Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment

WHAT'S KNOWN ON THIS SUBJECT: Puberty suppression has rapidly become part of the standard clinical management protocols for transgender adolescents. To date, there is only limited evidence for the long-term effectiveness of this approach after gender reassignment (cross-sex hormones and surgery).

WHAT THIS STUDY ADDS: In young adulthood, gender dysphoria had resolved, psychological functioning had steadily improved, and well-being was comparable to same-age peers. The clinical protocol including puberty suppression had provided these formerly gender-dysphoric youth the opportunity to develop into well-functioning young adults.

abstract

BACKGROUND: In recent years, puberty suppression by means of gonadotropin-releasing hormone analogs has become accepted in clinical management of adolescents who have gender dysphoria (GD). The current study is the first longer-term longitudinal evaluation of the effectiveness of this approach.

METHODS: A total of 55 young transgender adults (22 transwomen and 33 transmen) who had received puberty suppression during adolescence were assessed 3 times: before the start of puberty suppression (mean age, 13.6 years), when cross-sex hormones were introduced (mean age, 16.7 years), and at least 1 year after gender reassignment surgery (mean age, 20.7 years). Psychological functioning (GD, body image, global functioning, depression, anxiety, emotional and behavioral problems) and objective (social and educational/professional functioning) and subjective (quality of life, satisfaction with life and happiness) well-being were investigated.

RESULTS: After gender reassignment, in young adulthood, the GD was alleviated and psychological functioning had steadily improved. Well-being was similar to or better than same-age young adults from the general population. Improvements in psychological functioning were positively correlated with postsurgical subjective well-being.

CONCLUSIONS: A clinical protocol of a multidisciplinary team with mental health professionals, physicians, and surgeons, including puberty suppression, followed by cross-sex hormones and gender reassignment surgery, provides gender dysphoric youth who seek gender reassignment from early puberty on, the opportunity to develop into well-functioning young adults. Pediatrics 2014;134:696–704

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KEY WORDS gender dysphoria, transgenderism, adolescents, psychological functioning, puberty suppression, longitudinal outcomes

ABBREVIATIONS

ABCL—Adult Behavior Checklist
ASR—Adult Self-Report
BDI—Beck Depression Inventory
BIS—Body Image Scale
CBCL—Child Behavior Checklist
CGAS—Children’s Global Assessment Scale
CSH—cross-sex hormones
GD—gender dysphoria
GnRHa—gonadotropin-releasing hormone analogs
GRS—gender reassignment surgery
SHS—Subjective Happiness Scale
STAI—Spielberger’s Trait Anxiety Scale
SWLS—Satisfaction With Life Scale
TPI—Spielberger’s Trait Anger Scale
UGDS—Utrecht Gender Dysphoria Scale
YSR—Youth Self-Report

Dr de Vries conceptualized the study, clinically assessed the participants, drafted the initial manuscript, and reviewed and revised the manuscript; Dr McGuire conceptualized the study, planned and carried out the analyses, assisted in drafting the initial manuscript, and reviewed and revised the manuscript; Dr Steensma conceptualized the study, coordinated and supervised data collection, and reviewed and revised the manuscript; Dr Wagenaar coordinated and invited participants for assessments and reviewed and revised the manuscript; Drs Doreleijers and Cohen-Kettenis conceptualized the study and reviewed and revised the manuscript; and all authors approved the final manuscript as submitted.

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(Continued on last page)
Transgender adolescents experience an incongruence between their assigned gender and their experienced gender and may meet the Diagnostic and Statistical Manual of Mental Disorders 5 criteria for gender dysphoria (GD). Fifteen years ago, pubertal delay was introduced as an aid in the treatment of a gender dysphoric adolescent. Although not without debate, blocking pubertal development has rapidly become more widely available and is now part of the clinical management guidelines for GD.

Gonadotropin-releasing hormone analogs (GnRHa) are a putatively fully reversible medical intervention intended to relieve distress that gender dysphoric adolescents experience when their secondary sex characteristics develop. A protocol designed by Cohen-Kettenis and Delemarre-van de Waal (sometimes referred to as “the Dutch model”) considers adolescents, after a comprehensive psychological evaluation with many sessions over a longer period of time, eligible for puberty suppression, cross-sex hormones (CSH), and gender reassignment surgery (GRS) at the respective ages of 12, 16, and 18 years when there is a history of GD; no psychosocial problems interfering with assessment or treatment, for example, treatment might be postponed because of continuous moving from 1 institution to another or repeated psychiatric crises; adequate family or other support; and good comprehension of the impact of medical interventions. Puberty suppression is only started after the adolescent actually enters the first stages of puberty (Tanner stages 2–3), because although in most prepubertal children GD will desist, onset of puberty serves as a critical diagnostic stage, because the likelihood that GD will persist into adulthood is much higher in adolescence than in the case of childhood GD.

Despite the apparent usefulness of puberty suppression, there is only limited evidence available about the effectiveness of this approach. In the first cohort of adolescents who received GnRHa, we demonstrated an improvement in several domains of psychological functioning after, on average, 2 years of puberty suppression while GD remained unchanged. The current study is a longer-term evaluation of the same cohort, on average, 6 years after their initial presentation at the gender identity clinic. This time, we were not only interested in psychological functioning and GD, but added as important outcome measures objective and subjective well-being (often referred to as “quality of life”), that is, the individuals’ social life circumstances and their perceptions of satisfaction with life and happiness. After all, treatment cannot be considered a success if GD resolves without young adults reporting they are healthy, content with their lives, and in a position to make a good start with their adult professional and personal lives. Because various studies show that transgender youth may present with psychosocial problems, a clinical approach that includes both medical (puberty suppression) and mental health support (regular sessions, treatment when necessary, see Cohen-Kettenis et al.) aims to improve long-term well-being in all respects.

In the present longitudinal study, 3 primary research questions are addressed. Do gender dysphoric youth improve over time with medical intervention consisting of GnRHa, CSH, and GRS? After gender reassignment, how satisfied are young adults with their treatment and how do they evaluate their objective and subjective well-being? Finally, do young people who report relatively greater gains in psychological functioning also report a higher subjective well-being after gender reassignment?

**METHODS**

**Participants and Procedure**

Participants included 55 young adults (22 transwomen [natal males who have a female gender identity] and 33 transmen [natal females who have a male gender identity]) of the first cohort of 70 adolescents who had GD who were prescribed puberty suppression at the Center of Expertise on Gender Dysphoria of the VU University Medical Center and continued with GRS between 2004 and 2011. These adolescents belonged to a group of 196 consecutively referred adolescents between 2000 and 2008, of whom 140 had been considered eligible for medical intervention and 111 were prescribed puberty suppression (see de Vries et al.). The young adults were invited between 2008 and 2012, when they were at least 1 year past their GRS (vaginoplasty for transwomen, mastectomy and hysterectomy with ovariec- tomy for transmen; many transmen chose not to undergo a phalloplasty or were on a long waiting list). Nonparticipation (n = 15, 11 transwomen and 4 transmen) was attributable to not being 1 year postsurgical yet (n = 6), refusal (n = 2), failure to return questionnaires (n = 2), being medically not eligible (eg, uncontrolled diabetes, morbid obesity) for surgery (n = 3), dropping out of care (n = 1), and 1 transfemale died after her vaginoplasty owing to a postsurgical necrotizing fasciitis. Between the 55 participants and the 15 nonparticipating individuals, Student’s t tests revealed no significant differences on any of the pretreatment variables. A similar lack of differences was found between the 40 participants who had complete data and the 15 who were missing some data.

Participants were assessed 3 times: pre-treatment (T0; at intake), during treatment (T1; at initiation of CSH), and post-treatment (T2; 1 year after GRS). See Table 1 for age at the different time points. The VU University Medical Center medical ethics committee approved the study, and all participants gave informed consent.
MEASURES

Time was the predominate independent variable. Other demographic characteristics were incorporated in some models, including, age, natal sex, Full Scale Intelligence, and parent marital status; where significantly different they are reported.

Gender Dysphoria/Body Image

There was 1 indicator measuring GD (Utrecht Gender Dysphoria Scale [UGDS]) and 3 indicators measuring body image (Body Image Scale [BIS] with primary, secondary, and neutral subscales). Higher UGDS (12 items, 1–5 range) total scores indicate higher levels of GD, for example, "I feel a continuous desire to be treated as a man/woman." These separate versions of the UGDS for males and females with mostly different items, permitting no gender difference analyses. BIS (30 items, 1–5 range) higher scores indicate more dissatisfaction with primary sex characteristics (important gender-defining body characteristics, eg, genitals, breasts), secondary sex characteristics (less obvious gender-defining features, eg, hips, body hair), and neutral (hormonally unresponsive) body characteristics (eg, face, height). The male and female BIS are identical except for the sexual body parts. The UGDS and the BIS of the natal gender were administered at T0 and T1. At T1, we chose the UGDS of the assigned gender, because no physical changes had occurred yet and some were still treated as their assigned gender. This way, however, decreased GD caused by social transitioning was not measured. At T2 young adults filled out the versions of their affirmed gender.

Psychological Functioning

There were 10 indicators assessing psychological functioning. To assess global functioning, the Children’s Global Assessment Scale (CGAS) was used. The Beck Depression Inventory (BDI; 21 items, 0–6 range) indicates presence and severity of depressive symptoms. Spielberger’s Trait Anger (TPI) and Spielberger’s Trait Anxiety (STAI; 10 and 20 items, respectively, 1–4 range) scales of the State-Trait Personality Inventory were administered to assess the tendency to respond with anxiety or anger, respectively, to a threatening or annoying situation. Behavioral and emotional problems were assessed by the total, internalizing, and externalizing T scores as well as clinical range scores for these 3 indices (T score ≥63) of the Child/Adult Behavior Checklist (CBCL at T0 and T1, ABCL at T2), the Youth/Adult Self-Report (YSR at T0 and T1, ASR at T2). Items referring to GD in the CBCL/YSR and ABCL/ASR were scored as 0 (for more explanation, see Cohen-Kettenis et al). The Beck Depression Inventory (BDI; 21 items, 0–6 range) indicates presence and severity of depressive symptoms. The Satisfaction With Life Scale (SWLS, 5 items, 5–35 range, 20 being neutral) was used to assess life satisfaction. Higher scores on the Subjective Happiness Scale (SHS, 4 items, 7–point Likert scale, average score 1–7) reflect greater happiness.

Data Analyses

General Linear Models examined the repeated measures with an analysis of variance-based model, incorporating continuous and categorical predictors, and correcting for the unbalanced cell sizes. Linear and quadratic effects of the 14 indicators across 3 time points, with time as the within-subjects factor, and sex as a between-subjects factor in a second set of analyses are reported in Tables 2 and 3 and Fig 1. A linear effect signifies an overall change across T0 to T2. A quadratic effect signifies that the change was not continuous, such as when an indicator does not improve from T0 to T1 but improves from T1 to T2. It is possible to have both a significant linear and quadratic effect on the same
neutral body characteristics and secondary sex characteristics were examined. There were no significant sex differences on neutral body characteristics at baseline, but transwomen reported less satisfaction at T1 than T0, but the age gap in body dissatisfaction widened over time. The age gap in body dissatisfaction was not significant at T2. In contrast, transmen showed reduced body dissatisfaction with secondary and neutral sex characteristics at T1 compared to T0, but improvement was modest and not significant from T1 to T2. Age was a significant covariate with secondary sex characteristics (the only significant demographic covariate with any outcome indicator in the study), indicating that older individuals were more dissatisfied at T0, but the age gap in body satisfaction narrowed over time (F(1, 42) = 8.18, P < .01).

**Psychological Functioning**

As presented in Table 3, significant linear effects showed improvement over time in global functioning (CGAS), CBCL/ABCL total, internalizing and externalizing T scores, and YSR/ASR total and internalizing T scores. Quadratic effects revealed decreases from T0 to T1 followed by increases from T1 to T2 in depression and YSR/ASR internalizing T scores. Quadratic trends revealed decreases from T0 to T1, followed by increases from T1 to T2 in depression and YSR/ASR internalizing T scores. For all CBCL/ABCL and YSR/ASR indicators except YSR/ASR externalizing, the percentage in the clinical range dropped significantly (McNemar test, P value < 0.05) from T0 to T1, from T0 to T2, or from T1 to T2. Over time, transmen showed reduced anger, anxiety, and CBCL/ABCL externalizing T scores, whereas transwomen showed stable or slightly more symptomatology on these measures. Transwomen improved in CBCL/ABCL total T scores in a quadratic fashion (all the improvement between T1 and T2), but transmen showed reduced scores between T1 and T2.
whereas transmen improved steadily across the 3 time points (linear effect only).

**Objective Well-Being**

At T2, the participants were vocationally similar to the Dutch population except they were slightly more likely to live with parents (67% vs 63%), and more likely, when studying, to be pursuing higher education (58% vs 31%).

Families were supportive of the transition process: 95% of mothers, 80% of fathers, and 87% of siblings. Most (79%) young adults reported having 3 or more friends, were satisfied with their male (82%) and female peers (88%), and almost all (95%) had received support from friends regarding their gender reassignment. After their GRS, many participants (89%) reported having been never or seldom called names or harassed. The majority (71%) had experienced social transitioning as easy.

**Subjective Well-Being**

None of the participants reported regret during puberty suppression, CSH
treatment, or after GRS. Satisfaction with appearance in the new gender was high, and at T2 no one reported being treated by others as someone of their assigned gender. All young adults reported they were very or fairly satisfied with their surgeries.

Mean scores on WHOQOL-BREF, the SWLS, and the SHS are presented in Table 4, together with scores from large validation and reliability studies of these measures, revealing similar scores in all areas except WHOQOL Environment subdomain, which was higher for the participants than the norm. There were some differences across gender; transwomen scored higher than transmen on the SWLS (mean = 27.7; SD = 5.0 vs mean = 23.2; SD = 6.0; t (52) = 2.82; P < .01) and on the psychological subdomain of the WHOQOL (mean = 15.77; SD = 2.0 vs mean = 13.92; SD = 2.5; t (53) = 2.95; P < .01).

**FIGURE 1**
BIS for transwomen and transmen at T0 (pretreatment, at intake), T1 (during treatment, at initiation of cross-gender hormones), and T2 (post-treatment, 1 year after GRS).

**Correlations With Residual Change Scores**
The residual change scores of secondary sex characteristics, global functioning, depression, anger, anxiety, and YSR total, internalizing and externalizing from T0 to T2, were significantly correlated with the 6 T2 quality of life indicators. Most correlation coefficients were within the moderate to large magnitude (eg, 0.30–0.60), except depression, which was highly correlated (0.60–0.80) (see Table 5).

**DISCUSSION**
Results of this first long-term evaluation of puberty suppression among transgender adolescents after CSH treatment and GRS indicate that not only was GD resolved, but well-being was in many respects comparable to peers. The effectiveness of CSH and GRS for the treatment of GD in adolescents is in line with findings in adult transsexuals. Whereas some studies show that poor surgical results are a determinant of postoperative psychopathology and of dissatisfaction and regret, all young adults in this study were generally satisfied with their physical appearance and none regretted treatment. Puberty suppression had caused their bodies to
not (further) develop contrary to their experienced gender.

Psychological functioning improved steadily over time, resulting in rates of clinical problems that are indistinguishable from general population samples (eg, percent in the clinical range dropped from 30% to 7% on the YSR/ASR30) and quality of life, satisfaction with life, and subjective happiness comparable to same-age peers.17,19,34 Apparently the clinical protocol of a multidisciplinary team with mental health professionals, physicians, and surgeons gave these formerly gender dysphoric youth the opportunity to develop into well-functioning young adults. These individuals, of whom an even higher percentage than the general population were pursuing higher education, seem different from the transgender youth in community samples with high rates of mental health disorders, suicidality and self-harming behavior, and poor access to health services.21,22,39,40

In this study, young adults who experienced relatively greater improvements in psychological functioning were more likely to also report higher levels of subjective postsurgical well-being. This finding suggests value to the protocol that involves monitoring the adolescents‘ functioning, physically and psychologically, over many years, and providing more support whenever necessary.

This clinic-referred sample perceived the Environmental subdomain (with items like “access to health and social care” and “physical safety and security”) of the WHOQOL-BREF as even better than the Dutch standardization sample.17 Whereas in some other contexts transgender youth may experience gender-related abuse and victimization,22,41,42 the positive results may also be attributable to supportive parents, open-minded peers, and the social and financial support (treatment is covered by health insurance) that gender dysphoric individuals can receive in the Netherlands.

Both genders benefitted from the clinical approach, although transwomen showed more improvement in body image satisfaction (secondary sex characteristics) and in psychological functioning (anger and anxiety). None of the transmen in this study had yet had a phalloplasty because of waiting lists or

### TABLE 4 Subjective Well-Being: Quality of Life, Satisfaction With Life, and Subjective Happiness Mean Scores With Scores From Validation Studies

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean (SD)</th>
<th>Range</th>
<th>Validation Studies Scores Mean (SD)</th>
<th>Comparison P</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHOQOL Physical</td>
<td>55</td>
<td>15.22 (2.49)</td>
<td>8.6–20.0</td>
<td>15.0 (2.9)³</td>
<td>.56</td>
</tr>
<tr>
<td>WHOQOL Psychological</td>
<td>55</td>
<td>14.66 (2.44)</td>
<td>6.67–20.0</td>
<td>14.3 (2.8)¹</td>
<td>.24</td>
</tr>
<tr>
<td>WHOQOL Social Relations</td>
<td>55</td>
<td>14.91 (2.35)</td>
<td>9.3–20.0</td>
<td>14.5 (2.5)¹</td>
<td>.18</td>
</tr>
<tr>
<td>WHOQOL Environment</td>
<td>55</td>
<td>15.47 (2.06)</td>
<td>10.3–20.0</td>
<td>13.7 (2.6)¹</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>SHS</td>
<td>54</td>
<td>4.73 (0.77)</td>
<td>2.75–6.0</td>
<td>4.83 (1.1)¹4</td>
<td>.17</td>
</tr>
<tr>
<td>SWLS</td>
<td>54</td>
<td>24.88 (6.0)</td>
<td>9.0–35.0</td>
<td>26.18 (5.7)⁴</td>
<td>.16</td>
</tr>
</tbody>
</table>

¹ WHOQOL, Bref, Skevington et al.16
² Dutch young adults, Arindell et al.33
³ US Public College Students, Lyubomirsky.18
⁴ International field trial, ages 21 to 30 years, Skevington et al.16

### TABLE 5 Correlations Between Residual Change in Psychological Functioning Over Time and Young Adult Subjective Well-Being

<table>
<thead>
<tr>
<th></th>
<th>Physical</th>
<th>Psychological</th>
<th>Social</th>
<th>Environment</th>
<th>SWLS</th>
<th>SHS</th>
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</thead>
<tbody>
<tr>
<td>Gender dysphoria (UGDS)</td>
<td>0.01 (.37)</td>
<td>0.05 (.75)</td>
<td>−0.09 (.57)</td>
<td>−0.02 (.88)</td>
<td>0.06 (.71)</td>
<td>0.50 (.04)</td>
</tr>
<tr>
<td>Body image subscales (BIS)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary sex characteristics</td>
<td>−0.22 (.14)</td>
<td>−0.25 (.09)</td>
<td>−0.35 (.02)</td>
<td>−0.04 (.78)</td>
<td>−0.22 (.14)</td>
<td>−0.21 (.17)</td>
</tr>
<tr>
<td>Secondary sex characteristics</td>
<td>−0.39 (.006)</td>
<td>−0.45 (&lt;.001)</td>
<td>−0.47 (&lt;.001)</td>
<td>−0.34 (.02)</td>
<td>−0.35 (.02)</td>
<td>−0.26 (.08)</td>
</tr>
<tr>
<td>Neutral body characteristics</td>
<td>−0.21 (.16)</td>
<td>−0.27 (.07)</td>
<td>−0.15 (.32)</td>
<td>−0.28 (.08)</td>
<td>−0.26 (.08)</td>
<td>−0.16 (.28)</td>
</tr>
<tr>
<td>Psychological functioning</td>
<td></td>
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<tr>
<td>Global functioning (CGAS)</td>
<td>0.60 (&lt;.001)</td>
<td>0.52 (.002)</td>
<td>0.52 (.002)</td>
<td>0.27 (.14)</td>
<td>0.58 (&lt;.001)</td>
<td>0.50 (.004)</td>
</tr>
<tr>
<td>Depression (BDI)</td>
<td>−0.76 (&lt;.001)</td>
<td>−0.72 (&lt;.001)</td>
<td>−0.51 (.002)</td>
<td>−0.49 (.003)</td>
<td>−0.61 (&lt;.001)</td>
<td>−0.77 (&lt;.001)</td>
</tr>
<tr>
<td>Trait anger (TPI)</td>
<td>−0.37 (.03)</td>
<td>−0.18 (.31)</td>
<td>−0.22 (.20)</td>
<td>−0.29 (.08)</td>
<td>−0.33 (.07)</td>
<td>−0.35 (.05)</td>
</tr>
<tr>
<td>Trait anxiety (TAA)</td>
<td>−0.58 (&lt;.001)</td>
<td>−0.64 (&lt;.001)</td>
<td>−0.38 (.03)</td>
<td>−0.44 (.01)</td>
<td>−0.49 (.004)</td>
<td>−0.57 (&lt;.001)</td>
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<tr>
<td>CBCL-ABCL</td>
<td></td>
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<tr>
<td>Total T score</td>
<td>−0.20 (.20)</td>
<td>−0.12 (.45)</td>
<td>−0.07 (.65)</td>
<td>−0.14 (.35)</td>
<td>−0.32 (.03)</td>
<td>−0.16 (.29)</td>
</tr>
<tr>
<td>Internalizing T score</td>
<td>−0.29 (.06)</td>
<td>−0.29 (.08)</td>
<td>−0.23 (.14)</td>
<td>−0.12 (.44)</td>
<td>−0.48 (.007)</td>
<td>−0.36 (.02)</td>
</tr>
<tr>
<td>Externalizing T score</td>
<td>−0.13 (.40)</td>
<td>−0.05 (.75)</td>
<td>0.16 (.29)</td>
<td>−0.20 (.19)</td>
<td>−0.15 (.36)</td>
<td>0.00 (.99)</td>
</tr>
<tr>
<td>Youth Self Report (YSR–ASR)</td>
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<tr>
<td>Total T score</td>
<td>−0.55 (&lt;.001)</td>
<td>−0.45 (.002)</td>
<td>−0.33 (.03)</td>
<td>−0.42 (.005)</td>
<td>−0.52 (&lt;.001)</td>
<td>−0.55 (&lt;.001)</td>
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<tr>
<td>Internalizing T score</td>
<td>−0.62 (&lt;.001)</td>
<td>−0.61 (.001)</td>
<td>−0.47 (&lt;.001)</td>
<td>−0.40 (.007)</td>
<td>−0.66 (&lt;.001)</td>
<td>−0.60 (&lt;.001)</td>
</tr>
<tr>
<td>Externalizing T score</td>
<td>−0.23 (.13)</td>
<td>−0.10 (.53)</td>
<td>−0.07 (.67)</td>
<td>−0.37 (.02)</td>
<td>−0.22 (.15)</td>
<td>−0.35 (.02)</td>
</tr>
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</table>

P values are in parentheses.
a desire for improved surgery techniques. This finding warrants further study of the specific concerns of young transmen. Despite promising findings, there were various limitations. First, the study sample was small and came from only 1 clinic. Second, this study did not focus on physical side effects of treatment. Publications on physical parameters of the same cohort of adolescents are submitted or in preparation. A concurring finding exists in the 22-year follow-up of the well-functioning first case now at age 35 years who has no clinical signs of a negative impact of earlier puberty suppression on brain development, metabolic and endocrine parameters, or bone mineral density. Third, despite the absence of pretreatment differences on measured indicators, a selection bias could exist between adolescents of the original cohort that participated in this study compared with nonparticipants. Age criteria for puberty suppression and CSH are under debate, although they worked well for adolescents in the current study. Especially in natal females, puberty will often start before the age of 12 years. Despite the fact that developing evidence suggests that cognitive and affective cross-gender identification, social role transition, and age at assessment are related to persistence of childhood GD into adolescence, predicting individual persistence at a young age will always remain difficult. The age criterion of 16 years for the start of CSH may be problematic especially for transwomen, as growth in height continues as long as cross-sex steroids are not provided (causing the growth plates to close). Therefore, psychological maturity and the capacity to give full informed consent may surface as the required criteria for puberty suppression and CSH in cases that meet other eligibility criteria.

**CONCLUSIONS**

Results of this study provide first evidence that, after CSH and GRS, a treatment protocol including puberty suppression leads to improved psychological functioning of transgender adolescents. While enabling them to make important age-appropriate developmental transitions, it contributes to a satisfactory objective and subjective well-being in young adulthood. Clinicians should realize that it is not only early medical intervention that determines this success, but also a comprehensive multidisciplinary approach that attends to the adolescents’ GD as well as their further well-being and a supportive environment.

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