Ethical dilemmas related to puberty suppression

Dilemas éticos relacionados con la supresión de la pubertad

María Guadalupe Grimaux*
Universidad Austral, Pilar, Argentina

Gustavo Paez**
Universidad Austral, Pilar, Argentina

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Abstract

Pediatric gender dysphoria is a psychiatric pathology whose incidence has increased significantly. Several therapies have been proposed, but there is still no consensus on the behavior to follow in these cases. One of the suggested treatments is the suppression of puberty, whose objective is to reduce the distress of the child suffering from this pathology. However, this treatment has generated several ethical dilemmas that have not yet been resolved. For this reason, based on the current evidence, its indication does not seem prudent since there are other therapeutic alternatives that do not arouse controversy.

Keywords: dysphoria, gender, bioethics.

* Specialist in Medical Clinic. Member of the Department of Bioethics, School of Biomedical Sciences, Universidad Austral, Pilar, Argentina. Master in Bioethics from Universidad Católica San Antonio de Murcia. E-mail: mgrimaux@austral.edu.ar https://orcid.org/0000-0002-7594-5610

** Member of the Department of Bioethics, School of Biomedical Sciences, Universidad Austral, Pilar, Argentina. Master in Bioethics and PhD from Universidad de Navarra. E-mail: gpaez@austral.edu.ar https://orcid.org/0000-0003-3862-7426
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1. Introduction

"Gender dysphoria" is defined by the *American Psychiatric Association* as "discomfort that may accompany incongruity between the gender experienced or felt by a subject and the assigned gender" (1). This concept gained notoriety when it was included in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) replacing "gender identity disorder", which appeared in the previous edition (2).

As expressed by the *World Professional Association for Transgender Health (*WPATH), some people experience gender dysphoria to such a level that distress meets the criteria for a formal diagnosis that could be classified as a mental disorder. Such a diagnosis is not a license for stigmatization or deprivation of civil and human rights (3). It is a problem experienced by a person and is aimed at alleviating the distress that person experiences, especially caused by the rejection he or she often suffers from others (4).

A phenomenon that has always existed, although the terminology is more recent. The incidence of this pathology has been increasing with a current prevalence of 0.002-0.003% in women and 0.005-0.014% in men (1). It occurs in both girls and boys, adolescents and adults. A broad and complex issue is still under study.

Children and adolescents who experience gender dysphoria at the onset of puberty that they experience as wrong are at high risk for depression, anxiety, isolation, and self-harm (5).

This article focuses on gender dysphoria in girls and boys, and the therapies proposed to treat it. Gender dysphoria that occurs in patients with disorders of sexual development will be excluded since it is a case that has its own characteristics. Among the proposed treatments, we will focus on the suppression of puberty. We will analyze the positions of those who promote this alternative and of some authors who are prevented when deciding. The bioethical dilemmas that this treatment presents are also reflected in the legal controversies that can be found in various countries.

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To simplify the reading, when we mention "children" we are referring to all boys and girls before adolescence.

2. Pediatric gender dysphoria

2.1. Diagnosis

The DSM-5 considers gender dysphoria in children to be "a marked incongruence between one's felt or expressed sex and one's assigned sex, of at least six months' duration, manifested by at least six of the following characteristics (one of which must be Criterion 1):

1. A powerful desire to be of the other sex or an insistence that he or she is of the opposite sex (or of an alternative sex other than that to which he or she is assigned).
2. In boys (assigned sex), a strong preference for cross-dressing or for simulating female attire; in girls (assigned sex), a strong preference for wearing only typically male clothes and a strong resistance to wearing typically female clothes.
3. Marked and persistent preferences for the role of the other sex or fantasies concerning belonging to the other sex.
4. A marked preference for toys, games or activities customarily used or practiced by the opposite sex.
5. A marked preference for playmates of the opposite sex.
6. In boys (assigned sex), a strong dislike of typically masculine toys, games, and activities, as well as a marked avoidance of rough play; in girls (assigned sex), a strong dislike of typically feminine toys, games, and activities.
7. A marked dislike of one's own sexual anatomy.
8. A strong desire to possess the sexual characteristics, both primary and secondary, corresponding to the sex one feels.

The problem is associated with clinically significant distress or impairment in social, school or other important areas of functioning" (1).

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2.2. Prognosis

For pediatric patients, the WPATH states that an important difference between children and adolescents with gender dysphoria is the rate at which gender dysphoria persists into adulthood. In follow-up studies of prepubertal boys who were referred to clinics for evaluation of gender dysphoria, gender dysphoria continued into adulthood in only 6-23% of cases. Other studies that also included girls showed a persistence of 12-27% (3). That is, for most children, the dysphoria resolves without treatment, although the trend points to an increase in persistence. Some studies maintain that this fluctuation is maintained even in young adults (6).

2.3. Associated psychiatric disorders

Children with gender dysphoria frequently have other coexisting psychiatric disorders such as anxiety and depression (7). On the other hand, the prevalence of autism spectrum disorders seems to be higher in children with gender dysphoria than in the general population (8, 9). It has also been shown that they have a higher tendency to use illicit drugs, eating disorders, self-injury and suicide attempts (10). Therefore, the following skills are required of mental health professionals who assess, refer and provide therapy to children with gender dysphoria: a) meet the competency requirements for mental health professionals working with adults; b) be trained in child and adolescent developmental psychopathology; and c) be competent in the diagnosis and treatment of the everyday problems of children and adolescents (3).

The *minority stress theory*, originally developed with the experience of LGB (lesbian, gay, bisexual) people in mind and later extended to transgender people, argues that LGBT (lesbian, gay, bisexual, and transgender) people experience higher rates of poor mental health because of discrimination and other forms of stigma. However, the theory does not consider the fact that gender minority adolescents

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may experience gender dysphoria, generating greater vulnerability for mental disorders, especially in those patients with risk factors (11).

2.4 Therapeutic guidelines

There are three distinct approaches to treating gender dysphoria, each supported by its own clinical paradigm. We will describe them briefly:

a) *Therapeutic model*: this was the initial model. It seeks to diminish gender dysphoria. It maintains that the possibility of transgenderism entails physical, psychological and social difficulties (12). It considers biological factors as possible predisposing factors for the expression of a particular gender identity phenotype, but not as determining factors that invariably lead to a certain gender identity throughout development. Psychosocial factors, social cognition, associated psychopathology and psychodynamic mechanisms can be conceptualized as predisposing, precipitating or perpetuating (13).
b) *Watchful waiting*: accompanies the child and family and allows the development of gender identity in a natural way. It is advisable to keep the different gender identity options open, but to avoid an early social transition (change of name, clothing, etc.) as much as possible. It prefers to wait until adolescence to carry out the sex reassignment trajectory (social transition, hormone treatment, etc.) (14).
c) *Affirmative model*: changes in gender identity are often seen as valid and desirable and therefore affirmation of the child's perceived gender identity is sought. Children are allowed and assisted to make an early social transition (in clothing, name, etc.) if they wish, after case-by-case counseling. Once adolescence arrives, puberty suppression and cross-hormonal treatment are offered to young people (15).

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Regarding the comparison of alternative therapeutic approaches, the APA *Task Force on Treatment of Gender Identity Disorder* found no randomized studies (APA level A) or adequately controlled nonrandomized longitudinal studies (APA level A-), and very few follow-up studies without a control group with (APA level B) or without (APA level C) an intervention. Most of the available evidence is derived from qualitative reviews (APA level F) and experimental systematic single case studies that do not fit into the APA evidence grading system (16).

For that reason, consensus was reached only on the following points:

1) Accurate DSM assessment and diagnosis of the gender-referred child, including the use of validated questionnaires and other validated assessment instruments to assess gender identity, gender role behavior, and gender dysphoria.
2) Diagnosis of any coexisting psychiatric conditions in the child and ensuring appropriate treatment or referral.
3) Identifying mental health concerns in caregivers and difficulties in their relationship with the child; ensuring that they are adequately addressed.
4) Providing appropriate psychoeducation and counseling to caregivers to enable them to choose a course of action and give their fully informed consent to any chosen treatment.

It can be noted that these are general guidelines, due to the lack of consensus among Task Force members. Opinions vary widely among specialists, supported by widely debated theories on gender identity (17). The subject is very complex and multifactorial, and there is still little scientific knowledge about the etiology of gender dysphoria (18). Research has been done on psychosocial and biological factors, including characteristics of the parent-child relationship, exposure to sex hormones in utero, patterns of brain activation and anatomy, and genetic variations (19). Due to the scarce scientific evidence, there are still diverse opinions and an extensive debate about the

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treatment that should be suggested for a patient with gender dysphoria.

3. Treatments used with children

3.1. Psychological therapy

A psychodiagnostic and psychiatric evaluation is indicated, covering the areas of emotional functioning, social relationships and intellectual functioning/school performance (3,20).

The most usual therapies are: a) insight-oriented psychoanalytic or psychodynamic psychotherapy; b) protocol-based psychotherapy such as behavior modification; c) parent-peer relationship-focused therapy and parent-child therapeutic groups (21) and; d) support groups for primary caregivers, community education through websites and conferences, school curricula and specialized youth summer camps (3).

Often attention is directed first to the child's caregivers (especially parents) through psychoeducation and counseling for behavior modification and resilience building in the child and measures that tend to prevent bullying (12). Even if parents have a supportive attitude towards the child, they may initially adopt a rejecting stance caused by fear or ignorance, which does not facilitate the child's trust and, therefore, cannot help him or her.

Tobin *et al.* propose an ecological model to describe biopsychosocial vulnerability risks and protective factors for the mental health of "minority genders" (transgender and gender nonconforming). They propose that support groups facilitate the elimination of these risks, so that adolescents are in a family, community and social environment that favors the development of the gender perceived by the young person (11).

All psychological treatments are aimed at achieving an improvement in the psychosocial health of the patient with gender dysphoria. However, there are conflicting opinions as to how to achieve this

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goal, especially about whether or not minimization of gender atypical behaviors and prevention of transsexualism should be part of the therapy (12).

3.2. Pubertal suppression

The onset of endogenous female or male puberty for many children who do not identify with their gender is a painful and sometimes traumatic experience. The development of one's own body that the young person experiences as "wrong" can lead to the permanence of gender incongruence and can trigger negative psychosocial outcomes (4).

The use of GnRH agonists for the purpose of suppressing endogenous puberty and thus preventing the development of unwanted secondary sexual characteristics is a relatively new strategy in the approach to treating children with gender dysphoria. Initiated primarily by a team of gender specialists in the Netherlands, pubertal suppression is a resource increasingly used in many gender clinics around the world (22). The clinical goal is to decrease the anxiety caused by pubertal changes and to allow more time to get to know one's own gender (23). Those who support this method affirm that it is an essentially reversible treatment and that, in this way, a step is being taken to respect the changing dynamics of childhood development (24).

Oslon and Garofalo (5) recommend this method at the onset of pubertal development, with counseling by mental health professionals trained in child psychology and skilled in gender issues. The WPATH recommendation to start using this therapy is that children are at the onset of puberty, which corresponds to Tanner stage 2. It should be clarified that some children may reach this period at 9 years of age.

There are published studies showing a decrease in distress and other psychological symptoms in adolescents after this intervention. However, they also recognize that the effects of the treatment have not been sufficiently investigated (25). Among them, we find a study

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of 70 children with gender dysphoria undergoing pubertal suppression that showed positive effects. In contrast, Butler *et al.* state that the impact on the reduction of psychological difficulties is limited (24). It should be noted that the good of the patient and the centrality of the person should be considered before proposing a treatment that even from a scientific point of view does not present sufficient evidence.

Some authors, such as Day *et al.* point out the risk of suicide and the distress of patients with gender dysphoria. These authors refer that there are many factors that affect the psychological health of these patients and exemplify it through a case. They present a 13-year-old patient who received hormonal treatment for gender reassignment at an early age due to gender nonconformity. Subsequently, the same patient expresses her desire to discontinue the treatment for not being able to improve her distress. In both cases, she came to the idea of suicide (26). Other authors mention that in many cases that have been treated medically, suicidal ideation may persist (18).

Temple-Newhook *et al.* followed up studies on transgender and gender nonconforming children. These authors rely on the findings of children with gender dysphoria who ultimately persist in their birth gender to argue that this is a very complex reality, in which one could not even speak of "persisting" or "desisting" in gender. This way of describing a reality that, in some cases, would have a more fluid evolution, seems inadequate to them (27).

3.2.1. Dilemmas surrounding pubertal suppression

Although the method of suppressing puberty is spreading in practice for children with gender dysphoria, there is no shortage of some warnings by those who have contrasted what is stated by the different theories with experience in medical care:

- López and González point out the following side effects of pubertal suppression:

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1. Problems related to the development of bone mass and growth.
2. Possibility of affecting fertility.
3. Ability to cause a lack of development of the external genitalia that could compromise future surgical reassignment.
4. Suspicion that these treatments may have negative neurodevelopmental consequences (28).

- The high rate of children with dysphoria who later persist in their birth gender (29) leads to consider that this treatment may be disproportionate, even more so if the lack of knowledge of future physical and psychological risks is considered. This aspect is accentuated if one considers that the gender of children fluctuates even up to adolescence (30). The desired effect of alleviating the anxiety of these children would be achieved with the support of mental health professionals and other specialties. In fact, the support of counselors and counselors for those suffering from this situation is widely recommended (31).
- The low age of the patient to consent to an issue that may affect the rest of his or her life (32). Although the child's parents are also involved in the decision, it is likely that the child does not have the capacity to appreciate the consequences of treatment.
- Hruz *et al.* (33) caution that claims about the supposed reversibility of the method should be carefully reviewed. According to them, in developmental biology it makes little sense to speak of reversibility: if the child does not develop certain characteristics during his or her adolescence, that he or she later does so at an older age does not mean that it has reversed, because there has been a disruption in the process, which affects the young person in various psychological and psychosocial aspects (33). The physical effects that this disruption may have on the development of the child or adoles-

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cent are also unknown. It should be noted that the article by Hruz *et al.* has been cited in numerous publications, which gives an understanding that their observations are relevant to the subject under study.

- In some cases, the management of anxiety in girls or boys with dysphoria could be achieved by simpler means (e.g., menstruation could be prevented by continuous progestogen such as norethisterone and topical treatments such as eflornithine cream can help reduce unwanted facial and body hair growth (23). These studies support the idea that with early identification, psychological therapy, and support from family and friends, young people with dysphoria can reach adulthood with reduced psychological sequelae.

4. Ethical discussion: is pubertal suppression an advisable treatment for children with gender dysphoria?

Gender dysphoria is a disorder that has not yet been sufficiently studied. This phenomenon causes the so-called *gender minority stress*. When it occurs in children, research is even scarcer and, due to the lack of scientific evidence, there is no agreement on the best course of action to follow. All specialists agree that an effective solution should be offered to this problem, which significantly affects the quality of life of the children who suffer from it. However, when considering possible treatments, the various options are radically different. There is full agreement that the overall goal of psychotherapeutic treatment for childhood gender dysphoria is to optimize the psychosocial health and well-being of the child. The controversy lies in what should be indicated to promote that well-being (32).

Those who defend a personalist bioethical stance will consider that what is appropriate cannot go against what the person is. They will argue that the aim of treatment should be to achieve harmony between the psychological and the physical (34). On the other hand,

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those who maintain that autonomy must be above any other principle will assert that any method is acceptable if it respects that autonomy, regardless of the biological data (35). The purpose of this article is not to take a position, but to present the situation and the contradictions it presents.

As we have seen above, the suppression of puberty in infancy is one of the treatments proposed to improve the quality of life of the child with gender dysphoria. However, this treatment brings with it several ethical dilemmas that must be considered when indicating therapeutic behavior. From an ethical point of view, there is controversy between those who consider the change of sexual identity ethically illicit and those who consider it morally appropriate. Within those who support gender reassignment, there are also controversies regarding the indication and efficacy of pubertal suppression in childhood (26,32,36). The possible adverse effects at the physical level (32), the questioning of its presumed reversibility, the possible psychological consequences that this therapy could entail, added to the scarce scientific evidence regarding its efficacy (36), safety and risks (26), make the health professional who must advise the patient and his family, really question whether there is not another therapeutic alternative that allows achieving an adequate psychosocial health without the dilemmas that this therapy brings with it. This approach is even more relevant when evidence shows that gender dysphoria remits without treatment in most children (32). Is it lawful to offer a child a treatment that involves a change of identity with physical consequences to treat a psychiatric illness? Is it lawful to offer a child a therapy with risks when it is known that the vast majority remit without treatment?

In addition to the above, the other great ethical dilemma faced by the suppression of puberty is the child's lack of autonomy to make such an important decision, not without risks and adverse effects (32). The lack of informed consent on the part of the patient, since he lacks sufficient capacity to understand everything that it implies and is unable to consider all the edges and consequences of his deci-

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sion (32), leads to this treatment encountering great consequences. Objections among specialists who treat children with gender dysphoria. Is it lawful to accept the request for gender change in a patient who still does not have the capacity to understand the consequences of their decisions? Would that decision be truly autonomous? Although parents try to seek the good of their daughter or son, by opting for this method, they would be seriously affecting the child's future (32). As in other situations that affect the child, it would be expected that parents would opt for the one that offers more scientific support and, therefore, less risk for the child. The child manifests his problem, but at that age, he does not have the ability to choose how to alleviate it.

In this context, it is worth asking, is it the best solution to change the child's identity —his body, his name, among others— so that the child's mind does not suffer? Would it not be more logical to help the child's mind so that it does not suffer with its own identity? If what is affected were the psychological health of the child for not accepting his own identity, wouldn't a valid alternative be psychological treatment of the child so that he tries to accept himself as he is? This is a different path to the one that seems to find more room in some positions of current medical practice. However, it is worth analyzing it, as it could be a simpler solution, with fewer risks, fewer adverse effects, and more in line with the child's own way of being.

5. Conclusions

Throughout this article, we have presented the different views on pubertal suppression. This therapy aims to reduce the distress of the child suffering from gender dysphoria. However, this treatment has generated several ethical dilemmas that have not yet been cleared. For this reason, based on the current evidence, its indication does not seem prudent since there are other therapeutic alternatives that do not arouse controversy.

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