents and young adults from the USA aged 18 on average, those affected expressed a desire for individualised, more flexible access to puberty-suppressing and gender-affirming interventions (Gridley et al., 2016).

4. Summary of the reviewed evidence

Overall, it can be stated that reported data from previous uncontrolled clinical cohort studies on hormonal interventions in adolescents with diagnosed gender incongruence or gender dysphoria provide preliminary evidence for a favourable outcome of parameters for mental health and life satisfaction if gender-affirming hormone treatment was part of the treatment. The level of evidence is low to moderate due to the methodological limitations discussed above (Taylor, Mitchell, Hall, Langton et al., 2024). For the reported Dutch cohort studies in particular, the transferability of the results is limited due to selection effects caused by narrow inclusion criteria and the fact that three studies originate from the same centre. The systematic review of the British National Institute for Health and Care Excellence (2020b) states :

> "The results of five uncontrolled, observational studies (Achille et al., 2020; Allen et al., 2019; Kaltiala et al., 2020; Kuper et al., 2020; López De Lara et al., 2020) suggest that, in children and adolescents with gender dysphoria, gender-affirming hormones are likely to improve symptoms of gender dysphoria, and may also improve depression, anxiety, quality of life, suicidality, and psychosocial functioning. The impact of treatment on body image is unclear. All results were of very low certainty [in terms of their level of evidence]." (2020b, p. 50).

The two most recent international reviews commissioned by the *Cass Review for the National Health Service England & Wales* come to similar conclusions (Taylor, Mitchell, Hall, Heathcote et al., 2024; Taylor, Mitchell, Hall, Langton et al., 2024).[2] The evidence base for the administration of sex-reassigning hormones in adolescents with gender incongruence is described as uncertain to moderate, as there is a lack of studies that can be categorised as methodologically high-quality. The available evidence suggests a

[2] These two reviews were published after completion of the draft version for the commenting phase of this guideline. In the course of the revision of the guideline in this commenting phase, these two systematic reviews, as well as all newer original studies cited in them, were analysed individually and included in the assessment of the current evidence (see Methods Report), insofar as they had not yet been received by the guideline commission

positive effect on medium-term mental health (Taylor et al., 2024b). The authors of this systematic review summarise the evidence on the effects on mental health as follows:

> "Regarding psychological health, evidence from mainly pre-post studies suggests hormones are associated with improvements in depression, anxiety and other mental health difficulties after 12 months of treatment, although there were inconsistencies regarding suicidality and/or self-harm, with three of four studies reporting an improvement and one no change. " (Taylor, Mitchell, Hall, Langton et al., 2024, p. 6).

However, in studies in which the reported intervention consisted solely of puberty suppression, there was at best weak evidence for a favourable outcome on the measured parameters (National Institute for Health and Care Excellence (NICE), 2020a). The evidence in this regard is described as very uncertain, as high-quality studies are largely lacking. However, the only study that the authors in the review by Taylor, Mitchell, Hall and Heathcote (2024) recognise as being of high methodological quality reports significant positive effects of puberty suppression on mental health and psychosocial functioning (van der Miesen et al., 2020). The evidence regarding positive effects on mental health, as well as possible negative effects on cognitive development, bone density and cardiac health, is nevertheless described as insufficient or inconsistent overall. The NICE review from 2020 and the Cass Interim Report (2022) explain that the effectiveness of puberty suppression can only be measured to a limited extent by an *improvement in mental health*, as the (undisputed) primary effect of temporary puberty suppression is to stop further progression of the development of secondary sexual characteristics and thus prevent an aggravation of the gender dysphoric condition, the non-exacerbation of which can therefore already considered a treatment success in individual cases. Effects in the sense of an unspecific reduction in stress that can lead to an improvement in the level of psychosocial functioning are possible and have been reported in isolated cases, but in particular it cannot be expected that a temporary halt to an increasingly irreversible virilisation or feminisation of the physical appearance alone can permanently reduce body-related gender dysphoric distress (Cass, 2022; National Institute for Health and Care Excellence (NICE), 2020a).

A general risk-benefit assessment of puberty suppression in the treatment of gender incongruence with gender dysphoria in adolescence does not currently appear possible based on the current study situation or cannot do justice to the complexity of the medical decision-making situation in individual cases. Provided that the diagnosis is confirmed, the potential benefits must be weighed against the potential risks in each individual case when determining the clinical recommendation. For this individualised assessment, the German Ethics Council also demands that the benefits and risks of

refraining from treatment should also be carefully weighed up (Deutscher Ethikrat, 2020). There is widespread agreement in the medical community that further studies are needed to improve the data situation, particularly on the long-term outcomes after temporary puberty-blocking treatment in adolescence.

Statement on the state of knowledge:

VII.E1.	There is evidence from uncontrolled follow-up studies that patients with persistent gender dysphoria diagnosed in adolescence who received staged body-altering treatment in the context of a socially supported transition show a long-term improvement in quality of life and mental health in adulthood.

The evidence for this statement is uncertain. There are three studies from the same centre (Cohen-Kettenis & van Goozen, 1997; de Vries et al., 2011, 2014).

In the reported studies, such a *staged body-altering treatment* generally included *a specific recommendation in* each stage:

1. temporary pubertal suppression;
2. a subsequent gender-affirming hormone treatment; and
3. gender-affirming surgery at a later date.

All patients included in the reported studies were given an multi-disciplinary recommendation according to the so-called *Dutch Protocol* and continuous professional support over the entire duration of the transition process.

Special vote of the German Society for Psychiatry, Psychotherapy, Psychosomatics and Neurology (DGPPN):

The DGPPN is in favour of deleting this statement on the state of knowledge.

Justification see appendix.

5. Standard from previous guidelines and review articles for the professional recommendation

The key points from guidelines and review articles can be subdivided into required professional qualifications of the person giving the recommendation, required preceding mental health assessments or interventions, preliminary physcial examinations and the requirements for informed consent of the person concerned.

The following five international guidelines and recommendations are based on a transparent guideline development methodology:[3]

Guidelines of international medical societies:

- *World Professional Association for Transgender Health (WPATH)* - Standards of care for the health of transgender and gender diverse people, Version 8. (Coleman et al., 2022a): Extensive compliance with NICE criteria, including independent external literature review[4], broad involvement of recognised international experts, structured Delphi process for consensus finding (comparable to AWMF[5] S2k level)
- *Endocrine Society* - Endocrine treatment of gender-dysphoric/gender-incongruent persons: an Endocrine Society Clinical Practice Guideline (Hembree et al., 2017) : Systematic literature search and systematic literature review, grading of recommendations according to strength of evidence, expert consensus and consensus by several participating professional societies (comparable to AWMF S2k level).

Guidelines of national medical societies:

- *Royal Australian and New Zealand College of Psychiatrists (RANZCP,* Medical Association for Psychiatry/ Child and Adolescent Psychiatry): Recognising and addressing the mental health needs of people experiencing Gender Dysphoria/ Gender Incongruence (RANZCP, 2021): Simple

[3] A method-critical analysis of international guidelines and recommendations is provided in a separate appendix chapter of this guideline.

[4] In this guideline, a systematic literature review was conducted on the evidence base for all interventions in adulthood. For the chapter on interventions in adolescence, the authors of the guideline stated that there were too few studies for a systematic review, which is why a narrative review was carried out for this chapter (Coleman et al., 2022).

[5] Translator's note: AWMF is the abbrevation for the German Association of Scientific Medical Societies who sets up methodologic standards for the development of medical guidelines in Germany and certifies new guidelines according to their adherence to these standards. S2k is the label for consensus-based guidelines with a transparent methodology of stakeholder involvement and consensus procedures.

consensus-based practice recommendations of a medical society (most comparable to S1 level of the AWMF).

- *American Pediatric Association* - Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents (Rafferty et al., 2018): Simple consensus-based practice recommendations from a medical speciality society (most comparable to AWMF S1 level)

The systematic DELBI assessments of the methodological quality of all guidelines reviewed can be found in Table 2 of the guideline report (p. 13).

Further current recommendations and statements

- *Cass Report for NHS England and Wales (2024):*

  In the so-called *Cass Report*, an expert appointed for this purpose on behalf of the National Health Service England and Wales (NHS) developed recommendations for the approach to counselling and support for children and young people with gender incongruence after an extensive review of the current evidence. The final report concludes, among other things, that comprehensive psychosocial support is needed for children and young people with gender incongruence. The report contains a number of specific recommendations for the English care system, particularly with regard to reducing waiting times due to previously extensive waiting lists and improving the accessibility of specific treatment options for adolescents with gender incongruence. With regard to the recommendations of medical interventions, it is recommended that puberty blockers should only be used after careful consideration with an individualised treatment plan and as part of clinical trials to be designed in the future. Gender-affirming hormone treatment is not recommended for minors before the age of 16 and is only recommended if carefully justified and as part of a comprehensive individual psychosocial treatment plan. Medical treatment recommendations for minors with gender incongruence should be made by a multidisciplinary team. Minors receiving medical treatment should receive prior counselling on fertility preservation (Cass, 2024).

  Since its publication in April 2024, the Cass Review has been criticised in several methodological papers (Grijseels, 2024; McNamara et al., 2024; Noone et al., 2024). In addition to a series of criticised methodological shortcomings of the Cass Review, it is pointed out that some of the central recommendations of the report cannot be derived from the reported evidence. Of particular note is the comprehensive evidence-based critique of the methodological approach of the Cass Review by the Integrity Project at Yale University, which was prepared by several authors with proven expertise of

clinical application in the field (McNamara et al., 2024). The authors conclude that the review of the available evidence was in part recognisably selective and that some key recommendations cannot be supported by the reported evidence (McNamara et al., 2024). In the meantime, the British Medical Association (2024) has explicitly addressed these criticisms of the Cass Review in a press release dated 31 July 2024 and recommended that its recommendations should not be implemented for the time being. An evaluation of the Cass Review should first be carried out by an appointed commission.[6]

- *ESCAP Statement (2024)*

In a policy statement by the European Society of Child and Adolescent Psychiatry (ESCAP) from April 2024 (Drobnič Radobuljac et al., 2024), a careful and extremely cautious approach is recommended with regard to the recommendations for puberty blocking or gender-affirming hormone treatment in minors with gender incongruence due to the currently still uncertain evidence situation. The principles of "non-maleficence", "beneficence", "autonomy" and "justice" should be observed equally and in a balanced manner. This means that experimental or outdated methods should not be used uncritically, but treatments should be used in a well-considered manner and with a careful risk-benefit assessment. A risk-benefit assessment of non-treatment should also be carried out. Co-occuring psychological problems must be adequately addressed. The diagnosis of gender incongruence should not only be based on self-reporting, but also be based on a comprehensive, professional diagnostic assessment. Children and adolescents should be significantly involved in the decision-making process. All children and adolescents should have access to comprehensive information as well as diagnostic and treatment options and the rights of this particularly vulnerable group should be protected both in transition and in a possible detransition. Medical treatments should, where possible, be carried out within the framework of studies or defined clinical protocols and long-term follow-up examinations are still required (Drobnič Radobuljac et al., 2024).

5.1 Standards of professional qualification of the specialist who provides the treatment recommendation

The above-mentioned international guidelines specify criteria regarding the professional qualifications of the specialists who are to provide the recommendation for body-altering treatment in adolescents with gender incongruence. The current guideline of the *World Professional Association for*

[6] https://www.bma.org.uk/bma-media-centre/bma-to-undertake-an-evaluation-of-the-cass-review-on-gender-identity-services-for-children-and-young-people

Transgender Health requires a mental health professional at postgraduate level with additional training and expertise in the topic of gender identity development and gender incongruence. For professionals working with gender dysphoric adolescents on the autism spectrum, expertise in this area or collaboration with professionals with specific expertise in this area is also required (Coleman et al., 2022a).

The *Endocrine Society*'s guideline also requires a mental health specialist with qualifications in psychiatric diagnostics to determine the recommendation. In addition, specific knowledge of the differential diagnosis of gender incongruence, criteria for body-altering treatments for gender incongruence and the ability to assess the patient's understanding of possible treatment interventions and possible psychosocial circumstances that may interfere with treatment are required. Regular participation in further training activities is also required (Hembree et al., 2017).

The recommendation of the *Royal Australian and New Zealand College of Psychiatrists (RANZCP)* defines (child and adolescent) psychiatrists, along with other *mental health professionals*, as suitable specialists for making recommendations (RANZCP, 2021). Reference is made to the necessary experience of the practitioners, but this is not defined further. It also emphasises the importance of multi-disciplinary collaboration when determining recommendations.

The American Pediatric Association guideline (Rafferty et al., 2018) calls for collaboration between paediatric or endocrinology professionals and mental health professionals with expertise in developmental psychology and gender incongruence.

5.2 Mental health diagnostic and therapeutic interventions

An basic prerequisite for the recommendation of body-altering interventions in adolescents in all existing guidelines and narrative reviews is the presence of diagnostically confirmed stable/persistent gender incongruence or gender dysphoria. This is usually described as *persistent*, with no minimum duration and no clear criteria for a prognosis of persistence for the future (Agana et al., 2019; Hembree et al., 2017). In the current WPATH guideline, gender incongruence lasting *several years* is required for the recommendation of gender-affirming hormone treatment due to its partial irreversibility:

"Given potential shifts in gender-related experiences and needs during adolescence, it is important to establish the young person has experienced several years of persistent gender diversity/incongruence prior to initiating less reversible treatments such as gender-affirming hormones or surgeries." (Coleman et al., 2022a, p. 60).

Although the recommendation for a puberty suppression also requires a persistent experience of gender incongruence over a longer period of time as a prerequisite for the start of treatment, it is nevertheless stated that a period of several years cannot be required in early puberty for practical and developmental reasons and it would not be suitable to avert the stress that would result from the progression of pubertal body changes:

"However, in this age group of younger adolescents, several years is not always practical nor necessary given the remise of the treatment as a means to buy time while avoiding distress from irreversible pubertal changes." (Coleman et al., 2022a, p. 60).

Both the definition of the diagnosis of gender incongruence according to ICD-11 (WHO, 2022) and the diagnosis of gender dysphoria according to DSM-5 (APA, 2013) explicitly include non-binary gender identities. Therefore, all recent guidelines based on this definition explicitly do not exclude young people with non-binary gender identities from body-altering treatments (T'Sjoen et al., 2020).

International guidelines and review articles unanimously call for a mental health assessment to be carried out before a body-altering intervention is recommended, taking into account the accompanying psychological circumstances and any co-occuring mental health problems (Aganaet al., 2019; Coleman et al., 2022a; Hembree et al., 2017; RANZCP, 2021), whereby the assessment of resilience factors and resources is also explicitly emphasised in some cases (T'Sjoen et al., 2020). The recommendations of the RANZCP (2021) also specify that the circumstances of the initial onset of gender dysphoria should be explored. All guidelines and recommendations point out that before starting treatment, it must be ensured that, in the case of diagnostically confirmed gender incongruence or gender dysphoria, any existing associated mental health difficulty is diagnosed professionally and should not interfere with diagnostic clarity regarding gender incongruence or with the implementation of body-altering treatment. If necessary, the treatment should be adapted to these individual circumstances.

As described in Chapter IV → "*Associated mental health problems and health problems in children and adolescents with gender incongruence and gender dysphoria*", psychiatric morbidity in children and adolescents with gender incongruence or gender dysphoria is high. Since, according to the clinical experience of the experts involved in drawing up the guidelines, accompanying psychopathology in adolescents with gender incongruence or gender dysphoria is often caused by the circumstances surrounding the gender dysphoria (including body dysphoric stress, psychosocial problems in the environment due to a lack of acceptance, minority stress, experiences of discrimination, internalised

transphobia etc.), mental health difficulties should not be seen as a contraindication per se for body-altering medical interventions.

The aim of body-altering interventions with a confirmed diagnosis is to alleviate body dysphoria and psychological distress and thus the psychopathological burden. Current guidelines and review articles therefore recommend that in the presence of a mental health difficulty coinciding with a diagnosed gender incongruence, this must be professionally addressed and treated as part of an integrated treatment approach if body-altering interventions are to be considered (Agana et al., 2019; Coleman et al., 2022a; Hembree et al., 2017; RANZCP, 2021).

With regard to the social environment, previous international guidelines recommend ensuring that these interventions are sufficiently supported by the family or other social environment before the recommendation for body-altering interventions is given. In contrast, the accompanying psychotherapy that was still required in earlier decades as a mandatory prerequisite for the recommendation (Möller et al., 2014) is no longer included in current international guidelines (Coleman et al., 2022a; Hembree et al., 2017). The recommendation for psychotherapeutic support depends on the need in each individual case (see recommendations Chapter V → *"Psychotherapy and psychosocial interventions"*).

5.3 Physical examinations

With regard to preliminary physical examinations, it should be ensured that there are no somatic contraindications for the respective body-altering treatment in accordance with the available guidelines (Hembree et al., 2017; Rafferty et al., 2018; T'Sjoen et al., 2020). Further recommendations on this are set out in Chapter VIII → *"Somatic aspects of hormonal interventions".*

5.4 Important contents of patient education

All existing recommendations of international guidelines call for adolescents and their guardians to be informed in detail about the mechanisms and consequences, including possible side effects, of the recommended body-altering treatment (Agana et al., 2019; Coleman et al., 2022a; Hembree et al., 2017; RANZCP, 2021). It is recommended that this information also includes in particular the possible effects on fertility, sexuality, relationship experience, body experience and the effects of each intervention on any further gender-affirminginterventions (Coleman et al., 2022b; T'Sjoen et al., 2020). Uncertainties in decision-making and the evidence base should also be noted (RANZCP, 2021). In addition, informed decision-making and the capacity to give informed consent must be properly documented (RANZCP, 2021).

Information on determining capacity to consent[7] is explained in this guideline in Chapter X → *"Annotations on the legal basis and ethical standards for the treatment of minors with gender incongruence".*

6. Requirements of recommendations for body-altering medical interventions

6.1 Fundamentals

The wishes of the person seeking treatment must be individually explored and taken into account each time a recommendation is made. Possible advantages and disadvantages of treatment, information about the prognosis and treatment risks must be communicated transparently and comprehensibly in a process of *shared decision making* in dialogue with those seeking treatment and their legal guardians (see preamble and explanations on treatment decisions in Chapter X → *"Annotations on the legal basis and ethical standards for the treatment of minors with gender incongruence*"). A comprehensive diagnostic assessment regarding the persistence of gender incongruence must be carried out in a holistic approach based on the life history collected from various perspectives, taking into account the environment of the adolescents concerned. A comprehensive mental health assessment includes the diagnosis of possible co-occuring mental health difficulties and a careful assessment of life circumstances, taking into account relevant environmental factors (see the *Diagnostics* section in Chapter IV → "*Associated mental health difficulties in children and adolescents with gender incongruence and gender dysphoria")*. Recommendations should be made in multi-disciplinary collaboration between psychological, psychiatric and endocrinological specialists and, in complex cases, medical-ethical specialists, and should always include a risk-benefit assessment of treatment versus non-treatment in each individual case. Non-medical support options such as counselling and psychotherapy should be offered with easy access. Decisions for or against medical interventions require a comprehensive education process with the adolescents concerned and their legal guardians about the effects and risks of medical interventions, including counselling on fertility-preservation.

[7] Translator's note: In the German speaking region the legal terms for a minor's capacity to consent to medical treatment are different in each country: Germany – *Einwilligungsfähigkeit (engl. capacity to consent)*; Austria – *Entscheidungsfähigkeit (engl. capacity of decision-making*; Switzerland – *Urteilsfähigkeit (engl. capacity of judgement)*. In the English translation only the term *capacity to consent* is used.

Due to the still uncertain scientific evidence base, there is a great need for both clinical follow-up studies to expand clinical knowledge and clinical outcome and observational studies over longer follow-up periods in order to continuously improve the evidence base and patient safety.

The guideline therefore recommends that, in the case of body-altering medical interventions in adolescence, the practitioners should participate in or support clinical observations and follow-up studies wherever possible. In this guideline, body-altering medical interventions are defined as all medical interventions that are used to alleviate gender dysphoria in people with gender incongruence by means of hormone blockade, gender-affirming hormone therapy or surgical gender-affirming procedures.

Consensus-based recommendation:

VII.K0b	Before initiating body-altering medical interventions for the treatment of gender incongruence or gender dysphoria in adolescence, health professionals should point out to patients and their guardians the high relevance of clinical follow-up in the form of appropriate medical aftercare and should offer this.

Consensus strength: strong consensus (> 95%)

Special vote of the German Society for Psychiatry, Psychotherapy, Psychosomatics and Neurology (DGPPN):

The DGPPN is in favour of a stronger level of recommendation for information on the relevance of medical aftercare for body-altering interventions and proposes the following amended wording:

Before initiating body-altering medical interventions for the treatment of gender incongruence or gender dysphoria in adolescence, health professionals **shall** point out to patients and their guardians the high relevance of clinical follow-up in the form of appropriate medical aftercare and offer it.

Justification see appendix.

Consensus-based recommendation:

VII.K0c	If longitudinal scientific observational studies (e.g. registry studies) on body-altering medical interventions for gender incongruence or gender dysphoria in adolescence are available and accessible to patients, healthcare professionals should provide information about them and help to ensure that patients are offered the opportunity to participate in the study.

Consensus strength: strong consensus (> 95%)

Special vote of the German Society for Psychiatry, Psychotherapy, Psychosomatics and Neurology (DGPPN):
The DGPPN is in favour of a higher level of recommendation for scientific monitoring of body-altering interventions, not only in follow-up observations but also in clinical studies, and proposes the following amended wording:

If **clinical studies or** longitudinal scientific observations (e.g. register studies) on body-altering medical interventions for gender incongruence or gender dysphoria in adolescence are available and accessible to patients, healthcare professionals **shall** provide information about them and help to ensure that patients are offered the opportunity to participate in studies.

Justification see appendix.

Special vote of the Swiss Society for Child and Adolescent Psychiatry and Psychotherapy (SGKJPP):

The SGKJPP Executive Board strongly recommends that treating centres collect clinical outcome data and proposes the following additional wording:

Every centre that indicates and/or performs medical interventions for gender incongruence or gender dysphoria in adolescence has a duty, in the interests of good documentation and quality assurance, to establish a register that allows long-term progress to be tracked. If scientific follow-up observations or studies are available to patients, treating professionals should inform them about this and help to ensure that patients are offered the opportunity to participate in a study.

Justification see appendix.

6.2 Puberty suppression

Blocking puberty in adolescents with diagnosed gender incongruence or gender dysphoria primarily serves to temporarily prevent the irreversible progression of secondary sexual characteristics (e.g. breast growth, beard, voice change, gender-typical facial features, gender-typical physique, etc.). This suppression of pubertal maturation, which is only carried out for a limited period of time, does not yet serve the purpose of reassigning a patients's bodily appearance, but is primarily intended to prevent the progression of bodily sexual maturation and thus the increase of gender dysphoric distress. This can temporarily alleviate existing gender dysphoric distress, which could otherwise deterioate and contribute to the development of symptoms such as depression. Thus psychological symptoms may temporarily improve during puberty suppression or may just not worsen as puberty progresses, but the specific symptoms of gender dysphoria may not measurably reduce (de Vries et al., 2011).

According to the international guideline of the Endocrine Sociey, it is a widely recognised endocrinological opinion, that temporary pubertal blockade is considered completely reversible with regard to its physical effects. This is supported by the available evidence for the use of GnRH analogues in precocious puberty (Hembree et al., 2017). This means that further genetically determined pubertal maturation can take place fully when treatment is discontinued. Accordingly, the development of secondary sexual characteristics in the sex assigned at birth can be achieved fully despite the time delay caused by the treatment (Hembree et al., 2017). Possible physical risks and side effects as well as the endocrinological management to minimise them are explained in detail in Chapter VIII → *"Somatic aspects of hormonal interventions"*. Possible effects on the final body height must be taken into account due to a possible delayed closure of the epiphyseal groove (see Chapter VIII → *"Somatic aspects of hormonal interventions").* Nevertheless, the possible effects of pubertal blockade on the psychosexual development of gender-incongruent adolescents have not been fully clarified.

In the guidelines of international medical societies (Coleman et al., 2022a; Hembree et al., 2017), there is consensus that temporary puberty suppression with GnRH analogues is a medically justifiable treatment option for gender incongruence in adolescence if it is highly likely to persist and recommended by a specialist. The currently available level of evidence for treatment decisions should be no higher than level IV according to the criteria of the *Oxford Centre for Evidence-Based Medicine* (OCEBM, 2011) (i.e. evidence based on uncontrolled descriptive cohort studies and case series).

In addition, the treatment recommendation is based on the very well-studied mechanisms of its effects as well as on the longstanding clinical experience and clinical studies on puberty suppression in precocious puberty, particularly with regard to patient safety. The corresponding evidence level V according to the OCEBM criteria (OCEBM, 2011) *Reasoning by Mechanism* or *Mechanistic Evidence* (Aronson, 2020; Howick et al., 2009) is often the guiding principle for endocrinological interventions such as hormone replacement therapies, especially if there are no controlled studies in the absence of an ethically justifiable and equally effective treatment alternative. The interim report of the *Cass Review* (2022), which was conducted for the National Health Service England (NHS), emphasises that as long as the available evidence from follow-up studies is uncertain, an experience-based expert consensus that is as broad as possible and designed as a *learning system* through structured exchange should serve as a preliminary basis for treatment decisions. A professional treatment recommendation for complex medical interventions requires an individual assessment of the expected benefits and risks to be considered. These must be discussed in detail with the patient and their legal guardians.

In summary, it should be emphasised that the recommendation for puberty suppression requires careful consideration of each individual case from a medical ethics perspective. In each case, the ethical considerations with regard to the benefits and risks of treatment and the alternative of non-treatment must be listed in the recommendation letter (see 6.5 in this chapter → *"Recommended contents of an recommendation letter"*).

6.2.1 Desired psychosocial effects of a puberty suppression

The rationale behind puberty suppression, as outlined in current international guideline recommendations from the *WPATH*, the *Endocrine Society* and the *American Pediatric Association* (Coleman et al., 2022a; Hembree et al., 2017; Rafferty et al., 2018), is to temporarily halt the progressive and irreversible virilisation or feminisation of physical appearance. In adolescents with diagnosed gender incongruence, body-related gender dysphoric distress can thus be temporarily alleviated or its intensification can be halted. This is intended to create a window of time which can be used with the help of professional support to prepare the young person for sufficient capacity to consent with regard to gender-affirming hormone treatment that may be desired later. Although puberty suppression in the above sense is reversible, it cannot be ruled out that its use could influence psychosexual development, e.g. by delaying pubertal brain maturation processes. This is taken into account when determining the recommendation by, among other things, requiring a diagnostically confirmed *persistent gender incongruence in adolescence* (see recommendations below). Nevertheless, those affected and their

guardians should be made aware of the uncertain evidence from previous studies so that they can consider this in their decision-making process.

One potential benefit of an initial puberty suppression may be that the decision for or against the start of gender-affirming hormone treatment can be postponed for a limited period of time without having to accept the further irreversible progression of virilisation or feminisation of the body as part of genetically programmed maturation. This leaves open the possibility of gender incongruence desisting without having to accept the serious consequences of physical maturation in the more likely event of its persistence, which would be expected to increase the level of distress later on. Adolescents with a very probable persistent gender incongruence can use this window of time to become more certain about the temporal stability/persistence or possible fluidity of their experienced gender identity. This allows for the possibility that, over the course of further professional support, a puberty suppression can be discontinued if the young person decides not to continue transitioning and wants to resume living in the gender assigned at birth or in a non-binary identity without gender-affirming interventions. Such cases of desistance after the onset of puberty suppression are rare, which is to be expected given the strict requirements for the recommendation and the duty of care during prior assessment and professional support during the process. However, they do occur and are reported in existing follow-up studies with a frequency of 0-4% (Brik et al., 2020; Coleman et al., 2022).

Case study: *Desistance after one and a half years of puberty suppression* (Rölver et al., 2022)

Alexa, who was born female, introduces herself as a boy at the age of 12 under the name "Claus". She had had an unremarkable childhood in the female gender without any particularly gender-typical or atypical behaviour. With the onset of puberty at the age of eleven and a half, increasing gender dysphoric symptoms developed with rejection of female body changes and an increasingly masculine experience of identity. At the initial presentation, the patient reported pronounced depressive symptoms and the desire to live as a boy on the outside. Due to the depression and subsequent self-harm, a high frequency psychotherapy programme lasting nine months was initiated. During this time, "Claus" underwent a complete social role change to the male gender, which in "his" experience and in the perception of "his" parents contributed to psychological stability with a reduction in depressive symptoms, although the body-related gender dysphoria persisted. After a total of 10 months of clinical observation, puberty suppression with GnRH analogues was initiated on the basis of diagnosed gender dysphoria (DSM-5) in conjunction with a moderate depressive episode following informed consent by the patient and parents. This lead to

a sustained reduction in gender dysphoric stress. "Claus" was able to cope with everyday life for several months. Outpatient psychotherapy was continued. After around 18 months of puberty suppression, the depressive symptoms worsened again, leading to inpatient admission to our clinic. The almost 15-year-old "Claus" said that the decision to undergo testosterone treatment had plunged "him" into a crisis, as this treatment also felt "somehow wrong" for "him". Under therapeutic supervision, a decision was made together with the parents to discontinue puberty suppression. "Claus" initially continued to live socially in male role under his male first name, but dealt intensively with the internal processes that were triggered by the onset of menstruation and progressive breast growth soon afterwards. Outpatient psychotherapy was resumed. A year and a half later, now almost 17 years old, the teenager decided to take on the female first name "Alexa" again. At the same time, she was prescribed a progestogen pill to suppress her menses, as this continued to cause her a great deal of stress. In her far-reaching self-reflection, Alexa now describes her identity as non-binary, whereby she accepts the external appearance of her female body. In retrospect, she stands by the decision of the path she took, including the puberty suppression, and states that she needed this time for her own self-discovery.

Puberty suppression temporarily halts the progression of pubertal maturation for the duration of treatment. Depending on the pubertal stage at which treatment begins, the adolescents remain in a physically early pubertal state or in the state of pubertal maturity in which treatment began for the duration of treatment. This can result in psychosocial stress due to differences with peers whose pubertal development continues. This must be taken into account when planning the timing of treatment. The timing of initiating subsequent gender-affirming hormone treatment also needs to be carefully considered during a follow-up assessment. Whilst natal puberty is halted, appropriate timing ensures that the prior high levels of dysphoria in relation to progressive development of secondary sex characteristics is not replaced by secondary suffering due to a strong desire for pubertal development in the identified gender. Adolescents often need social or psychotherapeutic support during this time.

Waiting without body-altering intervention is not a neutral option (Coleman et al., 2022a; German Ethics Council, 2020). The progression of physical maturation can lead to a considerable aggravation of gender dysphoric distress. The potential advantages and disadvantages of a treatment or its omission must therefore be weighed up in a very careful process to determine the appropriate recommendation (Deutscher Ethikrat, 2020).

Considerations of the physical aspects of puberty suppression and the clinical treatment guidelines for its implementation are described in Chapter VIII → *"Somatic aspects of hormonal interventions"* of this guideline. Puberty suppression requires a careful recommendation that is determined in multi-disciplinary collaboration between psychological, psychiatric and endocrinological specialists.

Consensus-based recommendation:

VII.K1.	A recommendation for puberty suppression in adolescents with gender incongruence or gender dysphoria should be determined in multi-disciplinary collaboration. The prerequisite for this recommendation is a careful diagnostic assessment and clarification appropriate to the urgency and complexity of the individual situation by a mental health specialist experienced in the diagnosis and treatment of gender dysphoria in childhood and adolescence. The medical assessment part of the recommendation should be carried out by an experienced paediatric endocrinological specialist with regard to its prerequisites (pubertal stage of maturity, absence of somatic contraindications, etc.).

Consensus strength: strong consensus (> 95%)

Special vote of the Swiss Society for Child and Adolescent Psychiatry and Psychotherapy (SGKJPP):

The SGKJPP Executive Board advocates emphasising the requirement for an individual risk-benefit assessment (see recommendation VII.K3a in this chapter) and certain aspects of patient information (see Section 6.2.6 in this chapter) at this point and proposes the following additional wording.

The recommendation for puberty blockers in adolescents with gender incongruence or gender dysphoria should be made in interdisciplinary collaboration **and after careful consideration of potential risks and after detailed information for the adolescents and their families**. A prerequisite for this recommendation is a careful diagnostic assessment and clarification appropriate to the urgency and complexity of the individual situation. **It also requires a differentiated and individual risk assessment after detailed information has been provided to patients and their families** by a mental health specialist experienced in the diagnosis and treatment of gender dysphoria in children and adolescents. **With regard to the risks, it is essential to provide information about the uncertain state of evidence as it stands today, with a lack of long-term studies.** The somatic part of the indication should be carried out by an experienced paediatric endocrinologist with regard to its prerequisites (stage of pubertal development, absence of somatic contraindications, etc.). Overall, the need for further clinical studies is strongly emphasised.

See appendix (or *here*) for justification.

Consensus-based recommendation:

VII.K2.	The expertise of the persons who provide the child and adolescent mental health part of the recommendation for puberty suppression in adolescents with gender incongruence or gender dysphoria should fulfil the following formal requirements: General qualifications: One of the following qualifications specific to childhood and adolescence: D: – Specialist qualification for child and adolescent psychiatry and psychotherapy – Licence for child and adolescent psychotherapy – Specialist medical title for paediatrics and adolescent medicine with additional qualification in psychotherapy CH: – Specialist in child and adolescent psychiatry and psychotherapy (Foederatio Medicorum Helveticorum/FMH) – Federally recognised psychotherapist A: – Specialist in child and adolescent psychiatry or specialist in child and adolescent psychiatry and psychotherapeutic medicine – Registration as a psychotherapist with further training in infant, child and adolescent psychotherapy Or, alternatively, with proven clinical expertise in the diagnosis and treatment of children and adolescents: D: – Specialist title for psychiatry and psychotherapy, psychotherapeutic medicine or psychosomatic medicine and psychotherapy – Licence for psychological psychotherapy CH: – Specialist in psychiatry and psychotherapy (FMH)

	A: – Specialist in psychiatry and psychotherapeutic medicine, specialist in psychiatry and neurology – Registration as a psychotherapist, registration as a clinical psychologist.

Consensus strength: strong consensus (> 95%)

Special vote of the German Society for Psychiatry, Psychotherapy, Psychosomatics and Neurology (DGPPN):

The DGPPN is in favour of a stronger level of recommendation regarding the necessary qualifications of the mental health specialist for the recommendation of puberty suppression and proposes the following amended wording:

> The expertise of the persons who provide the child and adolescent mental health-psychotherapeutic part of the recommendation for puberty suppression in adolescents with gender incongruence or gender dysphoria **shall** fulfil the following formal requirements:
>
> *(List of qualifications is identical)*

Justification see appendix.

A prerequisite for the recommendation of puberty suppression is the identification of stable/persistent *gender incongruence in adolescence* according to the diagnostic criteria of ICD 11 (WHO, 2022) with concurrent gender dysphoric distress. The latter can manifest itself in anticipatory fear of the progression of feminisation or virilisation of physical appearance, without clinically significant psychological problems having already occurred (see below). The diagnostic criteria for gender dysphoria in adolescence and adulthood according to DSM-5 (APA, 2013) can also be used to assess the extent to which clinically significant gender dysphoria exists or could be expected as pubertal maturation progresses. A double diagnosis (i.e. gender incongruence according to ICD-11 and gender dysphoria

according to DSM-5) is not necessary. If the criteria for gender dysphoria according to DSM-5 are also met, this should be recorded in the clinical documentation.[8]

The sole diagnosis of *gender incongruence in childhood* before the onset of puberty (ICD-11, HA61) is not sufficient for a recommendation, as it is not a meaningful predictor of its persistence through adolescent development (see Chapter II → *"Variant developmental trajectories (persistence, desistance and detransition)*"). Nevertheless, a diagnosis of *gender incongruence in childhood* already documented in the pre-pubertal developmental history can be used for the overall assessment of a developmental course in order to confirm a diagnosis at an early pubertal stage. For example, the persistence vs. desistance literature describes that desistant trajectories are common after the onset of puberty in cases of gender dysphoria that emerged in childhood, but persistence usually becomes clear by the age of 13 influenced by maturational development. (Steensma et al., 2011, 2013 see Chapter II → *"Variant developmental trajectories (persistence, desistance and detransition)"*).

Figure 5

Diagnostic criteria for gender incongruence in adolescence and adulthood (HA60/ICD-11, WHO, 2022)

Gender incongruence in adolescence and adulthood is characterised by

- a *marked and [persistent] incongruence* between a person's perceived gender and their assigned gender, often leading to a *desire to "transition" in order to live and be accepted as a person of the experienced gender*, through hormone treatment, surgery or other health services, in order to conform the person's body as *closely as possible and desired to the experienced gender*.

The diagnosis cannot be made before the onset of puberty.

Gender variant behaviours and preferences alone are not a basis for assigning the diagnosis.

[8] For research contexts in particular, it is advisable to document how often patients with GI were also diagnosed with GD according to DSM-5 due to the international comparability of the samples analysed.

Figure 6: *Diagnostic criteria for gender incongruence in childhood (HA61/ICD-11, WHO, 2022)*

Gender incongruence in childhood is characterised by a *marked incongruence* between a person's experienced/expressed gender and their assigned gender in pre-pubertal children. This includes:

- the strong desire to be a gender other than the assigned gender,
- a strong aversion of the child to its sexual anatomy or the expected secondary sexual characteristics and/or a strong desire for the primary and/or expected secondary sexual characteristics that correspond to the experienced sex,
- as well as fantasy games, toys, games or activities and playmates that are typical of the experienced gender and not the assigned gender.

The incongruence must *have existed for about 2 years*. Gender variant behaviours and preferences alone are not a basis for assigning the diagnosis.

Figure 7: *DSM 5 Diagnostic criteria for gender dysphoria in adolescence and adulthood (APA, 2013, p. 621)*

A. A pronounced discrepancy between gender and gender of assignment *that has existed for at least 6 months*, whereby *at least two of the following criteria* must be fulfilled:

1. Pronounced discrepancy between gender and the primary and/or secondary sexual characteristics (or, in the case of adolescents, the expected secondary sexual characteristics).
2. Pronounced desire to get rid of one's own primary and/or secondary sexual characteristics (or, in adolescents, the desire to prevent the development of the expected secondary sexual characteristics).
3. Pronounced desire for the primary and/or secondary sexual characteristics of the opposite sex.
4. Pronounced desire to belong to the opposite sex (or an alternative gender that differs from the assigned sex).
5. A strong desire to be treated as the opposite sex (or as an alternative gender that is different from the assigned sex).
6. Pronounced conviction to exhibit the typical feelings and reactions of the other gender (or those of an alternative gender that differs from the assigned gender).

B. Clinically relevant suffering or impairment in social, educational or other important areas of functioning.

In adolescents who are still at an early stage of puberty, the identification of gender dysphoric distress can primarily relate to an expressed anticipatory fear of a progressive virilisation or feminisation of physical appearance, which is experienced and rejected as not matching with the identified gender. Such anticipatory stress is particularly typical for adolescents who have already undergone a social role change in childhood and live with a high level of social satisfaction and acceptance in their identified gender and therefore no longer have any reason to feel distressed by the social gender role assigned to them at birth. In such cases, the vast majority of experts involved in the development of the guidelines believe that it would be unethical and incompatible with the ethical principle of "non-harm" to wait until the pubertal development of an adolescent who is currently not significantly psychosocially impaired until a "sufficiently pathological" level of physical dysphoric distress with psychological impairments can be determined.

In these cases, increasing gender dysphoric distress may already become apparent during the onset of puberty from a Tanner stage 2, at which point at the earliest the recommendation for a puberty suppression can be made. In cases in which gender incongruence or gender dysphoric distress occurs for the first time during puberty, a clinical assessment over a longer period of time is usually required to determine the recommendation in order to be able to adequately assess the entire course of development with regard to the persistence of the gender dysphoric symptoms.

According to the studies we have reviewed, there are no empirically validated individual criteria for determining the long-term stability/persistence of gender incongruence or gender dysphoria. It is therefore the responsibility of the mental health specialist with experience in the exploration of various gender identity developments in children and adolescents to develop an individual assessment and prognosis in a joint discussion with the affected person and their guardians based on the overall picture of the available psychological findings, the descriptions and reflections of the affected person and their life history.

This usually requires diagnostic-explorative process support over several months with careful collection of all findings. In addition to experience in the diagnostic assessment of gender incongruence and possible accompanying mental health difficulties, it is particularly important for the mental health specialist to have comprehensive knowledge of the range of variations in the relevant developmental processes. This includes knowledge of trajectories that are associated with the persistence of gender dysphoria during adolescence or with later detransition after transition has been completed (see Chapter II → *"Variant developmental trajectories (persistence, desistance and detransition)"*).

Consensus-based recommendation:

VII.K3.	A prerequisite for the recommendation of puberty suppression should be the presence of stable/persistent gender incongruence (GI, according to the diagnostic criteria of GI in adolescence/ ICD-11 HA60) with gender dysphoric distress that has arisen or intensified after the onset of puberty. The careful diagnostic assessment and clarification should be carried out in collaboration with the mental health specialist experienced in the diagnosis and treatment of gender dysphoria in childhood and adolescence with the patient and their carers/relatives based on the exploration of the psychological findings and life history.

Consensus strength: strong consensus (> 95%)

As stated in the preamble to this guideline, the recommendation for puberty suppression requires an individual risk-benefit assessment of treatment as well as non-treatment or further postponement of treatment. Among other things, the expected effects of spontaneous puberty (possibly aggravation of gender dysphoric distress due to body characteristics that do not correspond to gender identity) must be weighed against the risks of treatment (side effect profile and consequences in the event of detransition).

Consensus-based recommendation:

VII.K3a.	The justification for the recommendation of pubertal blockade should contain an ethically reflected risk-benefit assessment related to the individual case, both of the intended treatment and of not initiating this treatment or waiting until a later date.

Consensus strength: strong consensus (> 95%)

If there are clinical signs of psychopathological abnormalities, the recommendations on the diagnostic procedure set out in Chapter IV→ "*Associated mental health difficulties in children and adolescents with gender incongruence and gender dysphoria"* must be observed, in particular to avoid overlooking any co-occuring mental health difficulties requiring treatment, as symptoms could overlap or interfere with gender dysphoric symptoms. This can make it more difficult to achieve the diagnostic clarity required for a recommendation, which can lead to longer diagnostic processes in individual cases.

6.2.2 Special case: Initiation of a puberty suppression with a high degree of urgency

In care practice, particularly in cases of gender incongruence and high gender dysphoric distress in the early stages of pubertal development, there can be a great deal of time pressure for those affected, which creates a correspondingly increased pressure to act. After the onset of puberty, the progression of irreversible body changes can be associated with lifelong effects on body dysphoria and quality of life (e.g. male voice change, female breast growth), so that prompt intervention is often recommended. In these cases, long waiting times (e.g. more than 6 months) for an appointment for a child and adolescent mental health assessment would not be medically justifiable. In these situations, prompt access to mental health assessment and support as well as the necessary clarification with regard to medical treatment, sometimes by passing the waiting lists, is important. This avoids the additional damage to health that would be caused by long waiting times for child and adolescent psychiatric assessments.

Consensus-based recommendation:

VII.K4.	If, in individual cases, time pressure arises as a result of progressive pubertal maturation, in which irreversible physical changes (e.g. male voice change) could be expected to cause damage to health as a result of longer waiting times, access to child and adolescent mental health assessment and medical treatment options should be granted as soon as possible.

Consensus strength: strong consensus (> 95%)

Joint special vote of the Bundesvereinigung Trans*, Trans-Kinder-Netz e.V. and Verband für lesbische, schwule, bisexuelle, trans*, intersexuelle und queere Menschen in der Psychologie e.V.:

The three organisations mentioned above would like to leave the wording of the recommendation as it was formulated in the original draft version of the guideline before the start of the consultation phase unchanged as follows:

"In individual cases, the progressive development of pubertal maturity can lead to time pressure. In these cases, the paediatric endocrinological specialist may initiate puberty suppression promptly due to its urgency with a provisional recommendation in order to prevent irreversible bodily changes (e.g. male voice change, female breast growth), if the implementation of an appropriate mental health assessment for a recommendation would mean an unacceptable delay. In such a justified case, diagnostic consultation by a child and adolescent mental health specialist to confirm the recommendation should be carried out promptly after the beginning of treatment."

Justification see appendix.

6.2.3 Importance of sexual orientation and non-binary identifications

Both sexual orientation and gender identity can develop fluidly during adolescence. Coming out as transgender may be preceded temporarily by same-sex exploration ("trying out") and vice versa. According to the clinical observations of the experts involved in drawing up the guidelines, many adolescent patients with gender incongruence very clearly differentiate their sexual orientation from their gender identity ("one has nothing to do with the other for me"). In addition, there is usually little concern of being attracted to the same sex or being bisexual, which relativises the hypothesis sometimes put forward that a supposed transgender identification of adolescents could be a manifestation of "displaced homosexuality". Furthermore, in surveys with adult trans people, it was reported that only a minority stated a clear heterosexual orientation ("straight") in their identified gender, whereas most of the trans people surveyed stated a sexual orientation within the queer, bisexual or fluid spectrum (Katz-Wise et al., 2016).

Sexual orientation is therefore not a determining factor for the recommendation of body-altering interventions in the event of gender incongruence. Any unequal treatment of patients depending on their sexual orientation would be unethical and discriminatory. However, it cannot be ruled out that the reported sexual orientation and gender identity of individual adolescents who are in a general adolescent

developmental crisis, for example, may interfere in a way that makes it difficult for a clinician to confirm the diagnosis of persistent gender incongruence. Therefore, exploring the entire psychosexual development as part of a diagnostic process is important for determining the recommendation.

Adolescents with a non-binary gender identity only require puberty-blocking treatment in very rare exceptional cases. This may be the case, for example, if there is a persistently high level of body dysphoric distress regarding the development of secondary sexual characteristics, which does not differ in clinical manifestation from cases with binary-transgender identifications. As explained in Chapter V → *"Psychotherapy and psychosocial interventions"*, in-depth self-exploration, including a *non-binary understanding of gender roles* and a non-binary *gender identity*, can be an important experience *before starting gender-affirming treatment*, which can reduce the risk of later detransition. Adolescents and their guardians should be informed that puberty suppression can only serve to temporarily halt pubertal maturation. For adolescents with a non-binary identity and high gender dysphoric distress, time-limited puberty suppression can be used alongside psychotherapeutic support. At the end a treatment plan with recommendations of subsequent gender-affirming hormone treatment or going through puberty with the body's own hormones will be agreed.

Consensus-based recommendation:

VII.K5.	The recommendation for puberty suppression in adolescents with gender incongruence or gender dysphoria should be made regardless of a binary sense of belonging to a particular gender and regardless of sexual orientation.

Consensus strength: strong consensus (> 95%)

Special vote of the German Psychoanalytical Society (DPG):

"The recommendation for puberty suppression in adolescents with gender incongruence or gender dysphoria should be made regardless of sexual orientation."

This special vote to omit the reference to a binary sense of belonging in the recommendation was also made in the same way in the corresponding recommendations on gender-affirming hormone treatments (VII.K15) and surgical interventions.

Justification see appendix.

The current state of knowledge on the developmental trajectories of gender-incongruent or gender-dysphoric children into adolescence and adulthood is presented in Chapter II → *"Variant developmental trajectories (persistence, desistance and detransition)"* of this guideline. Not all children who report symptoms of gender incongruence or gender dysphoria before puberty persist beyond puberty. However, the samples of adolescents who already begun or were in advanced puberty when treated with puberty suppression according to professional recommendation have shown that only very few of these adolescents discontinue treatment later, and the vast majority want gender-affirming interventions in the future (Brik et al., 2020; de Vries et al., 2011, 2014; Khatchadourian et al., 2014). This corresponds to expectations. In the treatment centre where these studies were conducted, each recommendation was preceded by professional process support and, among other things, the diagnosis of a high probability of persistent gender incongruence in adolescence was a defined entry criterion for the recommendation (see above).

Affected adolescents and their guardians must be comprehensively informed about the various trajectories of gender-incongruent and gender-dysphoric developments in children and adolescents. This also includes information that, according to previous observations at most specialised treatment centres, the vast majority of those affected opt for treatment with gender-affirming hormones after puberty suppression has begun. Nevertheless, it should be pointed out that deciding in favour of puberty suppression does not necessarily imply a commitment to later gender-affirming hormone treatment, but that in the event of later desistance, complete sexual maturation in the sex assigned at birth would be possible without serious medical disadvantages.

In this respect, the temporary puberty blocking can be used as a justifiable temporary "moratorium" to protect against progressive irreversible changes to the body. The time gained in this way can be used to adequately prepare a decision in favour of or against gender-affirming hormone treatment which is much more serious in its consequences.

6.2.4 Possible onset of puberty suppression

Based on the evidence presented in Chapter II → *"Variant developmental trajectories (persistence, desistance and detransition)"*, all previous guideline recommendations have so far unanimously called for puberty suppression not to be performed before the onset of puberty in order to take into account the developmental aspect of gender identity in the context of early puberty. All of the original studies on the effects of puberty suppression on adolescents with gender incongruence or gender dysphoria referred to at the beginning of this chapter were conducted with the mandatory criterion of puberty of at least Tanner stage 2 having already begun. Earlier initiation of puberty suppression in prepubertal children is generally not recommended.

More recent guidelines define puberty at Tanner stage 2 as the lower limit for a recommendation (Coleman et al., 2022a; Hembree et al., 2017). Even in later phases of puberty, a temporary suppression of puberty can be useful if the person seeking treatment requests it, if there is a pronounced gender incongruence or gender dysphoria, if the further development of secondary sexual characteristics is to be prevented for the time being, and if the affected adolescents or their environment are not yet ready or have not yet decided to undergo gender-affirming treatment, or if the recommendation for this appears premature for other reasons.

Consensus-based recommendation:

VII.K6.	The recommendation for puberty suppression in adolescents with gender incongruence or gender dysphoria should not be given before Tanner stage 2.

Consensus strength: strong consensus (> 95%)

Consensus-based recommendation:

VII.K7.	The recommendation for puberty suppression can also be given at a later stage of puberty if desired. This can be useful if there is not yet a recommendation for gender-affirming

	hormone treatment in order to gain time to decide in favour of or against further treatment steps and to reduce the level of suffering.

Consensus strength: strong consensus (> 95%)

There is no evidence on the question of whether puberty suppression should be preceded by a social transition for those affected. Previous guidelines call for persistent gender incongruence or gender dysphoria, although preceding social transition is not explicitly mentioned (Agana et al., 2019; Hembree et al., 2017).

Whether or not a social transition takes place in children and adolescents depends not only on the extent of gender incongruence or gender dysphoria, but also on the acceptance of such a transition by the family and school environment. In the clinical experience of the experts involved in drawing up the guidelines, there are often cases in which there is a strong and long-standing gender incongruence with severe body-related gender dysphoria, but a social transition has not yet been made despite the desire to do so. In these cases, there is often a desire for a puberty suppression in order to gain time to find out about the possibilities of social transition and to receive counselling regarding the implementation of social transition without changing physically in an undesired direction during this time, which would make a later social transition even more difficult.

Consensus-based recommendation:

VII.K8.	An already initiated or completed social role change should not be considered a necessary criterion when determining the recommendation for a puberty suppression.

Consensus strength: strong consensus (> 95%)

6.2.5 Diagnosis and treatment of associated or co-occuring mental health difficulties

Due to the frequency of associated mental health difficulties in adolescents diagnosed with gender incongruence or gender dysphoria, any existing co-occurring mental health difficulties should be diagnosed and treated if necessary. A detailed description of psychiatric diagnoses frequently associated with gender incongruence in children and adolescents and their consideration in an individualised and integrated clinical formulation of an explanatory model, including differential diagnostic considerations, can be found in Chapter IV → "*Associated mental health difficulties in children and adolescents with gender incongruence and gender dysphoria".*

There are associated mental health difficulties to which particular attention should be paid when determining the recommendation for a body-altering treatment for gender incongruence. These mental health difficulties are not to be understood as differential diagnoses in the classical medical sense, as their presence does not allow the conclusion that there is no persistent gender incongruence, nor does it per se constitute a relative or even absolute contraindication for the recommendation of body-altering interventions. However, according to the predominant clinical experience of the clinical experts involved in this guideline, these mental health difficulties can interfere with the recommendation in a variety of ways and thus require longer diagnostic clarification processes in preparation for a recommendation.

As explained in Chapter IV → "Associated mental health difficulties in children and adolescents with gender incongruence and gender dysphoria", depending on the individual case constellation, these can

- play a role in the development of gender-related distress with gender dysphoria-like symptoms that are *not* based on permanent gender incongruence,
- occur independently of gender incongruence,
- as a consequence of gender incongruence and the increased psychological stress caused by it,
- interact in complex ways with gender incongruence or gender dysphoria.

Table 5

Possible associated mental health conditions to be taken into account when diagnosing gender incongruence before determining the recommendation for medical interventions

Depressive disorders
Disorders with social anxiety
Syndromes with self-injurious behaviour
Eating disorders
Personality disorders (especially with identity diffusion or self-uncertainty)
Adolescent developmental crises
Autism spectrum disorders

Autism spectrum disorders play a special role, as in the precence of a diagnosis of autism a reactive development as a consequence of gender incongruence cannot be assumed. Professional psychiatric diagnosis and treatment with the involvement of the family can be essential for a positive course of body-altering treatment and further psychosocial development in adolescents with associated mental health difficulties. An integrated treatment plan must be drawn up for each individual case. However, as not all children and adolescents with diagnosed gender incongruence are affected by mental health difficulties, the need should be assessed on an individual basis. However, a prerequisite for puberty-blocking treatment is always a thorough psychiatric diagnosis to ensure that existing difficulties are properly recognised and, if necessary, treated and do not interfere with body-altering treatment. Possible interference between diagnosed or suspected gender incongruence and an associated other mental health difficulty can manifest itself and have a variety of effects. For example, an associated mental disorder can (see Chapter IV → "*Associated mental health difficulties in children and adolescents with gender incongruence and gender dysphoria*"):

- impair diagnostic clarity in the assessment of gender dysphoric symptoms,
- affect the feasibility of recommended social role-testing in preparation for body-altering treatment (e.g. social phobia with school absenteeism),

- affect the timing of planned interventions (e.g. anorexic eating disorder with the need for weight rehabilitation before hormonal interventions),
- impair the psychosocial stability and medical treatment compliance sufficient for body-altering treatment (e.g. patients with repeated acute psychiatric admissions for borderline personality disorder),
- impair the capacity to consent with regard to body-altering interventions (e.g. acute mental health crisis with a restricted view of current stressors).

If necessary, an individualised clinical formulation of an explanatory model for the mental health difficulties (see above) should be developed together with the adolescents concerned, which includes possible interactions between gender dysphoria and the co-occurring mental health difficulty (e.g. depression, self-harming behaviour, social phobia or eating disorder). In an integrated treatment plan, if associated mental disorders are present, the recommendation for puberty-blocking treatment to reduce the gender dysphoric distress should be combined with or embedded in suitable psychosocial and psychotherapeutic interventions.

The following list summarises the important steps on how to proceedwith associated mental health difficulties.

Table 6

Procedure for clinical signs of associated mental health difficulties

1. Initiating a guideline-compliant diagnosis in relation to the respective mental disorder.
2. Check whether there is a need for treatment regardless of gender incongruence.
3. Dialogical development of an individualised clinical formulation of an explanatory model for symptom developmeent and possible interdependence between gender dysphoric experiences and associated mental health difficulties.
4. Diagnostic assessment of the extent to which the associated disorder interferes with the necessary prerequisites for a recommendation (e.g. diagnostic clarity, capacity to give consent or feasibility of a medical intervention).
5. Plan the next steps, taking points 1-4 into account (e.g. extended process support to clarify the requirements for a recommendation, involvement of external expertise or recommendation for the start of body-altering treatment in parallel with treatment of the associated mental disorder).

6.2.6 Important aspects of patient education

Adolescent patients and their guardians must be informed about the effects and consequences of puberty suppression, including possible side effects. This includes, in particular, possible effects on sexuality, fertility, subsequent gender-affirming interventions such as genital surgery, relationship experience and body experience (see explanations on this in Chapter VIII → *"Somatic aspects of hormonal interventions"*). Reference should also be made to the available options for fertility preservation (cryopreservation). It should be noted that the desire to have children often changes over the course of a person's life and that not undergoing cryopreservation harbours the risk of a later unfulfilled desire for biological parenthood. The advantages of waiting until sufficient sexual maturity for cryopreservation in adolescents who have not yet developed accordingly must be weighed against the disadvantages of waiting and the associated increased development of irreversible secondary sexual characteristics.

Depending on their level of maturity, the information should support the adolescents as much as possible in the process of reaching capacity to consent[9] and being able to make an informed decision (see explanations on this in chapter X → *"Annotations on the legal basis and ethical standards for the treatment of minors with gender incongruence"*). This includes pointing out the potential advantages and disadvantages of the treatment and weighing them up together with the person concerned and their legal guardians. Informed consent from the adolescent should make it clear that they have understood the possible positive and negative consequences of the intervention in question and have been able to adequately categorise and weigh them up for themselves. The patient's required understanding of the intervention and its possible consequences therefore goes beyond mere factual knowledge.

[9] Translator's note: In the German speaking region the legal terms for a minor's capacity to consent to medical treatment are different in each country: Germany – *Einwilligungsfähigkeit (engl. capacity to consent)*; Austria – *Entscheidungsfähigkeit (engl. capacity of decision-making*; Switzerland – *Urteilsfähigkeit (engl. capacity of judgement)*. In the English translation only the term *capacity to consent* is used.

Consensus-based recommendation:

VII.K9.	The recommendation for puberty suppression should include an assessment of the minor patient's capacity to consent by a child and adolescent mental health professional. If the minor does not have sufficient capacity to consent, the professionals involved should support the minor in developing this capacity.

Consensus strength: strong consensus (> 95%)

If a minor diagnosed with gender incongruence or gender dysphoria does not (yet) have capacity to consent and if there are valid reasons for starting treatment promptly (e.g. prevent irreversible male voice change), valid consent in favour of a puberty suppression can be given by the legal guardians, provided that the child was able to participate in this decision in accordance with their cognitive maturity and this corresponds to the clearly recognisable wish of the child (see explanations on this in Chapter X → *"Annotations on the legal basis and ethical standards for the treatment of minors with gender incongruence"*).

The support of the family environment for the transition and in particular for the initiation of body-altering interventions is of great importance for the mental health of children and adolescents with gender incongruence (see also Chapter VI → *"Inclusion of the family environment and family dynamics").* In cases where persistent gender incongruence with the desire to transition is rejected by parents and other caregivers, there is a high risk of the development of subsequent mental health difficulties, particularly depression and suicidal behaviour (see also Chapter IV → *"Associated mental health problems and health problems in children and adolescents with gender incongruence and gender dysphoria")*. In such cases, intensive family therapy should be used to support the caregivers in order to address their reservations about an accepting attitude towards their child's gender identity and, if possible, work through them so that an accepting environment can be created within the family. The aim of the family therapy process is to make room for the parents' concerns and to develop a joint process of understanding about suitable steps to support the adolescents concerned. This assumes that family therapy interventions are not expected to have any psychologically damaging effects on the adolescents concerned (e.g. in the case of physical separation supported by the safeguarding team following experiences of abuse).

Consensus-based recommendation:

VII.K10.	If the minor is capable of giving consent (D)/capable of judgement (CH)/capable of making decisions (A), a co-consensus with the legal guardians should be sought

Consensus strength: strong consensus (> 95%)

Special vote of the German Society for Psychiatry, Psychotherapy, Psychosomatics and Neurology (DGPPN):

The DGPPN is in favour of a stronger level of recommendation to strive for co-consensus with guardians before body-altering medical interventions and proposes the following amended wording:

If the minor has the capacity to give consent (D)/capacity to make judgements (CH)/capacity to make decisions (A), a co-consensus with the legal guardians **shall** be sought

Justification see appendix.

Consensus-based recommendation:

VII.K11.	In cases where there is no co-consensus between the patient and their legal guardians, intensive psychological support for the family system should be offered by a suitable specialist with family therapy expertise with the aim of facilitating support for the patient. Such psychological support is only recommended if no harmful effects on the health/psychological well-being of the patient are to be expected. In such cases, an assessment of the best interests in favor of the child's well-being is recommended.

Consensus strength: strong consensus (> 95%)

Explanation: Beyond the fundamental need to focus on the health of the child, the emphasis in this recommendation refers to cases in which there is reason to assume that a family therapy intervention involving the adolescent patient and their guardians could be harmful. Such an assumption should lead to the consideration of examining the case from the perspective of the child's welfare and, if necessary, child protection. In cases in which no consensus regarding puberty-suppressing treatment can be reached between the person concerned and their legal guardians or between the legal guardians themselves, despite intensive professional support, an independent body may need to initiate an examination of suitable steps, giving priority to the best interests of the child. This is the responsibility of the competent courts or authorities in the respective country and should not be assessed from a therapeutically biased position (for the legal regulations to be observed, see chapter X → *"Annotations on the legal basis and ethical standards for the treatment of minors with gender incongruence"*).

Special vote of the German Society for Psychiatry, Psychotherapy, Psychosomatics and Neurology (DGPPN):

The DGPPN is in favour of a stronger recommendation for family therapy process support if there is no co-consensus and proposes the following amended wording:

In cases where there is no co-consensus between the patient and their legal guardians, intensive psychological support for the family system **shall** be offered by a suitable specialist with family therapy expertise with the aim of facilitating support for the patient. Such psychological support is only recommended if no harmful effects on the health/psychological well-being of the patient are to be expected. In such cases, an assessment of the best interests in favour of the child's well-being is recommended.

Justification see appendix.

6.2.7 Physical aspects to be considered

A careful medical examination by a paediatric endocrinologist should ensure that there is no medical condition that could interfere with puberty-suppressing treatment. In special cases, the puberty-suppressing intervention must be adapted to the individual somatic situation.

In earlier recommendations, the differential diagnosis of a somatosexual differentiation disorder from the DSD spectrum (somatic diversity of sex development, intersex condition) was required as a prerequisite for a recommendation for hormonal interventions in cases of gender incongruence or gender

dysphoria. The coincidence of gender incongruence or gender dysphoria with a diagnosis from the DSD spectrum is rare. According to the currently available international guidelines (Coleman et al., 2022a; Hembree et al., 2017) and in the overwhelming opinion of the experts involved in the creation of this guideline, it does not represent a contraindication per se for body-altering interventions in cases of diagnosed gender incongruence with gender dysphoria. In these situations, both psychological and somatic conditions must be carefully assessed and the intervention should be adapted to the individual case. Corresponding recommendations can be found in Chapter VIII → *"Somatic aspects of hormonal interventions"*.

6.3 Gender-affirming hormone treatment (GAH)

Gender-affirming hormone treatment (GAH) should be considered if there is persistent gender dysphoric distress in adolescents who are capable of consent (D)/capable of judgement (CH)/capable of making a decision (A) with a confirmed diagnosis of gender incongruence according to ICD-11 (WHO, 2022) and have felt transgender for several years. The legal guardians must always be involved in the decision-making process and must be significantly involved, taking into account the legal framework and the family situation.

Professional support for this process aims to ensure that underage patients make an autonomous and informed decision in consensus with their legal guardians, carefully weighing up the benefits of the desired gender-affirming hormone treatment and the increasingly irreversible physical consequences of both treatment and non-treatment (Deutscher Ethikrat, 2020). Due to the still moderate to uncertain level of evidence regarding gender-affirming hormone treatment in minors (Taylor, Mitchell, Hall, Langton et al., 2024), it should only be recommended for minors on a case-by-case basis after careful and comprehensive assessment of the risks and benefits (Drobnič Radobuljac et al., 2024).

Due to the increasing partial irreversibility of gender-affirming hormone treatment, a high degree of cognitive and socio-emotional maturity of minors is required for the decision. In cases of doubt, if the minor has not yet reached full capacity to consent, the decision should not be made by the legal guardians on behalf of the minor due to the highly personal consequences of treatment or the omission of treatment. Instead, minors who wish to undergo treatment should be given intensive professional support, taking into account the perspective of their legal guardians, in order to enable them to make an autonomous and informed decision based on their capacity to consent. However, this should be achieved with the involvement of and, wherever possible, in consensus with the legal guardians. The physical consequences

of gender-affirming hormone treatment that need to be taken into account and the medical recommendations for carrying out this intervention are presented in Chapter VIII → *"Somatic aspects of hormonal interventions".*

The start of gender-affirming hormone treatment requires careful assessment and multi-disciplinary cooperation by a mental health specialist and an endocrinological specialist experienced in the treatment of adolescents (multi-professional recommendation, see below). The latter can come from the field of paediatrics, endocrinology or (paediatric) gynaecology

Special vote of the Executive Board of the German Society of Endocrinology (DGE):

The expertise of the person who provides the endocrinological part of the recommendation and the endocrinological care during gender-affirming hormone treatment for adolescents with gender incongruence or gender dysphoria should fulfil one of the following formal requirements (designations for Germany): - Specialist medical title for paediatrics with additional title in paediatric and adolescent endocrinology and diabetology - Specialist medical title for internal medicine and endocrinology and diabetology - Specialist designation for gynaecology and obstetrics with a focus on endocrinology and reproductive medicine

In particularly complex cases, when the case-related assessment by multi-professional teams appears difficult or controversial, the consultation of medical ethics experts should be considered for clarification. The ethical considerations made with regard to the benefits and risks of treatment and the alternative of non-treatment must be listed in the recommendation letter (see under 6.5 in this chapter→ *"Recommended contents of a recommendation letter"*).

Consensus-based recommendation:

VII.K12.	The recommendation for gender-affirming hormone treatment in adolescents with gender incongruence or gender dysphoria should be determined via multi-disciplinary co-operation. The prerequisite for a recommendation is a careful diagnostic assessment and clarification appropriate to the urgency and complexity of the individual situation by a mental health specialist experienced in the diagnosis and treatment of gender dysphoria in adolescents. The medical part of the recommendation should be carried out by an endocrinological specialist experienced in the treatment of adolescents, taking into account their prerequisites (pubertal stage of maturity, absence of somatic contraindications, etc.).

Consensus strength: strong consensus (> 95%)

Special vote of the Executive Board of the German Society of Endocrinology (DGE):

We are in favour of a second mental health specialist with experience in the diagnosis and treatment of gender dysphoria in adolescence confirming the recommendation for complex issues such as young age, existing psychiatric comorbidities or recent awareness of gender dysphoria in the sense of a two persons principle.

Checks and considerations to be made with regard to somatic contraindications to gender-affirming hormone treatment are described in Chapter VIII → *"Somatic aspects of hormonal interventions".*

Consensus-based recommendation:

VII.K13.	The expertise of the persons who provide the child and adolescent mental health part of the recommendation for gender-affirming hormone treatment in adolescents with gender incongruence or gender dysphoria should include one of the following formal qualifications specific to adolescence: D: – Specialist designation for child and adolescent psychiatry and psychotherapy – Licence for child and adolescent psychotherapy – Specialist medical title for paediatrics and adolescent medicine with additional qualification in psychotherapy CH: – FMH title in child and adolescent psychiatry and psychotherapy – Federally recognised psychotherapist A: – Specialist in child and adolescent psychiatry or specialist in child and adolescent psychiatry and psychotherapeutic medicine – Registration as a psychotherapist with further training in infant, child and adolescent psychotherapy Or alternatively with appropriate clinical expertise in the diagnosis and treatment of children and adolescents: D: – Specialist title for psychiatry and psychotherapy, psychotherapeutic medicine or psychosomatic medicine and psychotherapy – Licence for psychological psychotherapy CH: – FMH title in psychiatry and psychotherapy A: – Specialist in psychiatry and psychotherapeutic medicine, specialist in psychiatry and neurology – Registration as a psychotherapist, registration as a clinical psychologist

Consensus strength: strong consensus (> 95%)

Special vote of the German Society for Psychiatry, Psychotherapy, Psychosomatics and Neurology (DGPPN):

The DGPPN is in favour of a stronger level of recommendation with regard to the necessary qualifications of the mental health specialist for the recommendation of gender-modifying hormone treatment and proposes the following amended wording:

The expertise of the persons who provide the child and adolescent mental health partof the recommendation for gender-affirming hormone treatment in adolescents with gender incongruence or gender dysphoria **shall** include one of the following formal qualifications specific to adolescence. *(List of qualifications is identical)*

Justification see appendix.

Stable/persistent gender incongruence with concurrent gender dysphoria or gender dysphoria to be expected with increasing pubertal development is a prerequisite for a recommendation for gender-affirming hormone treatment. Empirically validated individual criteria for the determination of permanent stability/persistence of gender incongruence or gender dysphoria are not available according to the studies we have reviewed. It is therefore the responsibility of the mental health specialist to develop an individual assessment in a joint discussion with the affected person and their guardians based on the overall picture of the existing psychological findings, the descriptions and reflections of the affected person and their life story. This usually requires diagnostic-explorative process support over several months with careful collection of all findings. In addition to experience in the diagnostic assessment of gender incongruence and possible accompanying mental health difficulties, it is important for the mental health specialist to have comprehensive knowledge of the range of variations in the relevant developmental processes, including those associated with the persistence of gender dysphoria during adolescence or with later detransition after transition has been completed.

In the current guideline of the WPATH *Standards of care for the health of transgender and gender diverse people, version 8,* it is recommended as a time criterion that before starting gender-affirming hormone treatment in adolescence, those affected should report a gender-incongruent experience that has existed for several years (Coleman et al., 2022a). The criterion described in our guideline of a stable transgender experience over several years takes this recommendation into account. When exploring the duration of gender incongruence or gender dysphoria, it should be noted that the internal experience is

decisive, which can differ considerably from the externally observable gender expression depending on the psychosocial situation.

Consensus-based recommendation:

VII.K14.	A prerequisite for the recommendation of gender-affirming hormone treatment should be the presence of stable/persistent gender incongruence (according to the diagnostic criteria of GI in adolescence/ ICD-11 HA60) with gender dysphoric distress present after the onset of puberty with several years of transgender perception and the associated desire for the development of the gender-specific physical changes to be expected as a result of hormone treatment. The careful diagnostic assessment should be carried out in collaboration between the mental health specialist experienced in the diagnosis and treatment of gender dysphoria in childhood and adolescence and the patient and their carers/relatives on the basis of an exploration of the psychological findings and life history.

Consensus strength: Consensus (> 75%)

Joint special vote of the Bundesvereinigung Trans*, Trans-Kinder-Netz e.V. and Verband für lesbische, schwule, bisexuelle, trans*, intersexuelle und queere Menschen in der Psychologie e.V.:

The three organisations mentioned above would like to leave the wording of the recommendation originally agreed before the consultation phase unchanged with this special vote:

"A prerequisite for the recommendation of gender-affirming hormone treatment should be the presence of stable/persistent gender incongruence (according to the diagnostic criteria of GI in adolescence/ ICD-11 HA60) with gender dysphoric distress present after the onset of puberty and the associated desire for the development of the gender-specific physical changes to be expected as a result of hormone treatment. The diagnostic assessment should be carried out as part of a collaboration between a mental health specialist and the patient and their guardians/caregivers based on the exploration of the psychological findings and life history."

Justification see appendix.

As stated in the preamble to this guideline, both treatment and non-treatment with body-altering medical interventions can have irreversible consequential risks for adolescents with gender incongruence. Individual medical ethical considerations must therefore be made in each case. This should involve an age- and development-dependent assessment of the potential benefits of treatment (in terms of preventing an increase in gender dysphoric distress) versus the risks of treatment (side effect profile).

Consensus-based recommendation:

VII.K14a.	The justification for the recommendation of gender-affirming hormone treatment should contain an ethically reflected risk-benefit assessment based on the individual case, both of the planned treatment and of not initiating this treatment or waiting until a later date.

Consensus strength: strong consensus (> 95%)

6.3.1 Non-binary gender identities and fluid sexual orientation in adolescence

A particular diagnostic challenge is a non-binary identity experience of adolescents, which, according to the experience of the experts involved in drawing up the guidelines, has recently been reported with increasing frequency. It may initially be unclear to what extent such an identification is primarily an expression of a *non-binary understanding of social gender roles*, which does not necessarily go hand in hand with a permanent *non-binary gender identity*. Recommendations for the psychotherapeutic support of open-ended self-exploration and self-discovery processes in this regard are set out in Chapter V → *"Psychotherapy and psychosocial interventions"* of this guideline.

The following two case studies illustrate this variability:

Case study 1: Trans boy with initially non-binary identification

16-year-old Luisa introduces herself under her female first name at birth with the self-ascription "I am non-binary". In the exploration, a pronounced gender dysphoric experience with a reflected rejection of female role expectations and a strong sense of disturbance towards the female sexual characteristics of her body

is stated. Luisa used binding her breasts daily for several months. At the same time, the adolescent states that she does not identify with the male gender either. She expresses a fear that she could "jump out of the frying pan into the fire" if she transitions into a different gender role which is just as unsuitable for her as a person. In a psychotherapeutic process lasting several months, the adolescent is encouraged to consistently and openly explore a social gender role that is right for her. She engages in this process with reflected introspection. During the process, it becomes increasingly clear to her that a harmonious experience with her own gender identity can only be experienced in the long term in a body that appears male. A trial outing at school as a trans boy with the newly chosen male first name Milan leads to an increasing experience of congruence and psychological relief. The freedom gained through the previous non-binary self-exploration, being able to be an "atypical" young man without adopting typical expectations of a "male role", acts as an inner impetus for the desire to transition. Milan now wants testosterone treatment, the recommendation for which can be affirmed due to the now reliably diagnosable gender incongruence. Shortly after starting testosterone treatment, the legal change of name and civil status takes place. One year later, at the age of 18, he undergoes a mastectomy. As a boy, Milan successfully completes his A-levels at grammar school. Over the next two years, Milan's psychological development in a male gender is stable and accompanied by social and health-related well-being.

Case study 2: Open-ended development over three years

16-year-old Carla introduces herself with a non-binary identification using her female name given at birth. She says that she rejects all male and female role ascriptions and imagines that she would feel more comfortable in a body that appears male within this perceived non-binary. She dresses typically for a boy and has a short haircut. During the exploration, it is noticeable that there does not appear to be any pronounced body-related psychological distress. The adolescent says that she could well imagine transitioning and taking male hormones later on. In a psychotherapeutic exploration lasting several months, Carla is encouraged to openly explore a social gender role that she can experience as coherent. She initially decides to come out socially as a non-binary trans person and gives herself the male first name Benno, which she now uses in all areas of everyday life. Benno experiences social acceptance in their family and at school and shows themselves to be socially active and competent in many ways. Benno seems very happy and says that they are in no hurry to decide in favour of gender-affirming medical interventions. Due to the unclear diagnostic picture - no gender incongruence can be diagnosed for the time being - Benno is advised to give themselves at least two more years to explore his non-binary social roles and to

live as the person they are without medical interventions. Benno seems relieved by this recommendation. The question of medical transition treatment no longer comes up in the appointments for over a year. At the same time, Benno appears stable and continues to be competent and self-effective in actively shaping their life - after successfully graduating from high school.

There are no published data on the body-altering treatment of non-binary adolescents, which is why particular caution is required when determining recommendations. On the other hand, both the ICD-11 and the DSM-5 explicitly include non-binary gender identities as part of the diagnostic spectrum for gender incongruence and gender dysphoria. As a result, it would be medically, socio-legally and ethically unacceptable to exclude non-binary people with gender incongruence and persistent gender dysphoria from professional treatment as a matter of principle. The above-mentioned problems and challenges must therefore be addressed on an individualised case-by-case basis, which in adolescence justifies the need for ongoing diagnostic process support with a longer clinical observation interval. Both sexual orientation and gender identity can develop fluidly in adolescence. Coming out as transgender may be preceded by a temporary same-sex exploration ("trying out") and vice versa. According to the clinical observations of the experts involved in drawing up the guidelines, many of the adolescent patients with gender incongruence are differentiate clearly between their sexual orientation and gender identification ("one has nothing to do with the other for me"). In particular, most patients have little worry of being gay or bisexual, which is why internalised homophobia is only considered as an aetiological explanatory model for the gender identity issue in a few cases.

Furthermore, in surveys with adult trans people, it was reported that only a minority stated a clear heterosexual orientation ("straight") in their identified gender, whereas most of the trans people surveyed stated a sexual orientation within the queer, bisexual or fluid spectrum (Katz-Wise et al., 2016). Sexual orientation is therefore not a determining factor for the recommendation of body-altering interventions in the case of gender incongruence. Unequal treatment of patients based on their sexual orientation would be unethical and discriminatory. However, it cannot be ruled out that in individual adolescents who are in a general developmental crisis, reported sexual orientation and gender identity may interfere in a way that makes it difficult to determine persistent gender incongruence. Therefore, the exploration of the entire psychosexual development as part of a diagnostic process is important for determining the recommendation.

Consensus-based recommendation:

VII.K15.	The recommendation for gender-affirming hormone treatment should be made regardless of the polarity or binary nature of gender identity and regardless of the patient's sexual orientation.

Consensus strength: strong consensus (> 95%)

Special vote of the German Psychoanalytical Society (DPG):

"The recommendation for gender-affirming hormone treatment should be made regardless of the patient's sexual orientation."

Justification see appendix.

6.3.2 Gender-affirming hormone treatment without preceding puberty suppression

In the international guidelines of the Endocrine Society from 2017 (Hembree et al., 2017), it was recommended that adolescents with gender dysphoria for whom a recommendation for somatomedical hormonal treatment is confirmed should be given a mandatory puberty suppression before initiating gender-affirming hormone therapy. This corresponded to the original Dutch treatment protocol, which was also the basis for the first follow-up cohort studies. In many places, this has led to puberty blockers being regularly used for a year or longer, even in late adolescence, e.g. in 16-year-old patients who have already fully matured. This was also the strictly prescribed practice in NHS England until April 2024, which has significantly influenced the medical controversy there about the benefit-risk profile of puberty blockers, because in older adolescents whose pubertal maturation is largely complete, the benefit-risk balance for the use of puberty blockers is usually negative. With increasingly advanced maturation, the potentially harmful side effects of puberty suppression (including anhedonia, reduced bone density, menopausal symptoms) must be weighted significantly higher than the expected benefit of reducing gender dysphoric distress. For this reason, the regular use of puberty blockers as a precursor to gender-affirming hormone therapy is now often dispensed with in cases of advanced pubertal maturation. There is no evidence that it is always beneficial for adolescents to undergo puberty suppression before starting

gender-affirming hormone therapy. Although the first follow-up studies report exclusively on adolescents who first underwent puberty suppression and then received gender-affirming hormone treatment (de Vries et al., 2014), the samples of later studies also include adolescents who were treated with gender-affirming hormones without prior puberty suppression due to their already advanced pubertal maturation (Olson-Kennedy et al., 2018). For a differentiated description of the somatic implications of puberty suppression or gender-affirming hormone treatment, see Chapter VIII → *"Somatic aspects of hormonal interventions"*.

Consensus-based recommendation:

VII.K16.	For the recommendation of gender-affirming hormone treatment in adolescents, it should not be assumed that a puberty suppression has previously been performed.

Consensus strength: strong consensus (> 95%)

6.3.3 Social role testing in the identified gender

As a rule, gender-affirming hormone treatment (GAH) is preceded by a social transition in as many areas of everyday life as possible. The available literature does not provide any information as to whether the adolescents studied also included those for whom gender-affirming hormone treatment was initiated prior to social transition. Current international guidelines unanimously require persistent gender incongruence or gender dysphoria as a prerequisite for a recommendation, although a completed social transition is not explicitly mentioned (Agana et al., 2019; Coleman et al., 2022a; Hembree et al., 2017). A social transition prior to the GAH is recommended, as it gives the person seeking treatment and their environment the security and confirmation that the chosen path is both consistently experienced by the person concerned and socially viable. It also makes it easier for the social environment to adapt to the expected physical changes, and it protects adolescents who are treated with GAH from potentially negative reactions to the feminising or virilising changes in their physical appearance by their social environment. According to the clinical experience of the experts involved in the development of the guidelines, there are individuals with a persistent desire for gender-affirming hormone treatment and a stable gender identity before socially transitioning in all areas of everyday life. These individuals usually desire to facilitate a social role change through the changes expected as a result of hormone treatment.

In these cases, special emphasis should be placed on the changes that can realistically be expected. The psychosocial difficulties of those affected in relation to social transition should be addressed and the adolescents should receive support in this regard. In these cases, the adolescents should be informed that social fears about transition cannot realistically be resolved by gender-affirming hormone treatment alone.

In any case, all effects on the social environment should be adequately reflected upon by those seeking treatment in preparation for GAH. Protection against discrimination must always be taken into account in counselling regarding social transition. To support young people in this process, reference should be made to existing community services (including peer counselling) and youth welfare services.

Consensus-based recommendation:

VII.K17.	In preparation for gender-affirming hormone treatment, a social trial of the desired gender role should take place, provided this is compatible with the protection against discrimination. In cases where social support from the environment is not sufficient, psychotherapeutic support for the transition process should be offered.

Consensus strength: strong consensus (> 95%)

6.3.4 Consideration of associated mental health difficulties

Due to the frequency of mental health difficulties in adolescents with gender *incongruence* or gender *dysphoria*, these difficulties, if present, should be diagnosed and, if necessary, treated professionally (see Chapter IV → *"Associated mental health problems and health problems in children and adolescents with gender incongruence and gender dysphoria").* Sufficient psychosocial support for those affected and their families is an important factor for a positive course of body-altering interventions and further development. However, since not all adolescents with gender incongruence are affected by mental health difficulties that require treatment, the need must be assessed on an individual basis. However, a prerequisite for a recommendation for hormone treatment is always a mental health assessment and

professional support in order to ensure that any disorders are properly recognised and, if necessary, treated and do not interfere with the body-altering treatment.

A possible interference between a diagnosed or suspected gender incongruence and another associated mental disorder can manifest itself and have a variety of effects.

A coinciding mental disorder can, for example:

- impair diagnostic clarity in the assessment of gender dysphoric symptoms,
- affect the feasibility of recommended social role-testing in preparation for body-altering treatment (e.g. social phobia with school absenteeism),
- affect the timing of planned interventions (e.g. anorexic eating disorder with the need for weight rehabilitation before hormonal interventions),
- impair the psychosocial stability and medical treatment compliance sufficient for body-altering treatment (e.g. patients with repeated acute psychiatric admissions for borderline personality disorder),
- impair the capacity to consent with regard to a treatment decision (e.g. acute psychiatric crisis with a restricted view of current stressors).

Consensus-based recommendation:

VII.K18.	If there is a co-occuring mental disorder that interferes with the treatment and goes beyond the gender dysphoria before gender-affirming hormone treatment is recommended a professional mental health intervention should be recommended and offered as part of an integrated or networked treatment concept. The treatment steps should be prioritised in dialogue with the patient.

Consensus strength: strong consensus (> 95%)

Special vote of the German Society for Psychiatry, Psychotherapy, Psychosomatics and Neurology (DGPPN):

The DGPPN is in favour of a stronger level of recommendation for the networked treatment of a co-occurring mental disorder if sex-modifying hormone treatment is planned and proposes the following amended wording:

If, before a gender-affirming hormone treatment is recommended, there is a co-existing mental disorder that goes beyond the gender dysphoria and interferes with the treatment, a professional mental health intervention **shall** be recommended and offered as part of an integrated or networked treatment concept. The treatment steps **shall** be prioritised in dialogue with the patient.

Justification see appendix.

6.3.5 Important contents of patient education and informed consent

Chapter VIII → *"Somatic aspects of hormonal interventions"* contains important information for adolescents and their guardians on the effects of gender-affirming hormone treatment and consequences, including possible side effects. This includes in particular the possible effects on sexuality, fertility, later gender-affirming interventions such as operations, relationship experience and body experience. Information should also be provided on the available options for preserving fertility through cryopreservation. It should be pointed out that the desire to have children often changes over the course of a person's life and that not undergoing cryopreservation may harbour the risk of a later unfulfilled desire to have children.

In view of the implications of the decision to undergo gender-affirming hormone treatment, it is essential that underage patients are able to give their informed consent on their own responsibility. This in turn requires a professional individual assessment of their capacity to consent[10] (see explanations in

[10] Translator's note: In the German speaking region the legal terms for a minor's capacity to consent to medical treatment are different in each country: Germany – *Einwilligungsfähigkeit (engl. capacity to consent)*; Austria – *Entscheidungsfähigkeit (engl. capacity of decision-making*; Switzerland – *Urteilsfähigkeit (engl. capacity of judgement)*. In the English translation only the term *capacity to consent* is used.

Chapter X → *"Annotations on the legal basis and ethical standards for the treatment of minors with gender incongruence*").

Consensus-based recommendation:

VII.K19.	Before a gender-affirming hormone treatment is recommended in adolescence, adolescents and their guardians should be informed about the possible effects of the treatment on sexuality, fertility, relationship experience, body experience, possible experiences of discrimination and further gender-affirming body-altering treatment steps. The possibilities of fertility-preserving medical interventions should be pointed out and access to professional counselling should be made possible.

Consensus strength: strong consensus (> 95%)

Special vote of the German Society for Psychiatry, Psychotherapy, Psychosomatics and Neurology (DGPPN) in favour of a stronger level of recommendation to the effect that the possibility of fertility-preserving medical interventions should be pointed out and proposes the following amended wording:

Before a gender-affirming hormone treatment is recommended in adolescence, adolescents and their guardians should be informed about the possible effects of the treatment on sexuality, fertility, relationship experience, body experience, possible experiences of discrimination and further gender-affirming body-altering treatment steps. They **shall** be made aware of the possibilities of fertility-preserving medical interventions and given access to professional counselling.

Justification see appendix.

Consensus-based recommendation:

VII.K20.	The adolescent mental health part of the recommendation for gender-affirming hormone treatment should include the assessment of the patient's capacity to consent in relation

	to the specific treatment planned - by the specialist making the recommendation. If the patient does not have sufficient capacity to consent, the minor should be supported in achieving this capacity.

Consensus strength: strong consensus (> 95%)

6.3.6 Family support and consent of legal guardians

As already explained in the section on puberty-blocking treatment (see above), the support of the family for the transition process and in particular for the initiation of body-altering interventions is of great importance for the mental health of affected adolescents (see also Chapter VI → *"Inclusion of the family environment and family dynamics"*). In cases where adolescents experience long-term rejection by their parents and other family caregivers due to their transgender identity and desire to transition, there is a high risk of mental health difficulties, particularly depression and suicidal behaviour (see also Chapter IV → *"Associated psychological abnormalities and health problems in children and adolescents with gender incongruence and gender dysphoria"*). In these cases, intensive family therapy should be used to support the caregivers in order to address their reservations about accepting their child's perceived gender identity and, if possible, to work through them so that an accepting environment can be created within the family.

The aim of family therapy is to make room for the parents' concerns and to develop a joint process of agreement on suitable steps to support the adolescents concerned. This assumes that family therapy interventions are not expected to have any psychologically damaging effects on the adolescents concerned (e.g. in the case of physical separation supported by the safeguarding team following experiences of abuse).

Consensus-based recommendation:

VII.K21.	If the patient has the capacity to consent regarding the implementation of gender-affirming hormone treatment, a co-consensus of the legal guardians should be sought.

Consensus strength: strong consensus (> 95%)

Special vote of the German Society for Psychiatry, Psychotherapy, Psychosomatics and Neurology (DGPPN):

The DGPPN is in favour of a stronger level of recommendation to strive for co-consensus with the legal guardians before body-altering medical interventions and proposes the following amended wording:

If the patient has the capacity to consent regarding the performance of gender-affirming hormone treatment, a co-consensus of the legal guardians **shall** be sought.

Justification see appendix.

If in individual cases, despite intensive counselling, no co-consensus can be reached between the affected person and their legal guardians regarding the desired and recommended gender-affirming hormone treatment, a complex dilemma arises with regard to the health risks. The long-term psychosocial implications of an ongoing conflict between an adolescent trans person and their parents over the question of support for a self-determined path in life are considerable for both sides and therefore do not appear to be resolvable solely in the interests of the adolescent's health and well-being by means of revoking parents their custody rights. On the other hand, persistent psychological distress implies an increased risk of negative health consequences if professionally recommended medical treatment is not carried out. In such cases, intensive psychosocial interventions should be considered in the primary interest of the adolescent's health in order to support them on the path to shaping their life in accordance with their gender identity. In individual cases, this may also include therapeutic support for a necessary process of psychological separation from the parents. If a conflict remains unresolvable despite all professional efforts, it is the responsibility of the youth welfare agency to initiate appropriate steps to establish the interests of the child's health. The legal requirements of the respective country that must be observed in the case of a minor patient with full capacity to consent when assessing whether and how they can make a solely responsible and self-determined decision are explained in Chapter X → *“Annotations on the legal basis and ethical standards for the treatment of minors with gender incongruence*".[11]

[11] Translator’s note: In the German speaking region the legal terms for a minor’s capacity to consent to medical treatment are different in each country: Germany – *Einwilligungsfähigkeit (engl. capacity to consent)*; Austria – *Entscheidungsfähigkeit (engl. capacity of decision-making*; Switzerland – *Urteilsfähigkeit (engl. capacity of judgement)*. In the English translation only the term *capacity to consent* is used.

Consensus-based recommendation:

VII.K22.	In cases where there is no co-consensus between the patient and their legal guardians, intensive process support for the family system should be offered by a suitable specialist with the aim of facilitating support for the patient. Such process support is only recommended if no harmful effects on the health/psychological well-being of the patient are to be expected.

Consensus strength: strong consensus (> 95%)

Special vote of the German Society for Psychiatry, Psychotherapy, Psychosomatics and Neurology (DGPPN):

The DGPPN is in favour of a stronger level of recommendation for family therapy process support if there is no co-consensus and proposes the following amended wording:

In cases where there is no co-consensus between the patient and their legal guardians, intensive process support for the family system **shall** be offered by a suitable specialist with the aim of facilitating support for the patient. Such process support is only recommended if no harmful effects on the health/psychological well-being of the patient are to be expected.

Justification see appendix.

6.4 Gender-affirming surgery in adolescence

Gender-affirming surgery in patients with gender incongruence/gender dysphoria is an irreversible procedure that can have significant and lasting consequences for the psychological and somatic health of those affected, both in the positive sense of reducing suffering, body dissatisfaction and psychological stress and improving quality of life, and in the negative sense in the event of medical or psychosocial complications or in the event of later regret for the surgery performed. If gender incongruence or gender

dysphoria persists in adolescence and gender-affirming surgery is requested by patients before they reach the age of majority and the medical recommendation for this is to be examined, the procedure and the decision-making process must meet correspondingly high requirements in terms of both diagnostic clarity and the reliable determination of the patient's capacity to consent which are set out in Chapter X → *"Annotations on the legal basis and ethical standards for the treatment of minors with gender incongruence*". Genital reassignment surgery is generally only performed after the age of 18. In addition, clinical experience to date has shown that there can be changes in the desire for treatment with regard to genital reassignment surgery in young adulthood, even in the case of stable persistent gender incongruence, i.e. that there are increasingly also adult trans people who do not want genital surgery. Based on these considerations, the recommendation for genital reassignment surgery is therefore only recommended from the age of 18. The current international guideline *Standards of Care, version 8* of the WPATH does not fundamentally rule out the possibility of a recommendation for genital reassignment surgery in adolescence if strict criteria are observed. Only the genital reassignment procedure of phalloplasty is expressedly not recommended for minors (Coleman et al., 2022a).

When weighing up irreversible surgical interventions, the potential permanent damage to health in the event of later desire for detransition must be weighed much more heavily than in the case of partially and progressively irreversible hormone treatments. This must be weighed up against the current gender dysphoric distress, which can be very high, particularly in the case of breast dysphoria in trans male adolescents, and can have a considerable impact on mental health.

If a stable gender identity has been established for several years in the course of persistent gender incongruence following a fully completed social transition in adolescence and including a stable improvement in the sense of congruence with the virilisation or feminisation that has occurred under gender-affirming hormone treatment, then the recommendation for gender-affirming breast surgery can also be considered in adolescence in cases of pronounced gender dysphoric distress and a corresponding desire for treatment. According to the clinical experience of the experts involved in the development of this guideline, this has so far almost exclusively concerned mastectomy in trans boys who have already been living stably in the male gender role for a long period of time and have further consolidated this role under ongoing testosterone treatment. Experience has shown that the gender dysphoria related to the appearance of breasts usually persists or can even increase during testosterone treatment (Olson-Kennedy et al., 2018).

This guideline therefore only contains recommendations on the procedure for determining the recommendations for gender-affirming surgery on the breast. Genital reassignment surgery is only recommended after the age of 18. The recommendations of the [German] S3-guideline[12] *Gender incongruence, gender dysphoria and trans health* for adulthood (DGfS, 2018) and the international guideline *Standards of Care 8* of the WPATH (Coleman et al., 2022a) are authoritative in this regard.

In current international guidelines, mastectomy is listed as a surgical option for trans male minors if there is a justified recommendation (Coleman et al., 2022a; Hembree et al., 2017). Previous cohort studies have reported that minors can also receive gender-affirming mastectomies in cases of high individual distress - particularly in the case of trans male adolescents who have already been treated with testosterone and have lived stably in a male gender for many years (Marinkovic & Newfield, 2017; Olson-Kennedy et al., 2018).

The available studies report a predominantly positive treatment outcome with regard to the reduction of breast dysphoria and the satisfaction of those treated. In many cases, trans male adolescents with gender dysphoria suffer considerably from breast dysphoria. According to the clinical experience of the experts involved in the development of the guidelines, this can result in health risks. Years of daily chest binding can lead to respiratory impairment and postural damage with back problems, which can severely restrict sporting activity. In addition, the psychosocial participation of many gender dysphoric adolescents is restricted, e.g. through years of avoiding swimming pools or other social activities due to shame over the visibility of female breasts bulge. Access to the labour market is also often more difficult for gender-incongruent adolescents after social transition without adjustment of their physical appearance, as incongruences between the socially lived gender and the biological sexual characteristics are externally visible and can encourage trans-hostile reactions from the social environment. It is therefore necessary to carefully weigh up the risks of gender-affirming surgery against the risks and burdens of non-surgically treated gender dysphoria in each individual case.

According to current guidelines, there is no evidence from study results in favour of or against defined age limits for gender-affirming breast surgery in underage adolescents with diagnosed gender incongruence. The timing of the recommendation should therefore be based on the individual's state of

[12] According to the rules for medical guideline development set out by the German Association of Scientific Medical Societes (AWMF), the label S3 requires both that the guideline is based on evidence that has to be systematically reviewed, and on defined transparent involvement of professional societies and consensus procedures.

health (Hembree et al., 2017). Aspects of psychological distress, cognitive and emotional maturity and the long-term stability of the diagnosis must be weighed up. Gender-affirming breast surgery in minors with gender incongruence or gender dysphoria therefore requires careful case-by-case assessment in multi-disciplinary cooperation between the mental health and surgical specialists involved. The ethical considerations to be made with regard to the irreversibility of the intervention are complex. They are explained in Chapter X → *"Annotations on the legal basis and ethical standards for the treatment of minors with gender incongruence*". In particularly complex cases, where the weighing up of options in interprofessional dialogue is difficult or controversial, the advisory involvement of a medical ethics expert should be considered for clarification.

Consensus-based recommendation:

VII.K23.	The recommendation for a gender-affirming mastectomy or surgical breast reduction in adolescents with gender incongruence or gender dysphoria should be determined in multi-disciplinary co-operation. The prerequisite for a recommendation is a careful diagnostic assessment and clarification appropriate to the urgency and complexity of the individual situation by a mental health specialist experienced in the diagnosis and treatment of gender dysphoria in adolescence. The medical part of the recommendation should be made by an experienced specialist in surgical medicine with regard to its prerequisites.

Consensus strength: strong consensus (> 95%)

Consensus-based recommendation:

VII.K24.	The qualification of the specialist for the adolescent mental health part of the recommendation for a gender-affirming mastectomy or breast reduction in adolescents with gender incongruence or gender dysphoria should include one of the following formal qualifications specific to adolescence:

	D: – Specialist designation for child and adolescent psychiatry and psychotherapy – Licence for child and adolescent psychotherapy – Specialist medical title for paediatrics and adolescent medicine with additional qualification in psychotherapy CH: – FMH title in child and adolescent psychiatry and psychotherapy – Federally recognised psychotherapist A: – Specialist in child and adolescent psychiatry or specialist in child and adolescent psychiatry and psychotherapeutic medicine – Registration as a psychotherapist with further training in infant, child and adolescent psychotherapy Or, alternatively, with proven clinical expertise in the diagnosis and treatment of adolescents: D: – Specialist title for psychiatry and psychotherapy, psychotherapeutic medicine or psychosomatic medicine and psychotherapy – Licence for psychological psychotherapy CH: – FMH title in psychiatry and psychotherapy A: – Specialist in psychiatry and psychotherapeutic medicine, specialist in psychiatry and neurology – Registration as a psychotherapist, registration as a clinical psychologist

Consensus strength: strong consensus (> 95%)

Special vote of the German Society for Psychiatry, Psychotherapy, Psychosomatics and Neurology (DGPPN):

The DGPPN is in favour of a stronger level of recommendation regarding the necessary qualifications of the mental health specialist for the recommendation of a gender-affirming mastectomy or breast reduction and proposes the following amended wording:

The qualification of the specialist for the adolescent mental health part of the recommendation for a gender-affirming mastectomy or breast reduction in adolescents with gender incongruence or gender dysphoria **shall** include one of the following formal qualifications specific to adolescence: *(List of qualifications is identical)*

Justification see appendix.

Gender incongruence that has been stable/persistent for several years according to the diagnostic criteria of ICD-11 with concomitant body-related gender dysphoric distress is a basic prerequisite for the recommendation of gender-affirming surgery. There are no valid individual criteria for the persistence/stability of gender incongruence or gender dysphoria that can be expected in the future and cannot currently be derived from the available studies. It is therefore the responsibility of the mental health specialist with experience in the exploration of various gender identity developments in adolescents to develop an individual assessment based on the overall view of the psychological findings and the life history of the adolescent in a joint discussion with the person concerned and their guardians. In complex cases or if the mental health specialist does not (yet) have sufficient specific clinical experience in this field, it is at the discretion of the specialists from both disciplines involved to recommend to the patients and their legal guardians that an additional, more experienced specialist second opinion by a mental health specialist with proven experience is recommended in order to substantiate the recommendation (see recommendation VII.K0 above).

Consensus-based recommendation:

VII.K25.	The prerequisite for the recommendation of a gender-affirming mastectomy or surgical breast reduction should be the presence of a gender incongruence that has been stable/persistent for several years (according to the diagnostic criteria of GI in

	adolescence/ ICD-11: HA60) with gender dysphoric distress combined with a clear desire for a change in the organ or characteristic to be operated on. The careful diagnostic assessment of the stability/persistence of gender incongruence and the desire for treatment should be carried out in collaboration between themental health specialist experienced in the diagnosis and treatment of gender dysphoria in adolescence and the patient and their carers on the basis of careful exploration of the psychological findings and life history.

Consensus strength: strong consensus (> 95%)

As outlined in the preamble to this guideline, both treatment and non-treatment with body-altering interventions can entail irreversible consequential risks for adolescents with gender incongruence. Individual medical ethical considerations must therefore be made in each case. This should involve an age- and development-dependent assessment of the potential benefits of treatment (in terms of preventing an increase in gender dysphoric distress) versus the risks of treatment (side effect profile). The ethical considerations made with regard to the benefits and risks of treatment versus non-treatment must be listed in the recommendation letter (see 6.5 in this chapter → *"Recommended contents of a recommendation letter"*).

Consensus-based recommendation:

VII.K25a.	The justification for the recommendation of gender-affirming mastectomy or surgical breast reduction should contain an ethically reflected risk-benefit assessment based on the individual case, both of the planned intervention and of not performing this intervention or waiting until a later date.

Consensus strength: strong consensus (> 95%)

6.4.1 Procedure for young people with a non-binary gender identity

To date, there is insufficient clinical experience and there are no studies of breast surgery performed on adolescents with non-binary identity and gender dysphoria. Previous experience in adolescents has so far been limited to a few extremely rare individual cases. In principle, it is neither medically nor ethically justifiable to exclude patients with gender incongruence requiring treatment from access to medical care on the basis of their non-binary identification. For this reason, non-binary people are explicitly included in the diagnostic conceptualisations of both the ICD-11 and the DSM-5. Nevertheless, no guideline recommendation for breast surgery can currently be given for adolescents with non-binary identity under the age of 18. This is also a relatively new field of medical care in adulthood, which means that clinical experience and follow-up studies on the treatment outcomes of breast surgery in adult non-binary people with gender dysphoria must be awaited in the coming years, on the basis of which individualised medical advice and information can also be provided for younger patients.

Joint special vote of the Bundesvereinigung Trans*, Trans-Kinder-Netz e.V. and Verband für lesbische, schwule, bisexuelle, trans*, intersexuelle und queere Menschen in der Psychologie e.V.: The three orgamniaztions named above would like to leave a recommendation originally formulated before the consultation phase (see below) unchanged in the guideline:

"The recommendation for a gender-affirming mastectomy or breast reduction should be made regardless of the polarity or binary nature of gender identity and regardless of sexual orientation."

Justification see appendix.

6.4.2 Considerations in special cases

As a rule, gender-affirming surgery in minors is preceded by several years of stable social transition and several months of gender-affirming hormone treatment. The recommendation requires an assessment of the sufficient stability/persistence of the desire for treatment as well as the individual long-term psychosocial viability of a transition. There is no evidence to date for gender-affirming surgery without prior gender-affirming hormone treatment, as previous guidelines stipulated the order of interventions and that gender-affirming hormone treatment was mandatory prior to gender-affirming surgery. Nevertheless, clinical experience shows that in individual cases, for example, there is a stable desire for a mastectomy without prior testosterone treatment. The new WPATH guidelines explicitly mention this possibility for individual cases, even in minors (Coleman et al., 2022a). According to clinical

experience, such cases are more common in people with non-binary gender identity and/or with co-occuring autism spectrum disorder. These cases require particularly careful examination with regard to persistent specific gender dysphoric distress and the stability of the desire for treatment in order to weigh up the health benefits and risks of such a procedure in each individual case. Furthermore, there is no information in the literature on the course of adolescent patients who have undergone gender-affirming surgery without prior social transition. There are clinical reports of cases of adult patients with non-binary identities in which neither social transition nor gender-affirming hormone treatment is desired, but there is a persistent desire for a gender-affirming mastectomy in cases of severe persistent body dysphoria with regard to breasts. In the S3 guideline for adulthood, an individualised approach is recommended for such cases, in which a previous social transition or testosterone treatment is not recommended as a mandatory prerequisite for the recommendation of a mastectomy (DGfS, 2018)

According to the predominantly unanimous opinion of the experts involved in the development of this guideline, in adolescence it is particularly important and should be emphasised that the social viability of the perceived gender identity must be adequately checked and remain stable in the long term before gender-affirming surgery is recommended due to the otherwise largely unforeseeable risks of irreversible damage to health.

Consensus-based recommendation:

VII.K26.	In preparation for a gender-affirming mastectomy or breast reduction in adolescents with gender incongruence or gender dysphoria, social testing of the desired gender role should take place, provided this is compatible with protection against discrimination. In cases where social support from the environment is not sufficient, psychotherapeutic support for the transition process should be offered.

Consensus strength: strong consensus (> 95%)

Special vote of the German Society for Psychiatry, Psychotherapy, Psychosomatics and Neurology (DGPPN):

The DGPPN is in favour of a stronger level of recommendation regarding the offer of accompanying psychotherapy in the transition process if the social environment offers little support and proposes the following amended wording:

In preparation for a gender-affirming mastectomy or breast reduction in adolescents with gender incongruence or gender dysphoria, a social trial of the desired gender role should take place, provided this is compatible with the protection against discrimination. In cases where social support from the environment is not sufficient, psychotherapeutic support for the transition process **shall** be offered.

Justification see appendix.

According to the predominant experience of the experts working in the guideline commission, the first months after the start of gender-affirming hormone treatment for adolescents are often a phase in which further stabilisation of the overall situation of those affected can be seen. An observation phase of at least 6 months prior to gender-affirming breast surgery therefore appears to be suitable to ensure that the persistence of a consolidated gender identity does not change under the impression of hormonally induced body changes. According to the clinical experience of surgeons specialising in gender-affirming breast surgery, breast tissue also changes when testosterone is administered, so that the cosmetic result of gender-affirming breast surgery may be favourably influenced by an interval of several months between the start of hormone treatment and the surgery. According to the overwhelming clinical experience of the experts involved in the development of the guidelines, a period of at least 6 months has proven to be beneficial and is therefore considered sensible by the commission. The current international medical guidelines of the *Endocrine Society* and the *World Professional Association for Transgender Health (WPATH)* make no statement on the recommended minimum duration of hormone therapy.

Consensus-based recommendation:

VII.K27.	In justified individual cases, gender-affirming mastectomy or breast reduction surgery may be considered for adolescents with gender incongruence or gender dysphoria without prior gender-affirming hormone treatment.

Consensus strength: strong consensus (> 95%)

6.4.3 Diagnosis and treatment of associated mental health difficulties

Due to the frequency of mental health difficulties in gender-incongruent or gender-dysphoric adolescents, these disorders should be professionally diagnosed and treated if necessary. Psychosocial support for those affected and their families is essential for a positive course of body-altering treatment and further health development. However, as not all adolescents with gender incongruence are affected by mental disorders, the need for professional psychosocial support must be assessed on an individual basis. Nevertheless, a prerequisite for a professional recommendation for gender-affirming surgery is always a mental health assessment and professional support in order to ensure that any existing mental health problems are adequately diagnosed and treated if necessary and do not interfere with diagnostic certainty or body-altering treatment.

Consensus-based recommendation:

VII.K28.	If, before a gender-affirming mastectomy or breast reduction is recommended, there is a co-existing mental disorder that goes beyond the gender dysphoria and interferes with the treatment, a professional mental health intervention should be recommended as part of an integrated or networked treatment concept.

Consensus strength: strong consensus (> 95%)

Special vote of the German Society for Psychiatry, Psychotherapy, Psychosomatics and Neurology (DGPPN):

The DGPPN advocates a stronger level of recommendation for the networked treatment of a co-occurring mental disorder and for the joint prioritisation of treatment steps if a gender affirming mastectomy or breast reduction is planned, and proposes the following amended wording:

If, before a gender-affirming mastectomy or breast reduction is recommended, there is a co-occurring mental disorder that goes beyond the gender dysphoric distress and interferes with the treatment, a professional mental health intervention **shall** be recommended as part of an integrated or networked treatment concept. **The treatment steps shall be prioritised in dialogue with the patient.**

Justification see appendix.

6.4.4 Important contents of patient education and informed consent

Before a gender-affirming mastectomy or breast reduction surgery is recommended for adolescents with gender incongruence or gender dysphoria, patients and their legal guardians must be fully informed about the possible consequences and complications of the operation as well as the possible effects on their physical experience, relationship experience, sexuality and ability to breastfeed. Possible advantages, disadvantages and risks of gender-affirming surgery must be pointed out and weighed up together with the patient and their legal guardians. Care should also be taken to provide information at an early stage about the available options for cryopreservation to preserve the patient's own reproductive capacity in the event that genital reassignment surgery is desired at a later date. When providing information, it should be pointed out that the desire to have children often changes over the course of a person's life and that not undergoing cryopreservation harbours the risk of a later unfulfilled desire to have children.

Given the implications of a decision in favour of an irreversible surgical procedure, it is essential that underage patients are able to give their informed consent on their own responsibility. This in turn requires a professional individual assessment of their capacity to consent[13]. This includes careful

[13] Translator's note: In the German speaking region the legal terms for a minor's capacity to consent to medical treatment are different in each country: Germany – *Einwilligungsfähigkeit (engl. capacity to consent)*; Austria – *Entscheidungsfähigkeit (engl. capacity of decision-making*; Switzerland – *Urteilsfähigkeit (engl. capacity of judgement)*. In the English translation only the term *capacity to consent* is used.

consideration of the irreversibility of the procedure, including the risk of later regretting the decision in the event of detransition (see Chapter X → *"Annotations on the legal basis and ethical standards for the treatment of minors with gender incongruence*").

Consensus-based recommendation:

VII.K29.	The recommendation for gender-affirming surgery in adolescents with gender incongruence or gender dysphoria should include an assessment of the patient's capacity to consent by an adolescent mental health specialist. If the capacity to consent is not sufficient, the minor should be supported in acquiring this capacity.

Consensus strength: strong consensus (> 95%)

Consensus-based recommendation:

VII.K30.	If the minor has capacity to consent, a co-consensus with the legal guardians should be sought

Consensus strength: strong consensus (> 95%)

Special vote of the German Society for Psychiatry, Psychotherapy, Psychosomatics and Neurology (DGPPN):

The DGPPN is in favour of a stronger level of recommendation to strive for co-consensus with guardians before body-altering medical interventions and proposes the following amended wording:

If the minor has the capacity to consent, a co-consensus with the legal guardians **shall** be sought.

Justification see appendix.

Consensus-based recommendation:

VII.K31.	In cases where there is no co-consensus between the patient and their legal guardians, intensive process support for the family system should be offered by a suitable specialist with the aim of facilitating support for the patient. Such process support is only recommended if no harmful effects on the health/psychological well-being of the patient are to be expected.

Consensus strength: strong consensus (> 95%)

If in individual cases, despite intensive counselling, no co-consensus can be reached between the affected person and their legal guardians regarding the performance of a desired and professionally recommended masculinising breast operation, a complex dilemma arises with regard to the health risks. The long-term psychosocial implications of an ongoing conflict between an adolescent trans person and their parents over the question of support for a self-determined life path are considerable for both sides and therefore do not appear to be resolvable solely in the interests of the adolescent's health and well-being by means of revoking parents their custody rights. On the other hand, persistent suffering implies an increased risk of negative health consequences if professionally recommended medical treatment is not carried out. In such cases, intensive psychosocial interventions should be considered in the primary interest of the minor's health in order to support them on the path to shaping their life in accordance with

their gender identity. In individual cases, this may also include therapeutic support for a necessary process of psychological separation from their parents. If a conflict remains unresolvable despite all professional efforts, it is the responsibility of the youth welfare agency to initiate appropriate steps establishing the interests of the child's well-being. The legal requirements of the respective country that must be observed in the case of a minor patient with full capacity to consent when assessing whether and how they can make a solely responsible and self-determined decision are explained in Chapter X → *"Annotations on the legal basis and ethical standards for the treatment of minors with gender incongruence*".[14]

[14] Translator's note: In the German speaking region the legal terms for a minor's capacity to consent to medical treatment are different in each country: Germany – *Einwilligungsfähigkeit (engl. capacity to consent)*; Austria – *Entscheidungsfähigkeit (engl. capacity of decision-making*; Switzerland – *Urteilsfähigkeit (engl. capacity of judgement)*. In the English translation only the term *capacity to consent* is used.

6.5 Recommended contents in a clinical recommendation letter

In line with the recommendations explained in this chapter, the following is a summarised list of what should be included in a recommendation letter from a child and adolescent mental health professional for body-altering interventions in adolescence (i.e. puberty suppression, gender-affirming hormone treatment or breast surgery). Such a recommendation letter should contain information on the following points, which are comprehensible for the other clinicians who are responsible for the medical part of a recommendation to be provided on a multi-disciplinary basis:

- Ethical assessment of the individual case, taking into account the expected benefits and potential risks of treatment and non-treatment with individual justification of the necessity of the recommended intervention
- Diagnostic assessment of stable/persistent gender incongruence together with justification based on the developmental history to date
- Previous and existing or anticipated gender dysphoric distress
- Previous or planned social role testing or social transition
- Mental health status and, if present, information on any co-occuring mental health difficulties or disorders
- in the case of co-occurring mental disorders: diagnosis and assessment of interdependence with gender dysphoria (individualised clinical formulation of explanatory model) and integrated treatment plan
- Persistent and reflected desire for medical intervention
- Differentiated assessment of capacity to consent on the basis of informed consent to the desired treatment
- Information provided to the patient about the possible prospect of a later detransition
- Information provided on the possible effects of treatment on subsequent fertility and options for fertility protection
- Information provided about possible risks of the treatment (e.g. risk of discrimination, risk of detransition)
- Information on the support of the family and social environment for the further course of the transition, including co-consensus of the guardians

Chapter VIII

Somatic aspects of hormonal interventions

1. Introduction and key questions

Hormonal interventions as part of a staged and development-oriented treatment of adolescents with persistent gender incongruence (GI) or gender dysphoria (GD) are complex interventions in the course of pubertal development that require a careful individualised recommendation. This includes a risk-benefit assessment tailored to the circumstances of the individual case. The experts involved in the preparation of this guideline predominantly share the views of the current international guidelines of the *Endocrine Society* (Hembree et al., 2017) and the *World Professional Association for Transgender Health (WPATH;* Coleman et al., 2022). According to these, a generalised risk-benefit assessment based solely on study data cannot do justice to the complexity of medical decision-making situations in this field, particularly for the use of puberty blockers.

This ambiguous risk-benefit balance for the use of puberty blockers means that puberty-suppressing hormone blockers are only recommended by the NHS England, for example, in the context of clinical studies (see chapter on critical discourse and deviating recommendations in other countries in the appendix). The treatment principles applied there to date deviate considerably in some cases from internationally established *best practice* (Pang et al., 2022). For example, until April 2024, every adolescent diagnosed with GD in England had to undergo puberty blockade for at least twelve months before recommended gender affirming hormone treatment could begin. Due to the extremely long waiting times, many patients are already 16 years or older when treatment begins. They are therefore at an age at which the benefits of puberty blockade are questionable due to the fact that they have largely completed their sexual maturation, while undesirable menopausal side effects predominate (Hembree et al., 2017; O'Connell et al., 2022).

It is because such outdated treatment recommendations from past decades have been included in the available study data that they contribute to the ambiguous evidence base.[1] To give hormonal interventions for the staged treatment of adolescents with diagnosed persistent GI or GD, the expected benefits and risks to be considered need to be weighed up on a case-by-case basis. Among other things, the stage of pubertal maturity at the start of treatment and the extent and duration of the gender dysphoric distress must be taken into account. If puberty blockade is being considered, the planned time limit is an important aspect to consider, along with the background of possible undesirable side effects.

[1] A tabular list of all systematically reviewed studies on outcomes and side effects of puberty blockade with information on the age of the study participants at the start of the study (mean or median and range) is presented in the appendix to the methods report.

The following three key questions were formulated a priori by the guideline commission for this chapter:

Key questions on somatic aspects of hormonal interventions in adolescence:

- Which somatic aspects need to be taken into account in the endocrinological part of the recommendation, patient education and individual planning of hormonal interventions in adolescence?
- Can treatment with GnRH analogues for pubertal suppression in adolescents with persistent GI/GD be considered sufficiently safe with regard to known risks?
- Can gender-affirming hormone treatment with testosterone or oestrogen in adolescents with persistent GI/GD be considered sufficiently safe with regard to known risks?

The prerequisite for starting hormonal treatment is always an interdisciplinary professional assessment as basis of the recommendation to be made by qualified medical or psychotherapeutic specialists who have sufficient experience with the topic (see Chapter VII → "*Guidance for recommending body-altering medical interventions*"). The desired and realistically achievable goal of hormonal treatment must be examined in each individual case and weighed up together with the risks to be considered with the patient and their legal guardians.

2. Treatment with GnRH analogues (puberty blockers)

2.1 Goals of puberty suppression

As explained in the previous chapter VII → "*Guidance for recommending body-altering medical interventions"*, according to the recommendations of current international medical guidelines, when a comprehensive mental health assessment has identified persistent GI with gender dysphoric distress in an adolescent, temporary puberty-suppression may be considered from Tanner stage 2 of pubertal development at the earliest (Coleman et al., 2022; de Vries et al., 2006; Hembree et al., 2017). Alternatively, if pubertal maturation is already more advanced, suppressive hormone treatment (e.g. antiandrogens in trans female adolescents) can be considered to counteract the progressive development of secondary sex characteristics or to suppress menstruation with a *progestogen preparation* in trans male adolescents (see section 3 "Alternatives to puberty suppression" below).

The medical intervention of puberty blockade (see below) merely *prevents the progression of pubertal maturation*, i.e. the development of secondary sex characteristics which have already begun, and are *halted* for a limited period of time at the stage they were at at the start of treatment. In the

case of early puberty - there may be a slight regression of the signs of puberty (such as reduced breast development or testicular volume). The basic aim behind this is to alleviate the main focal point of gender dysphoric distress, i.e. the progressive masculinisation or feminisation of physical appearance. Although female or male sex characteristics may have already developed (e.g. female breast growth in trans-male adolescents or male voice change in trans-female adolescents), the focal point of the distress remains unchanged under puberty blockade, i.e. only its *aggravation* is prevented. This should be put into perspective when defining outcome measures in studies investigating the isolated effect of puberty blockade (Cass, 2022). For example, it may be a realistic goal to keep a state of mental health that existed before treatment reasonably stable, i.e. *to prevent it from deteriorating*. This must be taken into account when evaluating the weak evidence for positive change effects of puberty suppression alone on mental health parameters in this regard. This could explain why, comparing the weak evidence for the sole benefit of temporary puberty blockade, the evidence for positive outcomes for mental health is much clearer and more consistent in *studies on gender affirming hormone treatment* as well as on the long-term outcome of the "overall package" of *staged transition treatment beginning* in *adolescence, including subsequent gender affirming surgery* (see comments on the study situation in Chapter VII → "*Guidance for recommending body-altering medical interventions"*).

When considering individual cases, young people with persistent GI can experience lifelong health disadvantages if puberty progresses (German Ethics Council, 2020), for example through long-term stigmatising physical appearance on account of the increased GD and increased impairment of psychosocial participation, for instance when entering into romantic relationships, going to the beach or swimming pool, etc. One of the aims of temporary puberty suppression in adolescents is to gain time for psychological maturation and further reflection before a decision can be made to embark upon gender affirming hormone treatment (Brik et al., 2020; van der Loos et al., 2022). This time may be required, among other things, to achieve the necessary capacity to consent (D)/capacity to make decisions (A)/capacity for judgement (CH), i.e. the ability to make an informed decision before a partially irreversible gender affirming intervention is initiated (see Chapter VII → "*Guidance for recommending body-altering medical interventions"*).

If there is a high probability of permanent persistence of GI at the start of treatment, the resulting appearance of a young trans person will largely correspond to their perceived gender subsequent to the initiation of subsequent gender affirming hormone treatment much more so if pubertal development has been halted in its early stages. This means that they can largely be spared the lifelong stigmatisation resulting from the physical characteristics of the gender assigned at birth. In addition, later gender affirming surgeries such as mastectomies, laryngectomies, beard epilations

or maxillofacial surgery are often no longer necessary if puberty suppression begins early (van de Grift et al., 2020).

2.2 Pharmacodynamics and pharmacokinetics of GnRH analogues

Depot GnRH analogues suppress the gonadotropins very effectively and thus also the production of sex hormones from the testicles and ovaries (Mejia-Otero et al., 2021; Schagen et al., 2016). In this way, physical changes such as male voice change, beard growth or female breast growth can be prevented or halted. By preventing the progression of irreversible masculinisation or feminisation of the physical appearance (see above), the suffering of those affected should be relieved.

The depot GnRH agonists are released continuously from microcapsules and *block* the GnRH receptors of the pituitary gland through a prolonged half-life and lead to a decrease in the number of GnRH receptors and the sensitivity of the LH- and FSH-producing cells (for a detailed description of the pharmacodynamics, see Lahlou et al., 2000). As it is an agonist, puberty is activated at the start of therapy with an increase in gonadotropins. To shorten this *flare-up phase*, the interval between the first two injections can be shortened. In approx. 80% of those treated, there is a complete suppression of the gonadotropic axis after six months.

GnRH analogues are effective in suppressing gonadotropins (and thus downstream sex steroids) in both trans male and trans female adolescents (de Vries et al., 2011). As a rule, leuprorelin depot 11.25 mg every three months or 22.5 mg s.c. every six months is used, alternatively triptorelin depot 22.5 mg i.m. every six months.

2.2.1 Laboratory checks to be carried out

Gonadotropins are usually suppressed during treatment with GnRH analogues. Even with insufficient suppression, menstrual bleeding almost always stops in treated trans male adolescents. A suitable indicator of effective pubertal suppression is a suppressed estradiol or testosterone level in the prepubertal range. Laboratory checks should be carried out every six months.

2.3 Possible impact on the growth forecast

The increasing concentrations of sex hormones during puberty not only induce the progressive development of secondary sexual characteristics, but also influence bone growth (pubertal growth spurt). Suppression of puberty can therefore cause a slowdown in the rate of growth (Schulmeister et al., 2022) - however, the epiphyseal plates remain open longer in return. This can lead to an increased adult height if used for several years, which can be problematic for trans female adolescents in particular. However, recent studies have shown that temporary treatment with GnRH analogues

followed by gender-affirming hormone treatment had no relevant long-term effects on adult final height in adolescents in either sex (Boogers et al., 2022; Willemsen et al., 2023).

2.4 Effects on fertility

If puberty suppression using GnRH analogues is carried out at an early pubertal stage, this usually results in *permanent infertility* due to a lack of maturation of the gonads and reproductive tract in the event of subsequent gender-affirming hormone treatment, whereby the oocyte/spermatogonia reserve is preserved (Feil et al., 2023). Before starting puberty-blocking treatment, the question of possible future reduced fertility should therefore be discussed in detail and medical counselling on *medical options for fertility protection* should be offered (see explanations in Chapter VII → "*Guidance for recommending body-altering medical interventions"*). Raising awareness of this is important in order to be able to keep the option of biological reproduction open for a young person at a later stage and to ensure they have sufficient information. In cases where oogenesis or spermatogenesis has not yet taken place by the time of menarche or spermarche, which in turn would be a prerequisite for being able to obtain eggs or sperm for cryopreservation, considerations in this regard can influence a decision on the question of whether the desired and recommended puberty suppression should be started. This must be carefully weighed against the existing gender dysphoric distress with regard to the health of the young person and the associated urgency of starting treatment. The young person concerned and their legal guardians must be involved in this consideration process (see explanations in Chapter VIII → "*Annotations on the legal basis and ethical standards for the treatment of minors with gender incongruence*").

To date, the rate of utilisation of fertility preservation measures in the form of cryopreservation among adolescents with GI who are seeking hormone therapy is still very low. In a study by Nahata et al. (2017), out of 72 trans adolescents, only two birth-gendered males (i.e. trans female adolescents) requested fertility preservation. This finding is remarkable in comparison to surveys of adult trans people: in a comparative multi-centre survey in Germany (*N* = 99 trans female; *N* = 90 trans male), adult trans people of both genders stated significantly more frequently that they were considering having children (trans women approx. 70%, trans men 47%) and that they were therefore looking for information on the possibilities of fertility preservation measures (Auer et al., 2018). However, only 10% of trans women and 3% of trans men in this study stated that they had actually decided in favour of cryopreservation of gametes after obtaining information (Auer et al., 2018). In addition to the fact that starting testosterone treatment preserves the functionality of the ovaries for later reactivation in the event of a desire to have children, two main reasons are given for

the very low proportion of trans men: firstly, the legal ban on egg donation in Germany, and secondly, the possibility that within a partnership with a cis woman, a joint desire to have children could realistically be realised through anonymous sperm donation (Auer et al., 2018).

Trans women still have the option of cryopreserving testicular tissue when the testicles are removed as part of gender affirming surgery, as there are isolated mature and mostly immature germ cells (if at least pubertal development stage G4 was reached before the start of hormone treatment), which can be used for later fertilisation purposes (de Nie et al., 2022).

It can be assumed that young people's attitudes towards their own reproductive capacity may change in adulthood, which emphasises the importance of comprehensive education that anticipates this. Fertility preservation counselling for young trans people is a relatively new and developing field in medical care. It is expected to become increasingly important in the coming years - and thus also in future medical guidelines (for current reviews, see Lai et al., 2020; Nahata et al., 2017; Quinn et al., 2021). According to current experience reports, adolescents with GI and their guardians predominantly view targeted information and professional support in the decision-making process for or against fertility-preserving measures before or at the start of hormonal treatment positively (Boguszewski et al., 2022). If targeted reproductive counselling is provided, there is a particularly high chance that trans girls will opt for sperm cryopreservation and trans boys for egg donation (Segev-Becker et al., 2020).

Consensus-based recommendation:

VIII.K1.	Before starting puberty-suppressing or gender-affirming hormone treatment, the patient should be informed about the possibility of impaired fertility as a result of the treatment and the possibility of fertility-preserving measures.

Consensus strength: strong consensus (> 95%)

2.5 Possible effects on sexual sensitivity

With regard to the effects of hormonal interventions in adolescence on later sexual satisfaction and sensitivity, the research findings are inconsistent. Direct negative effects of hormonal

interventions alone have not yet been proven. From the clinical experience of the experts involved in developing the guidelines, it is known that trans male adolescents who have started testosterone treatment often report an increase in libido with increased sexual desire. As these adolescents are sometimes sexually active in relationships with male romantic partners, which can include vaginal sexual intercourse (in which they usually still experience themselves as male), sexual activities should be enquired about and, if necessary, the need for contraception should be pointed out, especially as ovulation is not reliably prevented during testosterone treatment. Trans female adolescents undergoing oestrogen treatment mainly report that spontaneous erections decrease, although this is usually experienced as positive. In a recent study on the subsequent sexual satisfaction and sensitivity of adults after undergoing both hormonal and surgical gender affirming treatments, it was reported that sexual sensitivity correlates in particular with general satisfaction with physical appearance (Gieles et al., 2023).

This would tend to speak in favour of starting hormonal treatments in adolescence, as this is expected to lead to better results in terms of later satisfaction with one's own physical appearance and the associated experience of congruence as a male or female person.

2.6 Possible effects on the performance of subsequent genital reassignment surgery

It is recognised that the starting of puberty-suppressing treatment in early puberty in trans female patients followed immediately by gender-affirming treatment with oestrogen could be disadvantageous for those affected if gender-affirming surgery is performed at a later date, as pubertal penile growth is interrupted and therefore less penile skin may be available later for the formation of a sufficiently deep neovagina (Khatchadourian et al., 2014). Alternative solutions include augmentation with a free skin graft of the scrotum. If more extensive skin tissue is required and the scrotal skin is not sufficient due to a hypoplastic scrotum as a result of early pubertal blockage, augmentation with a free skin graft, e.g. from the lower abdomen, may be an alternative. However, its removal can leave larger visible scars (Buncamper et al., 2017). In a review, it was reported that there was no significant difference in vaginal depth and patient satisfaction with or without a free skin graft with the alternative surgical techniques mentioned (Buncamper et al., 2017). Another established option is the creation of a primary sigmoid vagina (Bouman et al., 2016). Overall, these alternative options therefore do not directly mitigate against the early starting of puberty-suppressing treatment. Please refer to the current S2k guideline "*Gender-affirming surgery for gender incongruence and gender dysphoria*" for information on the options for genital reassignment surgery after early puberty-blocking treatment.

However, the information that the choice of available surgical procedures may be smaller in the case of a later desired genital reassignment surgery in trans female patients is important (van de Grift et al., 2020) and must be weighed against the long-term consequences of waiting longer with regard to later satisfaction with the physical appearance. In the course of this consideration, it must be borne in mind, particularly in trans female patients, that an irreversible voice change could occur as biological maturity progresses. The result would be a lifelong deep or male-sounding voice. This is often perceived by those affected as a permanent stress burden that restricts their lifestyle and well-being.

2.7 Possible undesirable side effects of GnRH analogues

In the experience of the clinical experts involved in this guideline, undesirable somatic side effects are very rare when used correctly, particularly with endocrinological monitoring and a reasonably limited duration of treatment. Local reactions such as subcutaneous hardening, haematomas or allergy-related papules may occur at the injection sites; in very rare cases, abscess formation may occur. Adolescents who are already at an advanced stage of pubertal maturation at the start of treatment may experience *menopausal symptoms* such as hot flushes, sweating, mood swings, anhedonia and (less frequently) headaches during treatment with GnRH analogues. This must be taken into account in advanced pubertal development when *weighing up the individual risks and benefits.* In trans-male adolescents in particular, menopausal symptoms caused by the drop in estradiol are to the fore. These often improve within a few weeks or months. Nevertheless, in view of these side effects, the use of a progestogen preparation is preferable in trans male adolescents if their menses are to be suppressed as a priority to reduce GD (see below).

2.7.1 Effects on juvenile bone metabolism

Long-term suppression of sex hormones in adolescence through GnRH analogue treatment could lead to the development of osteoporosis. Puberty blockade has an effect on the bones. Four studies (Joseph et al., 2019; Klink et al., 2015; Schagen et al., 2020; Vlot et al., 2017) examined, among other things, bone density after puberty blockade and subsequent gender-affirming hormone administration. What the studies have in common is that a significant decrease in absolute bone density was observed during puberty blockade. In the study by Klink et al. (2015) with 15 trans female and 19 trans male patients (average age at the start of PB 15.0 years, range: 11 - 18 years), a temporary statistically significant reduction in bone density was observed in the period between the start of puberty blockade and the start of treatment with gender affirming hormones (average duration 1.5 years) compared with the normal sample in the group of trans male adolescents. In the further course of the subsequent gender affirming hormone treatment, this difference in the trans male persons as

compared with the normal sample wa reduced again significantly and the values reached the average normal range of an age cohort for the natal sex. In the group of trans female adolescents, there were no statistically significant changes in bone density compared with the normal sample during the study period. In the study by Vlot (2017*; N* = 28 trans female and *N* = 42 trans male; average age at the start of treatment 13 years, range: 12 - 14 years), the t-value for bone density decreased statistically significantly for both reported genders in the period between the start of puberty blockade and the start of gender affirming hormone treatment (duration for trans female adolescents *M* = 2.5 years and for trans male adolescents *M* = 1.2 years). It increased again statistically significantly for both groups within the first 24 months after the start of the gender affirming hormones and reached the normal range for adult trans women on average for adult cis men. For adult trans men, however, bone density after 24 months was on average still below the population average for cis women. In the study by Joseph et al. (2019*; N* = 10 trans females and *N* = 21 trans males; mean age at onset 15.1 years, range: 12 - 14 years), it was shown over a period of three years under puberty blockade (without gender affirming hormones) that bone density was statistically significantly reduced. In this study, the recompensation effect of subsequent gender affirming hormone treatment was not investigated.

Schagen et al. (2020) report a similar pattern (*N* = 10 trans female and *N* = 21 trans male; mean age at onset 15.1 years): *Initially*, there was a statistically significant reduction in bone density under pubertal blockade (mean duration: 1.89 years), which the trans male adolescents, however, fully compensated for under later gender affirming hormone treatment, but the trans female adolescents tended not to fully compensate for this.[2]

Another study (Lee et al., 2020) showed that children and adolescents with GI or GD already had lower bone density *before puberty blockade*, which was attributed to reduced physical activity. The cause is assumed to be the frequently limited enjoyment of sporting activities in adolescents with GD. The bone structure of trans boys is similar to that of cis boys if, after GnRH analogue treatment started at an early age, sex-suppressing hormone treatment is carried out for at least two years. If the suppressive treatment was started at an advanced stage of puberty, this effect is not evident (van der Loos et al., 2022).

Navabi et al. (2021) showed a reduction in bone density under treatment with GnRH analogues, but there was no evidence of an increased fracture rate in the group studied. Only 44.7% of the adolescents had a sufficient serum vitamin D concentration, so that a recommendation for

[2] This was exactly the reverse of the above-mentioned study by Klink et al.(2015)

appropriate supplementation was made. In a study by Tack et al. (2018), the use of antiandrogens (cyproterone acetate) led to a reduction in bone density in the lumbar spine in trans girls, whereas progestogens (lynestrenol) did not affect bone density in trans boys.

2.7.2 Other physical side effects

In another study (Schagen et al., 2016), physical health parameters were regularly recorded in *N* = 49 trans female and *N* = 67 trans male adolescents (average age: 13.9 years, range: 11-18 years) from the start of puberty blockade over a total of 12 months. Neither liver nor kidney parameters increased significantly as a result of the puberty blockade, but actually decreased in line with the trend. The BMI SDS (age-standardised body mass index) increased statistically significantly in trans male adolescents, but not in trans female adolescents. There was a statistically significant increase in body fat percentage for both groups, but this was not compared with a comparison sample or an age norm. It therefore remains unclear whether the increase is due to the pubertal blockade. Diastolic blood pressure increased significantly in trans boys under GnRH analogue treatment (however, the criteria for arterial hypertension were not met), but later decreased under testosterone treatment. (Perl et al., 2020). In further follow-up studies, no serious side effects were found in treated adolescents over a period of at least six months and up to 24 months (Jarin et al., 2017; Olson-Kennedy et al., 2018; Tack et al., 2016, 2017).

Most of the study results on potential undesirable side effects of puberty blockers are based on outdated treatment protocols, according to which puberty blockers had to be used for at least one year before gender affirming hormone treatment was permitted during adolescence, which in turn had only been recommended from the age of 16 at the earliest (see above). In the majority of cases investigated, this led to puberty blockers being used for too long and at too old an age of maturity from an endocrinological perspective with regard to a favourable risk-benefit ratio, i.e. at an age of over 15 years at which the risk-benefit balance may produce undesirable side effects. The following recommendation serves to ensure that an appropriate risk-benefit ratio is sought in each individual treatment situation with regard to undesirable somatic side effects of temporary puberty suppression.

Consensus-based recommendation:

VIII.K2.	The duration of puberty-suppressing treatment should be limited on a case-by-case basis in order to minimise potentially undesirable long-term somatic effects, particularly on bone mineralisation. The recommendation on an acceptable duration of treatment should be made in cooperation between the endocrinological and psychiatric/psychotherapeutic specialist.

Consensus strength: strong consensus (> 95%)

In summary, there is evidence that puberty blockade may have an effect on bone density despite subsequent gender-affirming hormone treatment. Therefore, a medically justifiable time limit for puberty blockade is important in order to avoid somatic risks.

Consensus-based recommendation:

VIII.K3.	Before treatment with GnRH analogues for puberty suppression, the patient should be informed about possible side effects such as hot flushes and - in the case of several years of treatment - the development of osteoporosis.

Consensus strength: strong consensus (> 95%)

2.7.3 Possible effects on psychosexual development

The extent to which pubertal suppression with GnRH analogues in adolescents diagnosed with persistent GI after the onset of puberty can influence the further development of gender identity by preventing the physiological influence of steroid hormones on juvenile brain development is unclear. Hormonal influences on the development of *gender-typical role behaviour* in pubertal gender-conforming adolescents are known. However, there is no evidence to date that steroid hormones can still have an altering influence on an existing sense of belonging to a gender after the onset of puberty.

However, such a potential influence of steroid hormone levels on the course of later gender identity development is very likely in pre- and postnatal brain development. For example, in DSD individuals[3] with adrenogenital syndrome who were assigned female gender after birth, it was shown that an increased *postnatal androgen level* increased the probability of later male identity development (Meyer-Bahlburg et al., 2008). In contrast, no increased rates of GI (female to male) are known to date, e.g. among adolescent girls or women with post-pubertal hyperandrogenism (e.g. polycystic ovary syndrome as its most common cause), which rather suggests that steroid hormone levels no longer influence the sense of gender identity after the onset of puberty.

On the other hand, cohort studies and case reports have shown that GI can persist in individual cases even after the onset of puberty blockade (Brik et al., 2020; Rölver et al., 2022). This suggests that an open-ended or ongoing fluid development of gender identity is also possible under puberty blockade. However, as inhibitory influences on psychosexual development cannot be ruled out with certainty, the use of puberty blockers is contraindicated in the case of a diagnostically vague picture in the sense of an *identity that is* still *uncertain* with regard to gender. For an adequate recommendation, it is therefore necessary in any case that, according to diagnostic assessment, a stable persistent GI can be assumed with a high degree of probability after the onset of puberty (see explanations in Chapter VII → "*Guidance for recommending body-altering medical interventions*").

3. Alternatives to puberty suppression in adolescence before starting gender affirming hormone treatment

3.1 Treatment with progestogens when pubertal maturation has been already largely completed

For the suppression of menses in trans male adolescents, progestogen-containing oral contraceptives such as desogestrel (75µg daily). Drospirenone (4 mg daily), chlormadinone (2 mg daily), dienogest (2 mg daily), dydrogesgterone (10 mg daily) or lynestrenol (5 mg daily) are an orally applicable and cost-effective alternative to GnRH analogues (Tack et al., 2016). Lynestrenol is currently not available on the German market, but can be obtained from international pharmacies (although it is not reimbursable for patients with statutory health insurance). Regularity (and even daily punctuality) in taking the tablets is important for effective menses suppression. However, vaginal (spotting) bleeding sometimes occurs during this treatment. In most cases, doubling the dosage of the above-mentioned progestogens stops the menstrual or spotting bleeding.

[3] DSD (disorders of sex development): Spectrum of variants of sex development (also known as intersexuality)

Consensus-based recommendation:

VIII.K4.	If pubertal maturation has already been largely completed, pills containing progestogen can be used in the long-term cycle to suppress menstrual bleeding in trans boys with GD.

Consensus strength: strong consensus (> 95%)

3.2 Treatment with antiandrogens

In trans female adolescents whose male puberty is already advanced (voice change, adult testicular volume, increased body hair), antiandrogens such as cyproterone acetate can be used temporarily to suppress the androgen effect, e.g. on beard growth and male body hair (e.g. if time is still needed to prepare for oestrogen treatment or for overlapping treatment when oestrogen levels are gradually building up) (Tack et al., 2017). These drugs not only have a peripheral anti-androgenic effect, but also suppress the release of gonadotropins and subsequently testosterone centrally. Since the beginning of 2020, there has been a warning from the EMEA that one to ten additional meningiomas occur in 10,000 patients treated with cyproterone acetate - especially with several years of therapy with high doses above 25 mg/day (Weill et al., 2021). Observations have also been reported that cyproterone acetate can have a negative effect on bone density, especially in the lumbar spine (Tack et al., 2018). Other antiandrogens can also be used as an alternative to cyproterone acetate, such as spironolactone (Tangpricha & den Heijer, 2017), finasteride as a 5-alpha-reductase inhibitor (Spack, 2013) or bicalutamide (Neyman et al., 2019).

Consensus-based recommendation:

VIII.K5.	Antiandrogens can be used to reduce the androgen effects in trans female adolescents with persistent GI or GD and largely completed pubertal maturation.

Consensus strength: strong consensus (> 95%)

4. Gender-affirming hormone treatment

Although the suppression of puberty, which is experienced as incongruent with one's own gender identity, through the use of GnRH analogues usually leads to a temporary de-actualisation of psychological distress in gender dysphoric adolescents, this can only be a responsible, temporary postponement of the decision as to whether gender affirming hormone treatment is desired and recommended, and when it should be initiated. Adolescents who are treated with puberty blockers because of their GI experience an increasing discrepancy between their own stalled physical maturity development and the advancing puberty of their peers (Cohen-Kettenis & van Goozen, 1998).

The absence of the desired secondary sexual characteristics corresponding to the perceived gender identity is usually perceived as more and more stressful with advancing age. Most adolescents then want to undergo gender affirming hormone treatment to change their body and adapt it to their perceived gender. This second step of a staged medical transition treatment must be prepared for separately, including a careful review of the recommendation based on the progression of gender identity development in the meantime. In rare individual cases, this review may lead to a differing reassessment of the transition pathway taken by the adolescent, including desistance (see case example in Chapter VII → "*Guidance for recommending body-altering medical interventions";* Rölver et al., 2022). During the diagnostic assessment as part of the recommendation, the question again arises as to the extent to which adolescents already have the necessary psychological maturity to be able to assess the implications of the pending decision, including how the desired physical changes will affect their future life and, in particular, their sexuality and fertility (see explanations in Chapter VII → "*Guidance for recommending body-altering medical interventions"*).

4.1 Gender-affirming hormone treatment for trans-male adolescents

The masculinisation of the body of trans male adolescents is achieved by testosterone, which is available in various forms of administration. Growth in height and skeletal age must be taken into account when increasing sex steroids. In trans male adolescents undergoing treatment with GnRH analogues, puberty induction can be carried out in accordance with the available guidelines for the treatment of delayed puberty or hypogonadism (Nordenström et al., 2022; DGKED, 2021). A slower increase in testosterone dosage is recommended for trans male adolescents who have not yet reached adulthood in order to prevent the epiphyseal plates from closing too quickly. Before starting therapy, the bone age should be determined using an X-ray of the left hand. The equivalent *puberty induction process* can be started with transdermal testosterone at 10 mg/day, which can then be increased to 25 mg/day after six months (also depending on bone age). In rare cases, 50 mg/day must be used to

achieve a concentration in the adult male normal range. The testosterone gel should be rubbed into the inside of the forearms every day; alternatively, it can also be applied to the inside of the thighs. *(Added note in English translation:* Each preparation differs on their recommended application process.)

Consensus-based recommendation:

VIII.K6.	Growth and skeletal age should be taken into account during gender-affirming hormone treatment with testosterone. In growing trans male adolescents, the dosage of testosterone can be increased more slowly than in adolescents who are already fully grown, taking into account the growth prognosis.

Consensus strength: strong consensus (> 95%)

Special vote of the German Society for Psychiatry, Psychotherapy, Psychosomatics and Neurology (DGPPN):

The DGPPN is in favour of a stronger recommendation regarding the consideration of longitudinal growth and skeletal age in trans male adolescents and proposes the following amended wording:

Growth and skeletal age **shall be** taken into account during gender-affirming hormone treatment with testosterone. In growing trans male adolescents, the dosage of testosterone can be increased more slowly than in adolescents who are already fully grown, taking into account the growth prognosis.

Justification see appendix.

Testosterone enantate in ampoules of 250 mg is also available for treatment. Pubertal induction begins with 50-100 mg testosterone antate intramuscularly once a month for the first 6 months in not yet fully grown trans-male adolescents. During the slow increase in dosage, overlapping treatment with GnRH analogues is recommended, in particular to avoid painful vaginal bleeding.

Long-term hormone replacement therapy involves testosterone administration of 250 mg testosterone antate i.m. every three to four weeks. This testosterone is usually administered intramuscularly, but subcutaneous injections are also possible (Laurenzano et al., 2021). Alternatively,

1000 mg testosterone undecanoate can be administered as a depot preparation i.m. every three to four months. The trough level determines whether the application interval is shortened or extended. The aim is to achieve a testosterone level in the adult male normal range. If polycythaemia occurs (haematocrit over 50%), the interval should be extended.

If a trans male adolescent patient is already fully grown, a full substitution dose can be started (testosterone undecanoate 1000 mg every three months. *Saturation* after six weeks, as recommended for male hypogonadism, is not necessary. Patients with obesity and high blood pressure should rather be treated with a transdermal preparation, as there appears to be an increased cardiovascular risk for this group of people (Seal, 2007).

Previous treatment with GnRH analogues can be discontinued after testosterone has been increased; vaginal bleeding then only occurs very rarely. However, menstrual bleeding may recur despite a suppressed gonadal axis if, for example, a high level of testosterone is aromatised to oestrogen in the fatty tissue. Ovarian cysts can also cause an increase in oestradiol. This can cause the endometrium to build up, which then results in menstrual bleeding in the event of hormone fluctuations. If vaginal bleeding occurs during testosterone treatment, which can occur in around 25% of trans boys (Grimstad et al., 2021), and if the gonadotropins and/or estradiol are not suppressed, the additional intake of progestogens may be useful (see procedure under 3.1.). If bleeding persists despite this, a GnRH analogue should be administered. In this situation, it is advisable to perform an ultrasound examination of the internal genitalia to evaluate the endometrium and ovaries. Testosterone treatment appears to have an overall positive effect on the psychological situation of trans boys: The severity of anxiety and depression as well as suicidality decreases significantly and satisfaction with body image increases (Grannis et al., 2021; Green et al., 2022).

Consensus-based recommendation:

VIII.K7.	If bleeding occurs during testosterone treatment, the cause should be carefully evaluated. A progestogen preparation or GnRH analogue can be used in an overlapping manner to suppress the menstrual bleeding.

Consensus strength: strong consensus (> 95%)

Special vote of the German Society for Psychiatry, Psychotherapy, Psychosomatics and Neurology (DGPPN):

The DGPPN is in favour of a stronger level of recommendation regarding the search for causes of bleeding during testosterone treatment and proposes the following amended wording:

If bleeding occurs during testosterone treatment, the cause **shall be** carefully evaluated. A progestogen preparation or GnRH analogue can be used in an overlapping manner to suppress the menstrual bleeding.

Justification see appendix.

4.1.1 Important contents of patient education

The most important contents of an education pack on testosterone treatment include the following information: a change of voice is likely to occur around two to three months after the start of gender-affirming hormone treatment, in some cases it takes longer. Body hair also increases (upper lip fuzz, hair on arms, legs and stomach). However, it can take two to three years before a full beard appears and the degree of development depends on the familial hair pattern. The facial features become more angular as time goes on and the muscles increase. The fat distribution changes so that the physical appearance becomes more masculine (Klaver et al., 2018). The clitoris grows so that a small phallus can develop. Patients should be made aware that these physical changes are largely irreversible, that they should also expect to develop androgenic alopecia in the future (if genetically predisposed), that acne may occur, BMI may increase, HDL may decrease and polycythaemia may develop (Jarin et al., 2017; Madsen et al., 2021; Valentine et al., 2021). The latter is presumably responsible for the slightly increased risk of thrombosis. The long-term use of testosterone at a standard dosage does not appear to pose a permanently increased health risk in trans male patients without additional health risks (such as significant obesity or pronounced underweight), especially with regard to cardiovascular risk (Klaver et al., 2020). In the relevant study by Chan et al. (2018), for example, no lipometabolic disorders (apart from a drop in HDL cholesterol) or a deterioration in glucose metabolism parameters were reported. Millington et al. (2021) also reported a drop in HDL cholesterol and an increase in LDL cholesterol, which they associate with an increased risk of arteriosclerosis in trans men.

Furthermore, with regard to the possible future preservation of fertility (see above), it should be pointed out that although the possibility of later reactivation of the ovaries, including fertilisable

eggs, remains after discontinuation of testosterone treatment, a decrease in fertility can still be expected, especially after prolonged suppression.

4.2 Gender-affirming hormone treatment for trans-female adolescents

The aim of oestrogen treatment in trans female adolescents is not only to enable breast development and pubertal growth, but also, in the case of an unfavourably high growth prognosis for an adult woman, to help reduce the final size by accelerated closure of the epiphyseal plates. Consequently, a full substitution dose of estradiol valerate or estradiol 2 mg/day can be started in rather large trans female adolescents. The dose can be increased to 4 mg/day if necessary, depending on the estradiol concentration in the serum. The aim is to achieve an estradiol concentration in the adult female normal range in order to achieve good breast development. After three years of estrogen treatment, 86% of patients achieved breast development corresponding to Tanner B4 or B5 and a female fat distribution (Boogers et al., 2025; Hannema et al., 2017). Oestrogen treatment does not sufficiently suppress the gonadal axis. GnRHa treatment is therefore only discontinued after a gonadectomy or a switch to antiandrogen therapy.

If the growth prognosis is very high (*>185cm*), a high-dose ethinylestradiol treatment (with 100 µg/day), or alternatively high-dose oestrogens, can be considered. An increased risk of thrombosis may be associated with this treatment. No additional suppressive therapy of the testicles is then required. Before starting a gender-affirming oestrogen treatment, it may be advisable to carry out a thrombophilia test, especially if there is a positive family history, in order to rule out (genetic) risk factors for thrombosis.

Consensus-based recommendation:

VIII.K8.	Ethinylestradiol can be used if there is a desire to limit the final size of non-full-term trans girls by accelerating epiphyseal closure.

Consensus strength: strong consensus (> *95%*)

4.2.1 Important contents of the education

The most important contents of information about oestrogen treatment include the following information: When oestrogen is taken, breast budding occurs after just a few weeks and is often accompanied by an increased sensitivity to touch. It takes around two to three years for the breasts to fully develop, although the first year of treatment (and especially the first six months) appears to be quite decisive in determining the outcome (de Blok et al., 2018). If growth is unsatisfactory within the first few months despite a good estradiol concentration, the breasts will probably remain small. There is no evidence that the use of progesterone is conducive to increased breast development. As oestrogens are lipophilic, it is advisable to take the tablets with a meal. As an alternative to tablets, transdermal oestrogen treatment with a gel can also be carried out. This is particularly recommended for trans female patients with risk factors for thromboembolism. There is still very little knowledge about the long-term *side effects* of gender affirming hormone therapy in trans female patients, although statistically their risk of breast cancer increases - although it is still lower than the risk of breast cancer in adult cis women (Sonnenblick et al., 2018) or at least does not appear to be higher (Gooren et al., 2013). The long-term risk of cardiovascular disease remains unchanged for trans women under oestrogen treatment, in line with the "baseline risk" of cis men, but this is attributed to the use of ethinylestradiol, which was common in the past. The incidence of venous thromboembolism in trans women under oestrogen treatment was 2.3 per 1000 person-years in a systematic review with meta-analysis by Khan et al. (2019). Mullins et al. (2021) showed in a short-term observation that the risk of thrombosis did not increase in adolescents and young adults with estrogen levels in the reference range, even in the presence of certain risk factors such as smoking.

4.3 Clarification of off-label prescriptions

All the preparations that are used for hormonal treatment of patients with GI or GD in accordance with the recommendations of this guideline and current international medical guidelines based on expert consensus are generally *off-label prescriptions.* This means that although these medications are authorised under pharmaceutical law for other medical areas of application and have therefore been tested for their basic safety of use in other areas of application (e.g. GnRH analogues for the treatment of central precocious puberty), they are not authorised for the area of application of GI or GD. This also applies to the use of testosterone and oestrogen for gender affirming hormone treatment in adults. Due to the overall very low treatment numbers in this field of application and the non-feasibility of controlled efficacy studies (so-called phase 3 studies), no corresponding authorisation studies are to be expected in the foreseeable future, so that this off-label practice will

continue in the medium term. In general, off-label prescriptions in paediatrics and adolescent medicine often correspond to the guideline-based standard of care. According to a review, off-label prescriptions are used in 42 - 90% of cases of inpatient medical treatment of children and adolescents, and in 46 - 64% of cases of outpatient medical treatment (Kimland & Odlind, 2012). According to a recent meta-analysis, 82% of all international medical guideline recommendations for off-label treatments in childhood and adolescence *are based on weak or very weak evidence* according to the criteria of evidence-based medicine (Meng et al., 2022), i.e. they are largely based on uncontrolled cohort studies or on expert consensus in conjunction with study results from clinical trials with adult patients. The special information standards for off-label prescriptions for underage patients must be observed, as is usually the case in paediatric and adolescent medicine and psychiatry.

The tables on the following pages summarise the most important information on somatic aspects of hormonal treatments in adolescence.

Table 7

Overview of the risks and side effects of hormonal interventions for GI in adolescence

	Trans female patients	Trans male patients
GnRH analogues	local reactions such as subcutaneous hardening, bruising or allergy-related papules, in very rare cases abscess formation in the area of the injection site	
GnRH analogues in advanced puberty	menopausal symptoms such as hot flushes, sweating, mood swings, anhedonia and (less frequently) headaches, reduction in bone density	
Progestogens		Intermediate bleeding
Antiandrogens (cyproterone acetate)	Increased risk of meningioma, reduced bone density	
Testosterone		Polycythaemia Alopecia (baldness), Acne, Decrease in HDL cholesterol and increase in LDL cholesterol, Increased cardiovascular risk, Hypertension
Oestrogens	Risk of thrombosis Slightly increased risk of breast cancer Macroprolactinoma Cholelithiasis	
Liver and kidney values	No effects or slight increase in creatinine	
Glucose metabolism	No effects	

Table 8

Expected timing of physical changes after the start of gender affirming hormone therapy (adapted from Coleman et al., 2022)

Effect of testosterone		
	Start	**Maximum**
Skin greasiness/acne	1-6 months	1-2 years
Beard growth/body hair	6-12 months	> 5 years
Hair loss (baldness)	6-12 months	> 5 years
Increased muscle mass/ -Power	6-12 months	2-5 years
Fat redistribution	1-6 months	2-5 years
Absence of menstruation	1-6 months	1-2 years
Clitoris enlargement	1-6 months	1-2 years
Vaginal atrophy	1-6 months	1-2 years
Voice change	1-6 months	1-2 years
Effect of oestrogen and antiandrogenic therapies		
	Start	**Maximum**
Redistribution of body fat	3-6 months	2-5 years
Decrease in muscle mass/ -Power	3-6 months	1-2 years
Skin appearance changes/ Reduced greasiness	3-6 months	unknown
Decreased sexual desire Demand	1-3 months	unknown
Rarer spontaneous Erections	1-3 months	3-6 months
Reduced sperm formation	unknown	2 years
Breast growth	3-6 months	2-5 years
Reduced testicular volume	3-6 months	variable
Decrease in body hair	6-12 months	> 3 years
Increased scalp hair	variable	variable
Voice changes	None	

Table 9

Dosage recommendations for gender-affirming hormone treatment with testosterone (adapted from Coleman et al., 2022)

Used Hormone preparation	**Application**	**Dosage**	**Continuation of a Puberty blockage or menses suppression**	**Comment**
Trans male adolescents: starting therapy in those with incomplete growth				
Testosterone enantate (ampoules 250 mg)	intramuscular	Start: 50 mg every 4 weeks for 3-6 months, then increase to 100 mg every 4 weeks, individual increase up to 250 mg every 3-4 weeks (adult dose)	Continue already initiated puberty blockade or progestogen treatment unchanged until the adult testosterone dose is reached. This can then be discontinued.	Dose increase depending on skeletal age and growth rate; Regular blood count checks necessary; in the case of polyglobulia, extend the injection interval or reduce the dose transdermally
Testosterone gel (different concentrations depending on manufacturer, follow dosage instructions)	transdermal	Starting dose: 10 mg testosterone gel every day for 6 months, increase to 25 - (50 mg) adult dose. Dose adjustment depending on the testosterone concentration (note that the blood sample should not be taken from the arm on which the testosterone gel was previously applied, as this may result in falsely high testosterone concentrations).		

Trans male adolescents: starting therapy in those who have completed their growth				
Testosterone enantate (ampoules 250 mg)	intramuscular	125 mg every 4 weeks for 3 months, then 250 mg every 3-4 weeks	In Tanner stage 4-5, puberty suppression is generally no longer started. Previous treatment with GnRH analogues or progestogens can be discontinued.	Once growth is complete, the adult dose can be started. A gradual increase in dosage is not necessary, but is usually well received. Dosage according to testosterone concentration at the end of the injection interval
Testosterone gel (different concentrations depending on the manufacturer, follow the dosing instructions)	transdermal	25 mg testosterone gel every day for 3 months; if the testosterone concentration is then not in the adult range, increase to 50 mg per day if necessary		
Testosterone undecanoate	intramuscular	1000 mg every 10-12 weeks when growth is complete		

Table 10

Current dosage recommendations for gender-affirming hormone treatment with oestrogen (adapted from Coleman et al., 2022)

Used Hormone preparation	Application	Dosage	Continuation of a puberty blockade	Comment
Estradiol or estradiol valerate tablets	orally	Start with 0.5 or 1 mg/day for 6 months, then adult dose 2-4 mg/day.	The puberty blockade or anti-androgenic treatment must be continued unchanged even after an oestradiol concentration in the adult range has been reached. No anti-androgenic or puberty-suppressing treatment is required during growth-retarding ethinylestradiol treatment	Oestrogen treatment does not sufficiently suppress the gonadal axis. GnRHa treatment should only be discontinued after a gonadectomy or a switch to antiandrogen therapy. To reduce the predicted final length, the adult dose can be started. Alternatively, 100 µg/day of ethiynlestradiol can be given until the epiphyseal plates are closed. There is no data that the additional administration of progesterone improves breast development.
Estradiol patches	transdermal	Start: 12.5 to 50 µg patch/day. Adult dose 100 µg/day. Adhesive duration of 24 hours.		
Estradiol gel (0.62 mg per 1 g gel, single dose 2.5 g/day)	transdermal	Start: 1 dose of 2.5 g for 3-6 months, then increase to 2 doses. Adult dose 2-4 strokes. Transdermal estrogen administration is particularly recommended for patients with risk factors for thrombosis.		

Chapter IX

Professional interaction and discrimination-sensitive conduct with gender-nonconforming children and young people

1. Introduction and key questions

2. Definition of the concept of discrimination

3. National and international studies

4. Discrimination by peers, consequences and protective factors

5. Experiences of discrimination in the healthcare system

6. Literature on recommendations for a discrimination-sensitive approach to trans people

7. Statements on the state of scientific knowledge

8. Consensus-based recommendations

1. Introduction and key questions

Young trans people are a minority and can therefore be affected by specific experiences of social marginalisation or discrimination. It is therefore important for health professionals to sensitise themselves to the social context in which these children and young people grow up and to pay attention to experiences of discrimination or the threat of discrimination. Gender non-conforming children and young people often report experiencing exclusion, stigmatisation and even open hostility in their everyday experiences. These experiences can lead to psychological stress with subsequent symptoms that can occur even before a transgender self-disclosure to the outside world (social outing). Discriminatory attitudes and procedures can also occur in the healthcare system.

Although the UN Convention on the Rights of the Child prohibits discrimination on the basis of sex or gender identity (e.g. Art.2: The right to non-discrimination; Art.19: The right to be protected from all forms of physical or mental violence, injury or abuse; Art.24: The right of the child to enjoy the highest attainable standard of health; UNICEF, 2022), various national and international studies show that trans minors and their families often experience marginalisation and devaluation not only in the social context, but also in the healthcare system (Edenfield et al., 2019; Fuchs et al., 2012; Mizock & Lewis, 2008). Based on the results of a large-scale study on experiences of discrimination against trans people in the healthcare sector, which was conducted in several EU Member States, the EU Agency for Fundamental Rights therefore calls for EU Member States to ensure that healthcare staff receive appropriate training and that the needs of people with non-conforming gender identities are taken into account when designing healthcare policies (European Union Agency for Fundamental Rights, 2014).

An additional effect that causes health risks for those affected is the anticipatory expectation of discrimination (Hädicke & Wiesemann, 2021). This can be seen, for example, when trans people avoid the healthcare system in case of illness due to their fear of being discriminated against (Kcomt et al., 2020). It is therefore important for health professionals to be informed about these experiences as well as their preconditions and consequences in order to derive recommendations for discrimination-sensitive practice and for structural anti-discriminatory measures (e.g. appeals in the waiting room). An informed and sensitive approach to dealing with experiences of discrimination is therefore an important prerequisite for targeted professional support for young trans people and their relatives.

If gender-nonconforming children and adolescents and their parents have experienced discrimination, this can influence the relationship that evolves in the psychotherapeutic and medical setting. For example, restrained silence and mistrust can characterise the initial contact, with the result

that the young person is perceived by the other person as *difficult to talk to* or *unreasonably demanding*. It is therefore advisable to enquire about such previous experiences in biographical interviewing and, if necessary, validate them in order to make it easier to establish a trustful relationship. Outdated aetiological models on the part of health professionals who understand a transgender experience as a psychological maldevelopment or pathological disorder can also contribute to stigmatising and discriminatory attitudes when interacting with people seeking treatment.

Key questions for the guideline:

- What role do the experiences of people seeking treatment[1] with discrimination play in the process of counselling and treatment when using health services?
- What can and should professional helpers pay attention to in the counselling and treatment process?

2. Definition of the concept of discrimination

There are currently numerous definitions and interpretations of the concept of discrimination (Beigang et al., 2017; Ruhrmann, 2017). What the studies on which this chapter is based have in common is that discrimination is understood as the experience of marginalisation and devaluation as a result of not conforming to social norms and ideas (usually with regard to gender).

Differences between the studies are evident in the definition and recording of experiences of marginalisation and devaluation. Some studies focus in particular on experiences of *direct* discrimination, in which the targeted discrimination was based on gender. Other studies also look at *indirect* discrimination, which is not necessarily based on a negative intention on the part of the discriminator, but often on a lack of information and carelessness, as well as *structural* discrimination, in which discrimination occurs through institutions, such as through practically established practices in the medical system (Council of Europe & Commissioner for Human Rights, 2011; Günther et al., 2021). In addition to different forms of discrimination, the studies also focus on different contexts/systems in which discrimination can occur: e.g. family, school or healthcare system. The following section therefore first presents studies that relate to several contexts. This is followed by a

[1] In the text of the guideline, the term "patient" is used in the social law sense for young people who utilise a healthcare service. The term "treatment seeker", on the other hand, also includes the custodial caregivers who are involved in this utilisation.

section with further studies relevant to the context of *school and peer relationships* as well as a section with findings on *experiences of discrimination in and through the healthcare system*.

In this chapter, the term discrimination is based on the following definition by Hädicke and Wiesemann (2021) :

> Discrimination is understood to mean unequal treatment of members of a particular social group "with a lower status in the structure of social power relations", which "harms them, curtails their freedom rights, degrades them or impairs their equal opportunities" (Hädicke & Wiesemann, 2021, pp. 382-383). Intent is not a necessary prerequisite (Hädicke & Wiesemann, 2021).

3. National and international studies

As there have been very few studies to date that depict the equal treatment and discrimination situation of trans minors and their relatives in German-speaking countries, studies on the situation of trans adolescents in other countries and the situation of older trans people must also be taken into account. There is a particular lack of studies that explicitly address the situation of gender-nonconforming prepubertal children. This highlights a great need for research and makes it difficult to estimate the extent of discrimination in German-speaking countries.

A German study with a qualitative research design focussed on the experiences of guardians of a trans child/young person in the German healthcare system and identified some significant barriers for families in healthcare (Mucha et al., 2022). Experiences of uncertainty, lack of specialist knowledge and even disbelief and pathologisation of trans identity are reported, particularly in paediatric care. As a result, treatment was sometimes discontinued (Mucha et al., 2022).

The findings of a cross-sectional study by Strauss et al. (2020) provide a detailed impression of the situation of young trans people in Australia. Using an anonymous online survey, 859 young people (74.4% assigned female at birth) between the ages of 14 and 25 (M = 19.37, SD = 3.15) who self-identified as trans and 194 parents or carers were interviewed. In addition to data on mental health, the survey asked about experiences in the healthcare system that could potentially lead to psychological distress. As potentially distressing experiences participants reported rejection by peers (89%), problems at school/university (78.9%), bullying (74%), discrimination (68.9%), lack of family support (65.8%), isolation from services (60.1%), psychological abuse in the family (57.9%), problems with employment (41.9%), physical abuse in family (24.8%), homelessness/problems with housing (22%) and physical abuse outside the family (16.2%). Furthermore, 19.6% of respondents stated that they were not satisfied with their GP treatment and 31.7% with their psychiatric treatment. The reasons given for this included the fact that those treating them refused to use their first name and

the corresponding pronoun when addressing them, declared transidentity to be a developmental phase and that those affected felt pathologised or had been denied the treatment they wanted. As a result, many of those affected reported that they had to see several doctors or that visits to doctors had been avoided.

Similar findings on the situation of trans people in Germany and Europe are reported in a study by the European Union Agency for Fundamental Rights (2014) in a qualitative interview study by Sauer and Meyer (2016).

The data from the aforementioned EU-wide study depicts various aspects of equal treatment and discrimination of adult trans people (European Union Agency for Fundamental Rights, 2014). A total of 93,079 people over the age of 18 years (*M* = 34) were surveyed by means of an anonymous online survey. Of these, 6,771 people identified themselves as trans (including 1,329 Germans). Across the EU, 54% of trans people surveyed stated that they had felt harassed or discriminated against in the past 12 months because they were perceived as trans. Younger, unemployed and trans people with a low income were more likely to say they had felt discriminated against in the past year. In the employment context, 37% of the trans persons surveyed stated that they had felt discriminated against when looking for a job and 27% in the workplace. In the context of education, around a quarter of trans people who had attended school/university themselves or had children at school/university reported having felt personally discriminated against by staff members. Around a fifth of the trans people surveyed stated that they had felt discriminated against in the past year by healthcare staff or the relevant social services. Only a few people reported the last case of discrimination to the authorities. 60% did not report the relevant incident because they were convinced that it "would not help or change anything". In addition, 47% stated that it was not worth reporting incidents as this happens all the time. 30% did not know how/where the incident in question could have been reported. In addition to verbal experiences of discrimination, respondents were also asked about threats and experiences of physical violence and harassment.

Every second trans person reported an incident of violence or harassment in the past year. 44% of those who reported experiencing violence in the past year said this had happened three or more times. 8% of trans people had been physically or sexually assaulted or threatened with violence (due to being perceived as trans). Of the trans people surveyed who reported experiences of violence, 21% stated that they had reported the most recent case of hate-motivated violence to the police. Fears and restrictions in everyday life were reported as consequences of experiences of discrimination. For example, 32% of the trans people surveyed avoided acting out their gender role in public (for fear of being attacked, threatened or harassed). Half of them avoided places or locations due to

corresponding fears. One in five stated that they avoided being open about their trans identity even at home (European Union Agency for Fundamental Rights, 2014).

As part of the qualitative study by Sauer and Meyer (2016), 15 trans people living in Germany (14 of whom were assigned female at birth) aged between 14 and 26 were asked about their self-image, their life situation and their perceived need for support from society and institutions. With regard to discrimination, around half of the interviewees reported specific psychological stress, which was particularly often caused by family conflicts. In addition, respondents reported exclusion by peers (often classmates) and fears of avoiding certain public places due to the homophobic and transphobic behaviour of others. Reported experiences of discrimination mainly consist of a lack of acceptance by parents, peers, teachers, doctors, etc. Examples of discriminatory behaviour include refusing to use their chosen name up to actual violence. Positive experiences were reported by those affected when they were met with sincere interest, good information and a positive and benevolent attitude, which was then described as a source of support and stability (Sauer & Meyer, 2016).

4. Discrimination by peers, consequences and protective factors

An overview of the consequences of peer victimization in adolescence due to sexual orientation and the expression of one's own trans identity is provided by the systematic review by Collier et al. (2013).

This is based on a total of 39 studies[2], which often did not differentiate between sexual orientation and trans identity. The study results show that peer victimisation correlates with various negative psychosocial and health outcomes. Peer victimisation included: *verbal victimisation*, *physical victimisation*, *sexual victimisation* (e.g. sexual abuse), *sexual harassment* (e.g. comments, gestures, sexual touching/ groping), *relational victimisation* (being deliberately excluded from activities by peers), *indirect victimisation* (negative/harmful rumours) and *cyberbullying.* The most frequently analysed outcome parameters in studies were sense of belonging at school, depression and suicidality.

There were strong indications that those who experience victimisation have a lower sense of belonging to their school and show higher levels of depressive symptoms. With regard to the relationship between victimisation and suicidal thoughts or suicide attempts, the results vary: In large school-based samples, peer victimisation moderated the relationship between sexual orientation (including trans identity) and suicidality. In pure LGB studies (excluding trans identity), on the other hand, there was no independent correlation between peer victimisation and suicide attempts. The

[2] Of these, 12 studies with trans people

results regarding peer victimisation suggest that it is important for those treating trans adolescents who have learning-related or other difficulties in/at school to ask specifically about any peer victimisation they may have suffered. If such victimisation is known, specific attention should be paid to the possible presence of depression or suicidal thoughts (see consensus-based recommendation below).

The connection between suicidal thoughts and bullying experiences among trans adolescents compared to non-trans adolescents in the USA was investigated in the study by Ybarra et al. (2015). A total of 5,542 young people between the ages of 13 and 18 were surveyed using an online survey. 188 of the sample described themselves as *transgender*, 199 as *gender non-conforming* and 50 as *other gender*. Of these, 48% of trans young people, 44% of gender non-conforming young people and 55% of young people categorised as *other gender* stated that they had experienced social exclusion or bullying in the past 12 months. Among male cisgender adolescents, this figure was 21% and among female adolescents 25%. When asked about suicidal thoughts in the past week, gender-nonconforming adolescents were significantly more likely to answer "yes" (41-53%) than cisgender adolescents (13-21%).

A study by Wilson et al. (2016) shows that trans young people can also be affected by multiple discrimination. The study surveyed 216 adolescent trans girls between the ages of 16 and 24. The study analysed the correlation between differences in mental health depending on the extent of experiences of discrimination and protective factors. 37% of respondents reported being exposed to a low level of discrimination. 45.9% experiencing high levels of transgender-related discrimination and 26.2% of young people reported experiencing high levels of racial discrimination. 15.9% reported experiencing both forms of discrimination to a high degree at the same time. Stress in connection with suicidal thoughts was increased in all discrimination conditions. Experiencing discrimination due to trans identity was associated with 2.6 times the risk of PTSD symptoms, 2.6 times the risk of depression and 7.7 times the risk of suicidal thoughts in this sample. Furthermore, specific outcomes were also found depending on the type of discrimination, which indicates the need for specific approaches for transgender-related, racialised and mixed discrimination. In addition to non-specific resilience factors, the acceptance and support of transidentity by the family environment was found to be a significant protective factor that promotes mental health.

With 81,885 high school students (grades 9 and 11), 2,168 of whom identified as TGNC (transgender/nonconforming), the sample and control group sizes of the cross-sectional study by Eisenberg et al. (2017) are very large. Central questions of this study were the prevalence of TGNC identity in adolescents, differences in risk and protective factors in TGNC adolescents compared to

cisgender adolescents, and differences in risk and protective factors of TGNC adolescents between the genders assigned at birth. In summary, it is reported that TGNC adolescents are more affected than the cisgender comparison group in all risk factors analysed. The differences between TGNC vs. cisgender are particularly marked with regard to emotional well-being: over 60% of TGNC adolescents stated that they had already had suicidal thoughts, compared to 20% of cisgender adolescents; of the TGNC adolescents, around one in three stated that they had already attempted suicide. Furthermore, TGNC young people also reported significantly more frequent experiences of bullying and discrimination. In terms of physical attacks: TGNC 25.1% (cis-gender 12.7%), cyberbullying: TGNC 27.6% (cis-gender 12.3%), discrimination based on gender: TGNC 35.3% (cis-gender 4.7%). Within the group of TGNC adolescents, this study found that adolescents with a gender assigned at birth as female (trans boys) reported emotional stress and discrimination by peers significantly more often than adolescents with a gender assigned at birth as male (trans girls) and had less pronounced protective factors such as family ties or a positive teacher-student relationship (Eisenberg et al., 2017).

The influence of risk and protective factors on the mental health of adolescents can also be seen in a study by Veale et al. (2017). A total of 923 Canadian 14- to 25-year-olds were surveyed using an online survey. In the group of 14- to 18-year-olds (*N* = 323), 64% reported having been socially marginalised in the past year. Of these young people, 52% stated that they had (also) experienced bullying at school. A stigmatisation index calculated from the cumulative experiences reported consistently predicted increased mental health problems, in particular with regard to non-suicidal self-harming behaviour, the likelihood of exhibiting this behaviour increased by 25% with each additional point in the stigmatisation index. In contrast, all protective factors were negatively correlated with mental health problems, although not all met the criterion of an odds ratio of <0.5. *Family connectedness* was the strongest protective factor. *Feeling closely connected to school* was a significant protective factor with regard to extreme stress and extreme despair. The perception that friends care about you could predict a lower rate of suicide attempts.

A systematic review by Johns et al. (2018) provides a summarised overview of the importance and effectiveness of various protective factors and examines the findings of 21 studies on protective factors. The age range of the study participants ranged from 11 to 26 years. In the 21 articles, a total of 27 factors were analysed with regard to positive effects on the health and well-being of trans and gender non-conforming young people. The following proved to be protective:

- At the individual level, this was the young people's self-esteem.
- In terms of relationships, support from parents/family and peers proved to be central to the well-being of young people. Adults outside the family also represent an important resource. Especially in cases where no support is provided by the family or peers. Such adults could, for example, be of help when it comes to helping families and peers gain a better understanding of gender non-conformity.
- At the level of the (school) community, so-called *Gay-Straight-Alliances* have proven to be protective for LGB young people. These are student-led organisations supervised by a responsible teacher that advocate a safe and supportive environment for LGBTQ people in schools, especially in the United States and Canada (Johns et al., 2018).

The results of the study by Barbir and colleagues (2017) can provide a starting point for reducing discrimination by peers. They investigated the connection between the social contact of cisgender heterosexual college students with trans people and the self-reported positive and negative attitudes and behavioural intentions towards trans people. The results of this study indicate that social contact such as friendships with trans people can influence self-reported attitudes towards trans people. Social contact can also influence self-reported behavioural intentions: Those who had at least one friendship with a transgender person in the present study reported fewer negative attitudes and behavioural intentions towards trans people, more positive behavioural intentions as well as views and more public supportive intentions. Potential benefits of friendships with cisgender people for trans people also include access to *mainstream society*, a wider range of diverse perspectives and interactions, opportunities to increase knowledge and awareness of trans people's experiences, and possibly help in presenting themselves in the role of their chosen gender. Typical reported barriers to friendships with cisgender/heterosexual people included insufficient knowledge of gender issues, insensitive use of language and less shared experiences (Barbir et al., 2017)

5. Experiences of discrimination in the healthcare system

As described, trans people are also exposed to discrimination in the context of healthcare. This discrimination can occur both by people in the healthcare system who have been consulted for trans-specific issues and by all others, such as dentists, company doctors, vaccination consultations, etc. (European Union Agency for Fundamental Rights, 2014; Sauer & Meyer, 2016; Strauss et al., 2017). With regard to the reported rates of discriminatory experiences, a distinction must be made as to whether and how the concept of experiences of discrimination is operationalised in the respective studies.

Various online surveys recorded experiences of discrimination by adult trans people in the US healthcare system. Bradford, Reisner, Honnold and Xavier (2013) report that 41% of 387 trans respondents reported having experienced discriminatory behaviour. Shires and Jaffee (2015) describe that 41% of 1,711 trans people surveyed (FTM) reported that they had been refused treatment, physically assaulted, verbally harassed or verbally disrespected because of their trans identity. Kattari, Bakko, Hecht and Kinney (2020) report that 8% of 27,715 transgender and non-binary respondents reported a refusal of treatment from healthcare providers they sought out because of their trans identity. Less than 3% reported a refusal of treatment in healthcare contacts when the contact was for a reason other than trans identity.

Bradford and colleagues (2013) also report that low socioeconomic status, belonging to an ethnic minority, a younger age at disclosure of trans identity and less family support are factors associated with an increased likelihood of discrimination in healthcare.

In a focus group study with 34 trans participants by Sperber and colleagues (2005), respondents described ignorance, a lack of sensitivity and discrimination as common in contacts with the healthcare system. They also stated that healthcare professionals often addressed trans issues when this was not relevant to treatment (e.g. in the case of fractures or infectious diseases).

An assessment of the current situation and experiences of trans people in Germany made possible by the results of a comprehensive cross-sectional study by the Federal Ministry for Family Affairs, Senior Citizens, Women and Youth (2016): Data from 1,049 trans people was collected by means of an online survey. This included information from 117 trans children and adolescents (exact age unknown), whereby in 70% of these cases the questionnaire was completed by adults (usually a parent) on their behalf. With regard to the responses from the children and their relatives, around 75% of respondents stated that they found psychotherapists to be empathetic, supportive and knowledgeable in their conversations. At the same time, around 33% of respondents experienced such conversations as pathologising. Doctors were perceived as empathetic, supportive and knowledgeable by around 60% of the children, adolescents and their relatives surveyed. 28% of the participants felt rather pathologised. In response to the question "Which group of people/institution would you or your relative have liked more support from?", 52.14% said school and kindergarten, 39.32% doctors, 34.19% family, friends, acquaintances and 25.64% psychotherapists.

The consequences of experiences of discrimination include fear of discrimination in contact with healthcare facilities (Grossman et al., 2016), concealment of one's own trans identity due to an inconsistent practitioner-patient relationship or fear of negative consequences (Rossman et al., 2017) and postponement or avoidance of medical treatment due to experiences of discrimination. In a study

by Cruz and colleagues (2014), around half of the 4,049 trans people surveyed stated that they had already postponed curative treatment due to their own trans identity, half of whom cited previous experiences of discrimination as the reason for this. In an online survey by Bauer and colleagues (2014), 21% of 433 trans people stated that they had already avoided going to an emergency medical service.

Canadian and US studies point to uncertainties on the part of practitioners when dealing with trans persons. In a Canadian study by Snelgrove et al. (2012), 13 doctors from various specialities were asked about barriers for trans people in the healthcare system. With regard to their own experiences and assessments, the respondents stated that they had deficits in terms of the relevant specialised medical knowledge and found it very challenging to weigh up the ethical aspects of transition-related treatment. Doctors were often overwhelmed by not knowing who to turn to.

In another study on the stigmatisation of trans people in the healthcare system by Poteat et al. (2013), 12 doctors/nurses were interviewed alongside 55 trans people. A common theme among the healthcare professionals was uncertainty about how to deal with trans people and how to categorise the phenomenon of *trans* in general (including the question of needing treatment).

A subjectively perceived dilemma situation was reported by members of the nursing staff who were asked about their own insecurities in dealing with trans people (Beagan et al., 2012). The respondents stated that, on the one hand, they endeavoured not to differentiate between trans people and other patients, but on the other hand, they were also aware of existing differences that were relevant to treatment.

As part of a study by Kitts (2010), 184 doctors at a US university hospital were asked about barriers to optimal care for LGBT young people. The majority stated that they did not feel sufficiently competent to talk to LGBT young people about their sexual orientation/gender identity. Accordingly, the desire for further training was expressed.

The results of various studies show that even short workshops can promote knowledge about discrimination and vulnerability of trans people in and their access to the healthcare system as well as skills in dealing with trans children and trans adolescents: For example, in a study by Kelley and colleagues (2008), 75 medical students completed a two-hour teaching unit on LGBT* health. The impact on the students' knowledge and attitudes towards the treatment of LGBT* people was analysed. In the follow-up survey, significantly more students stated that access to the healthcare system is more difficult for LGBT* people than for the average population. Fewer respondents than before were convinced that LGBT* people rarely lived in stable relationships. Fewer students than before the workshop stated that they were reluctant to treat people in matters of gender identity.

Similar findings were also found in a study by Safer and Pearce (2013). 74 medical students took part in a lecture as part of the endocrinology programme. The effects on attitudes towards the treatment of trans people were examined. After the course, the number of students who would be uncomfortable treating trans people fell by 60%. In the follow-up survey, none of the students were of the opinion that trans issues were not relevant to medicine. In addition, the number of students who would refuse such treatment was significantly reduced.

McGravey (2015) has shown that discrimination-sensitive training workshops can also be useful in a psychotherapeutic context. The effectiveness of a workshop to expand knowledge and skills in dealing with LGBTQ young people was examined in 68 school psychologists. In general, the scores of knowledge and skills had improved significantly at both follow-up survey points.

6. Literature on recommendations for a discrimination-sensitive approach to trans people

The TGNC guidelines of the American Psychological Association (2015) and the Multicultural Guidelines of the American Psychological Association (2017) provide comprehensive guidance for professionals with regard to discrimination-sensitive conduct in the healthcare sector as well as a well-founded intersectional perspective. Context-sensitive models such as the minority stress model (Meyer, 2003) are described in detail in a trans-specific adaptation for recording and processing experiences of discrimination and their health consequences in Rood et al. (2016). Wanner and Landsteiner (2019) provide a comprehensive description of attitudes and procedures that are particularly critical for trans people with regard to discrimination, which are based on the now outdated psychopathological conceptualisations of *transsexualism* still referred to in the ICD-10 and which were nevertheless influential in the health care of trans people for decades.

7. Statements on the state of scientific knowledge

IX. E1.	There is evidence from survey studies that trans minors and their legal guardians frequently report a wide range of experiences of discrimination in various areas of life, including in the healthcare system.

The evidence for this statement is well documented by 25 studies (Bauer et al., 2014; Bradford et al., 2013; Federal Ministry for Family Affairs, Senior Citizens, Women and Youth, 2016; Collier et al., 2013; Cruz, 2014; Mucha et al., 2022; Rossman et al., 2017; Sauer & Meyer, 2016; Shires & Jaffee, 2015; Sperber et al., 2005; Strauss et al., 2017, 2020; Veale et al., 2017; Wilson et al., 2016; Ybarra et al., 2015).

Consensus strength: strong consensus (> 95%)

IX. E2.	There are indications that experiences of discrimination against trans minors and their legal guardians are not only made in individual interactions with practitioners, but also on a structural and institutional level.

The evidence for this statement is supported by 10 studies (Bauer et al., 2014; Bradford et al., 2013; Council of Europe & Commissioner for Human Rights, 2011; Cruz, 2014; Günther et al., 2021; Hädicke & Wiesemann, 2021; Kcomt et al., 2020; Mucha et al., 2022; Rossman et al., 2017)

Consensus strength: strong consensus (> 95%)

IX. E3.	In the case of reported experiences of discrimination against trans minors and their legal guardians in the healthcare system, there are also indications that these are often not caused by conscious or intentional attitudes on the part of health professionals, but can arise due to insufficient expertise and/or professional uncertainty.

The evidence for this statement is uncertain. There are eight studies on this (Beagan et al., 2012; Kelley et al., 2008; Kitts, 2010; McGravey, 2015; Mucha et al., 2022; Poteat et al., 2013; Safer & Pearce, 2013; Snelgrove et al., 2012)

Consensus strength: strong consensus (> 95%)

8. Consensus-based recommendations

IX.K1.	Practitioners (members of all health professions) should be informed about the risks and forms of discrimination to which trans minors and their legal guardians may be exposed. They should critically reflect on their own professional attitude with regard to potentially discriminatory aspects.

Consensus strength: strong consensus (> 95%)

IX.K2.	Wherever possible, practitioners (members of all helping professions in the healthcare system) should, within the scope of their field of activity, contribute to reducing discrimination that may occur at a structural or institutional level.

Consensus strength: strong consensus (> 95%)

IX.K3.	Those providing treatment (members of all health professions) should be informed about the psychological and health sequelae arising from experiences of discrimination and should take this knowledge into account in their work.

Consensus strength: strong consensus (> 95%)

IX.K4.	In the context of mental health assessment and psychological support for children and adolescents who present with gender incongruence or gender dysphoria, experiences of discrimination should be asked about and considered as risk factors for mental health difficulties.

Consensus strength: strong consensus (> 95%)

In addition to specifically asking about such experiences in the past, current experiences should also be enquired about. In line with a resource-orientated approach, it is also advisable to ask specifically about positive experiences in the social context and in the healthcare system.

Consensus-based recommendation:

IX.K5.	For an adequate support in progress for trans minors, the social environment (e.g. schools, educational institutions, sports clubs, youth facilities, church communities, etc.) should be provided with educational and information services, which also refer to information and counselling services offered by self-advocacy organisations of trans people and their relatives.

Consensus strength: strong consensus (> 95%)

Explanation: Such an offer of professional support for gender-nonconforming young people in their everyday social environment requires their transparent consent.

The terms *self-help* or *self-help organisation*, which are commonly used in other medical contexts for counselling services organised by patients and their interest groups, are not (or no longer) used in this field.

Consensus-based recommendation:

IX.K6.	When addressing gender-nonconforming children and adolescents, practitioners should ask for the desired pronouns and first names and use them where possible depending on the situation. The same approach should also be taken in professional communication with other professionals and institutions involved, in consultation with those seeking treatment.

Consensus strength: strong consensus (> 95%)

It is important to communicate the importance of respect for gender self-identification for the necessary trust relationship in the treatment setting to legal guardians and other important reference persons who express reservations about a trans minor's wish to be addressed according to their self-identified gender. It should be noted that the appropriate use of desired first names and pronouns does not imply a commitment with regard to future social, legal or medical steps of a transition.

Chapter X

Annotations on the legal basis and ethical standards for the treatment of minors with gender incongruence

1. Introduction

The controversies in the medical community about body-altering interventions in adolescents diagnosed with gender incongruence (GI) or gender dysphoria (GD) are often ostensibly fought over arguments about the uncertain evidence for this age group, but essentially touch on the following ethical and legal issues:

- How can the ethical dilemma particular to treatment decisions in adolescence be addressed, that both treatment and its postponement or omission can have irreversible consequences for later long-term mental health (Deutscher Ethikrat, 2020)?
- How should the right to self-determination and the underlying ethical principle of promoting autonomy be weighed against protecting minors from treatment decisions with potentially fatal consequences that reach far into their future (Hädicke et al., 2023)?
- Under what conditions can minors give informed consent to puberty-suppressing or gender reassignment medical treatment (Giordano et al., 2021)?
- How is the necessary capacity to consent (Germany), decision-making capacity (Austria) or capacity of judgement (Switzerland) to be assessed and determined in the case of minors?[1]
- What significance does the involvement and consent of custodians have in treatment decisions?

In this chapter, the relevant legal foundations are presented with primary reference to the German legal situation, important ethical standards from the international medical ethics discourse are also discussed. This is intended to provide information and orientation for practitioners when applying the guideline. As the legal framework is binding in any case and ethical principles must be weighed up in a considered manner when making responsible treatment decisions, this chapter does not contain any recommendations.

The authors of the guideline are aware that legal discussions in a medical guideline are not a matter of course. The legal situation must also be regarded as dynamic. Nevertheless, particularly in view of medical and social controversies in this field of application, there is a need for orientation on the basic legal principles for healthcare professionals who apply the guideline. On the one hand, the important principles of medical ethics on which the guideline is largely based cannot be separated

[1] For reasons of readability, the term "capacity to consent" relevant to the German legal situation is used in the following text of the chapter; the analogous terms from the Austrian and Swiss legal systems (Austria: decision-making capacity and Switzerland: capacity for judgement) are not repeated.

from the underlying legal norms. On the other hand, generally applicable legal provisions, e.g. on the capacity of minors to give consent, which are particularly important for this guideline, although binding in all areas of medicine, are not always fully known and available to practitioners in everyday care. The authors of the guideline expressly point out that the information and explanations in this chapter are intended to provide orientation for the ethical considerations to be made. The respective binding legal situation can be found in laws and current case law.

2. Protective function of the legal system

"The German legal system establishes a double protective space for the somatomedical treatment of minors with gender dysphoria - first and foremost for the constitutionally guaranteed right of every person to find and develop their gender identity [see below], and then for the decision-making process in the triangle of the transgender person, their legal guardians and the practitioners. This safe space, which also includes high requirements with regard to compliance with evidence-based medical standards, the quality of the treatment process, the determination of the ability to consent and the provision of information to those involved, serves to protect these individual decision-making and treatment processes against third parties and instrumentalisation of all kinds." (Gutmann, 2023, p. 4). The law thereby realises the central ethical challenge of "supporting minors on the path to their own gender identity and at the same time protecting them from - sometimes irreversible - harm" (Deutscher Ethikrat, 2020, p. 2).

A comprehensive diagnostic biopsychosocial assessment by the practitioner is recommended by international medical guidelines based on expert consensus (Coleman et al., 2022; Hembree et al., 2017) and by this guideline. It includes an assessment of the life situation of a trans minor, their developmental history, their social and family environment, assessment of other associated mental health problems, etc. and is an indispensable prerequisite for determining recommendations for body-altering interventions as required under German law by Section 630a (2) BGB (compliance with required professional diagnosis and treatment standards), Section 630c BGB (information obligations) and Section 630e BGB (individualized information obligations) (Gutmann, 2023).

In the context of the treatment of minors, the *child's right to an open future* is sometimes discussed (Cutas & Hens, 2015; Garrett, 2022; Jorgensen et al., 2024). It goes back to an essay by the philosopher Joel Feinberg from 1980 and implies that parents may only exercise children's autonomy rights by proxy and only to the extent that the child's future options are kept as open as possible (Feinberg, 1980). Feinberg (1980) was referring to a contemporary American debate about the right of parents not to send their children to school but to educate them themselves. Both the exact meaning

and the scope of the right to an open future remain undefined in the original publication and are still controversial today; in its practical application, it must always be supplemented by further considerations (Garrett, 2022; Mills, 2003; Millum, 2014). Feinberg (1980) does not, for example, take into account the rights that are recognised for *children as children* and that were codified in the UN Convention on the Rights of the Child (1990). The right to an open future may be taken into account as a maxim when assessing the scope of the right to parental proxy decision-making with regard to the child's future options.

3. Right to self-determination and highly personal core area

The right to self-determination over one's own body is a fundamental personal right. It applies to all medical and psychological/psychotherapeutic interventions, whether they are of a diagnostic, therapeutic or preventative nature. These are subject to the requirement of informed consent. In child and adolescent healthcare, consent is given either by the minor capable of giving consent themselves or - in the case of incapacity to consent - by the legal representatives, usually the parents (Rixen, 2020; Rothärmel, 2004; Wapler, 2015).

Some areas are of a highly personal nature and cannot be decided on by a third party. This includes gender identity. Gender identity is part of the inviolable core area of private life. In principle, only the person concerned is authorised to make decisions about this (Deutscher Ethikrat, 2020; Siedenbiedel, 2016). Medical and psychotherapeutic interventions must therefore aim to safeguard the self-determination of the person concerned regarding their gender identity as far as possible. Restricting the decision-making authority of minors is only permissible with the aim of facilitating future self-determined decision-making, i.e. up to the point at which the person concerned is capable of giving consent (Siedenbiedel, 2016). Achieving the capacity to consent is therefore an important threshold for interventions to treat gender incongruence or gender dysphoria in underage patients.

3.1 Self-determination for minors capable of giving consent

"In the case of minors, the capacity to consent [...] is not assumed on a generalised basis as in the case of adults, but requires a positive determination. Capacity to consent is not tied to a specific age and cannot be for constitutional reasons." (Gutmann, 2023, p. 4). If the minor is capable of giving consent, they alone are entitled to decide on medical and psychotherapeutic measures (Rixen, 2020). A self-determined decision requires comprehensive, comprehensible information about all aspects of the decision or non-decision. It is only possible if the person in the decision-making situation is free from external coercion (through threats from third parties, etc.) or internal coercion (through intoxication, hallucinations, etc.).

3.1.1 Definition of the capacity to consent

The ability to consent is a complex characteristic that encompasses both cognitive and emotional aspects of personality. It only emerges gradually in the course of personal development. It is not the same as intelligence.

The capacity to consent refers to a person's ability to understand the nature, significance and consequences of an action and to determine their will accordingly. It includes the capacity for insight, judgement and control (Laufs et al., 2015). In detail, a person is therefore capable of giving consent if they are able to,

"(a) understand the purpose, necessity and urgency, likely course, possible consequences, potential risks and potential benefits of the intervention and of not carrying it out,

b) to realize the value the rights concerned have for them and the alternatives they can choose from,

c) weigh up the pros and cons and make a decision,

(d) express this decision; and

e) to act in accordance with the decision." (Genske, 2020, p. 347)

When making decisions in childhood and adolescence, assessing the future risks and opportunities of an intervention or its omission poses a particular challenge. This is because assessing the value of the legal interests involved requires at least a certain amount of life experience, which children and adolescents only gradually acquire in the course of their personal development. A further specific difficulty arises from the fact that, in the case of adolescent patients, decisions to start a treatment or not - with irreversible consequences to be considered in each case - must be made at a time when many aspects of identity and personality are still subject to typical adolescent psychosocial development processes (Deutscher Ethikrat, 2020; Seiffge-Krenke, 2021).

Nevertheless, according to a legal opinion by Gutmann (2023), generalising objections regarding the capacity of minors to consent to complex medical interventions cannot be justified by the current legislation. "When it comes to somatomedical measures for the treatment of gender dysphoria, the assessment of a minor's capacity to consent must also take into account their level of development with regard to the perception and reflection of their own gender identity (their "gender identity maturity"). Cognitively mature minors with persistent gender incongruence or dysphoria may also regularly have the necessary power of judgement to be considered capable of consenting to somatomedical treatment measures." (Gutmann, 2023, p. 5).

Nevertheless, the requirements for a thorough *determination of* capacity to consent (as well as the quality of the informed consent and the process of shared decision-making) are higher when partially or even completely irreversible somatomedical measures are involved (Gutmann, 2023). Accordingly, demanding standards apply to the required procedure under German law. Mandatory prerequisites for due diligence of the medical/psychotherapeutic team when carrying out medical interventions in diagnostically confirmed gender incongruence or gender dysphoria are, among other things, "precise and comprehensive conversations, enquiries and assessments in order to be able to decide whether the requirements of a recommendation are fulfilled. This is also necessary to decide on the correct and professional procedure for the treatment, to determine the patient's capacity to consent, as well as to adequately inform and educate them. These procedures (history taking and further diagnostic assessment) ensure the integrity of the decision-making process and thus primarily the protection of the interests and rights of the patients themselves" (Gutmann, 2023, p. 5).

3.1.2 Threshold of capacity to consent

Capacity to consent is a threshold concept; it either exists or does not exist. It is only acquired in the course of individual personality development and is contingent on the complexity of the decision at hand (Lippert, 2016). Age limits are occasionally mentioned as thresholds in the literature. For example, it is stated that the capacity to consent can be given from the age of 13 in individual cases and from the age of 15 as a rule. However, these age thresholds should only be understood as guidance (Alderson, 2007, 2008; Duttge, 2013; Rixen, 2020). Capacity to consent is also not to be equated with legal capacity, for which rigid age limits apply (Genske, 2020). Furthermore, the prevailing opinion is that the threshold cannot be determined solely on the basis of objective factors that characterise the intervention. This means that serious, urgent or complicated interventions do not necessarily have their own age limits, but they can increase the requirements for capacity to consent (Lippert, 2016).

The capacity to consent must be assessed in each case on an individual, situation-, case- and intervention-specific basis (Laufs et al., 2015). The decisive factors are the individual maturity of the person, in the case of gender incongruence or gender dysphoria in particular the stability/persistence of the gender identity according to the diagnostic assessment, and the individual, case- and intervention-related, specific capacity for insight, judgement and control.

3.1.3 Examination of the ability to give consent

The legal duty to assess the presence of capacity to consent lies with the treating parties and is therefore a medical/psychotherapeutic task (Gutmann, 2023). The prerequisites for establishing the capacity of minors to give consent with legal certainty apply in particular in treatment settings in which a longer-lasting, continuous doctor-patient relationship is established (as recommended in

international guidelines; Coleman et al., 2022) and which are designed for slow step-by-step decision-making (Siedenbiedel, 2016). The assessment of minors' capacity to consent to complex medical interventions must be carried out by the person providing treatment, if necessary with the support of specialists of the developmental psychology of childhood and adolescence. This is ensured for this guideline in the recommendations of Chapter VII → "*Guidance for recommending body-altering medical interventions*" by the two-pronged approach described there, according to which such recommendation must be established on an interdisciplinary basis with the involvement of a mental health specialist and a specialist from somatic medicine. The assessment of the capacity to give consent must also be carried out in personal, and in the case of complex or far-reaching interventions in repeated conversations, supported by written information and explanatory material. The person providing information must ensure that the information has been understood (Laufs et al., 2015). The assessment of the ability to give consent must be documented in writing.

Aspects to be examined when determining capacity to consent:

In addition to an assessment of the mental and cognitive level of development and the assumed stability/persistence of a diagnosed gender incongruence, according to Gutmann (2023), it should be checked in separate discussions after the information has been provided whether the young patients can transfer the information received about the medical options to their own life perspective, i.e. whether they can explain it sufficiently plausibly,

- "which (positive and negative) aspects of their a) present and b) future situation and c) the options for action discussed in the counselling interview are particularly important for them (in the light of their own perspective on life);
- what the discussed treatment measure means for them and how it will affect their (everyday) life and their relationship with family, friends and other people;
- what their goals are and what is most important to them;
- what they are prepared to give up for this;
- what their greatest fears are for their personal future;
- what is understood to be the greatest risk if the measure is implemented or not implemented;
- why they therefore weighed up the "pros and cons" of the measure in this way and not otherwise and made their decision in this way;
- how they assess the long-term significance of irreversible gender reassignment measures for their own life, particularly with regard to the effects of gender reassignment on their future sex life and

the fact that, if applicable, an infertility-related renunciation of later biological parenthood may be perceived as a loss in the future;

- and how they assess the possibility that the experience of their gender identity, their attitudes towards their gender-related needs could change in the future." (Gutmann, 2023, p. 43)

In order to determine the stability of these deliberations, they should be deepened in at least two interviews with sufficient time between them (Gutmann, 2023). In addition, with regard to the stability of the treatment decision, it should be checked whether the young person is able

- "to come to a clear decision that this
- is their own decision, i.e. one for which they are responsible,
- communicate the decision clearly and
- uphold the decision even in the light of critical queries from those treating them or their carers" (Gutmann, 2023, p. 44).

The international guidelines *Standards of Care (Version 8)* of the WPATH[2] emphasize that, in order to establish capacity to consent, it is important for young patients to reflect on how to deal with irreversible consequences of treatment in the event of later detransition. The following questions are recommended to guide practitioners:

- Can the young person think carefully into the future and consider the implications of a partially or fully irreversible intervention?
- Does the young person have sufficient self-reflective capacity to consider the possibility that gender-related needs and priorities can develop over time, and gender-related priorities at a certain point in time might change?
- Has the young person, to some extent, thought through the implications of what they might do if their priorities around gender do change in the future?" (Coleman et al., 2022, p. 62)

3.2 Self-determination for minors unable to give consent

3.2.1 Participation

Minors who are not capable of giving consent have a right to participation. This means that their opinion must be heard in all matters concerning them and taken into account in accordance with their age and maturity. The right to participation requires adequate, age-appropriate information

[2] WPATH - World Professional Association for Transgender Health

(Mengel et al., 2019; United Nations, 1989). Accordingly, a child who is not yet capable of giving consent (in accordance with Section 630e para. 5 sentence 1 BGB) must be given an explanation of all aspects relevant for consent in accordance with their ability to understanding and based on their level of development and cognitive comprehension (Gutmann, 2023).

Participation is also necessary because, on the one hand, it helps the minor to gradually develop their capacity for insight, judgement and control (Wapler, 2015). Secondly, it enables the medical/psychotherapeutic staff to ascertain the abilities and developmental stage of the person undergoing treatment over the course of time and thus to assess the developing capacity for consent with greater certainty (Wiesemann, 2020b). This gives rise to an important ethical principle for practitioners: In cases where a minor patient who wishes treatment does not (yet) have the capacity to consent, the young person must be supported in the process of further professional support to achieve this capacity (Deutscher Ethikrat, 2020).

Participation is therefore also necessary with regard to the minor's personality rights, because it helps them to develop their capacity for insight, judgement and control and thus gradually establish their own ability to give consent.

3.2.2 Proxy consent and the best interests of the child

Consent to medical/psychotherapeutic measures for minors who are unable to give consent is given by the fully informed legal representative, usually the parents. Their decision must be based on the best interests of the child (Dettenborn, 2017; Dörries, 2003) and - as far as possible - on their right to an open future (Feinberg, 1980; Millum, 2014). Both the child's current and future well-being are relevant for their best interests. Objective values such as health or physical integrity and subjective values such as quality of life or suffering must be equally considered and, if necessary, weighed against each other (Oommen-Halbach & Fangerau, 2019).

The will and subjective assessment of the child must always be taken into account (Wiesemann, 2020a). Decisions on elective measures with irreversible consequences for the child's later self-determined life in their own gender identity should be postponed to a later age at which the child is capable of giving consent. This usually concerns the decision in favour of gender reassignment hormone treatment due to the intended irreversible redirection of the development of secondary physical sexual characteristics. On the other hand, in the case of temporary puberty blockade due to its reversibility, if it is discontinued and no sex reassignment hormone treatment is subsequently carried out, consent can be given by a person with parental authority if it can be justified that this is most in line with the child's best interests and wishes after all the considerations to be made.

3.2.3 Co-consent of minor patient and legal guardian

The more serious the decision to be made and the more difficult the determination of the minor's capacity to consent, the more important it is for the minor and their guardians to reach a consensus. As a rule, co-consensus should generally be sought because the caring support of the caregivers is significant for the minor in coping with the life issues at hand (Schickhardt, 2016).

In the event of a conflict, the options for a joint decision should first be explored, as the long-term psychosocial implications of an ongoing conflict between parents and child over the issue of supporting the child's self-determined life path as a trans person are considerable for both sides and therefore do not appear to be resolvable solely through custody proceedings (see explanations and recommendations in Chapter VI → "*Inclusion of the family environment and family dynamics*" and Chapter VII → "*Guidance for recommending body-altering medical interventions*"). However, if a conflict proves to be persistently unresolvable despite all professional efforts, the best interests of the child must be regarded as the primary legal focus (Siedenbiedel, 2016). It is the responsibility of the youth welfare office to examine if the child's welfare is at risk and, if necessary, to take appropriate steps to clarify the best interests of the child.

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Appendix A

Special votes of the Executive Board of the German Society of Endocrinology (DGE)

	Final consented version of the guideline	Special votes of the DGE	
No.	**Recommendation/ statement in the text**	**Suggested amended recommendation**	**Justification**
Chapter VII: Recommendations for body-altering medical interventions			
Gender-affirming hormone treatment (GAH)	The start of gender-affirming hormone treatment requires careful recommendation in interdisciplinary cooperation by a psychiatric-psychotherapeutic specialist and an endocrinological specialist experienced in the treatment of adolescents (interprofessional recommendation, see below). The latter can come from the field of paediatrics, internal endocrinology or endocrinology. (Paediatric) gynaecology.	The expertise of the person who provides the endocrinological part of the recommendation and the endocrinological care during gender affirming hormone treatment for adolescents with gender incongruence or gender dysphoria should fulfil the following formal requirements (designations for Germany): - Specialist designation for paediatrics with additional designation in paediatric and adolescent endocrinology and diabetology - Specialist title for internal medicine and endocrinology and diabetology - Specialist designation for gynaecology and obstetrics with a focus on endocrinology and reproductive medicine	None, as self-explanatory
VII.K12.	The recommendation for gender-affirming hormone treatment in adolescents with gender incongruence or gender	We are in favour of a second psychiatric-psychotherapeutic specialist with experience in the diagnosis and treatment of gender dysphoria in	None, as self-explanatory

	Final consented version of the guideline	Special votes of the DGE	
No.	**Recommendation/ statement in the text**	**Suggested amended recommendation**	**Justification**
	dysphoria should be determined in interdisciplinary co-operation. The prerequisite for an recommendation is a careful diagnostic assessment and clarification appropriate to the urgency and complexity of the individual situation by a psychiatric-psychotherapeutic specialist experienced in the diagnosis and treatment of gender dysphoria in adolescents. The somatic part of the recommendation should be carried out by an endocrinological specialist experienced in the treatment of adolescents, taking into account their prerequisites (pubertal stage of maturity, absence of somatic contraindications, etc.).	adolescence confirming the recommendation for complex issues such as young age, existing psychological comorbidities or recent awareness of gender dysphoria in the sense of a four-eyes principle.	

Special votes of the German Psychoanalytical Society (DPG)

	Final consented version of the guideline	Special votes of the DPG	
No.	**Recommendation/ statement in the text**	**Suggested amended recommendation/ special vote**	**Justification**
Chapter VII: Recommendations for body-altering medical interventions			
VII.K5.	The recommendation for puberty blockade in adolescents with gender incongruence or gender dysphoria should be made regardless of a binary sense of belonging to a particular gender and regardless of sexual orientation.	"The recommendation for puberty blockade in adolescents with gender incongruence or gender dysphoria should be made regardless of sexual orientation."	This special vote to omit the reference to a binary sense of belonging in the recommendation was also made in the same way in the corresponding recommendations on gender affirming hormone treatments (VII.K15) and surgical interventions.
VII.K15.	The recommendation for gender-affirming hormone treatment should be made regardless of the polarity or binary nature of gender identity and regardless of the patient's sexual orientation	"The recommendation for gender-affirming hormone treatment should be made regardless of the patient's sexual orientation."	**(A) Lack of evidence** While there are a number of studies for binary trans adolescents (see chapter introduction) that at least give clear indications or provide isolated evidence of positive effects of GnrH analogues and gender affirming hormone treatments on mental health, the empirical evidence for non-binary adolescents is completely unclear and at best speculative based on a few clinical empirical values (individual case decisions without knowledge of the long-term course). Current outcome studies, e.g. Achille(2020) and Becker-Hebly(2021) , only differentiate between "female to male" or "male to female". Non-binary adolescents are not mentioned and are not included in the study groups. The same applies to the Dutch cohort, for which some long-term follow-up and catamnesis data are available, but whose sample excluded non-binary developmental trajectories of medically treated cases (Abbruzzese et al., 2023) . In contrast, a study by Chen et

	Final consented version of the guideline	Special votes of the DPG	
No.	**Recommendation/ statement in the text**	**Suggested amended recommendation/ special vote**	**Justification**
			al.(2023) and Kuper et al.(2020) explicitly included non-binary adolescents, but did not analyse whether non-binary identified adolescents benefit equally from the treatment as binary identified adolescents. **(B) Psychosexuality and adolescence - theoretical assumptions** As part of the adolescent development process, from early, through middle and late adolescence (Blos, 2001) , the new literature (Quindeau, 2019) describes psychological bisexuality as a normal process of exploring one's own identity, during which there are strong fluctuations in gender identification. This process represents a kind of transitional stage of testing and identification that leads to a clear (binary) gender identity and a clear sexual orientation for most young people. In this understanding, non-binary identification is not a pathological solution, but rather an expression of an internal confrontation with developmental tasks, separation from parental objects and the development of one's own autonomous abilities. In this way of thinking, early medical intervention in the case of persistent non-binary identification would be an interruption of the development process and, in the worst case, a body-altering fixation of a transitional stage. **(C) Dealing with non-binarity in other guidelines and treatment recommendations** Non-binary is only explicitly mentioned in the most recent WPATH recommendations (SOC-8), where the term "TSG youth" is used throughout, a term that includes "people

	Final consented version of the guideline	Special votes of the DPG	
No.	**Recommendation/ statement in the text**	**Suggested amended recommendation/ special vote**	**Justification**
			who identify as non-binary" (Coleman et al., 2022a, p. 252) . However, no specific recommendations for dealing with non-binary identified young people are included. Rather, due to the lack of evidence and scarcity of clinical experience for body-altering measures in non-binary courses in adolescence, it appears to be an ethical recommendation to take this subgroup seriously and explicitly not to exclude them, but also not to include them in recommendations. Similarly, in other European countries (see appendix and corresponding lists of the guidelines and/or treatment recommendations there), conservative criteria such as age norms are sometimes clearly required and no position is taken on non-binary developmental trajectories with body-altering treatment wishes. **To summarise**, the developmental-dynamic aspect, which is particularly important here, the complete lack of empirical evidence and the mixture of undoubtedly sensible ethical principles and treatment decisions create a situation that makes it impossible to establish an recommendation for any body-altering measure in adolescence.

Special votes of the Bundesvereinigung Trans*, Trans-Kinder-Netz e. V. and Verband für lesbische, schwule, bisexuelle, trans*, intersexuelle und queere Menschen in der Psychologie e.V.

	Final consented version of the guideline	Special votes from BVT*, TRAKINE e.V., VLSP* e.V.	
No.	**Recommendation/ statement in the text**	**Suggested amended recommendation/ special vote**	**Justification**
Chapter VII: Recommendations for body-altering medical interventions			
VII.K4.	If, in individual cases, time pressure arises as a result of progressive pubertal maturation, in which irreversible physical changes (e.g. male voice change) could be expected to be detrimental to health due to longer waiting times, access to child and adolescent psychiatric or psychotherapeutic assessment and medical treatment options should be granted as soon as possible.	"In individual cases, the progressive development of pubertal maturity can lead to time pressure in which, in order to prevent irreversible changes to the body (e.g. male voice change, female breast growth) In individual cases, the paediatric endocrinological specialist may initiate a puberty blockade promptly due to its urgency with a provisional recommendation in order to prevent irreversible bodily changes (e.g. male voice change, female breast growth), if the implementation of child and adolescent psychiatric-psychotherapeutic (KJP) process support for an recommendation would mean an unacceptable delay. In such a justified case, diagnostic counselling by a child and adolescent psychiatrist should be carried out promptly to confirm the recommendation."	The **three organisations mentioned** would like to leave the wording of the recommendation as it was formulated in the original draft version of the guideline before the start of the consultation phase unchanged as follows. The pubertal physical changes from Tanner stage II onwards are unpredictable for gender-incongruent adolescents and can quickly reach an irreversible stage. These changes can therefore cause or intensify a massive gender dysphoric experience. Therefore, the effect of de-actualising these changes through treatment with GnRH analogues can hardly be overestimated in terms of overall mental well-being. Thus, while maintaining the interdisciplinary recommendation, such a procedure recognises the overall biographical significance of temporarily keeping the physical and gender identity-related spaces of possibility open. Gender-incongruent adolescents are thus enabled to make balanced, self-caring decisions. Ultimately, this special vote should also be understood in terms of its signalling effect on care, which should be made safer and more predictable for gender-incongruent adolescents and their parents with the help of knowledge transfer, broadening of the personnel base and good appointment management, so that this recommendation need not be taken into consideration.

	Final consented version of the guideline	Special votes from BVT*, TRAKINE e.V., VLSP* e.V.	
No.	**Recommendation/ statement in the text**	**Suggested amended recommendation/ special vote**	**Justification**
			However, professional medical care for gender-incongruent adolescents cannot be conceived and organised without reflecting on the contextual conditions in medical care and the social climate.
VII.K14.	A prerequisite for the recommendation of gender-affirming hormone treatment should be the presence of stable/persistent gender incongruence (according to the diagnostic criteria of GI in adolescence/ ICD-11 HA60) with gender dysphoric distress present after the onset of puberty with several years of transgender perception and the associated desire for the development of the gender-specific physical changes expected as a result of hormone treatment. The careful diagnostic assessment should be carried out in collaboration between the psychiatric-psychotherapeutic specialist experienced in the diagnosis and treatment of gender dysphoria in childhood and adolescence and the patient and their carers/relatives on the basis of an exploration of the	"A prerequisite for the recommendation of gender-affirming hormone treatment should be the presence of stable/persistent gender incongruence (according to the diagnostic criteria of GI in adolescence/ ICD-11 HA60) with gender dysphoric distress present after the onset of puberty and the associated desire for the development of the gender-specific physical changes to be expected as a result of hormone treatment. The diagnostic assessment should be carried out as part of a collaboration between a psychiatric-psychotherapeutic specialist and the patient and their guardians/caregivers based on the exploration of the psychological findings and life history."	The Bundesvereinigung Trans*, the Association for Lesbian, Gay, Bisexual, Trans*, Intersex and Queer People in Psychology and Trans-Kinder-Netz would like to leave the wording of the recommendation originally agreed before the consultation phase unchanged with this special vote: A blanket time criterion of "several years" is not supported by any evidence. The passage of time does not provide any greater certainty with regard to a responsible recommendation. A "transgender feeling" as an awareness depends on many factors. For example, a restrictive family, a threatening environment, a derogatory psychotherapeutic attitude or an internalised transnegativity can lead to an avoidance of transgender awareness. The quality and safety of the recommendation depends much more on whether the professionals succeed in adequately recording the individual experience, reflecting on the individual contextual conditions and bringing them up in the interaction. For individualised care, gender dysphoric distress over several months can be decisive for the recommendation, even without several years of transgender experience. A delay in meeting an ultimately arbitrary time criterion would then be detrimental. Professional medical care for gender-

	Final consented version of the guideline	Special votes from BVT*, TRAKINE e.V., VLSP* e.V.	
No.	**Recommendation/ statement in the text**	**Suggested amended recommendation/ special vote**	**Justification**
	psychological findings and life history.		incongruent adolescents cannot be organised without reflecting on the individual contextual conditions.
Section 6.4.1: *Procedure for adolescents with non-binary gender identity*		"The recommendation for a gender affirming mastectomy or breast reduction should be made regardless of the polarity or binary nature of gender identity and regardless of sexual orientation."	With this special vote, the Bundesverband Trans*, the Verband für lesbische, schwule, bisexuelle, trans*, intersexuelle und queere Menschen in der Psychologie e.V. and Trans-Kinder-Netz e.V. would like to leave a recommendation originally formulated before the consultation phase (see below) unchanged in the guideline: Non-binary adolescents are part of the gender-incongruent healthcare population. As a result of the gender-binary and dichotomous spectrum of expectations in medical care, non-binary adolescents have so far been underrepresented and less visible in care and research. The knowledge deficit on the part of healthcare providers is largely the effect of personal and structural biases as well as unreflected gaps in perception. The resulting discrimination against non-binary, gender-incongruent adolescents is particularly incompatible with the medical ethical principles of justice, autonomy and non-harm.

Special votes of the German Society for Psychiatry and Psychotherapy, Psychosomatics and Neurology (DGPPN)

Preamble

Preamble to the final consented version of the guideline	DGPPN special vote on the preamble
Consented with strong consensus (> 95%) 1. The guideline is based on the ethical principles of respect for the dignity and self-determination of the person as well as beneficence and non-harm and aims to realise these principles in the treatment setting. 2. The overarching aim of the guideline is to improve access for children and adolescents with gender incongruence1 and/or gender dysphoria2 to professional information and treatment on the basis of scientifically and ethically recognised standards, thereby enabling them to achieve the best possible health development. 3. Respecting the dignity of those seeking treatment, the guideline supports the elimination of discrimination and the depathologisation of people whose gender identity does not correspond to their anatomical sex or sex assigned at birth. This is reflected, among other things, in the terminology used. The term "*gender identity disorder"* from ICD-10 (WHO, 2019) is therefore no longer used. Instead, the terms *"gender incongruence"* and *"gender dysphoria"* are used according to ICD-11 (WHO, 2022) and DSM-5 (APA, 2013). 4. Patients3 with gender incongruence and/or gender dysphoria have a wide range of individual developmental trajectories. Counselling and treatment should therefore be tailored to individuals and their needs. The guideline is intended to provide professional orientation for the best possible individual treatment decisions. 5. In the process of its development, the guideline is committed to the idea of participation of all parties involved, including transgender people and	In the view of the DGPPN, this preamble requires comment on a number of points and should be rejected in its entirety because some of the statements are unbalanced, important aspects are missing and the preamble as a whole sets *a priori* inappropriate moral limits to the unbiased scientific evaluation of the evidence. The individual comments are as follows along the statements in the preamble: ***1. the guideline is based on the ethical principles of respect for the dignity and self-determination of the person as well as beneficence and non-harm and aims to realise these principles in the treatment setting.*** The orientation of a medical guideline towards generally recognised professional and medical ethical principles is a matter of course. Explicitly emphasising this for an individual guideline and also agreeing on it in a vote gives the impression that the medical ethical problems of the topic have been dealt with in particular detail or that a commitment was made to this at the beginning of the guideline work. However, this claim is not fulfilled. Chapter X ("Legal foundations and ethical standards for the treatment of minors with gender incongruence") deals primarily with legal aspects of the capacity of minors to give consent and refers almost exclusively to a single unpublished legal opinion, which was commissioned by the guideline coordinator Prof Romer and is therefore inaccessible to the addressees. Some questions of medical ethics are raised, but not discussed in detail. Mention is made of the "dilemma ... which consists in the fact that both treatment and postponement or omission can have irreversible consequences for later long-term mental health" and the question is raised "How should the right to self-determination and the underlying ethical principle of promoting autonomy be weighed against protecting minors from treatment decisions with potentially fatal consequences that reach far into

their relatives. The evaluation of previous experiences of people seeking treatment4 in the healthcare system is incorporated into the new version of the guideline, in particular to improve the range of treatment on offer and to avoid discrimination. 6. A person's gender identity is of a highly personal nature. Promoting self-determination and - where necessary - the ability to self-determine is therefore a key concern in the treatment setting with underage patients. Therapy approaches that are implicitly or explicitly based on the treatment goal of steering a person's sense of belonging to a particular gender in a certain direction are considered unethical. 7. Psychotherapeutic support should be offered and made available to those seeking treatment, e.g. to accompany open-ended self-discovery, to strengthen self-confidence, to overcome experiences of discrimination or for psychological preparation and follow-up of steps in the transition process. An obligation to undergo psychotherapy as a condition for access to medical treatment is not ethically justified for reasons of respect for the dignity and self-determination of the person. 8. Decisions in favour of medical measures that intervene in incomplete biological development imply a particular challenge and ethical responsibility for all those involved. On the one hand, the potential open-endedness of psychosexual and identity development to be assumed in individual cases and, on the other hand, the ever-increasing irreversibility of somatosexual maturity development and the increased risks to mental health that may result from this must be taken into account. When deciding on medical treatment steps for puberty interruption or gender-affriming hormone tretament in adolescence, the expected benefits and risks must therefore be carefully weighed up. The possible consequential health risks of a decision in favour of medical treatment that is subsequently regretted by those affected or treatment that turns out to be misguided for other reasons must therefore be	their future?" Answers to these and many other relevant medical-ethical questions are sought in vain and, consequently, no recommendations are formulated on either legal or ethical issues on the grounds that "... the legal framework is binding anyway and ethical principles must be weighed up in a considered manner when making responsible treatment decisions". ***2 The overarching aim of the guideline is to improve access for children and adolescents with gender incongruence1 and/or gender dysphoria2 to professional information and treatment on the basis of scientifically and ethically recognised standards, thereby enabling them to achieve the best possible health development.*** This statement omits the important point that it must of course also be a central aim of the guideline to provide those affected with a comprehensive child and adolescent psychiatric diagnosis and treatment of comorbid psychiatric disorders on the basis of scientific and ethical standards. ***3. in respect of the dignity of those seeking treatment, the guideline supports the elimination of discrimination and the depathologisation of persons whose gender identity does not correspond to their anatomical sex or sex assigned at birth. This is reflected, among other things, in the terminology used. The term gender identity disorder from ICD-10 (WHO, 2019) is therefore no longer used. Instead, the terms gender incongruence and gender dysphoria are used according to ICD-11 (WHO, 2022) and DSM-5 (APA, 2013).*** The choice of terms must be based on scientific evidence and corresponding national and international conventions and not primarily on objectives such as the reduction of discrimination and depathologisation. The approach chosen here of justifying the need for depathologisation with the dignity of those affected and the desire to reduce discrimination appears questionable and strange in the context of a science-based medical guideline. This could be understood as if the diagnosis of a mental disorder in itself would violate people's dignity and constitute unjustified discrimination.

weighed against the health risks that may arise if medical treatment is postponed or not initiated. 9. The guideline is intended to serve as a professional basis for responsible medical treatment decisions that are to be made jointly by the practitioners, minor patients and their legal guardians in the sense of *shared decision making*. The guideline is intended to provide orientation in this regard, particularly with regard to the requirements for sufficient information and counselling to enable those seeking treatment to understand the nature, significance and scope of the respective treatment options and to decide on them.	***6 A person's gender identity is of a highly personal nature. The promotion of self-determination and, where necessary, the ability to self-determine is therefore an essential concern in the treatment setting with underage patients. Therapy approaches that are implicitly or explicitly based on the treatment goal of steering a person's sense of belonging to a particular gender in a certain direction are considered unethical.*** This statement is unclear and misleading. With regard to conversion therapies, the legal prohibition and the risk of harm must be emphasised above all, while an apodictic moral assessment ("unethical") appears unscientific. ***7. psychotherapeutic support should be offered and made available to those seeking treatment, e.g. to accompany an open-ended self-discovery, to strengthen self-confidence, to cope with experiences of discrimination or for psychological preparation and follow-up of steps in the transition process. An obligation to undergo psychotherapy as a condition for access to medical treatment is not ethically justified for reasons of respect for the dignity and self-determination of the person.*** Here, too, it goes without saying that no one should be forced to undergo treatment and, in particular, that no one can be forced to undergo psychotherapy because this requires co-operation. However, it also goes without saying that comprehensive psychiatric treatment must be offered and made available for comorbid disorders. In fact, such treatment can also be a necessary prerequisite for access to body-altering treatments. It is standard procedure throughout medicine that the proper recommendation for the implementation of certain measures may require the implementation of other preparatory diagnostic or therapeutic measures. It is therefore entirely conceivable, depending on the scientific evidence, that hormone treatments or body-altering treatments should only be carried out after prior psychotherapeutic treatment and should not be regarded *a priori* as "ethically unjustified" with reference to "respect for the dignity and self-determination of the person". This guideline should therefore weigh up the evidence for and against such prior psychotherapeutic and possibly

	pharmacological treatment (e.g. of associated psychiatric disorders). This is not done and instead a "guard rail" is set in the preamble that cannot be scientifically justified, which declares further objective consideration to be morally impermissible. --- Finally, reference should also be made to points that are of fundamental importance for the guideline but which are not mentioned in the preamble: • From the DGPPN's point of view, the gaps in knowledge and the lack of evidence for the implementation of medical measures of any kind in the target group in question should be addressed. • From the DGPPN's perspective, it should be emphasised that this not only results in an obligation to exercise restraint and care, but also an obligation to increase knowledge about gender incongruence and actively promote research. • From the DGPPN's point of view, it should be addressed how complex and controversial the diagnostic process is that must precede medical measures of the scope proposed in this guideline in order to establish the recommendation basis and thus the necessary legitimisation for the interventions in the first place. Instead, even in the preamble to the guideline, before any scientific evidence has been weighted and evaluated, a primarily affirmative approach is chosen that makes the wishes and will of the person seeking counselling or treatment the only relevant yardstick.

	Final consented version of the guideline	DGPPN special vote	
No.	**Recommendation**	**Amended recommendation**	**Justification**
Chapter III Social role change in childhood			
III.K4.	When counselling children with gender incongruence or gender dysphoria who are considering a social role change before the onset of puberty and their guardians and, if applicable, other caregivers, the counsellor should offer professional support to protect the child and/or their caregivers from stigmatisation and discrimination, regardless of the individual decision and life path of those affected.	In counselling children with gender incongruence or gender dysphoria who are considering a social role change before the onset of puberty and their guardians and, if applicable, other caregivers, the counsellor **should** offer professional support to protect the child and/or their caregivers from stigmatisation and discrimination, regardless of the individual decision and life path of the person concerned.	The DGPPN is in favour of a higher level of recommendation regarding professional support to protect children considering a change of social role from stigmatisation and discrimination. Children with GI/GD can experience stigma and discrimination in various contexts and have an increased prevalence of mental health problems, such as depression, anxiety disorder, self-harming behaviour, suicidal thoughts and even suicide attempts (Strauss et al. 2020; European Union Agency for Fundamental Rights, 2014; Sauer & Meyer, 2016; Wilson et al., 2016). Due to the connection between experiences of stigmatisation/discrimination and the mental health of children with GI/GD, the DGPPN recommends a stronger level of recommendation for the offer of professional support by the counsellor to protect against stigmatisation/discrimination and to cope with such experiences. References

	Final consented version of the guideline	DGPPN special vote	
No.	**Recommendation**	**Amended recommendation**	**Justification**
			▪ Final consented Strauss, P., Cook, A., Winter, S., Watson, V., Wright Toussaint, D., & Lin, A. (2020). Associations between negative life experiences and the mental health of trans and gender diverse young people in Australia: Findings from Trans Pathways. Psychological Medicine, 50(5), 808-817. https://doi.org/10.1017/S0033291719000643 ▪ European Union Agency for Fundamental Rights. (2014). Being trans in the European Union: Comparative analysis of EU LGBT survey data. Publications Office. https://data.europa.eu/doi/10.2811/92683 ▪ Sauer, A. T., & Meyer, E. (with Bundesvereinigung Trans* e.V.). (2016). Like a green sheep in a white flock: Life situations and needs of young trans* people in Germany: Research report on "TRANS* - YES AND?!" as a joint youth project of the Bundesverband Trans* (BVT*) e.V.i.G. and the youth network Lambda e.V. Bundesverband Trans*. ▪ Wilson, E. C., Chen, Y.-H., Arayasirikul, S., Raymond, H. F., & McFarland, W.

	Final consented version of the guideline	DGPPN special vote	
No.	**Recommendation**	**Amended recommendation**	**Justification**
			(2016). The Impact of Discrimination on the Mental Health of Trans*Female Youth and the Protective Effect of Parental Support. AIDS And Behavior, 20(10), 2203-2211. cmedm. https://doi.org/10/f849bp
Chapter IV Associated mental disorders and health problems in children and adolescents with gender incongruence and gender dysphoria			
IV.E1.	When counselling children with gender incongruence or gender dysphoria who are considering a social role change before the onset of puberty and their guardians and, if applicable, other caregivers, the counsellor should offer professional support to protect the child and/or their caregivers from stigmatisation and discrimination, regardless of the individual decision and life path of those affected. There is evidence from cross-sectional studies that clinically relevant psychopathological abnormalities occur more frequently among gender dysphoric children and adolescents who present to healthcare facilities, which go beyond reported gender dysphoric distress.	In counselling children with gender incongruence or gender dysphoria who are considering a social role change before the onset of puberty and their guardians and, if applicable, other caregivers, the counsellor **should** offer professional support to protect the child and/or their caregivers from stigmatisation and discrimination, regardless of the individual decision and life path of those affected. There is evidence from cross-sectional studies that clinically relevant psychopathological abnormalities occur more frequently among gender dysphoric children and adolescents who present to healthcare facilities, which go beyond reported gender dysphoric distress.	The DGPPN is in favour of a higher level of recommendation regarding professional support to protect children considering a change of social role from stigmatisation and discrimination. The reasons for this special vote are set out in recommendation III.K4.
IV.K1.	Children and adolescents who present for diagnosis and/or treatment due to gender incongruence or gender dysphoria (GI/GD) should undergo a comprehensive child and adolescent psychiatric or psychotherapeutic assessment if there are indications of clinically relevant	Children and adolescents who present for diagnosis and/or treatment due to gender incongruence or gender dysphoria (GI/GD) **should undergo** a comprehensive child and adolescent psychiatric or psychotherapeutic assessment ~~**if there are indications of clinically**~~	The DGPPN is in favour of a higher level of recommendation and the removal of the condition that there must already be indications of psychopathological abnormalities as a prerequisite for diagnosis.

	Final consented version of the guideline	DGPPN special vote	
No.	**Recommendation**	**Amended recommendation**	**Justification**
	psychological or psychopathological abnormalities. The history of the reported abnormalities and their possible interactions with GI or GD should be carefully recorded.	~~**relevant psychological or psychopathological abnormalities**~~. The history of the reported abnormalities and their possible interactions with GI or GD **should** be carefully recorded.	All children and adolescents who present with GI/GD for diagnosis and/or treatment must undergo a comprehensive child and adolescent psychiatric or psychotherapeutic assessment. Clinically relevant psychological and psychopathological abnormalities may only become apparent in the course of a professional diagnosis. Their comprehensive and holistic clarification, taking into account the history of their origin, as well as the development of a common understanding of the problem and critical scrutiny, is therefore central to all subsequent steps. Dysphoric distress alone, even if it is not yet considered pathological, can impair the ability to give consent (DGPPN, 2014). A complete child and adolescent psychiatric diagnosis is therefore also a prerequisite for actively establishing the capacity to consent in children and adolescents (Gutmann, 2023). This corresponds to clinical diligence, is necessary to take account of the known high rate of comorbidity and to ensure the affected person's capacity to consent.

	Final consented version of the guideline	DGPPN special vote	
No.	**Recommendation**	**Amended recommendation**	**Justification**
			It goes without saying that no one should be forced to undergo treatment and especially not psychotherapy, as this requires their voluntary co-operation. However, a comprehensive diagnosis is absolutely necessary to determine the diagnosis of GI or GD and to rule out an interfering mental disorder, is reasonable and in the interests of holistic care for children and adolescents. <u>References</u> ▪ German Society for Psychiatry and Psychotherapy (DGPPN) (2014). Respect for self-determination and the use of coercion in the treatment of mentally ill people: An ethical statement of the DGPPN. The Neurologist 85:1419-1431 ▪ Gutmann, T. (2023). Legal opinion on the requirements for legally effective consent to puberty-suppressing or gender-affirming somatomedical treatment of minors with gender dysphoria. (Unpublished). Prepared for Münster University Hospital.

IV.K3.	In a child and adolescent psychiatric or psychotherapeutic diagnosis of children and adolescents with gender incongruence or gender dysphoria, attention should be paid specifically to the possible presence of depression, anxiety disorder, self-harming behaviour and suicidal tendencies that require treatment.	In a child and adolescent psychiatric or psychotherapeutic diagnosis of children and adolescents with gender incongruence or gender dysphoria, specific attention **should** be paid to the possible presence of depression, anxiety disorder, self-harming behaviour and suicidal tendencies that require treatment.	The DGPPN is in favour of a higher level of recommendation for the clarification of comorbid mental disorders. In a child and adolescent psychiatric or psychotherapeutic diagnosis of children and adolescents with GI/GD, special attention must be paid to possible accompanying psychopathological abnormalities. Children and adolescents with GD/GI have an increased prevalence of e.g. co-occurring depression or anxiety disorders, self-harming behaviour and suicidal tendencies (see Chapter IV, 2). Attention must also be paid to the presence of an autism spectrum disorder and other common concomitant mental disorders (see Chapter IV, 2.5). Mental and psychopathological abnormalities should be recognised as best as possible during a diagnosis, including differential diagnosis, so that they do not interfere with a possible treatment process and can be adequately taken into account in an individual treatment plan.
IV.K4.	If a mental disorder requiring treatment is diagnosed in association with gender incongruence or gender dysphoria (GI/GD) in childhood or adolescence, specialised treatment should be offered. This should be individually designed as part of a treatment plan that	If a mental disorder requiring treatment is diagnosed in association with gender incongruence or gender dysphoria (GI/GD) in childhood or adolescence, specialised treatment **should** be offered. This **should** be individually designed as part of a treatment plan that	The DGPPN is in favour of a higher level of recommendation for the professional treatment of comorbid mental disorders and their inclusion in an individual treatment plan.

	includes any indicated GI/GD-specific treatment measures.	includes any indicated GI/GD-specific treatment measures.	If a mental disorder requiring treatment in the context of a GI/GD has been professionally diagnosed, it is a professional duty of care to offer the affected person appropriate treatment. Of course, the acceptance of such treatment for associated mental disorders is based on the voluntary and self-determined decision and willingness of the person concerned and their legal guardians. A GI/GD should be appropriately considered in an individualised treatment plan to ensure successful therapy.
IV.K5.	When making a diagnostic assessment of psychopathological symptoms or mental disorders that are associated with gender incongruence or gender dysphoria (GI/GD), practitioners should avoid making generalised assumptions about causal relationships. Instead, in an open dialogue with patients, an attempt should be made to develop an individualised disorder model with regard to the psychopathological symptoms and complaints. (see Chapter V → "Psychotherapy")	When making a diagnostic assessment of psychopathological symptoms or mental disorders associated with gender incongruence or gender dysphoria (GI/GD), practitioners **should** avoid making generalised assumptions about causal relationships. Instead, in an open dialogue with patients, an attempt **should be made** to develop an individualised disorder model with regard to the psychopathological symptoms and complaints. (see Chapter V → "Psychotherapy")	The DGPPN is in favour of a stronger level of recommendation for the development of an individual case-related disorder model. Based on the current study situation, no generalised statements can be made about causalities between psychopathological abnormalities and GI/GD and their genesis; further research is needed here. For this reason, practitioners should not make any hasty or generalised assumptions about causal relationships. On the contrary, practitioners should discuss the individual situation in dialogue with those affected in order to develop a case-specific disorder model. This serves as the basis

			for an individual symptom genesis, possible interactions and helps with the diagnosis and planning of further steps.
IV.K6.	Children and adolescents who present with gender dysphoric symptoms should be checked for the possible presence of an autism spectrum disorder. If an autism spectrum disorder is suspected, the recommendations of the S3 guideline "Autism Spectrum Disorders in Childhood and Adolescence, Part 1: Diagnostics (AWMF Reg. No. 028-018) should be followed.	In children and adolescents who present with gender dysphoric symptoms, attention **should** be paid to the possible presence of an autism spectrum disorder. If an autism spectrum disorder is suspected, the recommendations of the S3 guideline "Autism Spectrum Disorders in Childhood and Adolescence, Part 1: Diagnostics (AWMF Reg. No. 028-018) should be followed.	The DGPPN is in favour of a stronger level of recommendation for the clarification of an autism spectrum disorder (ASD). There is clear evidence of an increased coincidence of GI/GD with abnormalities from the autism spectrum in children and adolescents (see Chapter IV, 2.5, Kallitsounaki & Williams, 2023). As part of the diagnosis and differential diagnosis of GI/GD in children and adolescents, autism screening is therefore recommended by the DGPPN. At the same time, the DGPPN recommends that the possibility of a dual diagnosis of ASD and GI/GD be taken into account diagnostically in order to minimise the risk of underdiagnosis with subsequent non-treatment/incorrect treatment. <u>Reference</u> ▪ Kallitsounaki, A., Williams D.M. (2023). Autism Spectrum Disorder and Gender Dysphoria / Incongruence. A systematic literature review and meta-analysis. J Autism Dev Disord, 53(8): 3103-3117. doi: 10.1007/s10803-022-05517-y.

IV.K7.	If children and adolescents with gender incongruence or gender dysphoria also have a diagnosed autism spectrum disorder, the expertise of both areas should be taken into account when providing professional support.	If children and adolescents with gender incongruence or gender dysphoria also have a diagnosed autism spectrum disorder, the expertise of both areas **should** be included in the professional support.	The DGPPN is in favour of a higher level of recommendation regarding professional support for a dual diagnosis of ASD and GI/GD. In the presence of a diagnosed autism spectrum disorder in children and adolescents with GI/GD, the expertise of both areas must be included in professional support. For therapy, please refer to the S3 guideline "Autism spectrum disorders in childhood, adolescence and adulthood. Part 2: Therapy" (AWMF register no. 028 - 047). Reference ▪ Association of the Scientific Medical Societies in Germany (AWMF). S3 Guideline Autism Spectrum Disorders in Children, Adolescents and Adults. Part 2: Therapy (S3 guideline AWMF register number 028-047). https://register.awmf.org/assets/guidelines/028-047l_S3_Autismus-Spektrum-Stoerungen-Kindes-Jugend-Erwachsenenalter-Therapie_2021-04_1.pdf

Chapter V Psychotherapy and psychosocial interventions			
V.K1.	Psychotherapeutic support should be offered and made available to those seeking treatment as support and guidance, e.g. for open-ended self-discovery, to strengthen self-confidence, to overcome experiences of discrimination or for psychological preparation and follow-up of steps in the transition process. An obligation to undergo psychotherapy as a condition for access to body-altering treatment is not ethically justified for reasons of respect for the dignity and self-determination of the person.	Psychotherapeutic support should be offered and made available to those seeking treatment as support and guidance, e.g. for open-ended self-discovery, to strengthen self-confidence, to cope with experiences of discrimination or for psychological preparation and follow-up of steps in the process of transition, **as well as for the treatment of comorbid mental disorders**. A general obligation to undergo psychotherapy as a condition for access to body-altering treatment is not ~~**ethically justifiable for reasons of respect for the dignity and self-determination of the person.**~~	The DGPPN is in favour of deleting the reference that there should be no obligation to undergo psychotherapy for ethical reasons of respect for dignity and self-determination. Of course, no one should or can be forced to undergo psychotherapy, as this requires their voluntary co-operation. However, psychotherapeutic counselling can help to weigh up possible treatment decisions and address interfering mental disorders in a professional manner. However, psychotherapy is not unreasonable, as the justification in the recommendation suggests, but rather open-ended support. It is undisputed that psychotherapy should not be used without a specific recommendation and that the recommendation should be determined in accordance with the guidelines for psychotherapy. However, psychotherapy can offer certain people professional and individualised support for comprehensive clarification and preparation of a potentially far-reaching life decision at a young age.

V.K3.	Adolescents with gender-nonconforming self-descriptions who seek psychotherapeutic support when their gender identity is still uncertain should be informed that exploratory social role explorations are important in order to support a process of introspection and self-reflection in connection with social interaction experiences through dialogue. Protection against discrimination should be taken into account. In this process, young people ~~**should**~~ be supported in questioning gender-stereotypical role expectations and reflecting on the possibility of a non-binary understanding of gender roles.	Adolescents with gender-nonconforming self-descriptions who seek psychotherapeutic support when their gender identity is still uncertain should be informed that exploratory social role explorations are important in order to support a process of introspection and self-reflection in connection with social interaction experiences through dialogue. Protection against discrimination should be taken into account. In this process, young people **should** be supported in questioning gender-stereotypical role expectations ~~**and reflecting on the possibility of a non-binary understanding of gender roles**~~.	The DGPPN is in favour of deleting the redundant reference to the possibility of a non-binary understanding of gender roles. Furthermore, the DGPPN is in favour of a stronger level of recommendation for reflecting on gender-stereotypical role expectations. The first part of the last sentence of the recommendation rightly points out that young people should be supported in questioning gender-stereotypical role expectations. According to the glossary of the guideline, this refers to "a person's reflected understanding of their own gender role [...] which is not rooted in heteronormative ideas of "male" or "female", but rather their own role beyond social role expectations" (see page 28). In this respect, the possibility of a non-binary understanding of gender roles should already be part of the reflection and, in the view of the DGPPN, a separate reference to this should be unnecessary.

V.K4.	Children and adolescents with gender incongruence or gender dysphoria who have begun a social transition or are aiming to do so can be offered psychotherapeutic process support to prepare for individual decisions and to reflect on the associated experiences.	Children and adolescents with gender incongruence or gender dysphoria who have begun a social transition or are aiming to do so **should be** offered psychotherapeutic counselling to prepare for individual decisions and to reflect on the associated experiences.	The DGPPN is in favour of a higher level of recommendation for psychotherapeutic process support during social transition. If there is no associated psychopathological disorder, the offer of psychotherapy for children and adolescents with GI/GD should be seen as support for open-ended self-exploration during the process of social transition. Such psychotherapeutic support should serve as an opportunity for those affected to reflect and prepare decisions. Of course, it is the voluntary and self-determined decision of those affected to accept or reject the offer. A "can do" recommendation does not do justice to the potential benefits of psychotherapeutic support in the development process. Furthermore, no groups of people should be excluded so that the offer of psychotherapeutic process support should reach all children and adolescents with GI/GD who have begun a social transition or are aiming to do so.
V.K5.	Psychotherapeutic professionals who accompany gender-nonconforming adolescents in the process of social role exploration or social transition should convey that they are open to any doubts and uncertainties that may arise with	Psychotherapeutic professionals who accompany gender-nonconforming adolescents in the process of social role exploration or social transition **should** convey that they are open to any doubts and uncertainties that may arise with	The DGPPN is in favour of a stronger level of recommendation for openness on the part of psychotherapeutic professionals with regard to desistance/detransition.

	regard to transition and to thoughts of desistance or detransition.	regard to transition and to thoughts of desistance or detransition.	When exploring and investigating social roles or transition, the psychotherapist should always offer open-ended support, in which the person seeking treatment is explicitly supported in dialogue by reflecting on doubts and uncertainty with regard to transition and detransition/desistance. The psychotherapeutic professional should express and disclose this basic attitude in the therapeutic context, even if desistance/detransition is rather rare (see Chapter II, 4). This transparency of an open attitude on the part of the professional should encourage the person seeking treatment to open up and prevent fears of disappointing others (see Chapter V, 6.5).

Chapter VI Inclusion of the family relationship environment and family dynamics			
VI.K1.	Legal guardians and carers should be informed that attempts at therapy aimed at changing the child's sense of belonging to a gender contrary to their expressed feelings are harmful and unethical.	Guardians and carers **should** be informed that attempts at therapy aimed at changing the child's sense of belonging to a gender contrary to their expressed feelings **can be** harmful ~~**and unethical**~~.	The DGPPN is in favour of a higher level of recommendation for informing guardians about the harmfulness of attempts to influence the child's sense of gender identity. As conversion treatments are a punishable offence in Germany (BGB 2020), the DGPPN recommends providing the relevant information. This law applies to all treatments performed on humans that are aimed at changing or suppressing sexual orientation or self-perceived gender identity. Custodians and carers should be informed about the legal framework and warned of the harmful psychological effects of an attempt to influence the child's sense of belonging to one gender.
VI.K2.	Parents and guardians should be informed that for children and adolescents with gender incongruence or gender dysphoria, the safe and constant experience of being accepted and supported by their own family is essential for self-discovery and, depending on the progression, for a social coming out, role testing and transition for a favourable course of mental health.	Guardians and educators **should** be informed that for children and adolescents with gender incongruence or gender dysphoria, the safe and constant experience of being accepted and supported by their own family is essential for self-discovery and, depending on the progression, for a social coming-out, role testing and transition for a favourable course of mental health.	The DGPPN is in favour of a higher level of recommendation for informing guardians about the importance of acceptance. Family support and acceptance for children and adolescents with GI/GD is considered a protective factor (see Chapter VI, 2). In this respect, the attitude of guardians and carers plays a central role in the mental health of children and adolescents with GI/GD. At the same time, the family members' own efforts to

			adapt to the potentially unsettling situation should not be underestimated. In order to prevent mental health problems in children and adolescents with GI/GD, such as depression, anxiety disorders, self-harming behaviour, suicidal thoughts and even suicide attempts (see Chapter IV, 2), guardians and carers should be informed at an early stage about the importance of family acceptance and support for their children in order to promote an accepting family environment.
Chapter VII Recommendations for body-altering medical interventions			
VII.E1.	There is evidence from uncontrolled follow-up studies that patients with persistent gender dysphoria diagnosed in adolescence who receive staged body-altering treatment in the context of a socially supported transition show a long-term improvement in quality of life and mental health in adulthood. Evidence level: low (2 studies with different cohorts from the same centre) References: (Cohen-Kettenis & van Goozen, 1997; de Vries et al., 2011, 2014)	~~**There is evidence from uncontrolled follow-up studies that patients with persistent gender dysphoria diagnosed in adolescence who receive staged body-altering treatment in the context of a socially supported transition show a long-term improvement in quality of life and mental health in adulthood.**~~	The DGPPN is in favour of deleting this statement on the state of knowledge. In the opinion of the DGPPN, it is not possible to make a clear statement on the improvement in quality of life and mental health in adulthood for children and adolescents with persistent GD who have received body-altering treatment in connection with a social transition on the basis of the current evidence. Decisions in favour of medical measures that intervene in incomplete biological development imply a particular challenge and ethical responsibility for all those involved. On the one hand, the potential open-endedness of psychosexual and

			identity development to be assumed in individual cases and, on the other hand, the ever-increasing irreversibility of somatosexual maturity development and the possibly resulting increased risks to mental health must be taken into account. When deciding on medical treatment steps for puberty blockade or gender-affriming hormone tretamenin adolescence, the expected benefits and risks must therefore be carefully weighed up. The possible consequential health risks of a decision in favour of medical treatment that is subsequently regretted by those affected or a treatment that turns out to be misguided for other reasons must therefore be weighed against the health risks that may arise if medical treatment is postponed or not initiated. The studies and endpoints mentioned in the recommendation are selective and do not comprehensively reflect the evidence in an appropriate manner. Three reviews based on a systematic review of the literature conclude that a general positive risk-benefit assessment of hormonal puberty blockade for adolescents with persistent GI is not yet possible (National Institute for Health and Care Excellence (NICE), 2020; Taylor, et

			al., 2024a; Zepf et al., 2024). There is also a considerable need for research into gender-affirming hormone therapy (Taylor, et al., 2024b; Zepf et al., 2024). There is a lack of high-quality research evaluating the use of gender-modifying hormone therapy in adolescents with gender dysphoria/incongruence. Moderately powered studies suggest that mental health may improve during gender-modifying hormone treatment, but robust studies are still needed. No conclusions can yet be drawn for endpoints other than mental health (Taylor et al. 2024b). In the opinion of the DGPPN, the overall study situation is not (yet) sufficient to make an evidence-based statement on quality of life and mental health in adulthood after body-altering treatment in adolescence, neither in one direction nor in the other. <u>References</u> ▪ National Institute for Health and Care Excellence (NICE). (2020). Evidence review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria. https://cass.independent-review.uk/wp-

			content/uploads/2022/09/20220726_Evidence-review_GnRH-analogues_For-upload_Final.pdf ▪ Taylor, J., Mitchell, A., Hall, R., Heathcote, C., Langton, T., Fraser, L., & Hewitt, C. E. (2024a). Interventions to suppress puberty in adolescents experiencing gender dysphoria or incongruence: A systematic review. Archives of Disease in Childhood. https://adc.bmj.com/content/109/Suppl_2/s33 ▪ Taylor, J., Mitchell, A., Hall, R., Langton, T., Fraser, L., & Hewitt, C. E. (2024b). Masculinising and feminising hormone interventions for adolescents experiencing gender dysphoria or incongruence: A systematic review. Archives of Disease in Childhood, archdischild-2023-326670. https://adc.bmj.com/content/109/Suppl_2/s48 ▪ Zepf, F. D., König, L., Kaiser, A., Ligges, C., Ligges, M., Roessner, V., Banaschewski, T., & Holtmann, M. (2024). Beyond NICE: Updated systematic review of the evidence for pubertal blockade and hormone administration in minors with gender dysphoria. Journal of Child and Adolescent Psychiatry and Psychotherapy, 52(3), 167-187.

			https://econtent.hogrefe.com/doi/10.1024/1422-4917/a000972
VII.K.xx.	Before initiating body-altering medical measures for the treatment of gender incongruence or gender dysphoria in adolescence, treating patients and their guardians should point out the high relevance of clinical follow-up in the form of appropriate medical aftercare and offer this.	Before initiating body-altering medical measures for the treatment of gender incongruence or gender dysphoria in adolescence, practitioners **should** inform patients and their guardians of the high relevance of clinical follow-up in the form of appropriate medical aftercare and offer this.	The DGPPN is in favour of a higher level of recommendation for information on the relevance of medical aftercare for body-altering measures. The reasons for this special vote are set out in recommendation VII.K.yy.
VII.K.yy.	If longitudinal scientific observational studies (e.g. registry studies) on body-altering medical interventions for gender incongruence or gender dysphoria in adolescence are available and accessible to patients, healthcare professionals should provide information about them and help to ensure that patients are offered the opportunity to participate in the study.	If **clinical studies or** longitudinal scientific observations (e.g. registry studies) on body-altering medical interventions for gender incongruence or gender dysphoria in adolescence are available and accessible to patients, healthcare professionals **should** provide information and help to ensure that patients are offered the opportunity to participate in studies.	The DGPPN is in favour of a higher level of recommendation for scientific monitoring of body-altering measures, not only in follow-up observations but also in clinical studies. Due to the uncertain or lack of evidence to date on the consequences of body-altering medical measures for GI/GD in adolescence, long-term clinical observations in the follow-up setting and clinical studies are of particular importance. The diagnostic process for establishing an recommendation and thus the necessary legitimisation for medical interventions is complex and controversial. This results in an obligation to increase knowledge about GI and actively promote research. A higher level of recommendation promotes the implementation of corresponding studies. The DGPPN considers the restriction to

			purely longitudinal scientific observational studies to be too narrow, so that the professional association formulates an extension to all clinical studies with this special vote. The DGPPN is aware that certain study designs with GI/GD questions present methodological challenges, e.g. in the area of blinding (see McNamara et al., 2024). Nevertheless, an improvement in the evidence base with a focus on methodologically high-quality study designs approved by ethics committees is necessary in order to be able to derive reliable recommendations. Not only adolescents with GI/GD themselves can benefit from studies, e.g. through close follow-up care, but the entire patient group. If appropriate studies are available and accessible to those affected, the DGPPN believes that information and education about the study and an offer to participate in the study are obligatory. References: ▪ McNamara, M., Baker, K., Connelly, K., Janssen, A., Olson-Kennedy, J., Pang, K. C., Scheim, A., Turban, J., & Alstott, A. (2024). An Evidence-Based Critique of "The Cass Review" on Gender-affirming Care for Adolescent Gender Dysphoria. https://law.yale.edu/sites/default/file

			s/documents/integrity-project_cass-response.pdf
VII.K0.	Specialist knowledge and several years of experience in the counselling and treatment of adolescents with gender incongruence are required in order to determine an appropriate recommendation. Professionals without sufficient specialist knowledge and experience in this area should consult a sufficiently experienced professional or a specialist outpatient clinic or treatment centre to ensure that an recommendation is made.	Specialist knowledge and several years of experience in the counselling and treatment of adolescents with gender incongruence are required in order to determine an appropriate recommendation. Professionals without sufficient specialist knowledge and experience in this area **should** consult a sufficiently experienced professional or a specialist outpatient clinic or treatment centre to ensure that an recommendation is made.	The DGPPN is in favour of a higher level of recommendation in favour of recommendation by a sufficiently experienced specialist. In the opinion of the DGPPN, it is essential for a professional recommendation of a body-altering medical intervention that the specialist making the recommendation, who does not have several years of experience in the process support and treatment of adolescents with GI, is professionally assured and does not make the decision alone. This professional assurance can be provided, for example, by consulting specialist treatment centres, a second opinion from an experienced professional, consultative co-assessments or case conferences. The involvement of experienced specialist colleagues also concerns the interdisciplinary cooperation of psychological, psychiatric and endocrinological specialisms, due to the complexity of the subject matter (e.g. involvement of specialists with autism expertise in young people with GI/GD from the autism spectrum).

VII.K2.	The expertise of the persons who provide the child and adolescent psychiatric-psychotherapeutic-psychotherapeutic part of the recommendation for puberty blockade in adolescents with gender incongruence or gender dysphoria should fulfil the following formal requirements: General qualifications: One of the following qualifications specific to childhood and adolescence: D: - Specialist designation for child and adolescent psychiatry and psychotherapy - Licence for child and adolescent psychotherapy - Specialist medical title for paediatrics and adolescent medicine with additional qualification in psychotherapy CH: - Specialist in child and adolescent psychiatry and psychotherapy (Foederatio Medicorum Helveticorum/FMH) - Federally recognised psychotherapist A: - Specialist in child and adolescent psychiatry or specialist in child and adolescent psychiatry and psychotherapeutic medicine - Registration as a psychotherapist with further training in infant, child and adolescent psychotherapy - Or, alternatively, with proven clinical expertise in the diagnosis and treatment of children and adolescents:	The expertise of the persons who provide the child and adolescent psychiatric-psychotherapeutic part of the recommendation for puberty blockade in adolescents with gender incongruence or gender dysphoria **should** fulfil the following formal requirements: General qualifications: One of the following qualifications specific to childhood and adolescence: D: - Specialist designation for child and adolescent psychiatry and psychotherapy - Licence for child and adolescent psychotherapy - Specialist medical title for paediatrics and adolescent medicine with additional qualification in psychotherapy CH: - Specialist in child and adolescent psychiatry and psychotherapy (Foederatio Medicorum Helveticorum/FMH) - Federally recognised psychotherapist A: - Specialist in child and adolescent psychiatry or specialist in child and adolescent psychiatry and psychotherapeutic medicine - Registration as a psychotherapist with further training in infant, child and adolescent psychotherapy - Or, alternatively, with proven clinical expertise in the diagnosis and treatment of children and adolescents: D:	The DGPPN is in favour of a higher level of recommendation regarding the necessary qualification of the psychiatric-psychotherapeutic specialist for the recommendation of puberty blockade. The qualifications listed are relevant and an absolute prerequisite for a professional recommendation (for puberty blockade, sex-altering hormone treatment, mastectomy or breast reduction). From the DGPPN's point of view, the ultimate responsibility for determining an recommendation must be borne by a medical specialist. The DGPPN also emphasises at this point that the recommendation cannot be considered in isolation from recommendations VII.K0., VII.K1.; VII.K12. and VII.K23. In addition to the formal qualification, several years of experience in the process support and treatment of adolescents with GI/GD as well as the unconditional involvement of further, experienced specialist medical expertise and interdisciplinary cooperation must be taken into account.

	D: - Specialist title for psychiatry and psychotherapy, psychotherapeutic medicine or psychosomatic medicine and psychotherapy - Licence for psychological psychotherapy CH: - Specialist in psychiatry and psychotherapy (FMH) A: - Specialist in psychiatry and psychotherapeutic medicine, specialist in psychiatry and neurology Registration as a psychotherapist, registration as a clinical psychologist.	- Specialist title for psychiatry and psychotherapy, psychotherapeutic medicine or psychosomatic medicine and psychotherapy - Licence for psychological psychotherapy CH: - Specialist in psychiatry and psychotherapy (FMH) A: - Specialist in psychiatry and psychotherapeutic medicine, specialist in psychiatry and neurology	
VII.K10.	If the minor is capable of giving consent (D)/capable of judgement (CH)/capable of making decisions (A), a co-consensus should be sought between the custodians.	If the minor has the capacity to give consent (D)/capacity to make judgements (CH)/capacity to make decisions (A), a co-consensus of the custodians **should** be sought.	The DGPPN is in favour of a stronger level of recommendation to strive for co-consensus with guardians before body-altering medical interventions. Family acceptance and support for social transition and, in particular, body-altering measures including gender-affirming surgery is of crucial importance for the mental health of adolescents with GI and is considered a protective factor. In this respect, a co-consensus between the legal guardians should be sought in order to prevent the risk of psychological disorders such as depression, suicidal tendencies or self-harming risk behaviour (see Chapters IV and VI).

VII.K11.	In cases where there is no co-consensus between the patient and their legal guardians, intensive process support for the family system should be offered by a suitable specialist with expertise in family therapy with the aim of providing support for the patient. Such process support is only recommended if no harmful effects on the health/psychological well-being of the patient are to be expected. In such cases, an assessment of the best interests of the child is indicated.	In cases where there is no co-consensus between the patient and their legal guardians, intensive process support for the family system **should** be offered by a suitable specialist with expertise in family therapy with the aim of facilitating support for the patient. Such process support is only recommended if no harmful effects on the health/psychological well-being of the patient are to be expected. In such cases, an assessment of the best interests of the child is indicated.	The DGPPN is in favour of a higher level of recommendation for family therapy process support if there is no co-consensus. If a co-consensus cannot be reached, an attempt should be made to promote an accepting family framework in the interests of the mental health of the children and adolescents with intensive family therapy process support, unless a family therapy intervention would be expected to have psychologically harmful effects on the adolescents concerned (e.g. in the case of spatial separation supported by the youth welfare office following experiences of abuse while custody is retained)" (see Chapter VII 6.2.6. and 6.3.6.).
VII.K13.	The expertise of the persons who provide the child and adolescent psychiatric/psychotherapeutic/psychotherapeutic part of the recommendation for gender-affirming hormone treatment in adolescents with gender incongruence or gender dysphoria should fulfil the following formal requirements: One of the following qualifications specific to adolescence: D: - Specialist designation for child and adolescent psychiatry and psychotherapy - Licence for child and adolescent psychotherapy	The expertise of the persons who provide the child and adolescent psychiatric/psychotherapeutic/psychotherapeutic part of the recommendation for gender-affirming hormone treatment in adolescents with gender incongruence or gender dysphoria **should** fulfil the following formal requirements: One of the following qualifications specific to adolescence: D: - Specialist designation for child and adolescent psychiatry and psychotherapy - Licence for child and adolescent psychotherapy	The DGPPN is in favour of a higher level of recommendation regarding the necessary qualification of the psychiatric-psychotherapeutic specialist for the recommendation of gender-modifying hormone treatment. In the view of the DGPPN, the ultimate responsibility for determining an recommendation must be borne by a medical specialist. The reasons for this special vote are set out in recommendation VII.K2.

	- Specialist medical title for paediatrics and adolescent medicine with additional qualification in psychotherapy CH: - FMH title in child and adolescent psychiatry and psychotherapy - Federally recognised psychotherapist A: - Specialist in child and adolescent psychiatry or specialist in child and adolescent psychiatry and psychotherapeutic medicine - Registration as a psychotherapist with further training in infant, child and adolescent psychotherapy Or alternatively with appropriate clinical expertise in the diagnosis and treatment of children and adolescents: D: - Specialist title for psychiatry and psychotherapy, psychotherapeutic medicine or psychosomatic medicine and psychotherapy - Licence for psychological psychotherapy CH: - FMH title in psychiatry and psychotherapy A: - Specialist in psychiatry and psychotherapeutic medicine, specialist in psychiatry and neurology - Registration as a psychotherapist, registration as a clinical psychologist	- Specialist medical title for paediatrics and adolescent medicine with additional qualification in psychotherapy CH: - FMH title in child and adolescent psychiatry and psychotherapy - Federally recognised psychotherapist A: - Specialist in child and adolescent psychiatry or specialist in child and adolescent psychiatry and psychotherapeutic medicine - Registration as a psychotherapist with further training in infant, child and adolescent psychotherapy Or alternatively with appropriate clinical expertise in the diagnosis and treatment of children and adolescents: D: - Specialist title for psychiatry and psychotherapy, psychotherapeutic medicine or psychosomatic medicine and psychotherapy - Licence for psychological psychotherapy CH: - FMH title in psychiatry and psychotherapy A: - Specialist in psychiatry and psychotherapeutic medicine, specialist in psychiatry and neurology - Registration as a psychotherapist, registration as a clinical psychologist	

VII.K18.	If there is a co-existing mental disorder that interferes with the treatment and goes beyond the gender dysphoria before a gender-affirming hormone treatment is indicated, a specialised psychiatric-psychotherapeutic intervention should be recommended and offered as part of an integrated or networked treatment concept. The treatment steps should be prioritised in dialogue with the patient.	If, before a gender-affirming hormone treatment is indicated, there is a co-existing mental disorder that goes beyond the gender dysphoria and interferes with the treatment, a specialised psychiatric-psychotherapeutic intervention **should** be recommended and offered as part of an integrated or networked treatment concept. The treatment steps should be prioritised in dialogue with the patient.	The DGPPN is in favour of a higher level of recommendation for the integrated treatment of a co-occurring mental disorder if sex-modifying hormone treatment is planned. Adolescents with GI/GD have a higher incidence of co-occurring mental disorders (see Chapter IV). In the opinion of the DGPPN, in order to ensure a clear recommendation and thus the success of treatment for a body-altering medical intervention, such as gender-modifying hormone treatment (GAH) or mastectomy or breast reduction, it is essential to treat co-occurring mental disorders that may interfere with the body-altering intervention professionally. This requires a psychiatric-psychotherapeutic diagnosis (assessment) prior to determining the recommendation for a body-altering intervention. The networked treatment of a co-occurring mental disorder is intended to ensure that adolescents are confident in their individual decisions about body-altering medical interventions and that those treating them can make a clear recommendation based on clear gender dysphoric symptoms. The treatment of a co-occurring mental disorder is also of great importance

			because it can have a negative impact on the ability to give consent. It is important that the individual treatment steps for both the co-occurring, interfering mental disorder and the body-altering intervention are planned and prioritised in dialogue with the patient in order to promote adherence.
VII.K19.	Before a gender-affirming hormone treatment is indicated in adolescence, adolescents and their guardians should be informed about the possible effects of the treatment on sexuality, fertility, relationship experience, body experience, possible experiences of discrimination and further gender-affirming body-altering treatment steps. The possibilities of fertility-preserving medical measures should be pointed out and access to specialised counselling for this should be made possible.	Before a gender-affirming hormone treatment is indicated in adolescence, adolescents and their guardians should be informed about the possible effects of the treatment on sexuality, fertility, relationship experience, body experience, possible experiences of discrimination and further gender-affirming body-altering treatment steps. **They should be** made aware of the possibilities of fertility-preserving medical measures and given access to specialised counselling.	The DGPPN is in favour of a stronger level of recommendation to the effect that the possibilities of fertility-preserving medical measures should be pointed out. Knowledge of the effects of treatment and the medical options is essential for adolescents and their guardians to make an informed decision. Both should always be part of an informed explanation before an recommendation is made.
VII.K21.	If the patient is capable of giving consent (D)/capable of judgement (CH)/capable of making a decision (A) regarding gender-affirming hormone treatment, a co-consensus should be sought between the legal guardians.	If the patient is capable of giving consent (D)/capable of judgement (CH)/capable of making a decision (A) regarding the performance of gender-affirming hormone treatment, a co-consensus of the custodians **should** be sought.	The DGPPN is in favour of a stronger level of recommendation to strive for co-consensus with guardians before body-altering medical interventions. The reasons for this special vote are set out in recommendation VII.K10.

VII.K22.	In cases where there is no co-consensus between the patient and their legal guardians, intensive process support for the family system should be offered by a suitable specialist with the aim of facilitating support for the patient. Such process support is only recommended if no harmful effects on the health/psychological well-being of the patient are to be expected.	In cases where there is no co-consensus between the patient and their legal guardians, intensive process support for the family system **should** be offered by a suitable specialist with the aim of facilitating support for the patient. Such process support is only recommended if no harmful effects on the health/psychological well-being of the patient are to be expected.	The DGPPN is in favour of a higher level of recommendation for family therapy process support if there is no co-consensus. The reasons for this special vote are set out in recommendation VII.K11.
VII.K24.	The qualification of the specialist for the adolescent psychiatric-psychotherapeutic-psychotherapeutic part of should fulfil the following requirements for the recommendation of a sex reassignment mastectomy or breast reduction operation in adolescents with gender incongruence or gender dysphoria: One of the following qualifications specific to childhood and adolescence: D: - Specialist designation for child and adolescent psychiatry and psychotherapy - Licence for child and adolescent psychotherapy - Specialist medical title for paediatrics and adolescent medicine with additional qualification in psychotherapy CH: - FMH title in child and adolescent psychiatry and psychotherapy - Federally recognised psychotherapist	The qualification of the specialist for the adolescent psychiatric-psychotherapeutic-psychotherapeutic part of the recommendation of a sex reassignment mastectomy or breast reduction surgery in adolescents with gender incongruence or gender dysphoria **should** fulfil the following requirements: One of the following qualifications specific to childhood and adolescence: D: - Specialist designation for child and adolescent psychiatry and psychotherapy - Licence for child and adolescent psychotherapy - Specialist medical title for paediatrics and adolescent medicine with additional qualification in psychotherapy CH: - FMH title in child and adolescent psychiatry and psychotherapy - Federally recognised psychotherapist	The DGPPN is in favour of a higher level of recommendation regarding the necessary qualification of the psychiatric-psychotherapeutic specialist for the recommendation gender-modifying mastectomy or breast reduction. In the view of the DGPPN, the ultimate responsibility for determining an recommendation must be borne by a medical specialist. The reasons for this special vote are set out in recommendation VII.K2.

	A: - Specialist in child and adolescent psychiatry or specialist in child and adolescent psychiatry and psychotherapeutic medicine - Registration as a psychotherapist with further training in infant, child and adolescent psychotherapy Or, alternatively, with proven clinical expertise in the diagnosis and treatment of adolescents: D: - Specialist title for psychiatry and psychotherapy, psychotherapeutic medicine or psychosomatic medicine and psychotherapy - Licence for psychological psychotherapy CH: - FMH title in psychiatry and psychotherapy A: - Specialist in psychiatry and psychotherapeutic medicine, specialist in psychiatry and neurology - Registration as a psychotherapist, registration as a clinical psychologist	A: - Specialist in child and adolescent psychiatry or specialist in child and adolescent psychiatry and psychotherapeutic medicine - Registration as a psychotherapist with further training in infant, child and adolescent psychotherapy Or, alternatively, with proven clinical expertise in the diagnosis and treatment of adolescents: D: - Specialist title for psychiatry and psychotherapy, psychotherapeutic medicine or psychosomatic medicine and psychotherapy - Licence for psychological psychotherapy CH: - FMH title in psychiatry and psychotherapy A: - Specialist in psychiatry and psychotherapeutic medicine, specialist in psychiatry and neurology - Registration as a psychotherapist, registration as a clinical psychologist	
VII.K26.	In preparation for a gender-affirming mastectomy or breast reduction in adolescents with gender incongruence or gender dysphoria, social testing of the desired gender role should take place, provided this is compatible with the protection against discrimination. In cases where social support from the environment is not	In preparation for a gender-affirming mastectomy or breast reduction in adolescents with gender incongruence or gender dysphoria, a social trial of the desired gender role should take place, provided this is compatible with the protection against discrimination. In cases where social support from the environment is not	The DGPPN is in favour of a higher level of recommendation regarding the offer of accompanying psychotherapy in the transition process if the social environment offers little support.

	sufficient, psychotherapeutic support for the transition process should be offered.	sufficient, psychotherapeutic support for the transition process **should** be offered.	Under social circumstances with a lack of support and possibly a lack of acceptance, the DGPPN considers it essential to provide professional support during the transition process in order to prevent the risk of psychological disorders such as depression, suicidal tendencies or self-harming risk behaviour (see Chapters IV and VI).
VII.K28.	If, before a gender-affirming mastectomy or breast reduction is indicated, there is a co-existing mental disorder that goes beyond the gender dysphoria and interferes with the treatment, a specialised psychiatric-psychotherapeutic intervention should be recommended as part of an integrated or networked treatment concept.	If, before a gender-affirming mastectomy or breast reduction is indicated, there is a co-existing mental disorder that goes beyond the gender dysphoria and interferes with the treatment, a specialised psychiatric-psychotherapeutic intervention **should** be recommended as part of an integrated or networked treatment concept. **The treatment steps should be prioritised in dialogue with the patient.**	The DGPPN advocates a higher level of recommendation for the networked treatment of a co-occurring mental disorder and for the joint prioritisation of treatment steps if a sex-modifying mastectomy or breast reduction is planned. The reasons for this special vote are set out in recommendation VII.K18. Following recommendation VII.K18., the sentence "The treatment steps should be prioritised in dialogue with the patient" should be added.
VII.K30.	If the minor has the capacity to consent (D)/capacity to make judgements (CH)/capacity to make decisions (A), a co-consensus should be sought between the legal guardians.	If the minor has the capacity to consent (D)/capacity to make judgements (CH)/capacity to make decisions (A), a co-consensus of the custodians **should** be sought.	The DGPPN is in favour of a stronger level of recommendation to strive for co-consensus with guardians before body-altering medical interventions.

			The reasons for this special vote are set out in recommendation VII.K10.
Chapter VIII Somatic aspects of hormonal interventions			
VIII.K6.	Growth and skeletal age should be taken into account during sex reassignment hormone treatment with testosterone. In growing trans male adolescents, the dosage of testosterone can be increased more slowly than in adolescents who are already fully grown, taking into account the growth prognosis.	Growth and skeletal age **should** be taken into account during sex reassignment hormone treatment with testosterone. In growing trans male adolescents, the dosage of testosterone can be increased more slowly than in adolescents who are already fully grown, taking into account the growth prognosis.	The DGPPN is in favour of a higher level of recommendation regarding the consideration of longitudinal growth and skeletal age in trans male adolescents. Sex hormones also influence bone growth during puberty. Sex-altering hormone treatment with testosterone in adolescents who have not yet reached adulthood should prevent the epiphyseal joints from closing too quickly and the bone age should be determined with clinical care (see Chapter VIII.2.3. and 4.1).
VIII.K7.	If bleeding occurs during testosterone treatment, the cause should be carefully evaluated. A progestogen preparation or GnRH analogue can be used in addition to suppress menstrual bleeding.	If bleeding occurs during testosterone treatment, the cause **should** be carefully evaluated. A progestogen preparation or GnRH analogue can be used in addition to suppress menstrual bleeding.	The DGPPN is in favour of a higher level of recommendation regarding the search for causes of bleeding during testosterone treatment. Even though menstrual bleeding under testosterone occurs in 25% of trans adolescents, the DGPPN recommends an obligatory careful evaluation, as this corresponds to the usual clinical care.

Special votes of the Swiss Society for Child and Adolescent Psychiatry and Psychotherapy (SGKJPP)

	Final consented version of the guideline	Special votes of the SGKJPP	
No.	**Recommendation as consented**	**Suggested amended recommendation**	**Justification**
Chapter IV Associated mental health difficulties			
IV.K1	Children and adolescents who present for assessement and/or treatment due to gender incongruence or gender dysphoria (GI/GD) should undergo a comprehensive mental health assessment if there are indications of clinically relevant psychological or psychopathological abnormalities. The history of the reported abnormalities and their possible interactions with GI or GD should be carefully recorded.	A comprehensive mental health assessment is essential for children and adolescents who present for a an assessemnt due to gender incongruence or gender dysphoria (GI/GD) and for whom medical interventions are to be initiated. The history of the reported abnormalities and their possible interactions with GI or GD should be carefully recorded.	The SGKJPP recommends that a comprehensive mental health assessement is essential before further medical interventions can be initiated so that the entire spectrum of differential diagnoses according to ICD-11 can be clarified. The SGKJPP does not wish to limit these disorders to anxiety, depression and ASD as well as self-harming and suicidal behaviour. This does not imply a pathologisation of GI/GD, but ensures a comprehensive CAP clarification.
Chapter VII Indications for body-altering medical interventions			
VII.K.0a	If longitudinal scientific observations (e.g. registry studies) on body-modifying medical interventions for gender incongruence or gender dysphoria in adolescence are available and accessible to patients, practitioners should provide information about this and help to ensure that patients are offered the opportunity to participate in the study.	Every centre that recommends and/or carries out medical interventions for gender incongruence or gender dysphoria in adolescence has a duty to set up a register to ensure good documentation and quality assurance, which makes it possible to track long-term follow-ups. If follow-up observations or studies are also available to patients, practitioners should inform them of this and help to ensure that patients are offered the opportunity to participate in studies.	As part of the treatment of gender incongruence - especially in the context of somatic, gender –affriming treatments - the collection and provision of data for quality assurance by the practitioners should be implemented. This also forms a basis for providing the missing data from follow-up examinations.

	Final consented version of the guideline	Special votes of the SGKJPP	
No.	**Recommendation as consented**	**Suggested amended recommendation**	**Justification**
VII.K2	A recommendation for puberty blockade in adolescents with gender incongruence or gender dysphoria should be determined in interdisciplinary cooperation. The prerequisite for this recommendation is a careful diagnostic assessment and clarification appropriate to the urgency and complexity of the individual situation by a mental health specialist experienced in the diagnosis and treatment of gender dysphoria in childhood and adolescence. The somatic part of the indication should be carried out by an experienced paediatric endocrinological specialist with regard to the prerequisites (pubertal maturity stage, absence of somatic contraindications, etc.).	A recommendation for puberty blockade in adolescents with gender incongruence or gender dysphoria should be made in interdisciplinary co-operation and after precise risk assessment and detailed information for the adolescents and their families. The prerequisite for this recommendation is a careful diagnostic assessment and clarification appropriate to the urgency and complexity of the individual situation. In addition, it requires a differentiated and individualised risk assessment after detailed information has been provided to those affected and their families by a mental health specialist experienced in the diagnosis and treatment of gender dysphoria in children and adolescents. With regard to the risks, it is essential to clarify the "current" uncertain state of evidence with a lack of long-term studies. The somatic part of the recommendation should be carried out by an experienced paediatric endocrinologist with regard to its prerequisites (pubertal maturity stage, absence of somatic contraindications, etc.). Overall, the need for further clinical studies is strongly emphasised	Due to the lack of evidence, particular weight should be given to risk assessment and information when deciding on a recommendation.

Appendix B for AWMF Guideline
"Gender incongruence and gender dysphoria in childhood and adolescence"

REVIEW: NATIONAL AND INTERNATIONAL TREATMENT RECOMMENDATIONS FOR GENDER DYSPHORIA IN CHILDREN AND ADOLESCENTS

Table of contents

Version: 24.06.2025

Overview of DELBI appraisals

Institution (year)	**Domain 1:** Scope and purpose	**Domain 2:** Stakeholder involvement	**Domain 3:** Methodological rigour	**Domain 4:** Clarity and presentation	**Domain 5:** General applicability	**Domain 6:** Editorial independence	**Domain 7:** Applicability in Germany
AACAP (2012, USA)	0,33	0,13	0,31	0,38	0	0,42	0,19
AAP (2018, USA)	0,33	0,17	0,07	0,13	0,06	0,33	0,08
Académie nationale de médecine (2022, France)	0,22	0	0,05	0,25	0	0	0,11
APA (2015, USA)	0,33	0,25	0,24	0,29	0,11	0,42	0,11
COHERE (2020, Finland)	0,56	0,25	0,33	0,50	0,33	0	0,22
Endocrine Society (2017, international)	0,44	0,25	0,40	0,63	0,22	0,50	0,42
Helsedirektoratet (2021, Norway)	0,22	0,58	0,05	0,50	0	0	0,22
NHS England (2024)	0,44	0,33	0,38	0,50	0,33	0,17	0,33
RANZCP (2021, Australia & New Zealand)	0,33	0,04	0,05	0,17	0,06	0,08	0,11
Socialstyrelsen (2022, Sweden)	0,56	0,50	0,62	0,67	0	0,33	0,28
UKOM (2023, Norway)	0,33	0,17	0,05	0,50	0	0	0,17
WPATH (2022, international)	0,61	0,42	0,50	0,63	0,28	0,50	0,44

Continuous colour scale with the following anchors:	0	0,50	1

The DELBI instrument (Beyer et al., 2008; German Instrument for Methodological Guideline Appraisal) with one or two reviewers was used to assess the extent to which the reviewed documents fulfil the quality standards for guidelines and similar publications with recommendations for clinical practice, even if some of the reviewed documents are not guidelines in the narrower sense. According to a DELBI rating, the methodological quality of the recommendations for the 7 domains listed in the table is indicated on a scale from 0 (poor quality) to 1 (very good quality).

AACAP (2012, USA)

Title:
Practice parameter on gay, lesbian, or bisexual sexual orientation, gender nonconformity, and gender discordance in children and adolescents

Publishing institution:
American Academy of Child and Adolescent Psychiatry [AACAP] (US-American professional association for child and adolescent psychiatry)

Authors & year:
Adelson, S. L. & The American Academy of Child and Adolescent Psychiatry Committee on Quality Issues (2012)

Type of publication and binding nature:
Collection of treatment principles; application not mandatory, reference is made to individual clinical decision-making

Methodology:
- Steward L. Adelson was commissioned as a clinical expert in collaboration with a subcommittee of the AACAP to develop treatment principles for children and adolescents with gender incongruence or non-heterosexual sexual orientation. The responsibilities within this subcommittee and to the first author is not reported.
- A systematic literature search was conducted on this topic, which is described. It may be assumed that this search was carried out by one or more persons from the subcommittee. The selection of literature after the search was only superficially described.
- On this basis treatment principles were formulated. The process of reaching consensus and the degree of consensus are not reported. The type of involvement of patients or their carers is not described, even if this is generally mentioned in the development process. Named external experts were involved without specifying the type or degree of their involvement. The AACAP reviewed the practice parameters before publication. There is a unspecified disclosure of conflicts of interest and it can be assumed that funding was provided by the AACAP.

Deviating recommendations:
None

Consensus strength:
Not specified

Level of evidence or grading of recommendation:
No grading of recommendations or levels of (overall) evidence reported.

Summarised DELBI (German Instrument for Methodological Guideline Appraisal) appraisal:

Scope & purpose	*Stakeholder involvement*	*mMethodological rigour*	*Clarity & presentation*	*General applicability*	*Editorial independence*	*Applicability in Germany*
0,33	*0,13*	*0,31*	*0,38*	*0*	*0,42*	*0,19*

The DELBI instrument (Beyer et al., 2008) with one or two reviewers was used to assess the extent to which the reviewed documents fulfil the quality standards for guidelines and similar publications with recommendations for clinical practice, even if some of the reviewed documents are not guidelines in the narrower sense. According to a DELBI- rating, the methodological quality of the recommendations for the 7 domains listed in the table is indicated on a scale from 0 (poor quality) to 1 (very good quality).

Appraisal based on DELBI:

- The scope and purpose is broadly described, which is reflected in a low to medium DELBI score. The relevant clinical guiding questions are rather general and not very specific. The target patient group is not clearly described; however, some terms are defined in the glossary. One difficulty in this regard is that common recommendations are often given for children and adolescents as well as patients with non-heterosexual orientation and gender incongruence, although the underlying evidence should be considered separately in some cases.
- The stakeholder involvement was low. The target group of users is clearly identified, although indirect users are not addressed. Not all relevant specialist disciplines were involved, no survey of patient preferences and views was carried out and no pilot study was conducted.
- The methodological rigour of the guideline development can be categorised as low to medium. A systematic literature search was conducted and described in full. The inclusion and exclusion criteria were not clearly stated. A consensus procedure is reported, but not comprehensibly described and no consensus strength is reported. There was a review by the AACAP (at a member forum at an annual meeting). No levels of evidence or grades of recommendation are given. Expiry after 5 years is stated on the website, but no procedure for updating is reported.
- According to DELBI, the clarity and presentation is rated as low to medium. Some of the recommendations are unambiguous, but the joint consideration of children, adolescents, sexual orientation and gender incongruence is again problematic in this respect. Hardly any different treatment options are mentioned in the recommendations. The key recommendations are always easy to identify as they are in bold type.
- The general applicability is considered to be very low. Neither barriers nor cost implications were analysed. Also, no criteria were defined for monitoring. The applicability in the German healthcare system can be assessed as low.
- Funding is considered to be provided by the AACAP. There are declarations of conflicts of interest without detailed discussion of all persons involved in the recommendations. This results in a medium degree of editorial independence.

Appraisal of the deviating recommendations:

Not applicable, as no deviating recommendations are recognisable.

AAP (2018, USA)

Title:
Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents

Publishing institution:
American Academy of Pediatrics [AAP] (US-American professional association for paediatrics)

Authors & year:
Rafferty, J., Yogman, M., Baum, R., Gambon, T. B., Lavin, A., Mattson, G., ... & Committee on Psychosocial Aspects of Child and Family Health (2018)

Type of publication and binding nature:
Policy statement; application not mandatory, reference is made to individual clinical decision-making

Methodology:
- The single author is Jason Rafferty, an expert on GD in children and adolescents. He takes responsibility for the entire content of the policy statement and apparently drafted it independently. The role of the "Committee on Psychosocial Aspects of Child and Family Health" in the process remains unclear.
- No systematic evidence research, selection or evaluation is indicated. There is no clear involvement of patients or other stakeholders. Funding is explained in general terms and there is a general statement about the absence of conflicts of interest.

Deviating recommendations:
1. If possible and ideally, the indication for medical treatment should be determined with the involvement of a mental health specialist for children and adolescents.
2. Affirmation of gender identity is also important for prepubertal children.

Consensus strength:
None due to single authorship

Level of evidence or grading of recommendation:
No grading of recommendations or levels of (overall) evidence reported.

Summarised DELBI (German Instrument for Methodological Guideline Appraisal) appraisal:

Scope & purpose	*Stakeholder involvement*	*Methodological rigour*	*Clarity & presentation*	*General applicability*	*Editorial independence*	*Applicability in Germany*
0,33	0,17	0,07	0,13	0,06	0,33	0,08

The DELBI instrument (Beyer et al., 2008) with one or two reviewers was used to assess the extent to which the reviewed documents fulfil the quality standards for guidelines and similar publications with recommendations for clinical practice, even if some of the reviewed documents are not guidelines in the narrower sense. According to a DELBI rating, the methodological quality of the recommendations for the 7 domains listed in the table is indicated on a scale from 0 (poor quality) to 1 (very good quality).

Appraisal on the basis of DELBI:
- According to DELBI, the purpose and scope are described with low to medium quality. Objectives are stated in general terms and key questions can be inferred, but are not made explicit.
- According to DELBI, the stakeholder involvement is to be assessed as qualitatively low. There is a single authorship and various relevant specialist groups were only involved in the development as part of a consultation. It is not clear that patients or carers were involved and the target user group is defined, but no indirect users. There is no report on a pilot test.

- According to DELBI, the methodological rigour is very low. No systematic evidence search, selection or evaluation is reported. There is also no evidence of a consensus process and no procedure for updating described. It is stated that a review by experts took place before publication, but no details are given.
- According to DELBI, the clarity and presentation is rated as low. Some recommendations are unambiguous, but not the majority (see e.g. "divergent recommendations"). The key recommendations are shared at the end of the policy statement, but are not emphasised in the design. Hardly any different treatment options are named and no supporting materials are evident.
- The general applicability can also be rated as very low. The same applies to applicability in the German healthcare system. No analysis of barriers or cost implications was carried out. No criteria for monitoring were defined either.
- There are general declarations on the absence of conflicts of interest and on the financing of the declaration of principles. As these are not specified, this is rated as low to medium quality according to DELBI.

Appraisal of the deviating recommendations:

ad 1 The recommendation seems ambiguously formulated. If the recommendation is meant to mean that a diagnosis by mental health professionals is not necessary for children, but only if requested by the family, this contradicts almost all other international standards of care (e.g. Coleman et al., 2022). These often do not provide for compulsory psychotherapy (in the sense of interventions), but they do stipulate the need for a professional diagnosis of eventual mental health problems. The previous evaluation studies of physical medicine treatment for children with GD also provided for this in the treatment protocol (Cohen-Kettenis & Goozen, 1997; de Vries et al., 2014). There is also no explicit justification given as to why puberty blockade or gender reassignment hormones should only "ideally" or "if possible" take place in a multidisciplinary setting (i.e. with the involvement of mental health professionals).

ad 2 This recommendation also seems ambiguous. The decisive factor here is what is meant by affirmation. If this refers to respecting gender identity and, for example, the use of desired pronouns, this would probably be justifiable against the background of avoiding stigmatisation, etc. As the wording in this regard seems rather unclear, it could also refer to a recommendation to change social roles in childhood. It should be considered here that this is a decision made by the family in each individual case.

Académie nationale de médecine (2022, France)

Title:
La médecine face à la transidentité de genre chez les enfants et les adolescents (Medicine in dealing with gender transidentity in children and adolescents)

Publishing institution:
Académie nationale de médecine (self-recruiting society of physicians from various disciplines in France; not a state or semi-state organisation)

Authors & year:
None named (2022)

Type of publication and binding nature:
Press release; application not mandatory

Other primary documents included:
English version of the press release (Académie nationale de médecine, 2022b)

Methodology:
No methodology is reported. A voting result the Académie is given (see "Consensus strength"). Authors are not named. There is no recognisable specific expertise for the healthcare of children with GD in the decision-making group. No recognisable experts were consulted.

Deviating recommendations:
1. Caution regarding social media in children with GD, assuming that the influence of social media in the sense of influencing young people is involved in the increasing prevalence of GD in adolescence.

Consensus strength:
Majority recommendation (74.7% with 59 votes in favour, 20 against, 13 abstentions)

Level of evidence or grading of recommendation:
No grading of recommendations or levels of (overall) evidence reported.

Summarised DELBI (German Instrument for Methodological Guideline Appraisal) appraisal:

Scope & purpose	*Stakeholder involvement*	*Methodological rigour*	*Clarity & presentation*	*General applicability*	*Editorial independence*	*Applicability in Germany*
0,22	0	0,05	0,25	0	0	0,11

The DELBI instrument (Beyer et al., 2008) with one or two reviewers was used to assess the extent to which the reviewed documents fulfil the quality standards for guidelines and similar publications with recommendations for clinical practice, even if some of the reviewed documents are not guidelines in the narrower sense. According to a DELBI rating, the methodological quality of the recommendations for the 7 domains listed in the table is indicated on a scale from 0 (poor quality) to 1 (very good quality).

Appraisal on the basis of DELBI:
- According to DELBI, the description of the scope and purpose is of low quality. The target patient group is named once and undifferentiated. The relevant clinical questions can be partially inferred and the objectives are not described.
- The stakeholder involvement is considered to be very low. No stakeholders are named to be consulted in the development process, no patients were involved, the target user group is not defined and no pilot study was conducted.

(Inter-)national guidelines for GD in children & adolescents - Académie nationale de médecine (2022, France)

- The methodological rigour of development must also be rated as very low. There is no recognisable systematic search for, selection or evaluation of evidence. Also, no structured consensus process beyond a simple vote is reported. No review or consultation outside the Académie took place and no validity period or updating procedure is specified.
- The quality of clarity and presentation is low according to DELBI. All recommendations can be clearly identified by highlighting. However, they are formulated ambiguously throughout and no treatment options are discussed.
- The general applicability is considered to be very low. Neither barriers nor cost implications were analysed. Also, no criteria were defined for monitoring. The applicability in the German healthcare system is considered to be low.
- According to DELBI, editorial independence is considered to be very low. There are no declarations regarding financing or conflicts of interest.

APA (2015, USA)

Title:
Guidelines for psychological practice with transgender and gender nonconforming people

Publishing institution:
American Psychological Association [APA] (US-American professional association of psychologists)

Authors & year:
dickey, l. m., Singh, A. A., Bockting W. O., Chang, S., Ducheny, K., Edwards-Leeper, L., ... & Magalhaes, E.

Type of publication and binding nature:
Guidelines without mandatory application

Methodology:
- An APA task force was commissioned to develop the guidelines for psychological work with people with GD. This working group consisted of various experts in the field of children and adolescents with GD. The members of the working group were all members of the APA and therefore psychologists. The working group members were selected by an APA committee as part of an application process. 50% of the working group members identified as transgender. The scope of the guideline includes people with GD of all ages, not just children and adolescents. However, some recommendations are explicitly specified for children and/or adolescents.
- The members of the working group conducted a literature search, the systematics of which are not described. No systematic approach to evidence selection and assessment is recognisable. The generally low study quality of the primary studies due to the study designs is acknowledged. It is stated that in the case of divergent professional opinions, this was documented. No further consensus process is described.
- External experts were consulted during the drafting process and after the creation of drafts of the guideline. Consultation on the recommendations also took place at professional congresses and a public comment phase.
- APA bodies provided the funding for the development and two named donors. The amount of funding is not specified. With regard to conflicts of interest of the members of the working group, it is stated that some members of the working group have received fees for lectures and book royalties based on information from the guideline.

Deviating recommendations:
None

Consensus strength:
Not specified

Level of evidence or grading of recommendation:
No grading of recommendations or levels of (overall) evidence reported.

Summarised DELBI (German Instrument for Methodological Guideline Appraisal) appraisal:

Scope & purpose	*Stakeholder involvement*	*Methodological rigour*	*Clarity & presentation*	*General applicability*	*Editorial independence*	*Applicability in Germany*
0,33	0,25	0,24	0,29	0,11	0,42	0,11

The DELBI instrument (Beyer et al., 2008) with one or two reviewers was used to assess the extent to which the reviewed documents fulfil the quality standards for guidelines and similar publications with recommendations for clinical practice, even if some

of the reviewed documents are not guidelines in the narrower sense. According to a DELBI rating, the methodological quality of the recommendations for the 7 domains listed in the table is indicated on a scale from 0 (poor quality) to 1 (very good quality).

Appraisal on the basis of DELBI:

- According to DELBI, the quality of the description of the scope and purpose is rated as low to medium. The objective is roughly described, the underlying guiding questions can be identified and the target patient group is roughly defined. The terms relating to the patient sample are explained in a glossary.
- According to DELBI, the stakeholder involvement was qualitatively low. Only psychologists were directly involved in the development, transgender people were part of the working group and there was a public consultation. The target user group is explicitly and relatively clearly defined. No pilot testing took place.
- According to DELBI, the methodological rigour of the compilation is to be assessed as low. There are no reports on a systematic approach to evidence search, selection and assessment. A structured consensus procedure is not reported, but a vote is. An external review took place without this being described in more detail. The expiry date of the guideline is stated and the body responsible for updating it is named.
- According to DELBI, the clarity and design are also of low quality. The recommendations are easy to identify by highlighting throughout, but hardly any different treatment options are discussed and no supporting materials are available. Recommendations are sometimes but not always clearly formulated. This is also because the target patient group includes transgender people of all ages.
- The general applicability is assessed as very low, the applicability in the German healthcare system as low. Neither barriers nor cost implications were analysed. No criteria for monitoring were defined either.
- According to DELBI, editorial independence is rated as medium. There is a declaration regarding the financing of the guidelines and financial interests of the working group members are disclosed without naming them.

Appraisal of the recommendations:

Can be omitted because no deviating recommendations are formulated.

COHERE (2020, Finland)

Title:
Alaikäisten sukupuoli-identiteetin variaatioihin liittyvän dysforian lääketieteelliset hoitomenetelmät (Medical treatment of dysphoria related to gender identity variants in minors)

Publishing institution:
Palveluvalikoima (Council for Choices in Health Care in Finland [COHERE]; Finland; government agency)

Authors & year:
Lohiniva-Kerkelä, M., Ahinko, K., Burrell, R., Kaltiala, R., Laukkala, T., Koivuranta, E., ... & Tynkkynen, L. (2020)

Type of publication and binding nature:
National treatment guidelines with recommendations mandatory for the provision/utilisation of state healthcare services

Other primary documents included:
- COHERE website, in particular on the procedure
- Memorandum and annexes to the treatment guidelines: COHERE (2022c)
- English summary of the treatment guidelines: COHERE (2022a)

Methodology:
- COHERE is a subordinate body of the Finnish Ministry of Health. It is primarily concerned with determining which services are provided by the Finnish National Health Service (i.e. which services are refinanced). The members of COHERE are physicians of all specialities, senior employees of the health administration and health politicians.
- COHERE set up an expert committee to draw up a guideline on which health services should be provided by the state health service in the case of GD in minors. Criteria for the selection of members of the expert group are not apparent. Experts for GD in children and adolescnts were involved. No direct involvement of patient or carer representatives is evident.
- A company was commissioned to conduct a systematic literature review and summarise it on various interventions for children and adolescnts with GD. The process and procedure are documented in an appendix. In addition, at least one hearing was held with stakeholder organisations.
- In several meetings the expert commission discussed the wording of recommendations. A structured consensus procedure for the wording of the recommendations is not evident. The guideline was ultimately adopted by COHERE.
- There is a general note on the COHERE website stating that a review of conflicts of interest always takes place; this is not specified for this guideline. No personal declarations of conflicts of interest are documented. There is no information on the financing of the guideline. It can be assumed that it was funded by COHERE. There is no declaration of non-influence by COHERE.

Deviating recommendations:
1. Specific treatment of GD in children and adolescents only in specialised research centres (Helsinki and Tampere) after any mental disorders have been eliminated (through treatment)
2. Puberty blockade possible ”on a case-by-case basis after careful consideration and appropriate diagnostic tests”
3. Hormone treatment in individual cases under the following conditions:

I. clinical judgement that GD is persistent,
II. severe gender dysphoria present,
III. capacity to give consent, and
IV. no contraindications

4. No chest reconstructions or gender-affirming surgery before the age of 18

Rationale for recommendations:

a. There may be uncertainty about gender identity in adolescence. Changes in demographics imply particular caution.
b. The data base on risks of puberty blockade, hormones, chest reconstruction, and gender-affirming surgery in minors is not systematic and too small. Therefore, no irreversible measures should be recommended.
c. The financial costs of physical medical treatment are considerable. Publicly funded treatment can only be justified if the benefits are proven to outweigh the risks and costs. This does not mean that such treatment is unethical.

Consensus strength:

Not specified

Level of evidence or grading of recommendation:

No grading of recommendations or levels of (overall) evidence reported.

Summarised DELBI (German Instrument for Methodological Guideline Appraisal) appraisal:

Scope & purpose	*Stakeholder involvement*	*Methodological rigour*	*Clarity & presentation*	*General applicability*	*Editorial independence*	*Applicability in Germany*
0,56	0,25	0,33	0,50	0,33	0	0,22

The DELBI instrument (Beyer et al., 2008) with one or two reviewers was used to assess the extent to which the reviewed documents fulfil the quality standards for guidelines and similar publications with recommendations for clinical practice, even if some of the reviewed documents are not guidelines in the narrower sense. According to a DELBI rating, the methodological quality of the recommendations for the 7 domains listed in the table is indicated on a scale from 0 (poor quality) to 1 (very good quality).

Appraisal according to DELBI:

- The scope and purpose is defined according to DELBI with medium quality. General but few specific objectives are formulated and the questions underlying the recommendations are named, but not consistently. The patient group and the area of care are clearly named. It is relevant to mention here that the recommendations only refer to the refinancing in public healthcare.
- Stakeholder groups were involved to a limited extent according to DELBI. It is not clear that all relevant specialist groups (e.g. endocrinologists) were involved. The guideline was also ultimately not decided by the expert committee, but by COHERE itself. Those affected were apparently only involved in one or more hearings, but not in the development of the recommendations themselves. Direct users are clearly named, but no indirect users. No pilot study is evident.
- According to DELBI, the methodological rigour of the development can be assessed as low to medium. A systematic literature search was fully and appropriately documented. There is no documentation on the number of inclusions and exclusions (e.g. according to PRISMA). A vote of recommendations is described, but no structured consensus techniques (e.g. DELPHI) are documented. An external review outside COHERE is not evident. It is explicitly stated that the validity is unlimited in time (except in the event of an initiative referral to COHERE).
- According to DELBI, the quality of clarity and design can be rated as medium. The key recommendations are consistently easy and unambiguous to identify. Different treatment options are only partially named. Recommendations were not graded.

- According to DELBI, the general applicability is assessed as low to medium. Organisational barriers regarding the recommendations (as well as possible negative effects) are hardly discussed. The financial effects are specified and criteria for monitoring are named. However, these criteria only indirectly relate to the effects of the recommendations made. According to DELBI, the applicability in the German healthcare system can be assessed as low.
- According to DELBI, editorial independence is rated as very low. There is no declaration of financing and non-influence. There are no declarations of conflicts of interest specific to the guideline for the persons involved.

Appraisal of the rationale for the recommendations:

ada A change in the population is assumed without taking into account biases in the survey and utilisation of specialised healthcare services.

adb Physical medical measures are generally considered too risky if they are irreversible. There is no ethical consideration of the risks of omission in the absence of an alternative treatment (e.g. increase in gender dysphoria due to irreversible progressive maturity development).

adc It should be emphasised that the ethical analysis stresses that further treatment may be justified from a medical-ethical point of view. The reluctance with regard to physical medical measures is derived in particular from the principle that publicly funded treatments require proven benefit and efficiency and that, in a situation of unclear risks in treatment and risks in non-treatment, non-treatment is preferable. Against the background of the different objectives (best possible patient care through a guideline versus justification of reimbursement of healthcare services here), the transferability of the recommendations to medical guidelines is therefore questionable.

The recommendation of this guideline in Taylor et al. (2024) is not consistent with our DELBI assessments. The guideline has relative strengths (e.g. in the description of scope and purpose) but also weaknesses (e.g. no editorial independence is documented). The different assessments could be partly due to differences to the DELBI instrument used here (Beyer et al., 2008), which is more operationalised than the AGREE II instrument (Brouwers et al., 2010).

Endocrine Society (2017, international)

Title:
Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society clinical practice guideline

Publishing institution:
Endocrine Society (international medical society for endocrinology)

Authors & year:

Hembree, W. C., Cohen-Kettenis, P. T., Gooren, L., Hannema, S. E., Meyer, W. J., Murad, M. H., ... & T'Sjoen, G. G. (2017).

Type of publication and binding nature:
Clinical guideline without mandatory application

Other primary documents included:
- Supplementary material of the guideline (Gender Dysphoria/Gender Incongruence Guideline Resources) on the website of the Endocrine Society
- Hembree et al. (2009; original guideline)

Methodology:
- This is an update of a guideline published in 2009 by the Endocrine Society, an international medical society specialising in endocrinology. For the original guideline and the update, the Endocrine Society commissioned a task force of experts in the field to develop the guideline. Criteria for the selection of the task force members are not recognisable. It is not apparent that patient or carer representatives were involved in the development process.
- Systematic reviews were conducted on the effects of gender reassignment hormones on blood values and cardiovascular outcomes as well as on bone health. The methodology of the reviews is barely described. The results of the reviews are only summarised.
- A consensus process is described superficially. It appears that no structured consensus procedure was used and no consensus strength was specified. However, the recommendations were graded by the task force in terms of their strength of recommendation ("we suggest", "we recommend") and in terms of the level of evidence. A consultation on drafts of the guideline took place with members of the Endocrine Society, other endocrinological societies and the WPATH (see below).
- Conflicts of interest are reported seperately for all persons involved. There is a general note on funding. There is no declaration of non-influence on the guidelines by the funding organisations.

Deviating recommendations:
1. Decisions regarding social transitions in prepubertal children should be made with the involvement of a professional with appropriate experience. (Recommendation 1.3; "Ungraded Good Practice Statement")
2. If indicated, adolescents should first be treated with puberty blockade and only then with sex reassignment hormones. (Recommendation 2.1, strength of recommendation "suggest", low level of evidence)

Consensus strength:
Not specified; full consensus may have been reached among task force members

Level of evidence or grading of recommendation:

Both are indicated: With a few exceptions, only low or very low evidence; grading of recommendations as "suggest" or "recommend" (see "deviating recommendations")

Summarised DELBI (German Instrument for Methodological Guideline Appraisal) appraisal:

Scope & purpose	*Stakeholder involvement*	*Methodological rigour*	*Clarity & presentation*	*General applicability*	*Editorial independence*	*Applicability in Germany*
0,44	0,25	0,40	0,63	0,22	0,50	0,42

The DELBI instrument (Beyer et al., 2008) with one or two reviewers was used to assess the extent to which the reviewed documents fulfil the quality standards for guidelines and similar publications with recommendations for clinical practice, even if some of the reviewed documents are not guidelines in the narrower sense. According to a DELBI rating, the methodological quality of the recommendations for the 7 domains listed in the table is indicated on a scale from 0 (poor quality) to 1 (very good quality).

Appraisal on the basis of DELBI:

- The report of scope and purpose has, according to DELBI, a medium quality. The objectives of the guideline are stated generally but not specifically. The underlying guideline questions are predominantly but not consistently comprehensible. The patient population is named in general terms.
- According to DELBI, the stakeholder involvement can be rated as low. Specialists were involved, but disciplines relevant to the guideline (e.g. surgery) were apparently not directly involved. However, they may have been included as part of the consultation. There is no recognisable involvement of patients in the development of the guideline. The target user group is defined. No pilot testing took place.
- According to DELBI, the methodological rigour can be assessed as qualitatively medium. A systematic literature search is given, but no search terms etc. Inclusion and exclusion criteria are not explicitly stated. A general consensus regarding the recommendations is described, but no structured consensus techniques (e.g. DELPHI) are documented. Levels of evidence and strengths of recommendation are given. Prior consultation with various other professional societies was carried out. No information is provided on the period of validity or the procedure for updates. However, it is itself an update, thus such an update can take place.
- According to DELBI, the clarity of the design can be assessed as medium to good. The recommendations in the guideline are mostly unambiguous and various options for action are roughly presented. The key recommendations are summarised at the beginning and are easy to identify throughout. Extensive material is available for dissemination.
- According to DELBI, the applicability is rated as low. Barriers to application are only implicitly named and no implications regarding resources are specified. According to DELBI, the applicability in the German healthcare system can be assessed as medium.
- According to DELBI, editorial independence can also be assessed as medium. The conflicts of interest of those involved in the preparation of the report were personalised collected. The influence of declared conflicts of interest on the development process is not stated. The funding can be assumed to be provided by the Endocrine Society. A detailed breakdown is not available.

Appraisal of the recommendations:

ad 1 The recommendation is based on the reported fact that a large proportion of children with GD largely desist with the onset of puberty. In the case of a complete social transition in childhood, it is reportedly difficult to "undo" the transition in the event of desistance. The GD of children after a social transition desists reportedly less frequently. The direction of causality (less frequent desistance due to social transition or social transition less frequent in cases with a low probability

of desistance from the outset) is not discussed. It is explicitly stated that the expression of gender variant behaviour in children should not be suppressed. There is no discussion of the extent to which this choice of transition is a healthcare issue or an educational issue in the parent-child dyad.

ad2 It is implied that adolescents should receive a puberty blockade before undergoing gender reassignment hormone treatment. It is unclear whether this is also mandatory in adolescence or only optional. The reasons given for the recommendation are that the diagnostic phase could be extended by puberty blockade and puberty blockade is, according to the guideline, completely reversible. The advantages of puberty blockade are not weighed up against the adverse effects that occur particularly in later adolescence (e.g. lack of increase in bone density).

Helsedirektoratet (2021, Norway)

Title:
Kjønnsinkongruens. Nasjonal faglig retningslinje (Gender incongruence. National professional guideline)

Publishing institution:
Helsedirektoratet (Norway; national health authority)

Authors & year:
Roland, B., Myrberg, A. J., Kolås, T., Aasen, C., & Stubberud Stey, K. (2021)

Type of publication and binding nature:
National guideline with mandatory recommendations

Methodology:
- The national guideline was developed by the Norwegian Ministry of Health to implement an action plan against discrimination. However, it would be also based on the wishes of professionals, patients and other stakeholders who wanted to standardise treatment. The guideline covers the treatment of gender dysphoria in childhood, adolescence and adulthood. The Ministry of Health appointed a steering group and a project group to develop the guideline, with the latter having editorial responsibility for the guideline. In addition, a reference group of various stakeholders was set up for consultation. Criteria for the selection of participants are not specified. Experts were involved at least in the reference group.
- There is no recognisable systematic approach to evidence search, selection or evaluation. The criteria for the recommendations in the guideline are the benefit of the treatments, necessary resources and severity of the condition.
- No structured consensus process is described. However, consultations were held with the reference group and other stakeholders.
- There are no declarations on conflicts of interest or on the funding of the guideline. Funding by the Ministry of Health can be assumed.

Deviating recommendations:
1. Gender affirming hormones from the age of 16, prior to this puberty blockade if necessary. Consent of legal guardians required for treatment up to the age of 18.
2. Sex reassignment surgery is generally excluded for minors. Mastectomy possible as an exception after appropriate indication and consent of the legal guardian.
3. Healthcare for children with GI should be organised on a decentralised basis. There should be interdisciplinary specialised outpatient clinics at regional level
4. A national quality register should be set up.

Rationale for recommendations:
a The recommendations would be in line with international guidelines (in particular WPATH & Endocrine Society, see the respective sections).

b There is no explicit rationale for the age limit of 16 years for sex reassignment hormones. It can be assumed that this was set in line with the original *dutch protocol* (de Vries et al., 2014). Furthermore, the consent of legal guardians is, according to the guideline, required under Norwegian law for irreversible interventions.

c Decentralised care close to home is seen as helpful for children and adolescents, especially as a supportive broader environment (neighbourhood, school, etc.) is reportedly important for healthy

identity development. A quality register is considered to be important for expanding the knowledge base and for quality assurance.

Consensus strength:
Not reported

Level of evidence or grading of recommendation:
No grading of recommendations or levels of (overall) evidence reported.

Summarised DELBI (German Instrument for Methodological Guideline Appraisal) appraisal:

Scope & purpose	*Stakeholder involvement*	*Methodological rigour*	*Clarity & presentation*	*General applicability*	*Editorial independence*	*Applicability in Germany*
0,22	0,58	0,05	0,50	0	0	0,22

The DELBI instrument (Beyer et al., 2008) with one or two reviewers was used to assess the extent to which the reviewed documents fulfil the quality standards for guidelines and similar publications with recommendations for clinical practice, even if some of the reviewed documents are not guidelines in the narrower sense. According to a DELBI rating, the methodological quality of the recommendations for the 7 domains listed in the table is indicated on a scale from 0 (poor quality) to 1 (very good quality).

Appraisal according to DELBI

- According to DELBI, the quality of the description of the scope and purpose of the guideline is to be rated as low. The objectives of the guideline are barely described with regard to health indicators. The key questions on which the recommendations are described selectively. The target patient group is simply named, but in some cases it remains unclear which recommendations are also aimed at adolescents and children with GD.
- Stakeholder groups were involved to a medium degree according to DELBI. Relevant medical specialist groups are named and involved, but not all relevant specialist groups. Patients were involved via the reference group, but without the specific influence of their involvement being documented. The target groups of practitioners and indirect users are named. No pilot testing is documented.
- According to DELBI, the methodological rigour is very low. There is no recognisable systematic approach to evidence search, selection or evaluation. There is also no recognisable structured consensus procedure. No review of the recommendations prior to publication is documented and no validity period or procedure for updating is specified.
- The clarity and presentation of the guideline can be rated as medium according to DELBI. Some of the recommendations are specific and unambiguous, some are not in relation to the relevant age range. Key recommendations are present, but not particularly emphasised and therefore not always easily recognisable. There is a reference to additional materials for application and implementation.
- The general applicability is considered to be very low. Neither barriers nor cost implications were analysed. Also, no criteria were defined for monitoring. The applicability in the German healthcare system can be assessed as low.
- According to DELBI, editorial independence is to be assessed as very low because there is no declaration of conflicts of interest and the financing of the guideline.

Appraisal of the deviating recommendations

ad1 It is argued that in Norwegian law, the consent of the legal guardians is always required for irreversible treatments (which includes hormone treatment). A legal assessment of this cannot be made here. However, this establishes a stricter criterion than the WPATH-SoC (Hembree et al., 2022).

ad 2 Analogue to ad 2.

ad 3 The advantages of a decentralised design of specific healthcare (better accessibility for patients, better connection to the living environment, etc.) are mentioned. A discussion of possible disadvantages or problems would also have been desirable (e.g. more difficult to build up expertise in the treatment centre, etc.).

ad 4 This seems sensible from a research perspective, provided that patients' rights are respected and research and medical ethics aspects are taken into account.

NHS England (2024)

Title:
Independent review of gender identity services for children and young people

Publishing institution:
National Health Service England (NHS; national health service in England, not UK as a whole)

Authors & year:
Cass, H. (2024) as sole author ("Review Team", personal communication, 18 July 2024)

Type of publication and binding nature:
The Review ("Cass Review") was commissioned by the National Health Service in England to an individual. The recommendations of the review itself are not mandatory. However, they were implemented directly by NHS England (in some cases before the final report was adopted; NHS England, 2023) with mandatory application. The review was commissioned by NHS England to formulate recommendations (Cass, 2024).

Other primary documents included:
- Appendices to the Cass Review; Cass Review website
- Commissioned systematic reviews including their supplementary material: Hall et al. (2024a, 2024b); Heathcote et al. (2024) and Taylor et al. (2024a, 2024b, 2024c, 2024d)

Methodology:
- It is not documented which individuals were involved in the development of the review and in what way. The appointment of Hillary Cass as chair of the review was made by NHS England (Cass, 2024). Hillary Cass is a renowned paediatrician with no prior experience in the treatment of or research in GD in children and adolescents. Apparently, no professional associations or scientific societies were consulted or involved in the development. A "Assurance Group" was appointed, but was explicitly not involved in the development of the Cass Review's recommendations (Assurance Group, n.d.). There are reports that an "Advisory Board" was also established. However, the members or potential influence of this board are not documented (Ruuska et al., 2024; Cass, 2024). Therefore, no assessment can be made reagarding the expertise of the contributors/authors.
- As part of the Cass Review, a research team from the University of York was commissioned to conduct systematic reviews addressing the issues in question. These included, for example, the outcomes of medical interventions and psychosocial interventions. Whether the responsibility for determining research questions lay with the Cass Review or with the University of York research team remains unclear (Cass, 2024; McNamara et al., 2024).
- The research team conducted systematic reviews. Distinct instruments were used to assess study quality in the reviews on puberty blockade and sex reassignment hormones and in the reviews on psychosocial interventions (Heathcote, 2024; Taylor et al., 2024c, 2024d). The reviews concerning puberty blockade and sex reassignment hormones, studies that were judged to be of low methodological quality were excluded from the review (Taylor et al., 2024c, 2024d). In contrast, all studies, regardless of their assessed quality, were included in the review on psychosocial interventions, (9 out of 10 studies were assessed as being of low methodological quality; Heathcote et al., 2024).
- In addition, (focus group) interviews were conducted with patients and practitioners, as well as a review of treatment histories of children and adolescents with gender incongruence within the NHS. Their influence on the Cass Review's recommendations remain unclear.

- No formal consensus procedure (e.g. DELPHI) was specified and it remains unclear which individuals were involved in the wording of recommendations and the wording of the rest of the report. The effects and side effects of physical medicine interventions were discussed within the text;these were not systematically weighed against one anotherIn contrast, the effects and side effects of psychosocial interventions or possible negative consequences of the reviews recommendations (e.g. possible underuse) are scarely adressed.
- An external review was not conducted prior topublication, nor was there any consultation regarding the text. No validity period was established, nor were any recommendations made for updates. An extensive research programme is proposed.. This does not explicitly refer to an evaluation of the recommendations of the Cass Review. A barrier analysis was not conducted (although training is identified as a relevant factor) and financial implications are barely discussed.
- There are no declarations regarding the funding of the Cass Review or conflicts of interest. It can be assumed that the Cass Review was funded by the NHS. It is stated that the content of the "independent review" (Cass, 2024, p. 4) did not require final approval or clearance by the NHS or the government (Cass, 2024). No documentation regarding the funding of the review is provided. The possible conflicts of interest of those involved in the development of the Cass Review are not disclosed. Individuals involved, aside from Hillary Cass, are not identified.

Deviating recommendations:

1. Psychotherapy should be used to manage gender-related distress (and co-occurring conditions). (Recommendation 3)
2. Counselling/treatment should be initiated as early as possible when families/carers make decisions about the social transition of a pre-pubertal child. (Recommendation 4)
3. Puberty blocking hormones should only be prescribed as part of a clinical trail. (Recommendation 6)
4. Gender affirming hormones should only be prescribed "with extreme caution". There should be a clear clinical rationale for not delaying the prescription until the age of 18. Implicit: No prescription possible before the age of 16. (Recommendation 8)
5. Each case of medical treatment should be decided in advance at national level by a multidisciplinary team. (Recommendation 9)
6. Suitable services should be offered for detransitioned persons outside the services for transgender persons. (Recommendation 25)

Consensus strength:

None due to single authorship

Level of evidence or grading of recommendation:

No grading of recommendations or levels of (overall) evidence reported.

Summarised DELBI (German Instrument for Methodological Guideline Appraisal) appraisal:

Scope & purpose	*Stakeholder involvement*	*Methodological rigour*	*Clarity & presentation*	*General applicability*	*Editorial independence*	*Applicability in Germany*
0,44	0,33	0,38	0,50	0,33	0,17	0,33

The DELBI instrument (Beyer et al., 2008) with one or two reviewers was used to assess the extent to which the reviewed documents fulfil the quality standards for guidelines and similar publications with recommendations for clinical practice, even if some of the reviewed documents are not guidelines in the narrower sense. According to a DELBI- rating, the methodological quality of the recommendations for the 7 domains listed in the table is indicated on a scale from 0 (poor quality) to 1 (very good quality).

Appraisal on the basis of DELBI:

- The scope and purpose is described to a medium degree, according to DELBI. The relevant key clinical questions can be identified for the most part, but are not explicit or easy to find. Some unclear terms are used to describe the population ("gender-related distress" or "young people").
- The stakeholder involvement yield low DELBI values, with significant variability depending on the area. The patient, carer and practitioner perspectives were determined through interviews and surveys. The results are reported and the implications briefly discussed, which can be rated as good. It is not shown whether and, if so, how the results of the interviews and surveys influenced the formulation of the recommendations. Furthermore, it was not disclosed which individuals were involved in the development of the recommendations (see "Methodology of preparation") and how the ones involved were recruited. The involvement of relevant professional associations or disciplines in the formulation of recommendations (e.g. child and adolescent psychiatry) is also not documented. No pilot testing is evident.
- Overall, the methodological rigour of development can be categorised as low to medium. As before, the areas diverge greatly. One positive aspect is that a high-quality literature search and selection process was conducted . The only issue is that different exclusion criteria regarding the methodological quality of the original studies were applied for medical interventions compared to psychosocial interventions. Consequently, the strengths and weaknesses of the evidence in the qualitative synthesis were not analysed in a consistent manner. The same applies to the weighing of effects and harms of the interventions. In the review of psychosocial interventions, the statement was made that there was "no indication of adverse or negative effects" in the reviewed original studies (Heathcote et al., 2024, p. 13). However, this is incorrect: Negative effects were described in some included studies (e.g. Bluth et al., 2021; Lucassen et al., 2020). A negative aspect is that no consensus finding procedure is specified. As no authors were named in addition to the chairperson, it appears that all recommendations were ultimately determined by the chairperson alone and not by a group representative of the field in a structured process and on the basis of the evidence obtained. Furthermore, no external review was conducted prior to publication.
- According to DELBI, the clarity and presentation are rated as average to good. The key recommendations can be easily and clearly identified throughout the document. The recommendations are also predominantly clearly formulated, although there are exceptions to this (e.g. "with extreme caution", exclusion of gender reassignment hormones before the age of 16 only implicitly). No reference is made to additional materials.
- According to DELBI, the applicability is rated as low. Barriers to application are only implicitly named and no implications regarding resources are given, although many recommendations require extensive restructuring of healthcare services in this area. Studies on the effects of interventions are proposed, but no explicit criteria for monitoring/auditing the effects of the recommendations in the Cass Review itself. According to DELBI, the applicability in the German healthcare system is considered to be low.
- Editorial independence is considered to be low. NHS England can be identified as the funder. It is stated that NHS approval was not required before the review was approved. The specific costs and types of funding for the Cass Review and the reviews at the University of York are not listed. No declaration on conflicts of interest of those involved in the Cass Review is evident.

Appraisal of the recommendations:

ada The rationale for recommending psychotherapy and other psychosocial interventions for GD is not clearly defined. Psychotherapy is recommended for co-occurring conditions, for which there

is already an indication due to the co-occurring disorder itself. However, it is also recommended for the "management of gender-related distress". None of the studies included in the review in question were able to show a reduction in gender dysphoria (or so-called "gender-related distress") as a result of psychotherapy. Also, as shown above, the outcomes in the original studies for psychosocial interventions were inconsistent (in one case even negative compared to cis youth), there was a decline in positive effects after a follow-up period and possible adverse effects were not discussed.

adb With regard to social transitions, the Cass Review postulates "in an NHS setting it is important to view it [social transitions, especially in childhood] as an active intervention because it may have significant effects on the child or young person in terms of their psychological functioning and longer-term outcomes" (Cass, 2024, 158). This significantly expands the concept of intervention. It also remains unclear whether only the affirmation of a social transition constitutes an intervention or the avoidance of a social transition as well. This would allocate resources for counselling/treatment of GD in childhood and adolescence primarily to prepubertal children (as opposed to adolescents).

adc The Cass Review attributes the recommendation for puberty blockade to the lack of data. Ultimately, it is a question of research and medical ethics whether participation in a study should be the only option for puberty-suppressing treatment in GD. Currently, and until such a trial is initiated, there is no possibility of such treatment (NHS England, 2023) and therefore currently no physical/medical treatment option for early and middle adolescence.

add It has already been discussed that the recommendation to exercise "extreme caution" when prescribing sex reassignment hormones is ambiguous. In contrast to puberty blockade, the outcomes of gender affirming hormones in minors in the reviewed original studies (Taylor et al., 2024d) point in the same direction towards an improvement, even if the study quality was almost consistently low. It would have been necessary to discuss not only the positive and negative effects of this intervention, but also in comparison with treatment alternatives.

ade Centralisation of all treatment decisions at national level is recommended as a method of quality assurance. The extent to which other methods of quality assurance (obtaining second opinions, inter- and supervision, audits, qualification standards and training), which are more common in other areas of medicine, would be sufficient was not discussed. There is a possibility that a centralised procedure for each individual case at national level could lead to further significant delays and/or barriers. A resource and barrier analysis and the definition of monitoring criteria would have been useful to assess the effects of the recommendations.

RANZCP (2021, Australia & New Zealand)

Title:
Recognising and addressing the mental health needs of people experiencing gender dysphoria / gender incongruence

Publishing institution:
Royal Australian and New Zealand College of Psychiatrists (RANZCP; medical society for psychiatry and paediatric psychiatry in Australia and New Zealand)

Authors & year:
None named (2021)

Type of publication and binding nature:
"position statement"; application not mandatory, reference is made to individual clinical decision-making

Methodology:
No methodology is reported. A committee of the RANZCP is stated as being responsible for the statement. No participants are named. For this reason, no (positive) statement can be made regarding the involvement of experts in the subject area or patients or carers. There is no information on conflicts of interest. It can be assumed that the funding was provided by the RANZCP, but this is not declared.

Deviating recommendations:
No deviating recommendations recognisable.
Even if the statement is sometimes reported as particularly "cautious" in secondary sources, e.g. by Block (2023), no deviating recommendations can be recognised.

Consensus strength:
Not specified

Level of evidence or grading of recommendation:
No grading of recommendations or levels of (overall) evidence reported.

Summarised DELBI (German Instrument for Methodological Guideline Appraisal) appraisal:

Scope & purpose	*Stakeholder involvement*	*Methodological rigour*	*Clarity & presentation*	*General applicability*	*Editorial independence*	*Applicability in Germany*
0,33	0,04	0,05	0,17	0,06	0,08	0,11

The DELBI instrument (Beyer et al., 2008) with one or two reviewers was used to assess the extent to which the reviewed documents fulfil the quality standards for guidelines and similar publications with recommendations for clinical practice, even if some of the reviewed documents are not guidelines in the narrower sense. According to a DELBI rating, the methodological quality of the recommendations for the 7 domains listed in the table is indicated on a scale from 0 (poor quality) to 1 (very good quality).

Appraisal according to DELBI:
- According to DELBI, the description of the scope and purpose is of low to medium quality. The target patient group is roughly named. However, it remains unclear in some cases whether recommendations apply only to adults or to all age groups. Some of the relevant clinical questions can be identified and the objectives are briefly described.
- The stakeholder involvement is considered to be very low. No stakeholders are named in the development process. Stakeholder participation is not evident. The target user group is only roughly defined and no pilot study was carried out.

- The methodological rigour of the development must also be rated as very low. There is no recognisable systematic search for, selection or evaluation of evidence. No structured consensus process is reported either. Possible side effects were discussed briefly and unsystematically. No external review or consultation is recognisable and no validity period or updating procedure is stated.
- According to DELBI, the clarity and presentation are poor. The recommendations are summarised in a concluding section, but are not highlighted compared to the body text. The recommendations are formulated ambiguously throughout and no treatment options are discussed.
- According to DELBI, the general applicability is very low. Neither barriers nor cost implications were analysed. No criteria for monitoring were defined either. The applicability in the German healthcare system is considered to be low.
- According to DELBI, editorial independence is considered to be very low. There are no declarations regarding financing, non-influence or conflicts of interest.

Appraisal of the deviating recommendations

Can be omitted because no deviating recommendations are formulated

Socialstyrelsen (2022, Sweden)

Title:
Vård av barn och ungdomar med könsdysfori. Nationellt kunskapsstöd med rekommendationer till profession och beslutsfattare (Care of children and adolescents with gender dysphoria. National knowledge support with recommendations for professionals and decision-makers)

Publishing institution:
Socialstyrelsen (autonomous government agency)

Authors & year:
Bodin, M., Elfving, M., Fazekas, A., Hedström, M., Indremo, M., Rengmann, J., Sahlin, N.-E., & Linnarsson, E. (2022)

Other primary documents included:
- Appendices to the knowledge base
- SBU (2022)
- El Khouri, B. et al. (2015)

Type of publication and binding nature:
"Knowledge support" with recommendations with generally mandatory application; it remains unclear whether general recommendations can only be deviated from under the conditions specified in the knowledge base or whether this is also subject to the decision in individual clinical cases

Methodology:
- A project group was set up by the health agency Socialstyrelsen. This comprised employees of Socialstyrelsen and clinical experts in the treatment of children and adolescents with GD. In addition, expert groups with clinical experts in the field were appointed. These expert groups were to assess the evidence and formulate draft recommendations. Neither the criteria for selecting the project group members nor the expert group members are specified.
- The knowledge support is an update of a previous version from 2015, which formulated significantly different recommendations. The SBU (a Swedish government agency) was commissioned to determine the evidence relating to the defined key questions. It conducted systematic reviews on the outcomes and negative effects of puberty blockade and/or gender reassignment hormone treatment in children and adolescents with GD and the frequency of discontinuation of such treatments. The systematic reviews were adequately conducted and documented.
- "The recommendations proposed by the [expert group] are then further processed as part of the [Socialstyrelsen's] internal preparatory process and finally adopted by the authority's management" (Bodin et al., 2022b, p. 9). A structured procedure for reaching consensus in the expert groups or with regard to the final adoption by the management of Socialstyrelsen was not documented. No separate consensus panel of experts was explicitly set up. No consensus strength is reported.
- The experiences of clinical experts were also obtained as part of a survey and at least one consultation with patients and their carers took place. A consultation phase also took place.
- The financing of the knowledge base and conflicts of interest are generally stated. The information is not specified. It seems possible that Socialstyrelsen influenced the recommendations, as the recommendations were ultimately decided by its board.

Deviating recommendations:

1. Screening for autism spectrum disorder and ADHD is recommended as standard if GD is suspected.
2. Treatment with puberty blockade, hormones or surgery under the age of 18 should only be recommended in the context of clinical trials.
3. Until clinical trials according to 2. have been started, treatments with puberty blockade before the age of 18 should be recommended under the following conditions:
   I. reaching at least Tanner stage 3 (not 2) and
   II. stable psychosocial situation (in particular no neuropsychiatric or cognitive disability or untreated mental disorders) and no severe obesity and
   III. stable GI with verifiable onset in childhood (early onset) or
   IV. GI with late onset for male assigned sex (for female assigned sex and late onset only contraceptive pill to suppress menstruation)
4. Until clinical trials according to 2. have been started, exceptional treatments with gender affirming hormones before the age of 18 under the following conditions:
   I. stable psychosocial situation (in particular no neuropsychiatric or cognitive disability or untreated mental disorders)
   II. stable GI with verifiable onset in childhood (early onset),
   III. previous puberty blockade with persistent GI and
   IV. reaching the age of 16.
5. Until clinical trials are started after 2., exceptionally chest reconstruction before the age of 18 under the same conditions as 4.

Rationale for recommendations:

Studies with positive outcomes for puberty blockade or hormones are considered inadequate mainly because the sample size is too small, drop-out too high, follow-up too short and lack of control groups.
Reasons for more cautious recommendations:

a. Changes in the patient population are assumed
b. Recent publications on detransition urge caution (e.g. Littman, 2018)
c. There is an increasingly controversial debate among clinical experts about appropriate treatment recommendations

Consensus strength

Not specified, but dissent noted by experts

Level of evidence or grading of recommendation:

No grading of recommendations or levels of (overall) evidence reported.

Summarised DELBI (German Instrument for Methodological Guideline Appraisal) appraisal:

Scope & purpose	*Participation*	*Methodological rigour*	*Clarity & presentation*	*General applicability*	*Editorial independence*	*Applicability in Germany*
0,56	0,50	0,62	0,67	0	0,33	0,28

The DELBI instrument (Beyer et al., 2008) with one or two reviewers was used to assess the extent to which the reviewed documents fulfil the quality standards for guidelines and similar publications with recommendations for clinical practice, even if some of the reviewed documents are not guidelines in the narrower sense. According to a DELBI- rating, the methodological quality of the recommendations for the 7 domains listed in the table is indicated on a scale from 0 (poor quality) to 1 (very good quality).

Appraisal according to DELBI:

- The scope and purpose are described as medium quality according to DELBI. The objectives of the guideline are generally defined, but not consistently specific. The guiding questions on which

the recommendations are based are clearly stated throughout (at least in the appendix or in the review of the SBU). The target group is named without further specification.

- According to DELBI, the stakeholder involvement was of medium quality. All relevant medical disciplines were involved, although they were not necessarily involved in the formulation of decisions. Patients and carers were only indirectly involved. The target user group is clearly named and indirect users are also named. No pilot study is evident.
- According to DELBI, the methodological rigour of the compilation can be assessed as medium to good. The literature search and selection is fully documented and follows a comprehensible system. The type of decision-making regarding the recommendations remains unclear, although it is clear that organised processes took place. The systematic reviews were assessed by external experts. An assessment of the knowledge base itself is not recognisable, but a consultation phase is. A period of validity or a procedure for updating is not specified.
- According to DELBI, the clarity of the design can also be rated as medium to good. The recommendations are consistently specific and uncertainties are reported. Several different options for action are named in an overview. The key recommendations can be clearly identified by highlighting throughout.
- According to DELBI, the general applicability is very low. Neither an analysis of barriers nor of the cost implications was carried out. Measures were defined for a research programme, but these do not relate to the recommendations themselves. The applicability in the German healthcare system is considered to be low.
- Editorial independence is rated as low to medium. There is a general declaration on the absence of conflicts of interest. However, there are no personalised declarations regarding conflicts of interest and the implications of conflicts of interest are not documented.

Appraisal of the deviating recommendations:

There is no clear rationale for very different recommendations in this knowledge base with essentially the same data on treatment outcomes as the previous knowledge base (El Khouri et al., 2015). The selection of the persons involved in the development and of Socialstyrelsen remains unclear. There is also no indication of the strength of consensus, it is noted that some experts held differing views on the final recommendations.

ad a A change in the population is assumed without taking into account possible biases in the survey and utilisation. It remains unclear why such a change implies a deviation from previous treatment standards and the newly established standards.

ad b Publications on detransition are considered without discussing their methodological limitations, while methodological limitations regarding the *dutch protocol* (de Vries et al., 2014) are discussed in great detail and are seen as an argument against puberty blockade and hormones. The systematic review (SBU, 2022) itself mentions a low frequency of discontinuation of puberty blockade and/or gender affirming treatment in childhood and adolescence.

ad c It is difficult to assess the impact of the expert's clinical knowledge in making recommendations if the recommendations were apparently not formulated as part of a structured consensus process and the strength of consensus is not reported.

The recommendation of this knowledge base in Taylor et al. (2024) is partially consistent with our DELBI assessments. The guideline has a comparatively high methodological quality, which according to our DELBI assessment is roughly comparable with the WPATH guideline (Coleman et al., 2022). The different ratings could be partly due to differences between the DELBI instrument used here (Beyer et al.,

2008) and the AGREE II instrument (Brouwers et al., 2010), where the former is more operationalised than the latter.

UKOM (Norway, 2023)

Title:
Pasientsikkerhet for barn og unge med kjønnsinkongruens (Patient safety for children and adolescents with gender incongruence)

Publishing institution:
Statens undersøkelseskommisjon for helse-og omsorgstjenesten (UKOM; semi-governmental organisation advising the government)

Authors & year:
None named (2023)

Type of publication and binding nature:
Report with non-binding recommendations (Phan, 2023); binding in Norway, however, is the guideline of the health authority Helsedirektoratet (see above).

Methodology:
- A report was published by the "Norwegian National Commission of Inquiry into Health and Care". The report is based on two complaints to UKOM about patient safety from relatives of patients. The persons involved in the preparation of the report and the formulation of recommendations are not specified. It is therefore not possible to assess whether experts were involved in the drafting process.
- No systematic literature search, selection or assessment is documented. No information is provided on how recommendations were derived (e.g. through a structured consensus process). Consultations were held with various specialist organisations and organisations of patients and caregivers. Possible negative effects of the recommendations are not discussed. For example, it is assumed without evidence that psychotherapy alone is safer for patients than a combined treatment of psychotherapy and medical interventions.
- There are no declarations on financing or conflicts of interest.

Deviating recommendations:
Revision of the binding Norwegian guidelines (Helsedirektoratet, see above) with the following stipulations:

1. Performing puberty blockade and gender affirming hormone treatment and surgery on adolescents with gender incongruence only as part of clinical trials.
2. Introduction of a national quality register for puberty blockades and gender affirming treatments.

Rationale for recommendations:
a There is reportedly no Norwegian systematic review on the treatment of gender incongruence. The national guideline is not based on such a review and would therefore not be evidence-based. According to the report, the national guideline leaves too much room for interpretation and is therefore not suitable for use.

b For safety reasons, given the unclear data situation, physical/medical treatment should only be used in clinical trials. Other interventions (e.g. psychotherapy) are reportedly less invasive and therefore preferable.

I. The studies on outcomes of physical medicine treatment of children with GI are too small in sample size, with too short a follow-up and without a control group.

II. Due to the reported increase in utilisation and higher psychological disstress, the results of outcome studies of gender affirming treatment could not be transferred to current cohorts.

III. There is not enough research on long-term side effects of such treatment.

c The generation of well-founded knowledge about outcomes and side effects of treatment is necessary. In order to generate such knowledge, a national quality register and the implementation of treatments in clinical trials would be useful.

Consensus strength:

Not specified

Level of evidence or grading of recommendation:

No grading of recommendations or levels of (overall) evidence reported.

Summarised DELBI (German Instrument for Methodological Guideline Appraisal) appraisal:

Scope & purpose	*Stakeholder involvement*	*Methodological rigour*	*Clarity & presentation*	*General applicability*	*Editorial independence*	*Applicability in Germany*
0,33	0,17	0,05	0,50	0	0	0,17

The DELBI instrument (Beyer et al., 2008) with one or two reviewers was used to assess the extent to which the reviewed documents fulfil the quality standards for guidelines and similar publications with recommendations for clinical practice, even if some of the reviewed documents are not guidelines in the narrower sense. According to a DELBI rating, the methodological quality of the recommendations for the 7 domains listed in the table is indicated on a scale from 0 (poor quality) to 1 (very good quality).

Appraisal according to DELBI:

- According to DELBI, the purpose and scope are described with low to medium quality. Objectives are stated in general terms and key questions can be inferred, but are not made explicit. The target group is named and specified in the glossary. It remains unclear to what extent the recommendations are aimed exclusively at minors (e.g. over 20-year-olds reported).
- According to DELBI, the stakeholder involvement is to be assessed as qualitatively low. The persons who worded the recommendations are not named. There were numerous consultations, but no direct involvement of patients and their carers. The target user group is defined, but no indirect users. There is no report on a pilot test.
- According to DELBI, the methodological rigour is very low. No systematic literature search or selection is documented. There is also no evidence of a consensus process and no review or updating procedure.
- According to DELBI, the clarity and presentation are rated as medium. The recommendations are mostly unambiguous, but possible negative effects of the recommendations are not discussed and no different options for action are presented. An summary is available.
- According to DELBI, the general applicability is rated as very low. No analysis of barriers or cost implications was carried out. No criteria for monitoring were defined either. According to DELBI, the applicability in the German healthcare system is assessed as low.
- There are no declarations regarding conflicts of interest and the financing of the report. This is to be assessed as low quality according to DELBI.

Appraisal of the deviating recommendations

ad1 A lack of evidence is cited for puberty blockade and gender affirming hormones. It is correct that the Norwegian Helsedirektoratet guideline does not adequately discuss the evidence base for certain recommendations. However, it would have been necessary for the UKOM recommendations as well to carry out *a systematic* literature review and not selectively use results when claiming that

there is generally not enough evidence and that treatments are therefore only experimental. Although reference is made to the reviews of the SBU (see "Sweden"), the evidence presented there is hardly discussed, but only referred to the recommendations of Socialstyrelsen (see above) based on it. It is also relevant here that no report is given on how the consensus was reached. How the (anonymous) authors arrive at this recommendation from the (unsystematic) evidence remains open.

ad 2 This demand is to be welcomed from a research perspective, provided that patients' rights are respected and research and medical ethics aspects are taken into account. This recommendation can already be found in the guidelines of the Helsedirektoratet.

WPATH (international, 2022)

Title:
Standards of care for the health of transgender and gender diverse people, Version 8

Publishing institution:
World Professional Association for Transgender Health (international professional association for transgender health care)

Authors & year:
Coleman, E., Radix, A. E., Bouman, W. P., Brown, G. R., De Vries, A. L., Deutsch, M. B., ... & Arcelus, J. (2022)

Type of publication and binding nature:
Standards of care; mandatory application cannot be assumed due to the status of the issuing organisation

Other primary documents included:
- Information on the guideline website
- Baker et al. (2021)

Methodology:
- The tstandards of care are the 7th update of WPATH standards of care. WPATH is an international professional organisation in the field of transgender health. Those involved in the development of the guidelines are named with details of their area of work. The participants were selected as part of an application process. It is not clear to what extent only WPATH members were involved. People who identify as transgender were also involved in the drafting process.
- A systematic review was commissioned for the treatment standards, which was adequately conducted and documented by an external research group (Baker et al., 2022). In this review, the outcomes of puberty blockade and gender affirming hormone treatment for adults and adolescents are considered together. In the chapter on the treatment of adolescents, it is noted that no separate systematic review was conducted as the number of published studies on this topic was too small (p. 46). It is therefore unclear how the recommendations for adolescents relate to the systematically reviewed evidence.
- A modified DELPHI procedure was used to derive recommendations. A subsequent consultation (also with patients and their carers) and review took place.
- The cost structure and financing of the preparation is roughly reported. There is a general declaration on conflicts of interest without any conflicts of interest being disclosed on a personalised basis.

Deviating recommendations:
No deviating recommendations recognisable.

Consensus strength:
Not specified

Level of evidence or grading of recommendation:
No levels of the (overall) evidence reported. Grading of the strength of recommendation (“suggest“, ”recommend”) specified.

Summarised DELBI (German Instrument for Methodological Guideline Appraisal) appraisal:

Scope & purpose	*Stakeholder involvement*	*Methodological rigour*	*Clarity & presentation*	*General applicability*	*Editorial independence*	*Applicability in Germany*
0,61	0,42	0,50	0,63	0,28	0,50	0,44

The DELBI instrument (Beyer et al., 2008) with one or two reviewers was used to assess the extent to which the reviewed documents fulfil the quality standards for guidelines and similar publications with recommendations for clinical practice, even if some of the reviewed documents are not guidelines in the narrower sense. According to a DELBI rating, the methodological quality of the recommendations for the 7 domains listed in the table is indicated on a scale from 0 (poor quality) to 1 (very good quality).

Appraisal according to DELBI:

- The scope and purpose is defined as medium to good quality according to DELBI. The objectives of the guideline are specifically named, but without reference to specific parameters. The underlying guideline questions are consistently accessible. The patient population is named generally, but not specifically.
- According to DELBI, the stakeholder involvement is rated as medium. Specialists were involved, although it is not certain that the application process involved all relevant medical specialist groups. Stakeholders were directly involved in the development process and an extensive consultation phase was carried out. Changes to the recommendations as a result of the consultation phase are documented. The target user group is named; indirect users are named in some cases. The target user group is defined. No pilot testing has taken place.
- According to DELBI, the methodological rigour can be assessed as qualitatively medium. The systematic literature search and selection are indicated. As this was not carried out specifically for minors, low scores were awarded for these points in our DELBI rating. Recommendations were formulated using the established DELPHI procedure. A consultation phase was carried out. Changes to the recommendations during the consultation phase are documented. Information is provided on the period of validity (but without specifying a time period). The treatment standards themselves are the 7th update, so this is likely to be the case.
- According to DELBI, the clarity and presentation can be assessed as medium to good. The recommendations in the guideline are mostly unambiguous and various options for action are roughly presented. The key recommendations are summarised at the beginning of each chapter and are easily identified by highlighting throughout.
- According to DELBI, the applicability is to be assessed as low. Only barriers to application are discussed superficially. No implications with regard to resources are given. Measured variables for monitoring are hardly defined. According to DELBI, the applicability in the German healthcare system can be assessed as medium.
- Editorial independence can also be assessed as medium according to DELBI. There is a general declaration on the procedure for conflicts of interest. Funding is discussed and it is made clear that those involved in the guideline did not benefit financially as a result.

The guideline is of comparatively high methodological quality, in our DELBI assessment it is roughly comparable to the Socialstyrelsen guideline (2022).

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