A commentary by a Pediatric Endocrinologist on Drs. Achen’s and Fenske’s “A Medical Response to Alberta Education’s Gender Diversity: Guidelines for Best Practices”

I wish to comment on Drs. Achen’s and Fenske’s submission to Parents for Choice in Education (parentchoice.ca) regarding Alberta Education’s recommendations for non-discriminatory inclusion and accommodation of transgender students within Alberta schools. However, they venture beyond commenting on the education policy and present an inaccurate assessment of the current scientific understanding of gender identity and inaccurate presentation of the medical evaluation and intervention of children and adolescents experiencing gender dysphoria.

1) Drs. Achen and Fenske are correct when they state “gender identity... is a complex developmental phenomenon”, but incorrect when stating it is “largely dependent on the pre-adolescent nurturing environment of a child”. Although, awareness of one’s gender identity is a post-natal developmental process, how that occurs is not understood (1). Equally poorly studied and understood is how one’s gender identity is determined. Genetics and prenatal hormones have been implicated but do not provide anywhere near the complete explanation (1). Anatomical brain differences have been found post-mortem in transgender adults and functional brain differences have been found on specialized imaging in transgender individuals prior to hormone therapy (1). Some parents of transgender adolescents and adults report noticing evidence of gender identity issues as early as 2 years of age. The current limited evidence suggests that gender identity is multifactorial in origin and primarily prenatally determined. To quote the American Academy of Pediatrics, “research suggests that gender (identity) is something we are born with; it can’t be changed by any interventions” (2). Many prepubertal children expressing gender variance or dysphoria will spontaneously choose their assigned birth gender once pubertal, but still require an understanding, accepting and supportive environment (3). The factors that lead to persistence versus desistence of the gender variance are not known (4). Adolescents expressing gender dysphoria are much less likely to change their expressed gender identity. Past attempts to “re-align” an individual’s gender identity to match their assigned gender at birth have been unsuccessful (5) and may cause psychological harm (6).

2) Drs. Achen’s and Fenske’s second stated concern is that “a child’s subjective gender self-identification be accepted without question or concern...” and go on to add “nowhere else in medicine, other than gender identity and sexuality, is such a reckless stance taken or practised presently.” These statements indicate a lack of awareness of the process of psychiatric and pediatric assessment of a child or teen identifying gender dysphoria. I can attest to the detailed history and life experiences obtained from the child and the parents by the psychiatrists who refer individuals to the Stollery Transgender Clinic for consideration of hormonal intervention. Many of these teens have seen more than 1 psychiatrist on more than 1 occasion; the diagnosis is never “casually accepted without question or concern”. Who else knows one’s true gender identity than the individual her- or himself? Current recommendations are very clear regarding the detailed assessment and continuing re-assessment of the child’s or adolescent’s concept of her or his gender identity (5, 7).
3) The physicians’ third concern is that Alberta Education’s guidelines require school personnel “to protect a student’s personal information and privacy, including where possible, having a student’s explicit permission before disclosing information related to the student’s sexual orientation, gender identity or gender expression to peers, parents, guardians or other adults in their lives”. Although school personnel are not bound by the same privacy regulations as physicians, I am surprised that physicians would not be aware that breach of confidentiality and trust is relevant for children and adolescents, not just adults. If a teen confides in a trusted adult and states that the information he or she is disclosing is provided in confidence, that adult should not pass the information on without the teen’s permission unless there is evidence of imminent risk of harm to the teen or someone else. It is standard practice in such situations for the trusted adult to strongly encourage the teen to disclose the information to his or her parents and other important supportive people in his or her life, and to offer to be present for support at that disclosure if the adolescent wishes. The evidence is very clear that positive outcomes for teens with gender dysphoria are related to parents’ and others’ trusted support. (8, 9). Thus, Drs. Achen and Fenske are correct when they state parents are “the most precious and prominent resource that children have to address such an incredibly significant issue”, but I would add that the parents need to be accurately informed and educated about gender dysphoria by experts in the condition, which is the process currently (5, 7). Unfortunately though data indicates many teens with gender dysphoria do not find their home environment safe or supportive (8). The Alberta Education guidelines do not specify school personnel to “counsel a person to make a life altering decision without the involvement of his or her parents”. School personnel are neither referring for nor mandating medical intervention. They are ensuring a safe, supportive environment at school. No child or adolescent receives treatment, regardless of diagnosis, without involvement and consent of the parents or legal guardians.

4) I would like to address the medical therapy options for adolescents with gender dysphoria as this is the area with which I am actively involved. The currently recommended medical therapy is that proposed by The Endocrine Society and the World Professional Association for Transgender Health (5, 7). These guidelines are based on the Dutch experience with this therapy which they began in 2000. The guidelines have subsequently been endorsed by the Canadian Professional Association for Transgender Health, the Pediatric Endocrinology Society, the European Society for Pediatric Endocrinology, the European Endocrinology Society and the American Academy of Pediatrics. The guidelines state definitively that gender variance/dysphoria be diagnosed by a mental health professional and recommend against a complete social role change and hormone treatment in prepubertal children. Once the individual has experienced at least 6 to 12 months of puberty, consideration of hormonal therapy requires that the gender dysphoria persists and has increased with the pubertal changes, the adolescent has social and psychological support for the therapy, and that the parents and teen can demonstrate understanding of the potential benefits and risks of the therapy. If these criteria are met, puberty suppression therapy is considered. This is accomplished with Gonadotrophin Releasing Hormone analogues (not cross sex hormones as indicated by Drs. Achen and Fenske). The purpose of this intervention is to prevent physical
changes that occur during puberty that may increase the dysphoria and require additional intervention if the adolescent persists with gender change, and allows the teen time to consider further their gender identity. This treatment has been used for over 30 years to treat inappropriate early onset of puberty in infants and young children. The effects of the therapy are completely reversible once the therapy is discontinued. Children treated for precocious puberty may be on this treatment for over 10 years, considerably longer than those with gender dysphoria. There are no known long term consequences; fertility is preserved. The guidelines recommend consideration for cross sex hormone therapy (estradiol or testosterone) once the adolescent is 16 years of age and a “mature minor”; consideration for earlier treatment is possible if the teen is assessed to be a mature minor and fully understands the pros and cons of the therapy. Cross sex hormone therapy does cause some irreversible effect which is the reason for delay in treatment until it is clear to the adolescent, the family and the healthcare professionals that the gender dysphoria is persisting. The adolescent must also have transitioned to the appropriate gender role within the home, school and community. At the Stollery Transgender Clinic, prior to commencing puberty suppression therapy and cross sex hormone therapy, signed informed consent is required from both the teen and the parents or legal guardians, even if the teen is a mature minor. Drs. Achen and Fenske state that cross sex hormone therapy has been “associated with vascular disease and cancer.” The heart disease and cancer risks are related to the individual’s pre-existing unmodifiable genetic risk, modifiable lifestyle risk factors and the fact that certain conditions are more prevalent in males or females, partly due to sex hormone effects, but not dependent on whether the sex hormone comes from the individual’s gonad or from medication. Surgical intervention is not recommended for consideration until after 18 years of age and is very much a personal decision. The evidence for these guidelines is admittedly weak as there are few long-term outcomes available on individuals treated in this way. The Dutch have reported that puberty suppression resulted in significant decrease in behavioural, emotional and depressive symptoms and an increase in global functioning, but no effect on gender dysphoria (10). They have also reported that transgender young adults who had undergone puberty suppression followed by cross hormone therapy followed by surgery had resolution of their gender dysphoria, improved psychological functioning and rated their quality of life similar to the same aged general Dutch population (11). Although these are early outcomes on a small number of individuals they are encouraging and certainly suggest improvement compared to the Canadian trans youth survey which found 37% of older youth had attempted suicide in the previous 12 months (8). Yes, additional outcome studies are needed and the current guidelines will presumably be revised based on those studies. However, since the previous standard of practice was not resulting in improved mental health and quality of life, recommendations for a different approach were necessary. The current guidelines have many other recommendations regarding counseling and psychological supports directed at improving the mental health outcomes. I suspect there are guidelines for assessment and management of conditions Drs. Achen and Fenske treat in their respective specialties for which the evidence is weak; but it is from implementation of such recommendations and subsequent outcome assessment that evidence is often obtained when none existed before.
5) Lastly I want to address the format and tone of Drs. Achen’s and Fenske’s article. The 2 physicians have titled their opinion piece a “medical response” and add their affiliation with the University of Alberta, implying they have some credibility, experience or qualification to comment beyond their MD degree. Certainly they are entitled to voice their opinions on Alberta Education’s guidelines, but they should not have presented those views with an air of expertise that they don’t have. Neither of them is a psychiatrist, child development expert, pediatrician, or endocrinologist; more specifically, neither is involved with the medical care of transgender youth as far as I am aware. Much of their information is not in keeping with the current body of scientific and medical literature on gender dysphoria. It would have been more appropriate if they titled their article “Two physicians’ response to...” I am reassured by the subsequent addition to their article on the Parent’s for Choice in Education website that the opinions expressed are not those of their respective departments within the Faculty of Medicine at the University of Alberta.

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References