Puberty Is Not a Disorder

We vigorously object to the normalization of childhood gender identity disorder (GID) promoted by the American Academy of Pediatrics (AAP) in the article "Psychological and Medical Care of Gender Nonconforming Youth,"[1] published in the December issue of *Pediatrics*. The recommendations of the authors to reinforce the delusions of gender identity–confused children, and to prescribe puberty-blocking hormones as though puberty were a disorder, are outrageous. This approach violates the oath physicians take to "do no harm."

Although some affected children and their parents may report being happier when health professionals, families, friends, and schools affirm their false beliefs, "happiness" is not always consistent with good health. It can also be short-lived.

A recent 30-year study in transgendered adults in Sweden, unquestionably a transgender-affirming culture, should give the AAP and American Psychiatric Association (APA) pause: it showed that individuals who underwent sex reassignment surgery suffered significantly greater morbidity and mortality when compared with matched controls. Shockingly, their suicide mortality rose almost 20-fold above the comparable nontransgender population. The authors concluded, "Our findings suggest that sex reassignment, although alleviating gender dysphoria, may not suffice as treatment for transsexualism . . . [emphasis added]."[2]

There is no adequate body of research on the long-term use of puberty blockers in early adolescence followed by lifelong administration of exogenous testosterone to biological girls or of exogenous estrogen to biological boys. However, there is significant evidence indicating stunted growth and infertility from puberty-blocking hormones, and possible malignancies from chronic use of synthetic hormones.[3] Yet, this is what the AAP and APA recommend.

We submit that children who dread the development of secondary sex characteristics are emotionally troubled; puberty is not a disease. In fact, puberty brings relief for the vast majority of children receiving therapy for GID, because hormone surges propel the development of their brains as well as their bodies and they come to identify with their biological sex.[4,5] Science and ethics trump the current recommendations of the AAP and APA, which amount to conducting an ideology-driven social experiment on vulnerable children and their families. All physicians must work for the reinstatement of the diagnosis and sound treatment of childhood GID.

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Author's Response

We respectfully disagree with many assertions made by the authors responding to our article "Psychological and Medical Care of Gender Nonconforming Youth."[1] First, the respondents' use of the psychiatric diagnosis of gender identity disorder (GID) is in itself problematic. The American Psychiatric Association changed this diagnosis in the *Diagnostic Statistical Manual of Mental Disorders, Fifth Edition* (DSM-V), to "gender dysphoria." The psychiatric and pathologic focus is not on the cross-gender identity but instead on the distress stemming from the mismatch between "assigned" and affirmed gender identity and from societal stigma and lack of acceptance. Our center and other major professional organizations do not view gender nonconformity as pathologic, as our article discusses at length; this may be at odds with the stated perspective of the respondents. Furthermore, the respondents suggest that gender-nonconforming children suffer from delusions regarding their gender identity; symptoms of delusions are not included in any diagnostic criteria for gender dysphoria in the DSM-V.

The respondents misinterpret the goals of our gender-affirming approach by stating that "affected children and their parents may report being happier when [professionals and community] affirm their false beliefs," and "'happiness' is not always consistent with good health." We not only want these youth to be happy, we want them to be less depressed, less suicidal, higher functioning, and, most importantly, thriving. As explained in our article, exposure to an environment that is supportive and affirming of gender nonconformity can be protective against suicidality, depression, and poor self-esteem.[2,3]

To promote their argument that gender-modulating therapies are deleterious, the responding authors cite a follow-up study in adults who had gender-affirming surgery. The

study compared these individuals to gender-conforming controls and compared mortality, mental illness, and criminality; it found that gender-nonconforming adults had higher rates of the latter at follow-up. The responding authors inappropriately cite this study to suggest that gender-affirming surgery leads to these psychosocial risks when the study does not take into account the societal stigma, ostracism, unemployment, and victimization that transgender adults may face even after surgery. The authors of the article explicitly state, "[this study] does not, however, address whether sex reassignment is an effective treatment or not." In fact, it is surprising that the respondents failed to acknowledge the 1 study, also recently published in *Pediatrics*, that is directly relevant to the gender-affirming model of care in adolescents and young adults. This study, using rigorous methodology, demonstrated that gender-nonconforming youth seeking gender-modulating medications with pubertal-blocking medications followed by cross-sex hormones have improved psychological and social functioning and improved quality of life.[4] In fact, "well-being" was found to be similar to or better than that in age-matched young adults from the general population.[4]

It is also striking that the respondents claim that pubertal blockers can lead to stunted growth when the reference they cite actually notes that any slowdown in growth is remedied once puberty ensues, either through discontinuation of blockers or through the addition of cross-sex hormones appropriate for the affirmed gender.[5] Any compromise of fertility would also be reversed should pubertal blockers be stopped with resumption of endogenous puberty.[5] The respondents also raise concern for malignancies with synthetic (cross-sex) hormones; yet, the reference they cite shows no increased risk of cancer during an observation period of up to 30 years and points to the need for long-term studies.[5] Finally, the respondents reject the value of pubertal blockers in gender-dysphoric adolescents because most will not persist as transgender adults. They have ignored the observation that gender dysphoria persists and worsens with onset of puberty in up to 20% of gender-nonconforming youth, and it is for this defined subset of youth that pubertal blockers can be life-saving. The respondents claim that the use of pubertal blockers "violates the oath physicians take to 'do no harm'." The respondents should recognize that nonintervention is not a neutral option and is the more likely path to an adverse mental health outcome.

We agree more research is needed to identify optimal provision of care to gender-nonconforming youth, but citing research not applicable to the target clinical population of our review article results in gross inaccuracies while neglecting the current research supporting the provision of gender-affirming care and gender-modulating therapies to youth meeting medical criteria as potentially life-saving.

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