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GUIDELINES FOR PUBERTAL SUPPRESSION TREATMENT IN TRANSGENDER ADOLESCENTS

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PROPOSED GUIDELINES

When considering whether to undertake pubertal-suppression treatment, doctors should ask the following questions:

1. What is the preferred treatment of the patient and the patient's parents? Is there a clinical reason not to follow their choice?
2. What is the likely prognosis for the patient? Is there a clear indication that the patient is unlikely to want to proceed to gender reassignment as an adult?
3. Can the doctor justify delaying access to pubertal-suppression treatment in the particular patient's case, bearing in mind the psychological and social pressures of adolescence, and the fact that pubertal-suppression treatment is reversible?
4. Would the non-provision of pubertal-suppression treatment prove genuinely beneficial for the particular patient?
5. Has the clinician ensured that the correct procedures will be followed if pubertal-suppression treatment is not given?

Such decisions must, of course, consider the age of the child and the likely support he or she will receive for a cross-gender life-style from parents, family members, peers, and school or college officials. Nevertheless, in our view, pubertal-suppression treatment should be used in all cases unless there are positive reasons for choosing the second method.

Before turning to an ethics committee for advice, we would recommend that clinicians evaluate the three available methods in the light of the following observations:

1. Is there any clinical basis for refusing treatment because the individual can be cured of gender dysphoria? The answer, at present, is *no*. Severe gender dysphoria is currently assessed as not being susceptible to any treatment other than hormonal (and surgical) gender reassignment.
2. Has valid consent to treatment been given by the adolescent or the adolescent's parents? If a parent consents to pubertal-suppression treatment, then, regardless of the child's level of competence to consent treatment should not be refused, unless there are specific contra-indications. If parents refuse to consent, then an adolescent's competence should be assessed if they are under 16.
3. Are there specific contraindications to pubertal-suppression treatment? These might be that the adolescent does not have an extreme cross-gender identification, or does not function well socially (apart from any anxiety or depression caused by the social stigma resulting from their cross-gender identification). If no, then pubertal-suppression

treatment should be provided. It is reversible, it relieves anxiety and distress and, perhaps importantly for the clinician involved, it removes the threat of possible future litigation as a result of the consequences of failing to provide such treatment.

CONCLUSION

Doctors and ethics committees must consider the implications of refusing pubertal-suppression treatment to gender-dysphoric adolescents who have a good prognosis for future gender reassignment. In deciding what path to take in the treatment of these adolescents, clinicians must also consider the possibility of future litigation as grounds for refusal to treat. The well-documented experiences of the Dutch model of treatment have shown that this treatment can provide an effective approach for young people experiencing gender dysphoria. The alternatives, to date, have been shown to prolong distress and to allow the development of secondary sex characteristics, which require extensive, painful and expensive medical intervention in later life.

Gender reassignment treatment is no longer a medical practice in its infancy. It was initiated at the end of the 19th century, and has been provided regularly since the late 1960s. The prognosis for patients is excellent. The younger they are allowed to commence some sort of treatment and cross gender lifestyle, the better.

Nevertheless, the social stigmas associated with gender reassignment, and the resulting concerns of clinicians who provide it, are still significant. Doctors must assess the best long-term medical interests of adolescent patients before refusing active intervention. Seeking guidance from their ethics committee would ensure they have shown why they have chosen a particular method of treatment.

In the long term, this process of consultation can safeguard the clinician and health authorities from litigation, and can safeguard individual patients, ensuring that they receive the treatment best suited to their clinical and social needs.