Joint commentary on the current draft of the new S2k Guideline

"Gender Incongruence and Gender Dysphoria in Childhood and Adolescence"


¹Department of Child and Adolescent Psychiatry, Psychosomatic Medicine and Psychotherapy, Jena University Hospital, Friedrich Schiller University Jena, Jena, Germany
²German Center for Mental Health (DZPG), Site Jena-Magdeburg-Halle, Jena, Germany
³Department of Child and Adolescent Psychiatry, University Hospital Ulm, Ulm, Germany
⁴Research Section Child Public Health, Department of Child and Adolescent Psychiatry, Center for Psychosocial Medicine, Psychotherapy and Psychosomatics, University Medical Center Hamburg-Eppendorf, Hamburg, Germany
⁵Department of Child and Adolescent Psychiatry, Catholic Children’s Hospital Wilhelmsdorf, Hamburg
⁶Central Institute of Mental Health, Medical Faculty Mannheim/Heidelberg University, Mannheim, Germany
⁷German Center for Mental Health (DZPG), partner site Mannheim-Heidelberg-Ulm, Germany
⁸Department for Child and Adolescent Psychiatry, Neurology, Psychosomatics and Psychotherapy, Rostock University Medical Center, Rostock, Germany
⁹Department of Child and Adolescent Psychiatry, Psychotherapy and Psychosomatic Medicine, Medical Faculty, Otto von Guericke University Magdeburg, Magdeburg, Germany
¹⁰Department of Child and Adolescent Psychiatry, Psychotherapy, and Psychosomatics, Medical Centre - University of Freiburg, Faculty of Medicine, University of Freiburg, Freiburg, Germany
¹¹Gesellschaft für Gesundheit und Pädagogik mbh, Rostock, Germany
¹²Department of Child and Adolescent Psychiatry, Psychotherapy and Psychosomatic Medicine, University Medical Center Hamburg-Eppendorf, Hamburg, Germany
¹³Child and Adolescent Psychiatry of the University Medicine Johannes Gutenberg University, Mainz, Germany
¹⁴Department of Child and Adolescent Mental Health, University of Erlangen-Nuremberg, Erlangen, Germany
¹⁵Department of Child and Adolescent Psychiatry and Psychotherapy, University of Regensburg, Regensburg, Germany
¹⁶Department of Child and Adolescent Psychiatry and Psychotherapy, Medical Faculty, RWTH Aachen University, Aachen, Germany
¹⁷Department of Child and Adolescent Psychiatry, TU Dresden, Dresden, Germany
¹⁸German Center for Child and Adolescent Health (DZJK), partner site Leipzig-Dresden, Germany
- Important notes on the translated version -

Because of the short timeline for the creation of this commentary and to allow this document to be introduced into the current discussion on the guideline draft in question here, the present translation of the German version of our commentary was carried out with the assistance of AI (ChatGPT) and further revisions by the authors on the machine translated version.

Of note, the German guideline assessment tool (Deutsches Leitlinien-Bewertungsinstrument, DELBI) distinguishes between three different levels of recommendation:

- **Recommendation level A**: Strong recommendation = in German “soll” / “soll nicht”, which can be understood in terms of “should be done” / “should not be done”. -> marked in this English translation with "A".

- **Recommendation level B**: Recommendation = in German “sollte”/ “sollte nicht”, which would also be translated as of “should be done“ / “should not be done”. Therefore, recommendation levels A and B cannot be distinguished in this translation unless the meaning of recommendation levels A and B are clearly indicated. We have indicated the intended meaning (either by the authors of the guideline draft in question here or by our group of commentators) in the respective sections of this document. -> marked in this English translation with "B".

- **Recommendation level O**: Open recommendation = in German “kann erwogen werden” / “kann verzichtet werden”, which can be understood in terms of “can be considered”/ “can be waived”. -> marked in this English translation with "O".
I. CURRENT SITUATION

As of April 19, 2024, the so-called consultation phase for the new S2k guideline "Gender Incongruence and Gender Dysphoria in Childhood and Adolescence" (registration number: 028-014), developed under the auspices of the Association of the Scientific Medical Societies (AWMF), has been completed. Moreover, as of April 29th 2024 the official website related to this particular guideline currently suggests that the guideline in question was already primarily registered as an S2k guideline as of December 16th 2020 in terms of as a class upgrade from the previous S1 guideline, which expired in 2014. However, only in January 2024 and after consultation with the AWMF, the board of the German Society for Child and Adolescent Psychiatry, Psychosomatics, and Psychotherapy (Deutsche Gesellschaft für Kinder- und Jugendpsychiatrie, Psychosomatik und Psychotherapie [DGKJP], the leading professional society for this particular guideline), decided to downgrade the guideline to the so-called S2k level instead of as an originally planned S3 guideline. The reason that was communicated for this decision was that the guideline draft was primarily based on the consensus of the respective committee members, and because the overall evidence base is not sufficient to justify an S3 status as the highest guideline level. The German academic chair professors in the field of child and adolescent psychiatry, psychosomatics, and psychotherapy (CAPPP) were informed about this downgrading procedure at their annual meeting in Heidelberg (Germany) in January 2024. Furthermore, at this particular meeting in Heidelberg as well as on March 18, 2024, the group of German CAPPP chair professors were informed by the DGKJP board that the ongoing consultation phase for professionals would solely serve for editorial improvements of the current guideline draft. This means that discussions and dialogue with the potential for changes to the respective recommendations, if desired by the CAPPP chair professors, are not possible. The reason given for this approach by the DGKJP board was that all individual recommendations and statements were adopted with a strong consensus (>95% or 100%). It was communicated to the CAPPP chair professors that all recommendations had been carefully reviewed by the DGKJP board and are currently in a form that has already received the board’s approval.

The public consultation began on March 20th 2024, and ended on April 18th 2024. Two days after the beginning of this consultation phase, on March 22nd 2024, an online press briefing
with selected media representatives regarding the current draft guideline was held (Science Media Center, 2024). At this particular press briefing, the current guideline draft, which was still under consultation with the CAPPP chair professors at that point in time, was made publicly available to the attending media representatives and is now being discussed controversially in the media. A critical assessment of the recommendations formulated in the current draft guideline, which stand in contrast to the recently updated recommendations of several other European countries (see for example the Scientific Services of the German Bundestag [Wissenschaftliche Dienste des Deutschen Bundestages], 2023, as well as Zepf et al., 2024, and the final Cass Review [Cass, 2024] for an overview of developments in other countries), and have far-reaching implications with potentially irreversible consequences for those affected, is urgently needed in the interest of affected individuals and their safety.

The authors' intensive work and effort in the development of the current guideline draft, which involved considering various stakeholder groups in its consensus-based development, should be explicitly acknowledged and appreciated. However, as part of the composition of the guideline group, initiatives and groups that may have a more critical stance towards affirmative approaches, such as the parent initiative "Trans Teens Sorgeberechtigt" (TTSB) or the “Association pour les jeunes en questionnement de genre” (AMQG), should have been more strongly considered and involved. From the perspective of child and adolescent psychiatry, psychotherapy, and psychosomatics, the authors of the present commentary believe that, in terms of child and adolescent welfare, some essential and highly critical points regarding the current guideline draft must be emphasized and modified.

From the perspective of the authors of this commentary the recommendations formulated in the current guideline draft, which in many critical points – in particular regarding potentially irreversible somatomedical interventions in physically healthy minors with GD – are not evidence-based or even significantly contradict the current evidence base and knowledge. This makes it urgently necessary to scientifically and comprehensively comment on the current guideline draft, and to contextualize and discuss the recommendations of the current guideline draft in the light of the actual medical evidence currently available.
A critical point of discussion is also the terminology used in the current guideline draft, and also the underlying concepts associated with the subject of the guideline. The authors of this commentary criticize that the current draft of the guideline could lead to, at times, a routine use of somatomedical measures in clinical practice that could have significant, lasting, or even irreversible negative consequences for affected minors, despite their effectiveness and sustainability not being scientifically proven in a sufficient manner. We also criticize that these particular measures are still given a high degree of recommendation, even though the scientific evidence is insufficient. In the event of publication, the recommendations in these particular guidelines could endanger vulnerable minors, especially because these measures have not been adequately tested. This concern is supported by new data regarding the low temporal constancy and stability of the diagnoses or similar symptoms in question here (Bachmann et al., 2024; Rawee et al., 2024). Of note, the current and final Cass Review (Cass, 2024) also urges an extremely cautious and measured approach.

The authors wish to explicitly and emphatically emphasize at this point that their statements outlined here are neither intended to discriminate against affected individuals or any other persons or individuals in any kind of way, nor to pathologize their behavior, feelings, and desires. However, due to what we perceive as substantial conceptual shortcomings in the current guideline draft, the language and expressions used therein and the scientifically unsubstantiated conclusions, the authors of this commentary feel compelled to comment on relevant aspects in detail and with the corresponding conceptual clarity according to actual medical evidence, correct and established conceptual-scientific terminology, and the conclusions based thereon from the perspective of child and adolescent psychiatry, psychosomatics, and psychotherapy. The risk of potentially incorrect scientific conclusions or linguistic distortions as a basis for the possible implementation of potentially irreversible somatomedical measures, including infertility as a potential outcome, without clear and sustainable evidence in physically healthy minors with GD, is too great.

In the following we will address the recommendations outlined in the current guideline draft, with a particular emphasis on potentially irreversible somatomedical interventions for children and adolescents with GD. These interventions include the administration of puberty-
blocking agents (PB), the administration of cross-sex hormones (CSH), also known as cross-sex hormone therapy, and surgical interventions.

II. INTRODUCTORY REMARKS, FUNDAMENTAL CONCEPTUAL FLAWS OF THE CURRENT GUIDELINE DRAFT AND CURRENT DEVELOPMENTS

To highlight the fundamental difficulties, contradictions and flaws regarding the construct of gender identity in minors, which is an essential subject of the guidelines in question, it is useful and necessary to closely examine aspects of minors’ expressions of identity.

Contradictory and circular logic in identity expressions

Many affected minors make statements about their own experience of identity within the context of medical or psychotherapeutic contact. Such statements vividly illustrate profound intrinsic and unresolved contradictions in the concept of gender identity in minors. The following example can illustrate this.

Statement of a male-born adolescent (XY chromosome set, male genitalia):

"I've always known, I am a woman."

This statement is logically incorrect. By definition, a woman is an adult, female person. Since this affected person, who was assessed as being male at birth, was never female, i.e., was never a woman or a girl, they cannot know what it is like to be a woman or a girl (since they have never been a woman or a girl).

Therefore, only statements like the following are logically correct, such as:

"I know I am male, but I would like to appear female, then hopefully I will feel better and this might fit me better."
However, many affected individuals are not aware of this, and these examples can illustrate a circular logic approach to the gender identity construct.

When asked to a transgender girl (biologically male at birth, XY chromosome set, male genitalia),

“Since it is important to understand what a woman or a man means to you, and since you identify as a woman or girl, please try to define what a man is without using the word 'man'.”

(because it is absolutely essential here to precisely comprehend the gender understanding of the affected individual, as otherwise, identifying a biological boy as a girl or vice versa would make no sense if a solid description cannot be given), responses are often expressed like:

"Anyone who feels like a man is a man."

Such responses as outlined above are often observed in clinical practice, and are indicative of a circular logic when attempting to justify or articulate the personal identity experience by affected children or adolescents. A so-called circular reasoning is a fallacy (also known as a hysteron-proteron, translated literally from Ancient Greek as "the later [is] the earlier"). Upon a closer look, here it is claimed to prove a statement through deduction, even though the statement itself is already used as a premise. Such profound contradictions should be conveyed to practitioners because, based on such expressions and statements, potentially irreversible somatomedical interventions without clear evidence may be carried out on physically healthy minors within the context of the current guideline draft.

**Identity concept**

In the context of a guideline dealing with the topic of gender identity, it is essential to provide a precise clarification of this very concept. In the current guideline draft, at no point is it exactly defined or at least explained what is actually understood by the repeatedly used and absolutely critical terms or expressions "gender," "gender identity," "gender role," or "gender expression" in terms of their respective meaning and interpretation of the guideline. Throughout the entire text of the present guideline draft, there is implicitly the empirically or
scientifically unjustified assumption of the clear existence of a fundamental, naturalistic "identitarian disposition" or a "primarily ubiquitous identity" that persists permanently and unchangeably, especially in minors regarding gender and its experience. Such an ubiquitous and clearly and primarily naturalistically determined identity in children and adolescents, or its presence and verifiability, is consistently suggested throughout the entire current guideline draft. However, such an assumption is not scientifically tenable. If such a ubiquitous and naturalistically determined identity were empirically demonstrable (which it is not), then its boundaries would also have to be clearly defined (i.e., which aspects of identity are naturalistically determined and to what extent, and which are not). However, this is currently not possible. At no point in the entire current guideline draft is it specified which theoretical identity model, concept, or understanding of identity is used in each line of argumentation and recommendation, or in what way these aspects understood as "identity" change or occur depending on developmental phases, and to what extent they may change or not change depending on other variables. In this respect, there is a lack of an evidence-based, conceptual framework concerning the definition of "identity" or "gender identity" in affected minors.

**Correlation between "sex" and "gender"**

A necessary prerequisite of the construct of gender identity in childhood and adolescence is that the two aspects, "biological sex" (often referred to as "sex" in English-language literature) and "psychological gender" (often referred to as "gender" in literature, although there are various definitions or uses of these terms in the literature, see, for example, Stock, 2022), as well as, in the broadest sense, the behaviors that can be expected from certain biological sexes ("gender roles"), are independent of each other. However, the opposite is true because there is empirically a nearly perfect mathematical correlation between biological sex and any form of "gender identity" or "gender" (not further specified in the current guideline draft).

Illustrating the extremely high correlation between the assumed variables "sex" and "gender":

Let's consider an example to illustrate the extremely high correlation between the assumed variables "sex" and "gender": Suppose an individual from a population of N = 1,000 people experiences gender incongruence (GI), meaning that their biological sex ("sex") and gender
identity ("gender") are not in alignment. While a prevalence estimate of 1:1,000 is clearly too high compared to the likely actual GI prevalence, this example allows for a simple demonstration of the underlying misconception. In this particular example, biological sex and gender identity would be congruent for the other N = 999 individuals in this population. Thus, there would be a nearly perfect mathematical correlation with an r-value or correlation coefficient of 0.999 between biological sex and gender identity. Considering the likely lower prevalence of GI in reality, this correlation would be even higher. Of note, such high correlations are typically found mainly in technical processes or similar contexts, and are extremely rare in empirical social sciences. Therefore, to claim independence between these two variables or dimensions, i.e., biological sex and gender identity, with a correlation coefficient of r = 0.999 lacks any scientific basis. This inconsistency should be clearly pointed out in the current guideline draft. Additionally, affected individuals and their families must be informed about this important aspect. Because of the above-mentioned partially contradictory concept and construct, potentially irreversible somatomedical interventions without clear evidence of their safe benefit regarding mental health or GD itself may be carried out on physically healthy minors according to the current guideline draft.

Language used and further terminology in the current guideline draft

Despite its multiple uses in the current guideline draft, the term "gender" is not defined or at least explained at any point. Consequently, many statements and conclusions on a conceptual level, and thus also on the level of understanding, are not clear.

For example, philosopher Kathleen Stock (2022) distinguishes four different meanings of the word "gender," divided into "Gender 1" to "Gender 4":

"Gender 1" = Synonyms / less contentious alternative to the term "sex"

"Gender 2" = Term for "social stereotypes, expectations, and norms of 'masculinity' and 'femininity,' which originally target biologically male and female individuals." (variation possible from culture to culture)
"Gender 3" = Social role assignment for two groups of people

"Gender 4" = Gender identity

The term "gender" should be specified more precisely in the guideline, especially since, for example, the expression "gender-nonconforming" is defined in the glossary.

Furthermore, it should be noted that the language used in the current guideline draft is sometimes imprecise, unjustified in many places, unilaterally affirmative, and sometimes scientifically incorrect regarding other aspects.

The term "sex assigned at birth" is another example of the need for clear definitions. This expression suggests that at birth doctors assign a sex to a newborn in an almost arbitrary manner. This is definitely not the case. The evidence and medical consensus on this issue have been unequivocal worldwide for a long time. Conditions or individuals with intersex variations (both with chromosomal or non-chromosomal causes of intersexuality) are exceptions to this and are to be understood as special cases within a demonstrably binary biological sex in the species Homo sapiens. Few other variables in medical or social sciences are as binary and pronounced in the species Homo sapiens as biological sex (as mentioned above). Affected individuals and their families must be made aware of this.

Another example is given within the terms "gender confirmation" or "gender-affirming" procedures. Both terms suggest that there is a change in the sense of an actual and natural "alignment" occurring as part of a potentially irreversible somatomedical intervention. Medically speaking, this is clearly not the case. Considering the lack of supposed independence between biological sex and gender identity, individuals with GD are an exception. In the vast majority of cases, biological sex and gender identity are congruent (see above regarding the extremely high correlation between "sex" and "gender"). Drawing conclusions from individual cases where these two levels, biological sex and gender identity, are not in alignment based on subjective self-identification (especially in minors who are still developing, potentially with or without accompanying psychopathology) to society as a whole is not permissible and does not contribute to scientific understanding.
As previously outlined in the current commentary, there is no empirically proven and clearly delineated ubiquitous identity, especially in minors regarding their own gender or its experience. Therefore, it is scientifically incorrect to speak of "alignment" or "gender-affirming procedures." Rather, this should be seen as a linguistic trivialization in terms of euphemistically portraying potentially irreversible somatic medical interventions without clear evidence of their safe benefit for physically healthy minors. The authors of this commentary are aware that the term "alignment" is likely to be understood by the authors of the current guideline draft to some extent as supportive or affirmative for affected individuals, or is intended as such. However, in the interest of these vulnerable minors, demonstrably false facts must not be suggested to them, in particular since such terms and expressions are used to justify the aforementioned serious medical interventions without clear evidence.

**Current developments on the topic of gender dysphoria**

In the current discourse, data leaks from the World Professional Association for Transgender Health (WPATH), also known as "WPATH Leaks" or "WPATH Files," are noteworthy. These leaked materials also reveal significant concerns within WPATH about experimental medical practices for minors with GD (Environmental Progress, 2024).

The new and final Cass Review was also published in April 2024, with a very critical approach regarding potentially irreversible medical interventions for minors with GI or GD (Cass, 2024). The aforementioned final Cass Review (Cass, 2024) extensively examined the relevant symptoms. The main findings and recommendations of the Cass Review (Cass, 2024) are listed below.

**Overview of the key findings of the Cass Review (Cass, 2024)**

There is no simple explanation for the increase in numbers of predominantly young people and young adults with a transgender or gender-diverse identity, but there is broad agreement that this is the result of a complex interplay between biological, psychological, and social factors. This balance of factors can be different for each individual person. There are currently conflicting views on the best clinical approach, with expectations of care sometimes diverging.
significantly from usual clinical practice. This has caused some clinicians to feel uncertain about working with young people questioning their gender, even though their presentation is similar to many children and adolescents presenting to other NHS services. Furthermore, an assessment of international guidelines for the care and treatment of children and adolescents with GI revealed that no single guideline in its entirety could be applied to the NHS in England. Although a considerable amount of research has been published in this field, systematic evidence reviews show the poor quality of published studies. This means that there is no reliable evidence base on which clinical decisions can be made or on which children and their families can make informed decisions. According to Cass (2024), the strengths and weaknesses of the evidence base for the care of children and adolescents are often misrepresented and overestimated, both in scientific publications and in public debate. The controversy over the use of medical treatments has diverted attention from what individualized care and treatment for individuals seeking support from NHS gender services should actually achieve. The rationale for early puberty suppression remains unclear, as there is only weak evidence regarding its effects on GD, mental, or psychosocial health. The effects on cognitive and psychosexual development are unknown. The use of masculinizing/feminizing hormone therapy (CSH) in individuals under 18 also raises many unknown aspects, although it has long been used in the adult transgender population. The lack of long-term follow-up data in individuals starting treatment at a younger age means that there is currently insufficient information about the range of outcomes for this group.

Furthermore, clinicians are unable to determine with certainty whether certain children and adolescents will have a persistent GI. For most young people, a medical treatment pathway is not the best way to address their gender-related distress. For those young people for whom a medical treatment pathway may be clinically appropriate, it is not sufficient to enable this without also addressing broader mental health and/or psychosocial challenges. Innovation is important if medicine is to progress, but there must also be an appropriate level of monitoring, oversight, and regulation that does not stifle progress while also preventing the infiltration of unconfirmed approaches into clinical practice. Innovation must draw from the evidence base and contribute to it.
Overview of the key recommendations of the Cass Review (Cass, 2024)

- Service providers must operate to the same standards as other services seeing children and young people with complex problems and/or additional risk factors.

- Capacity should be expanded through a distributed service model based on appropriate services for minors and ensuring stronger links between secondary and specialized services.

- Children and adolescents referred to NHS services for gender identity issues should receive a comprehensive assessment of their needs to develop an individualized care plan. This should include screening for neurological developmental disorders, including Autism Spectrum Disorders (ASD), and a mental health assessment.

- Standardized evidence-based psychological and psychopharmacological treatment approaches should be used to support coping with the burdens associated with GI and co-occurring disorders, including support for parents/caregivers and siblings.

- Service providers should establish separate diagnostic and treatment pathways for prepubertal children and their families and ensure they are informed early on how parents can best support their child in a balanced and non-judgmental manner. When families/caregivers make decisions about the social transition of prepubertal children, services should ensure they can be seen as early as possible by a clinical professional with appropriate experience.

- NHS England should ensure that each regional center has a follow-up service for 17- to 25-year-olds, either by expanding the regional child and adolescent service offering or through affiliated services, to ensure continuity of care and support during a potentially vulnerable phase of their "journey" or development. This should also enable the collection of clinical and research follow-up data.
- There should be a pathway for individuals considering detransitioning, recognizing that they may not wish to re-engage with the services they were previously under.

- A comprehensive research program should be established to investigate the characteristics, interventions, and outcomes of each young person presenting to NHS services.

- The previously announced review of PB provision by NHS England should be part of a research program that also evaluates the outcomes of psychosocial interventions and masculinizing/feminizing hormone therapy (CSH provision).

- While the possibility of providing masculinizing/feminizing hormone therapy (CSH provision) from the age of 16 exists in principle, the Cass Review (Cass, 2024) recommends extreme caution here. There should be a clear clinical rationale for administering CSH at this stage rather than waiting for a person to reach 18. Any case considered for medical treatment should be discussed by a national multidisciplinary team (MDT).

- The impacts of private healthcare on future NHS requests for treatment, monitoring, and/or involvement in research, as well as pharmacist responsibilities for private prescriptions, must be clearly communicated.

In addition to the new and final Cass Review (Cass, 2024), other important study findings on the persistence and desistence of the relevant symptoms (Bachmann et al., 2024; Rawee et al., 2024), the potential role of suicidality in minors with GI or GD (Ruuska et al., 2024), the evidence base for the use of P) and CSH (Zepf et al., 2024), as well as ethical aspects (Jorgensen et al., 2024) must be considered. Furthermore, previous high-level reviews on the evidence base for potentially irreversible somatic medical interventions in minors with GI or GD should also be taken into account (NICE, 2020a/b). The relevance of these mentioned works is highlighted at the appropriate points in our commentary and categorized according to the corresponding chapters and recommendations.
Additionally, the statements and open letters from concerned parent initiatives to the DGKJP as the lead professional society and also to the guideline group must be mentioned here. An international parents' alliance advocating for safe, empathetic, ethical, and evidence-based healthcare for children, adolescents, and young adults with GD (AMQG, 2024) contacted the relevant guideline group, the DGKJP as the leading professional society, and all other involved professional societies and institutions on April 15th, 2024, demanding a departure from the planned S2k guidelines. The primarily "trans-affirmative approach" was explicitly criticized in this correspondence. Furthermore, concerns regarding potential conflicts of interest among individuals involved in the guidelines were raised (AMQG, 2024). This issue is also reflected in media reports concerning the influence of a pharmaceutical company that produces PB on members of the guideline commission (Louis, C., 2023).

Since the documents submitted to media representatives regarding the current guideline draft do not include information on potential conflicts of interest of the guideline group members (as would be detailed in the methods report, which was not provided to the media representatives), the questions raised by these parent representatives remain unresolved. The parent initiative "Trans Teens Sorgeberechtigt" (TTSB, 2024) also recently addressed an open letter to the guideline group and the DGKJP, expressing their deep concern about the guidelines and calling for a halt to their publication.

Overall, the current situation reveals an emotionalized atmosphere within both the professional community and the public regarding the evaluation of the evidence base and the current guideline draft now circulating in the media landscape. This is particularly true concerning potentially irreversible somatomedical interventions, such as the administration of PB and CSH to physically healthy minors with GD. From the perspective of the authors of this commentary, there is an urgent need to depoliticize the debate and consider a slower pace. This is recommended before publishing a guideline that may soon need revisions in light of the volatile and, contrary to the guideline group’s position, controversially discussed facts.

The present commentary aims to serve as a connection point and stimulus for this crucial professional discourse, which must urgently be conducted in the interest of the affected individuals in the context of the current guideline draft.
III. GUIDELINE DRAFT AND RECOMMENDATIONS CONTAINED THEREIN

Introduction

In the introduction of the current guideline draft, the first point addressed is the depathologization of gender identity disorders (ICD-10 terminology), specifically with regard to the reclassification in ICD-11 as "gender incongruence" (GI) in the new category "conditions related to sexual health." However, a significant aspect is not sufficiently considered here: the decision-making basis for and the process of the mentioned depathologization must be transparently presented — especially since this depathologization is frequently referenced in the current guideline draft.

The wording on the current website of the World Health Organization (WHO) regarding the procedure for the depathologization of transsexuality as defined by ICD-10 (WHO, 2024) (current status as of April 6th, 2024) states in this context:

"... This reflects current knowledge that trans-related and gender diverse identities are not conditions of mental ill-health, and that classifying them as such can cause enormous stigma.
...
"

It is important to note the following point: A literal interpretation of the WHO's statement indicates that the depathologization of transsexuality according to ICD-10 has occurred because these conditions are not, or should not be, classified as mental disorders. Furthermore, classifying such conditions as mental disorders could lead to significant stigmatization. With this statement, the WHO implicitly stigmatizes all other individuals with one or more mental disorders of any age group. According to the WHO, suffering from a mental disorder is inherently stigmatizing, and they want to spare individuals with "...trans-related and gender diverse identities," i.e., those with the former ICD-10 diagnosis of transsexuality, from this stigma. Following this principle or logic, all other individuals with one or more mental disorders would remain categorized as having a mental disorder, which, according to the WHO, is stigmatizing. Thus, the WHO articulates, if not confirms, stigmatization for other affected individuals, accepting this without further comment. Only a single group of individuals is selectively argued to be removed from the context of mental
disorders. In this context, it should be briefly noted that the ongoing debate about what precisely defines a psychiatric disorder continues to this day. The many associated problems are easily recognizable in discussions about whether suffering must be present for a psychiatric disorder to exist (Phillips, 2009).

An inquiry with the German Medical Association (GMA; upon whose suggestion the aforementioned depathologization of transsexuality according to ICD-10 occurred during the World Medical Association meeting in Moscow in 2015) yielded the following information (see below) with the note that the procedure for the World Medical Association's (WMA) positioning can be summarized as follows:

A national member association submits a paper, then the WMA takes it over, discusses it in one of its standing committees, and shares it with all national member associations, which then provide comments and suggestions for changes. The submitting member association, a rapporteur, or a working group incorporates these proposed changes. The result is initially revised by a committee and later by the board. If the board considers it finalized, it is sent to the General Assembly, which may amend it again before the paper is adopted. Approximately every ten years, a position of the WMA is reviewed, and its revision or further handling is discussed. For medical ethical documents, a review is conducted every five years. In the case of the WMA’s statement on transgender issues, the submitted paper was developed with the German Society for Psychiatry, Psychotherapy, and Neurology (Deutsche Gesellschaft für Psychiatrie und Psychotherapie, Psychosomatik und Nervenheilkunde [DGPPN], Department "Sexual Orientations and Gender Identities in Psychiatry and Psychotherapy" and Department "Sexual Medicine"), as well as with, among others, the Hamburg Institute for Sexual Research and Forensic Psychiatry. The following literature, among others, which was provided to the GMA by its experts at that time, was considered:

1. Drescher et al., (2012): This work discusses various human rights aspects regarding gender identity and examines the question of how the relevant issues can be classified in appropriate classification systems.
2. WPATH, 2013: This is a statement or position paper from the increasingly criticized World Professional Association for Transgender Health (WPATH, see also the so-called WPATH Files or WPATH Leaks, Environmental Progress, 2024).

3. TGEU, 2013: This is a summary of monitoring on murders of transgender people (Link: Trans Murder Monitoring Update TDOR 2013 - TGEU).

4. Hatzenbuehler ML, 2009: This work is dealing with aspects of a psychological framework regarding the influence of stigma on mental aspects and the role of identity.

5. Heylens et al., 2013: In this is a work accompanying psychological symptoms/comorbidities in transgender individuals are described. A very high percentage of psychiatric problems in people identifying as transgender compared to the general population was detected.

6. Murad et al., 2010: This is a review article on hormone administration and "sex reassignment." Conclusion of the analysis: “Very low quality evidence suggests that sex reassignment that includes hormonal interventions in individuals with GID likely improves GD, psychological functioning and comorbidities, sexual function and overall quality of life.”

7. APA, 2009: This is a resolution of the American Psychological Association regarding discrimination against transgender individuals.

All the literature listed here are not original or review articles that definitively justify that GD cannot also be understood as a form of mental distress or mental disorder, or should initially be understood as an etiologically heterogeneous symptom.

Upon inquiry with the GMA and the aforementioned DGPPN departments, it was not possible to ascertain further which additional literature might be hidden under the designation or communication "among others" ("u.a."). Overall, in the course of reviewing the literature, it becomes clear that the works examined primarily illuminate the subject in question from the
perspective of the so-called Minority Stress Hypothesis. Simplified, this hypothesis or assumption states that individuals belonging to a minority experience more stressors due to their group membership, and therefore may experience more burdens or have a higher risk of developing psychological symptoms or disorders for reasons such as this. However, alternative considerations are neglected here in the present context. For example, individuals may develop psychological symptoms independently of the topic of GI or GD. The primarily unicausal assumption examined here of the development of potential psychological symptoms in individuals solely due to potential discrimination experienced or due to stressors associated with belonging to a minority group is an overall unsupported and potentially overly simplistic explanation for the complex phenomenon of GI or GD in minors.

The authors emphasize at this point explicitly that they do not question the depathologization of transsexuality (ICD-10 formulation) per se and explicitly do not consider it evaluative. However, the explanations provided here serve to illustrate the depathologization process, to clarify that the depathologization of transsexuality was primarily an ethical decision by the medical associations mentioned here, based on various views and motivations, but lacks a clear empirical foundation. The comparison mentioned in the introduction of the current guideline draft with homosexuality in the context of depathologization is therefore not correct, as in the case of homosexuality or non-heterosexual developments, unlike in the case of GI or GD, there is no desire or demand from the affected individuals and others for potentially irreversible somatic medical interventions without clear evidence in physically healthy minors. It must also be mentioned that there is a much more extensive data availability on various aspects of homosexuality, such as persistence over the lifespan, compared to transgender identity or GD. Similarly, there has not been and is not such an extreme increase in prevalence rates of homosexuality in childhood and adolescence in the years of destigmatization compared to transgender identity or GD. Therefore, the conditions for depathologizing GI are fundamentally different from homosexual or non-heterosexual developmental trajectories in minors.

Regarding the "Incorporation of Expert Controversy and Handling of Dissent" in the current guideline draft, reference is made to the participation of a total of 26 professional societies. However, organizations and associations critical of the recommended measures were not
sufficiently included (e.g., the parent initiative TTSB and others). Therefore, the consensus articulated in the current guideline draft reflects only that of the involved individuals and institutions. That is to say, the composition of the guideline group had and has, like any other commission or body, an influence on the respective voting results, such as in the context of consensus conferences.

Regarding the "Development of Recommendations in the Context of Overall Weak Evidence," the introduction outlines the goals of "providing the best possible information on the current state of knowledge" and "aligning with the current expert consensus-based opinion on 'best practice'," while remaining unclear on how these experts define what "best practice" is or should be, and how it is defined. The "best possible information on the current state of knowledge" has not been taken into account in the current guideline draft, including the conclusions drawn, regarding the current evidence base on the administration of PB or CSH, as well as surgical interventions in minors with GD. Therefore, this section of the introduction gives the impression of attempting to justify the notion that expert knowledge regarding the weighting for these guidelines should be considered higher than the current evidence.

Regarding the observed increase in the utilization of services due to GD in children and adolescents in recent years, the current guideline draft predominantly focuses on the overall one-sided explanatory models of the highly controversial WPATH, which have recently come under significant criticism in the context of the so-called WPATH Files or WPATH Leaks (Environmental Progress, 2024), and cannot be considered a reputable medical professional society. Other explanatory approaches for the observed increase in utilization are not adequately considered from the authors' perspective. These should be discussed as well, particularly the presumed influence of social contagion among vulnerable minors in the context of the benefits of social media (Littman, 2018). The argumentation presented by the authors of the current guideline draft for the causes of an unequal gender ratio (more affected biological females than males) is not convincing. The authors state that there are "indications" that "... in Germany, the step of a socially lived transition in trans-female individuals occurs on average at an age approximately 10 years older than in trans-male individuals." If this were indeed the case, then there should already be a significant increase in trans-female individuals in the approximately 10 years older age groups compared to the affected children or
adolescents, and not just assumed for a time point in approximately 10 years. However, such a current increase cannot be discerned from the current findings. Therefore, the argumentation by the authors of the current guideline draft is merely speculative in nature.

The studies mentioned regarding the question of "How does non-conforming gender identity develop?" do not unequivocally support the underlying assumption of the existence of a fundamental naturalistically determined "identitarian disposition" or a "primarily ubiquitous identity" that is permanent and unchangeable, especially in minors regarding gender and its experience. However, the explanations and recommendations of the guideline draft imply such a primary and naturalistically determined identity (as mentioned above). Furthermore, there is a lack of precise and explicit information regarding which concept or construct of identity is actually used in the current guideline draft.

**Glossary**

*Use of the terms "cis" or "cisgender":*

The authors of this commentary would like to note that it is inappropriate and derogatory to use terms such as "cis" for young people whose gender experience aligns with the sex assessed at birth (i.e., "cis"). These terms are borrowed or derived from the concept of so-called "cis-trans isomerism" from chemistry, which describes an arrangement of molecules in a chemical compound and is linguistically highly unsuitable for such a personal perception as one's own identity, in particular concerning such a personal feeling or topic as one's own gender and its experience in minors. A much more respectful and sensitive term should be used, and an abstraction or characterization of minors' identity experience based on the spatial position of chemical molecules should be avoided at all costs. Furthermore, a general precise definition of the term "gender" is lacking (see above).

*Use of the terms "Non-binary Gender Identity" and "Non-binary Gender Identity":*

In the current guideline draft, the authors write, "... A non-binary gender identity is located in a person's subjective perception of their gender identity beyond the binary of male and female
..." What exactly constitutes a non-binary gender identity and what subjective experience is being depicted in detail remains unclear. In the species Homo sapiens, there are only two empirically verifiable biological sexes, as there are only two different and exclusively distinct types of human gametes or germ cells (i.e., the presence of one biological variant generally excludes the other variant). The inherent capability of an individual to produce sperm typically excludes the capability to produce eggs, and vice versa (no capability to produce sperm in individuals who are inherently physically predisposed or designed to produce eggs during fertility). In the species Homo sapiens, the gametes in the corresponding life stages and given fertility or reproductive ability exist in the form of eggs (large germ cells) or sperm (small germ cells), and there are no intermediate forms of these gametes. Therefore, binary characteristics are clearly present.

During conception or fertilization, i.e., the union of an egg with a sperm, the inherent capacity of the individual to produce eggs (biological females) or sperm (biological males) during later life is determined. Conditions resulting in infertility need to be excluded from this consideration. Similarly, conditions resulting in intersexuality (with, for example, chromosomal or non-chromosomal causes) need to be distinguished as exceptions, but do not inherently refute the clearly binary nature of the variable biological sex in the species Homo sapiens. Analogous to the example of a coin toss with the mutually exclusive outcomes of "heads" or "tails," the inherent predisposition to produce eggs precludes an equivalent predisposition to produce sperm. In rare cases (e.g., 1 in approximately 5,000-7,000), a coin may land on its edge, i.e., the so-called "edge case" occurs. However, this does not negate the fundamental binary nature of the coin, nor does it negate the fact that the coin fundamentally has an edge.

Therefore, the authors of the current guideline draft should provide a medically accurate definition regarding the expression "beyond the binary of male and female." Ultimately, this initially involves a descriptive self-report by minors, which, according to the above explanations from a biological perspective, can still be classified into one of the aforementioned medical-biological categories (female or male, or the inherent biological predisposition of the respective body to produce corresponding gametes without intermediary forms, intersexuality, with or without fertility or reproductive ability).
Chapter I - Preamble

A preamble, including the preceding justification for its necessity as found in the current draft guidelines, is rather unusual for medical guidelines. Fundamentally, it can be observed that the authors of the current draft guidelines and the DGKJP as the leading professional society have perceived the subject matter of the guidelines regarding GI/GD in childhood and adolescence as a rather special issue. The preamble attempts to address some fundamental medical as well as ethical questions. From the perspective of the authors of this commentary, given this special approach regarding these particular guidelines, it does not seem justified to treat the adoption of the current draft guidelines as a routine process or "business as usual" and only allow editorial comments from the CAPPP department chair professors. In recent years, our field has been deeply divided over questions surrounding these particular guidelines. Therefore, efforts should be made towards further agreement, or at least towards documenting a broadly based "minority vote" or the current dissent of opinions.

In the preamble, the issue is primarily viewed from the perspective of the aforementioned Minority Stress Hypothesis, potentially complicating or effectively disallowing alternative viewpoints and approaches. The authors of the current draft guidelines state:

"The statement from the German Ethics Council (2020) emphasizes the deserving protection of the right to self-determination of children and adolescents regarding their gender identity and calls for careful consideration of the benefits and risks of both a contemplated treatment and the withholding of such treatment in adolescence.

As previously noted, at no point is it exactly specified what is actually meant by "gender identity" in this particular context, or what identity construct or concept is underlying. The weighing of benefits and risks as outlined by the Ethics Council does not align with the current evidence regarding the administration of PB or CSH (see NICE 2020a/b; Thompson et al., 2023; Zepf et al., 2024) as well as potential surgical interventions in minors with GD, contradicting the recommendations of the current draft guidelines. The authors of the current draft guidelines further state:
"The guideline is based on the ethical principles of respect for the dignity and self-determination of the individual as well as beneficence and non-maleficence, with the aim of realizing these principles in the treatment setting."

and

"The overarching goal of the guideline is to improve the access of children and adolescents with gender incongruence and/or gender dysphoria to appropriate information and treatment based on scientifically and ethically recognized standards, thereby enabling them to achieve the best possible health development."

With regard to the subsequent recommendations regarding the administration of PB or CSH as well as potential surgical interventions in minors with GD, the current draft guidelines contradict their own preamble with respect to the current evidence base (Cass, 2024; NICE 2020a/b; Thompson et al., 2023; Zepf et al., 2024).

Furthermore, the preamble includes the passage:

"The gender identity of a person is of the utmost personal nature. Therefore, promoting self-determination and, where necessary, capacity for self-determination is a fundamental concern in the treatment setting with minor patients. Approaches to therapy that are implicitly or explicitly driven by the treatment goal of directing a person's sense of belonging to a gender in a certain direction are considered unethical."

Considering the overall limited temporal consistency of the diagnosis of GD in childhood and adolescence (see Bachmann et al., 2024; Rawee et al., 2024), the ethical question must be raised as to the extent to which the primarily affirmative approach pursued in the current draft guidelines in accompanying children and adolescents with self-reported GI or GD here conflicts with this ethical principle. Based on current knowledge, it cannot be ruled out that the affirmative approach significantly influences the perception of affected minors in a certain direction (Brik et al., Carmichael et al., 2021; Chen et al., 2023; de Vries et al., 2011; see also
the newly released final Cass review [Cass, 2024]). In this case, the current draft guidelines would also contradict their own preamble.

The terms or principles of the so-called "shared decision making" are fundamentally important and welcome. However, in these very decisions, it depends on the information actually conveyed regarding the evidence for profound and potentially irreversible medical measures. In this regard, the evidence base for the administration of PB or CSH as well as potential surgical interventions in minors with GD is overall very poor, and this must be clearly communicated to the affected individuals and their families. It should also be mentioned that the authors of these guidelines fail to mention in the preamble the ever-present tension between Article 6 (2) of the German Basic Law (guaranteed right of the child to freely develop his or her personality) and Article 6 (3) of the German Basic Law (parents have the right and duty to care for and raise their children), as the self-determination of the minor is emphasized too one-sidedly and almost no mention is made of the parents' duty to possibly correct them. Also, the state's supervisory duty, which can be derived from Article 6 (3) of the German Basic Law in case of endangerment of the child's welfare, is mentioned, which, according to the authors of the current draft guidelines, rarely occurs, and for which the authors leave unclear what exactly constitutes a endangerment of the child's welfare. Clarification is urgently needed here. It should be explicitly emphasized that there is no medical indication in the true sense for the recommended, potentially irreversible, somatomedical measures (see comment below on Recommendation VII.K0.), especially not if there is no illness present.

In the preamble, it is written about the "depathologization of individuals whose gender identity does not correspond to their anatomical or assigned gender at birth." The term "assigned gender at birth" is misleading and medically incorrect (see also Section II). In most cases, a newborn's biological sex is clearly determinable immediately after birth, with rare exceptions or uncertainties. The term "assigned" suggests an arbitrary decision, which is not the case in reality. The determination of sex in newborns, for example, by obstetricians, is rather based on biological characteristics that are usually clearly recognizable. Therefore, it is medically correct to speak or write of the "sex assessed at birth." This is a medical examination process with extremely high sensitivity and specificity. See also our explanations in Section II of this commentary.
Chapter II – Variable developmental trajectories (persistence, desistance, and detransition)

**Recommendation II.K1.**: In professional counseling of children and adolescents with signs of gender incongruence/gender dysphoria (GI/GD) and their guardians and, if applicable, other caregivers, counselors should\(^A\) have comprehensive knowledge of the diversity of possible gender-variant developmental trajectories in childhood and adolescence.

**Comments and context**: It remains unclear what exactly constitutes such "signs." A precise specification and distinction are needed here for minors in various developmental phases who, for example, take on different roles during play situations or exploratory behavior (possibly over an extended period) that do not indicate an onset or continuation of GI. Recent study results further show that even symptoms of dissatisfaction with one’s own sex are no longer present in almost all cases (98%, see Rawee et al., 2024) in adulthood. This finding must be considered in professional counseling and included in the appropriate education of those affected and their guardians or other caregivers. Furthermore, it must be clearly defined what "gender-variant developmental trajectories" are meant in view of the empirically unequivocal binarity of sex in the species Homo sapiens (see above). The profound intrinsic unresolved contradictions regarding the concept of GI in children and adolescents also need to be considered (see our preliminary remarks in Section II of this commentary for a presentation of some of these contradictions in the identity articulation of minors with GI or GD and the identity aspects associated with GI).

**Recommendation II.K2**: If counseling occurs in connection with a desired or already initiated social role change, the child or adolescent, their guardians, and, if applicable, other caregivers should\(^A\) be informed about the diversity of developmental trajectories, including the possibility of later detransition.

**Comments and context**: Here, the current and final Cass Review (Cass, 2024), which explicitly points out the potentially harmful aspects of a social role change, needs to be mentioned (see below for a detailed presentation of important points of the final Cass Review). If such a social role change occurs, possibly only in parts (cf. Cass, 2024), and after extremely thorough prior psychopathological clarification and education, the authors of this commentary share the core
idea of this recommendation in principle. However, we find the wording "....a later detransition...." in the context of considerations of a social role change unfortunately chosen. In the glossary, detransition is defined as "....step of withdrawal from medical measures of a started or completed transition. It is used only if gender-affirming, body-modifying medical measures have already taken place....". We consider the sole emphasis on a possible later detransition unjustified, as, according to current data, this possibility is extremely rare compared to the possibility of ending a social role change, thus unnecessarily highlighting gender-affirming, body-modifying, possibly irreversible, somatic medical measures. See also the study results of Rawee et al. (2024) and the very low persistence of dissatisfaction with one's own sex (cf. also Bachmann et al., 2024).

**Recommendation II.K3.:** In pre-pubertal children showing signs of childhood gender incongruence (according to ICD-11 HA61), medical professionals should assume that predicting persistent gender incongruence in adolescence is not possible until puberty onset.

**Comments and context:** See also the commentary and classification regarding the unclear definition of "signs." Moreover, the new findings by Bachmann et al. (2024) and Rawee et al. (2024) need to be mentioned, which show that dissatisfaction with one's own sex does not persist into adulthood in most cases. Additionally, this recommendation suggests the scientifically unjustified assumption that after puberty onset, a possibly expected persistence of GI can be validly predicted. This is currently not possible.

**Chapter III – Change of social role in childhood**

**Recommendation III. K1:** In counseling sessions with children experiencing gender incongruence or gender dysphoria who are considering a social role change before puberty, as well as their legal guardians and potentially other caregivers, the counseling professional should respect the child's right to freely develop their personality.

**Commentary and Context:** While the authors of this commentary share the core element of this recommendation and acknowledge that a social role change, as discussed above regarding the low persistence of GI (Bachmann et al., 2024; Rawee et al., 2024) and potential harmful
aspects (Cass, 2024), should be approached with caution, they note the absence of addressing the inherent tension between Article 6 (2) of the German Basic Law (ensuring the child’s guaranteed right to freely develop their personality) and Article 6 (3) of the German Basic Law (parents have the right and duty to raise their children). It is also worth considering whether the German state’s guardianship duty derived from Article 6 (3) of the German Basic Law should be mentioned, which justifies German state intervention when it is imperative for the child’s well-being. The authors of this commentary do not consider it appropriate to unilaterally mention the child’s right to freely develop their personality in such significant decisions, as its limitations ensure the protection of important interests and a balanced approach between the child’s freedom rights and other legal interests.

**Recommendation III. K2:** In counseling sessions with children experiencing gender incongruence or gender dysphoria who are considering a social role change before puberty, along with their legal guardians and potentially other caregivers, the counseling professional should attempt to sensitize the legal guardians to adopt an attitude that allows the child to explore and autonomously develop their gender identity and social gender role.

The authors of this commentary believe that this recommendation, while potentially justified in certain individual cases, lacks a more balanced presentation of alternative approaches and information regarding the potential risks of a social role change. It is important to mention the potentially significant risks associated with a social role change (Cass, 2024) and explicitly highlight the low persistence of the relevant symptoms (Bachmann et al., 2024; Rawee et al., 2024).

**Recommendation III. K3:** In counseling sessions with children experiencing gender incongruence or gender dysphoria who are considering a social role change before puberty, along with their legal guardians and potentially other caregivers, a (potential) social role change should be perceived as a process tailored to the child’s needs. Steps considered for the experimentation of the role change should be tailored to the individual life situation.

The authors would appreciate it if, unlike in other recommendations, the individually and self-articulated needs of the child alone are not mentioned and isolated, but instead the term
"child's welfare" is used or at least the tension mentioned above (as expressed in the commentary on Recommendation III. K1.) is acknowledged. It must be made clear here what the child's welfare actually entails in light of the rather low persistence of GD (Bachmann et al., 2024; Rawee et al., 2024), and it needs to be clearly articulated who defines what the child's welfare is based on what criteria in individual cases, and how this can be cross-checked if necessary. Furthermore, the authors of this commentary refer to the right of minors to an open future (the concept of "children have a right of an open future", see Jorgensen et al., 2024).

**Recommendation III. K4:** In counseling sessions with children experiencing gender incongruence or gender dysphoria who are considering a social role change before puberty, along with their legal guardians and potentially other caregivers, the counseling professional should provide professional support to protect the child and/or their caregivers from stigma and discrimination, regardless of the individual decision and life path of the affected individuals.

While the authors of this commentary share the assumed core idea of this recommendation, they question here (as in other parts of the current guideline draft) whether it is correct and meaningful to (a) explicitly mention generally self-evident measures, which could be recommended for other issues or diagnoses in the field of child and adolescent psychiatry and psychotherapy as well (here: protection from stigma and discrimination of minors and/or their caregivers), and (b) whether the frequent mention of the terms "stigma" and "discrimination" is sensible and helpful - especially compared to other disorders, where the term "discrimination" is much less common in their guidelines. A search for the terms "stigmatiz*" or "discriminat*" in the current guideline draft yields N = 130 hits, while the search in the S3 guideline for ASD (combined analysis of Part 1 Diagnosis and Part 2 Therapy for children, adolescents, and adults) only yields N = 6 hits and in the guideline for eating disorders only N = 1 hit. Furthermore, the authors of this commentary refer to their comments regarding the definition of "discrimination". The authors of the current guideline draft use their own definition of discrimination here, which is often imprecise and allows for multifaceted interpretations or understandings.
Chapter IV - Associated mental health issues and health problems in children and adolescents with gender incongruence and gender dysphoria

Page 61

"Before the diagnosis of a persisting, i.e., stable/persistent gender incongruence or gender dysphoria in childhood and adolescence can be made with sufficient diagnostic clarity based on present symptoms and findings, as well as a comprehensive examination of individual developmental trajectories, associated or coincidental mental disorders should be accurately diagnosed and evaluated in terms of their interdependence with gender dysphoric symptoms."

This sentence implicitly postulates that the diagnosis of a persisting, i.e., stable/persistent GI or GD in childhood and adolescence can be made with sufficient diagnostic clarity and certainty. This postulate is - at least currently - not adequately justifiable based on evidence-based criteria. Please refer to further comments regarding the current state of evidence regarding new study results (Bachmann et al., 2024; Rawee et al., 2024), as well as corresponding explanations and considerations regarding the assumption of a stable naturalistically determined identity in children and adolescents, especially regarding gender, which is not proven (see Section II).

Page 62

"On the other hand, severe mental disorders that can significantly impair diagnostic clarity (such as psychoses or complex personality disorders with pronounced identity diffusion) are not in themselves evidence that stable/persistent gender incongruence or gender dysphoria is not present, just as, for example, the presence of such a severe disorder does not make a non-heterosexual orientation inherently unlikely or less credible."

The analogy to a non-heterosexual orientation that is made here is misleading in this context, in particular as a non-heterosexual orientation is typically not the subject of a diagnosis and does not require any potentially irreversible somatic medical interventions involving changes to a primarily physiologically healthy body or demands for such interventions. Moreover, there is no clear evidence regarding whether a severe mental health disorder alters the likelihood of GI/GD in the same way as the likelihood of a non-heterosexual orientation in a
person. The prevalence of mental health disorders and symptoms is not similarly elevated in the population of non-heterosexually oriented individuals.

"From follow-up studies of transitioned transgender individuals who received staged somatic medical interventions starting in adolescence (puberty blockage, gender-affirming hormone therapy, and surgeries), consistent evidence is found for a favorable course of mental health and quality of life..."

This summary and assessment by the authors of the current guideline draft clearly does not align with the current state of evidence (Cass, 2024; NICE 2020a/b; Thompson et al., 2023; Zepf et al., 2024).

"From predominantly cross-sectional study results on the prevalence and severity of accompanying mental health issues in adolescents with GI or GD, no statement can be derived about the extent to which the associated psychopathology is a consequence of the stress associated with gender dysphoria or to what extent mental disorders may have arisen independently of GI or GD. Accordingly, no statement can be made about the extent to which assumed reactive mental disorders resulting from GD are caused by aversive environmental experiences, such as inadequate perceived social acceptance of transgender identity (so-called Minority Stress, see below), and/or by body-related dysphoria from puberty onset."

With an unknown etiology of GI or GD, no statements can generally be made about the relationship between GI or GD and associated psychopathology. It is possible that associated psychopathology underlies GI or GD, just as it is possible that the reverse relationship exists, or that they are independent phenomena. Therefore, the possibility should be mentioned that GI or GD may be understood as a consequence, or at least partially conditioned by the associated psychopathology (an indication of this is, for example, the increased prevalence of ASD, see below). However, current studies show that suicidality is not significantly increased in affected individuals when results are adjusted for a potentially existing psychiatric
diagnosis, and the administration of PB or CSH does not contribute beneficially to a reduction in suicidality in affected individuals (Ruuska et al., 2024).

Page 71
Here, for the first time, the term "sex spectrum" is mentioned or written, however, without any explanations of what exactly is meant by it. Is a spectrum meant to exist in terms of biological sex in the species Homo sapiens? Biological sex in the species Homo sapiens is clearly binary (see also Section II). In the text (elsewhere in the current guideline draft) the German Society for Transidentity and Intersexuality (DGTI) is mentioned. This is quite relevant for the use of the term "sex spectrum." On the current website of the DGTI (2024), among other aspects, there are illustrations and explanations of the so-called "Genderbread Person" which suggests a "sex spectrum" (incl. biological sex) in humans.

The depicted "Genderbread Person" sub-scale "Biological Sex" (= biological gender) on the current website of the DGTI (2024) shows two arrows, each starting from the left (beginning with the value "0" = no femininity or masculinity) and extending to the right for femininity and masculinity ("Female-ness" and "Male-ness"). In the subtitle, physical characteristics (voice, hairiness, etc.) are named as examples of corresponding features for female and male persons. According to this logic, a person would be considered more womanly or more feminine if they had more feminine physical attributes (higher voice, less hairiness, etc.), and conversely, a person would be considered more manly if they had more male biological characteristics (e.g., deeper voice, more hairiness, masculine physique, etc.). This way of evaluating femininity or masculinity is discriminatory, stigmatizing, and in no way tolerable.
Since the DGTI is cited within the context of this guideline draft and an unspecified aspect of a "gender spectrum" is addressed, this point must be clarified to avoid any misunderstandings of possible thought patterns according to the above example.

Page 75
"IV. K3. If there are no indications of clinically relevant mental or psychopathological abnormalities and no psychotherapeutic treatment is desired, no further diagnostic measures are necessary for the time being. Thus, general development-oriented counseling or advisory
support for preparing social role experiments does not require prior child and adolescent psychiatric or psychological diagnostics."

In order to identify indications of clinically relevant mental or psychopathological abnormalities at all, at least a screening for the presence of clinically relevant mental or psychopathological abnormalities or symptoms must be conducted. Similarly, any deviations in blood values can only be detected if a blood sample is taken and the sample is analyzed in accordance with standardized procedures. Such a simplification of a thorough psychological diagnosis in minors, as depicted here in the current guideline draft, does not correspond to the standards that are to be applied here according to good clinical child and adolescent psychiatric and psychotherapeutic practice (see also the recently published final Cass review [Cass, 2024], which explicitly highlights the role of a multidisciplinary team [MDT] in this particular context).

Page 76
"In child and adolescent psychiatric or psychotherapeutic diagnostics of children and adolescents with gender incongruence or gender dysphoria, attention should be specifically paid to the possible presence of clinically significant depression, anxiety disorder, as well as self-harming behavior and suicidality."

The selection or listing of the diagnoses or problematic behaviors or psychopathologies mentioned here appears arbitrary. In child and adolescent psychiatric or psychotherapeutic diagnostics of children and adolescents with GI or GD, attention should at least also be paid to the presence of ASD (see below) as well as potentially other accompanying mental health disorders.

Page 78
"If a properly diagnosed GI or GD diagnosis is present, a coincident ASD diagnosis does not justify delaying or not generally indicating desired medical measures to support social transition."
Here, there is a misleading and distortion of medical reality through the use of the word "indicated" (see comment below on Recommendation VII.K0). Since according to current evidence, there is no clear, distinct, and sustained medical benefit to be expected (see e.g., NICE 2020a/b; Thompson et al., 2023; Zepf et al., 2024), it cannot be referred to as an indication in the medical sense.

Page 79
"A diagnostic overlap between ASD and GI or GD is indeed statistically more frequent than chance, yet rare in absolute terms. Therefore, a general autism screening is unnecessary if there are no clinical indications of possible ASD."

A prevalence of approximately 11% regarding such a common occurrence of GI/GD and ASD (see the meta-analysis Kallitsounaki & Williams, 2023) is not considered "rare" from a scientific perspective. Without an ASD screening, clinical indications for the possible presence of ASD may be overlooked. A general ASD screening is therefore not unnecessary, but is urgently needed.

Page 81
"The suspicion of gender incongruence, per se, does not justify a need for psychiatric or psychotherapeutic diagnostics in the absence of psychopathological symptoms. In particular, in the absence of psychopathological symptoms, there is no need for differential or exclusion diagnostics."

The absence of psychopathological symptoms cannot be confirmed without a thorough diagnosis.

Page 83
"In addition, four English-language questionnaire instruments validated for adolescence are established internationally for assessing gender dysphoric symptoms, two of which have been validated in a German translation (see Table 4). ... Table 4: Validated questionnaire instruments for assessing gender dysphoric symptoms (according to Bloom et al., 2021; Bowman et al., 2022)."
The claim that the mentioned questionnaire instruments are validated cannot be inferred from the cited works. On the contrary, Bloom et al. (2021) state:

„Although tools such as the GDQ might address non-binary or fluid aspects of gender identity (and several of the other limitations we have described), they have not yet been validated as a clinical assessment tool. UGDS was revised and is now known as the UGDS-Gender Spectrum (UGDS-GS), which is a gender-neutral, single-version adaptation of the original that is inclusive of all gender identities and expressions and allows for the fluid nature of these constructs across the lifespan. However, to our knowledge, the UDGS-GS has only been used in adult samples.” „The GIQC, which assesses gender expression, has shown adequate psychometric properties, such as high cross-national and cross-clinic reliability, and also has the advantage of being easily administered and scored. ... However, given the tool was created in 1984 and was last revised in 2004, revision and revalidation to align the GIQC with more modern concepts of childhood interests and play, which do not rely on references to gender stereotypes, would be beneficial."

Bowman et al. (2022) state:

„Poor content validity was evident across all measures and internal validity and construct validity were mixed, ranging from inadequate to very good. ... A need to develop reliable and valid measures that are appropriate for use with adolescent samples experiencing gender dysphoria was also identified.”

In this respect, this section needs to be corrected or fundamentally revised.

Chapter V - Psychotherapy and psychosocial development

Page 89

"A regular obligation to psychotherapy for treatment seekers, for example as a prerequisite for accessing somatic medical measures for gender reassignment surgery in children and adolescents, is unethical and obsolete. The S3 guideline of the AWMF for adults provides the following consensus-based recommendation on this matter: 'Psychotherapy should not be applied without specific indication and should never be seen as a requirement for body-
modifying treatments. The indication should be made according to the guidelines of the psychotherapy directive.' (AWMF, 2018, p. 45). The international guideline Standards of Care, Version 8 of the World Professional Association for Transgender Health (2022) formulates the following recommendation: 'We recommend that healthcare providers for transgender and gender-nonconforming individuals not necessarily prescribe psychotherapy before initiating gender-affirming treatment. It is recognized that psychotherapy may be helpful for some transgender and gender-nonconforming individuals.' (p. 177).

The assertion that a regular obligation to psychotherapy for people seeking treatment, such as a prerequisite for accessing somatic medical measures for gender reassignment surgery in children and adolescents, is unethical and obsolete, merely reflects the opinion of the authors of the current draft guidelines and cannot be justified with reference to the S3 guideline of the AWMF for adults or the non-evidence-based guideline of the international Standards of Care (Version 8) of the WPATH. A careful clarification of the motivation behind the desire for somatic medical measures for gender reassignment surgery (not 'gender alignment,' as this terminology trivializes irreversible medical interventions) must necessarily precede the initiation of somatic medical measures, given the context of a fundamentally open identity development and the frequency of identity crises, especially in adolescents. This clarification is best conducted in a psychotherapeutic process. Furthermore, this understanding of the therapeutic mandate, according to information from the responsible Federal Ministry, which initiated the law to protect against conversion therapies at the time, does not violate this law (Korte and Tschuschke, 2023), as falsely claimed (e.g., by Romer & Möller, 2020).

The distinction made by the authors of the current draft guidelines between "psychotherapy," "psychotherapeutic support" (see also the following points), and "psychosocial interventions" urgently needs to be improved with better and more specific definitions of these terms. Due to the fluid boundaries and significant overlaps of the various methods, achieving a sufficiently clear distinction seems almost impossible in the available literature and clinical practice, especially if it is intended to be derived securely from the current evidence base. Regardless of precise definitions, given the current evidence base, it cannot be ruled out that for certain groups of children or adolescents who meet the diagnostic criteria for GD, psychotherapy (e.g., as a clarifying process and/or to change potentially dysfunctional thoughts) may prove to be the most sensible option for long-term life satisfaction, quality of life, etc. See also the
criticism by Kohls and Roessner (2023) of the currently contradictory practice, where on the one hand, in Body Dysmorphic Disorder (BDD), almost any form of medical alteration of appearance is considered contraindicated, and the underlying thoughts should primarily be changed psychotherapeutically, while on the other hand, in GD, almost any form of psychotherapeutic change of underlying thoughts is considered contraindicated, and appearance should primarily be changed through potentially irreversible somatic medical measures. Together with the results of Ruuska et al. (2024), the need and usefulness of developing new subgroup-specific interventions (including psychotherapeutic elements) in an open-ended manner and determining their risk-benefit ratio becomes evident. Given the poor evidence base and intrinsic contradictions, there is a responsibility to research better and more targeted interventions.

Page 90

"Psychotherapeutic support should be offered to treatment seekers as assistance and guidance, for example, for open-ended self-discovery, strengthening self-confidence, coping with experiences of discrimination, or psychological preparation and follow-up of steps in the process of transition, in a low-threshold manner and made available."

See previous point: The distinction made by the authors of the current draft guidelines between "psychotherapy" and "psychotherapeutic support," as well as "psychosocial interventions" (see following points), urgently needs to be improved with better and more specific definitions of all terms. However, achieving such a distinction appears to be almost impossible in the available literature and clinical practice if a secure derivation from the current evidence base is intended. The term "self-discovery" is misleading here because nothing is actually "discovered" in the sense of finding something individual "for oneself" in the clarification process (if so, where was it previously, and in what form, or possibly hidden?), but rather, a subjectively - currently or temporarily - coherent interpretation of the self-concept is achieved. However, this interpretation can change at any time. This statement suggests that there is (also in children and adolescents) a clearly definable "self" that can be "found" through appropriate (although not defined) procedures, and this "self" can then be understood as an unchangeable aspect of identity. Furthermore, nowhere in the current draft guidelines is there any indication of which understanding or construct of identity is used
depending on the question. Unlike adults, it is also important to consider that, on average, children and adolescents have a much higher volatility and lower validity of a subjectively coherent interpretation of the self-concept compared to adults, which not only makes assessing the risk-benefit ratio significantly more difficult but also requires an even greater predominance of benefits over risks than in adults.

Page 90

"A commitment to psychotherapy as a condition for accessing somatic medical treatment is not ethically justified out of respect for the dignity and self-determination of the individual."

The assertion that a regular obligation to undergo psychotherapy for treatment seekers, for example, as a prerequisite for access to potentially irreversible somatic medical interventions for "gender alignment" (or for changing the visual appearance to one that more closely matches the desired appearance) in children and adolescents, is unethical, merely expresses the opinion of the authors of the current draft guidelines. Before the "indication" (where, due to the current evidence base, there can be no clear medical indication, see comment below on recommendation VII.K0.) regarding potentially irreversible somatic medical measures, the diagnostic assessment of the irreversibility of gender identity transposition is essential. However, this can only be achieved, if at all, in most cases within the framework of a longer diagnostic-therapeutic process. It would be particularly reckless to refrain from mandatory psychotherapy in the presence of associated psychological problems (because psychotherapy is a guideline-compliant treatment for many psychological symptoms and often the first step in a recommended treatment chain after psychoeducation), especially when decisions for potentially irreversible somatic medical measures are made for physically healthy minors with existing psychological symptoms. For example, if there are no psychological problems present in GI without GD, the use of the medical system would not be justifiable purely from a formal perspective. Furthermore, referring to the previous discussions regarding the higher volatility and lower validity of a minor’s own identity or self-concept compared to adults. The statements of the authors of the current draft guidelines would also imply, conversely, that treatments against a person’s own will (e.g., in the case of anorexia nervosa with extreme or life-threatening starvation) or significant harm (e.g., in the case of substance abuse) would not
be "... ethically justified out of respect for the dignity and self-determination of the individual." Therefore, this section also requires urgent revision.

Page 94

"In the 'gender affirmative' model, which also includes various psychosocial interventions, it is recommended to validate a child’s self-declared sense of gender identity and to approach them with an affirming attitude."

See also previous comments and assessments regarding the necessary precise definitions of terms, especially regarding "psychotherapy," "psychotherapeutic support," and "psychosocial interventions." An open-ended psychotherapeutic support and clarification process should remain neutral (the basic rules of therapy, including the rule of abstinence, apply here as well), neither validating nor invalidating the child's or adolescent's self-declared sense of gender identity. The general prioritization of the 'gender affirmative' model should be rejected, as there is no evidence that somatic medical measures are always beneficial for all affected minors with GD or generally have a favorable benefit-risk profile. See also the current final Cass review (Cass, 2024) for more information.

Page 96

"In the Guidelines for Psychological Practice with Transgender and Gender Nonconforming (TGNC) People by the American Psychological Association (APA, 2015), it states in the first of 16 professional statements: 'Psychologists understand gender identity as a non-binary construct that allows for a range of gender identities and believe that a person’s gender identity does not have to align with the sex assigned at birth' (quoted translation according to AWMF, 2018, p.37)."

Biological sex is not arbitrarily assigned or attributed at birth. Prescriptive or apodictic postulates about what psychologists, psychotherapists, or other professional groups should understand as gender identity do not belong in a medical guideline. Biological sex is determined in almost all cases by chromosomes or the inherent ability of the body to develop
a certain type of gamete in adulthood (either eggs or sperm, hence biological sex in the species Homo sapiens is binary, see our explanations in section II of this commentary). Especially when the concept of an open-ended approach is taken seriously and the changeable nature of human identity and gender identity experience is acknowledged, it must follow that the diagnosis of persistent GI or GD and the initiation of irreversible somatic medical measures, especially in adolescence, should be approached with great caution. The identification as "trans," "non-binary," are self-interpretations that, in principle, cannot be classified as true or false, nor as stable interpretations of one's own existence, and are not necessarily always the result of actual self-awareness (although it is not clear how such "awareness" can be distinguished from a temporary idea, inclination, or even symptoms of any accompanying psychopathology with or without influencing developmental aspects). What is crucial is that self-interpretations are generally neither causally determined nor inevitable, and are subject to lifelong change.

"An important prerequisite for an appropriate professional attitude towards transgender individuals is considered to be that professional helpers have a reflective theoretical understanding of the development of gender identities. This should not be entrenched in outdated assumptions of exclusively binary two-gender systems, nor in cis- and heteronormative notions, but should also recognize non-binary as well as fluid gender identities over the course of life (Ehrensaft, 2016; Quindeau, 2014a, 2014b)."

This section cannot be left as it is because it merely presents the opinion of the authors of the current guideline draft, which cannot be uncritically applied to other professional groups.

Specifically, the following questions arise:

- What constitutes an "appropriate professional attitude" in this context? Who determines what is "appropriate" according to which criteria and standards?

- What exactly is a "reflective theoretical understanding of the development of gender identities"? As explained earlier, there is no precise and exact indication in the current guideline draft of what is understood by "gender identity," especially in minors. There
is no information about any underlying model or construct of identity. Does this understanding also include knowledge of the current research and evidence base according to the Cass Review (Cass, 2024) as well as other findings (Bachmann et al., 2024; NICE 2020a/b, Rawee et al., 2024; Thompson et al., 2023; Zepf et al., 2024)?

- What is meant by "outdated assumptions of exclusively binary sex and not in cis- and heteronormative concepts"? Who determines what is supposed to be "outdated"? As previously stated in earlier comments and explicitly detailed in Section II of this document, there are only two biological sexes in the species Homo sapiens, with states of intersexuality (with or without chromosomal causes and with or without infertility) being distinct from this. The binary nature of sex in the species Homo sapiens is expressed by the fact that there are only two types of gametes in humans (eggs and sperm). The fundamental predisposition of a person to produce these gametes during fertility is established at fertilization (see above). There are no intermediary forms in human gametes, and the basic predisposition to produce sperm during life (male) excludes the basic predisposition to produce eggs (female), and vice versa. Thus, these two variants are usually exclusive, i.e., binary is explicitly and clearly given. No other variable in the species Homo sapiens is as binary as biological sex. Biological sex in the species Homo sapiens is often even used as an example of a binary situation. Furthermore, reference to the inadequate definitions of the terms "non-binary" (see comments on the glossary) and "fluid." The statements made here by the authors of the current guideline draft contradict basic biological and medical knowledge. This passage cannot remain in a medical guideline.

Here is the section or passage "4.3 Rejection of 'Reparative' Therapy Goals":

Treatment methods aimed at changing gender identity and gender-typical behavior to better align with the sex assigned at birth, based on the assumption of a psychopathological malformation, have been attempted unsuccessfully. Such treatment methods are now considered ethically unacceptable (Meyenburg, 2020, p. 12). In Germany, attempts at therapy with minors with such a reparative intention (so-called conversion therapies to change sexual
orientation or gender identity) have been illegal since 2020 (Law for the Protection against Conversion Therapies, Federal Law Gazette I, p. 1285). Therefore, there is no need for a separate consensus-based recommendation in this guideline.

This section, as it stands, is misleading to the readership. Furthermore, see also the comments and assessments regarding the term "... sex assigned at birth...", which is not scientifically correct; there is no arbitrariness in determining biological sex in the species Homo sapiens, as suggested here (medical examination process with extremely high specificity and sensitivity, see above). Furthermore, at this point, reference is made to the well-known volatile and variable will of children and adolescents during development (including puberty), including the possible influence of any accompanying psychopathology, the changeability of personality, and its unclear demarcation from identity aspects, and the absence of any indication of identity models or constructs in the context of the current guideline draft. The term "conversion" implies, in this context, that there is a clearly demonstrable and unequivocally defined ubiquitous identity in children and adolescents which is unchangeable, from which these minors would then be "converted away". This is in no way clearly demonstrable, especially as the boundaries of such a naturalistically defined ubiquitous identity are unclear (see our explanations above; what is identity and what is not?). The comparison made in the introduction of the current guideline draft with homosexuality or non-heterosexual developments for depathologization is therefore inappropriate and factually incorrect, as homosexuality or non-heterosexual developments do not involve potentially irreversible somatic medical measures without clear evidence in minors with physiologically healthy bodies, unlike with a GI or GD. The relevant cited paragraph of the law naturally has its validity. However, the conditions for minors with GI/GD are fundamentally different and must be considered in a developmental context.

Page 98
Under "Affirmative Attitude," there is mention of "...unconditional acceptance of gender-nonconforming identities." At this point, once again, reference is made to the absence of any information regarding the identity construct or model used here, especially in developing children and adolescents and with regard to their own gender. Furthermore, reference is made to the changing will of children and adolescents during development, and the
misconception of a clearly defined and unchangeable, ubiquitous, naturalistically determined identity in children and adolescents. Furthermore, reference is made to our discussions regarding therapeutic principles.

"For psychotherapists, it is important to acknowledge the extensive history of a healthcare and legal system that has been restrictive towards trans individuals. This includes, for example, the requirement for trans individuals to undergo extensive evaluation by two independent psychological or psychiatric experts for legal recognition of their gender identity under the current Transsexual Law (TSG), in order for their trans identity to be recognized by a court. Additionally, the 2020 published evaluation guideline of the Medical Service of the Association of Statutory Health Insurance Physicians (Medical Service of the Association of Statutory Health Insurance Physicians, 2020), whose authorship and associated scientific legitimacy are opaque, requires, as a condition for the cost coverage of a guideline-compliant gender-affirming surgery by statutory health insurance, that the transgender person seeking treatment must have previously completed guideline psychotherapy - to demonstrate that this "treatment attempt" to alleviate existing gender dysphoria has been "exhausted". This requirement of the Medical Service stands in open contradiction to the current S3 guideline for adults Gender Incongruence, Gender Dysphoria and Trans* Health (AWMF, 2018), published two years (!) earlier, which explicitly states, based on recognized scientific knowledge, that the requirement of mandatory psychotherapy as a prerequisite for access to surgical gender-affirming measures is scientifically untenable, unethical, and therefore obsolete. This outlined history of the instrumentalization of psychotherapy as a restrictive barrier towards trans individuals in healthcare may also lead to a subjectively perceived power imbalance in the psychotherapeutic relationship in the context of participative and affirmative relationship building, in terms of latent mutual expectations and role assignments."

The standpoint outlined here is a subjective evaluation by the authors of the current guideline draft and cannot be categorically applied to all clinicians. There are currently no scientifically sufficient arguments for or against the requirement of mandatory psychotherapy as a prerequisite for access to surgical gender-affirming measures. The assessment of psychotherapy in this context as unethical is also highly contentious, as ethical assessment
involves considering and evaluating various aspects alongside the autonomy of the subject, and there is no consensus in the professional community. Current works on the ethical complex of issues in question here explicitly emphasize the right of children and adolescents to an open future (Jørgensen et al., 2024), and the evidence and findings in adults cannot be extrapolated to the pediatric and adolescent domain. Furthermore, reference is made to the differing approach in the medical context with body dysmorphic disorder in childhood and adolescence (BDD, see above). Also essential in the medical context is the Hippocratic Oath, namely the primary principle of doing no harm (see further below in the text our comments on the UN Convention on the Rights of the Child, the Geneva Declaration of Physicians, and the Constitution of the German Society of Child and Adolescent Psychiatry). The notion that psychotherapy has been instrumentalized to create a restrictive barrier towards trans individuals in healthcare is disputable. In our opinion, this passage therefore does not belong in a medical guideline.

Page 103
"Young people with gender-nonconforming self-descriptions who seek psychotherapeutic support with an uncertain perspective on gender identity should be informed that exploratory social role explorations are important to support a process of introspection and self-reflection in connection with social interaction experiences dialogically. Discrimination protection should be observed in this process. In this process, young people should be supported in questioning gender-stereotypical role expectations and reflecting on the possibility of a non-binary gender role understanding."

The significance of exploratory social role explorations is not generalizable and must be discussed for each specific case, also considering the risks outlined in the current final Cass Review (Cass, 2024). It is also not clear why discrimination protection should be explicitly observed at this point and not generally, which implies or at least gives the impression that this may not be necessary for other forms of psychotherapeutic support.

Page 109
"Although there is no causal psychotherapeutic treatment for gender dysphoria, because it is definitionally based on gender incongruence, which in turn is a lasting inner disposition of a
person not influenced by psychosocial interventions, psychotherapeutic interventions can be helpful in coping better with negative emotions and stress states associated with gender dysphoria."

The claim that every form of GD, as a result of GI, cannot be fundamentally treated causally by psychotherapy, and the implied suggestion that only potentially irreversible somatic medical measures are suitable to address the issue of any form of GD in a causal manner, is unscientific and based on an essentialist and naturalistic misunderstanding. GI, like GD, reflects a subjective interpretation or experience of unknown genesis, stability, and intensity in affected individuals (see Bachmann et al., 2024; Rawee et al., 2024). From the experience that current psychotherapeutic treatments, if they are even conducted, often do not lead to a reduction in the symptoms of GD, this postulate cannot logically be derived. (See also comments on the limitations of psychotherapy above).

Chapter VI - Inclusion of family relationship environment and family dynamics

Statement VI.E1: There is evidence that in children and adolescents with GI/GD, a family environment that accepts and supports the perceived gender identity is a significant protective factor for mental health.

Comment and context: In principle, this is a very unspecific or general statement, as an "accepting and supportive family environment" has a positive or protective effect on the mental health of all children and adolescents. Here, too, there is a lack of a precise definition of what is meant by the term "gender identity". There is also no indication of the identity construct or model used here, especially in children and adolescents. See our comments regarding the fundamental and unproven assumptions of a ubiquitous, naturalistically determined identity, especially in children and adolescents.

Statement VI.E2: There is evidence that in children and adolescents with GI/GD who experience low or lacking acceptance of their perceived gender identity in their family environment, the risk of depressive disorders and suicidality, as well as self-harming behaviors, is increased.
Comment and context: See previous comments and evaluations regarding the definition of "gender identity," especially in children and adolescents and throughout development (with or without accompanying psychopathology). What exactly is meant by "acceptance" remains unclear. Because as commonly known, the will of children and adolescents is quite changeable or very volatile (this is almost a characteristic of childhood and adolescence). It cannot be meant here that parents or legal guardians unquestioningly validate all expressions of their own child or adolescent, especially regarding the mentioned identity aspects and the changeable will of children and adolescents. Statements regarding an increased risk of potential suicidality are contradicted by current findings (see Ruuska et al., 2024). These findings indicate that suicidality is not significantly increased in affected individuals when adjusted for a potentially existing psychiatric diagnosis, and the administration of PB or CSH does not contribute to a reduction in suicidality in affected individuals (Ruuska et al., 2024). Furthermore, the findings of the new and final Cass Review (Cass, 2024), which contradict the corresponding statements, must also be taken into account. Therefore, this section of the current guideline draft is inaccurate and needs fundamental revision.

**Recommendation VI.K1:** Parents and caregivers should be informed that therapy attempts aimed at changing a child's sense of belonging to a gender contrary to their expressed feelings are harmful and unethical.

Comment and context: Upon closer examination, this recommendation, taken by itself, is not correct. Also, consider the new research findings from the Netherlands (Rawee et al., 2024):

Gender or gender dissatisfaction was most common at around 11 years of age in this study, and the frequency of this symptom decreased with age. Furthermore, three different trajectories regarding different developmental paths could be identified:

1. The clear majority (78% of the sample examined) consistently showed no further gender or gender dissatisfaction.

2. Another group showed gender or gender dissatisfaction in early adolescence but no longer in adulthood (19% of the sample).
3. Only a very small group (2% of the sample) showed a reverse development with increasing gender or gender dissatisfaction over the years.

Taken together, this means that only about 2% of the cohort researched in this study exhibited gender or gender dissatisfaction that persisted or increased in adulthood, which in turn means that 98% of the cohort studied did not show this symptomatology in adulthood (Rawee et al., 2024). In this context, also see our comments and evaluations regarding psychotherapy. Since this recommendation does not correspond to the facts and evidence, it needs fundamental revision.

**Recommendation VI.K2:** Parents and caregivers should be informed that for children and adolescents with gender incongruence, the safe and consistent experience of being accepted and supported by their own family is crucial for self-discovery and, depending on the course, for a favorable outcome of mental health during social coming-out, role experimentation, and transition.

**Comment and context:** For one part of the recommendation, see the comment and evaluation regarding Statement VI.E1. The other part of this recommendation is not in line with the current facts and evidence (see also the final Cass Review [Cass, 2024]).

**Recommendation VI.K3:** Parents and caregivers should be advised that in all developmental processes of gender-nonconforming children and adolescents, providing a safe social space for exploratory role exploration and, depending on the course, a safe social space for the potential future change of a lived gender role should be supported.

**Comment and context:** Analogous comment and assessment to Recommendation VI.K2.

**Recommendation VI.K4:** Parents and caregivers of gender-nonconforming children and adolescents should be informed about the offerings of parent groups from self-representation organizations as a possibility for networking and mutual support.

**Comment and context:** Analogous comment and assessment to Recommendation VI.K2. Considering the general intrinsic contradictions in the concept of GI and current findings
(Rawee et al., 2024; Cass, 2024), it is currently not estimable to what extent self-representation organizations, especially regarding vulnerable children and adolescents, adequately consider such important aspects (Rawee et al., 2024; Cass, 2024). Therefore, this recommendation needs fundamental revision.

**Recommendation VI.K5:** Parents and caregivers who present with their child due to the possible presence of gender incongruence or gender dysphoria should be offered professional process support with the goal of assisting the child, involving the family, in exploring their own gender identity and coping with possible psychosocial difficulties associated with gender incongruence or gender dysphoria.

**Comment and context:** Analogous comment and assessment to Recommendations VI.K1, VI.K2, and VI.K4.

**Recommendation VI.K6:** If the views and wishes of minors and their legal guardians regarding the family's handling of the non-conforming gender identity of the child or adolescent are not compatible, family system process support by an appropriate professional with family therapy expertise should be recommended with the aim of promoting an accepting and supportive attitude towards the child/adolescent's gender identity. Such process support is only recommended if no harmful effects on the child's health are expected.

**Comment and context:** See comments and assessment as with Recommendations VI.K1, VI.K2, and VI.K4. The one-sided consideration of a potential conflict situation as outlined here with the general requirement for legal guardians to uncritically and generally affirmatively accept and not question all expressions of a minor is not justifiable in light of previous contradictions (see above). Therefore, this recommendation needs thorough revision.

**Chapter VII - Indication for body-modifying medical interventions**

A recently updated systematic review on PB and CSH administration in children and adolescents with GD according to established NICE and Modified GRADE methodology, and thus exclusively considering studies whose quality was assessed using the widely recognized
PICO standard and deemed sufficient, was pre-published online in an open-access full-text version in the Journal of Child and Adolescent Psychiatry and Psychotherapy (ZKJPP, the official organ of the DGKJP) and came to the following conclusions (see Zepf et al., 2024 for a detailed summary of the evidence on the administration of PB and CSH in minors with GD):

- The evidence base regarding the administration of PB and/or CSH in minors with GD is currently very limited and based on few studies with inadequate methodology and quality. Controlled long-term studies are lacking.

- The current evidence does not reliably demonstrate, according to PICO criteria and Modified GRADE methodology, that GD and mental health significantly improve over time with PB and/or CSH administration in minors.

- There is currently no evidence for the potential cost-effectiveness of GnRH analogues in children/adolescents with GD compared to one or more psychosocial supports, social transition to the preferred gender, or no intervention.

- If PB and CSH should be used in minors with GD after a completed, thorough, and comprehensive child and adolescent psychiatric diagnostic assessment, careful consideration and weighing of the probabilities of potential benefits and harms of watchful waiting, different interventions regarding GD and possibly accompanying mental health problems or disorders, such an approach could contribute to further knowledge gain and provide important data within the framework of research projects or clinical studies, for example as currently practiced in England.

These conclusions largely align with other relevant and high-ranking international publications (Cass, 2024; NICE 2020a/b; Thompson et al., 2023). In this particular context, an important new study from Finland should also be mentioned, which clearly demonstrated that GD per se does not influence the general mortality as well as the suicide-related mortality in minors with GD (Ruuska et al., 2024). Rather, the main predictor for mortality in this population was psychiatric morbidity. Medical measures in the form of "medical gender reassignment," hormonal or surgical, had no influence on the suicide risk of the affected individuals (Ruuska
et al., 2024). Thus, a significant argument often brought forward by proponents of potentially irreversible somatomedical measures, here in terms of possibly increased suicide risk if medical measures to change appearance to the desired one in minors with GD were omitted, can be substantially weakened or clearly refuted in essential points.

Below, the individual recommendations regarding potentially irreversible somatomedical interventions in minors with GD (administration of PB, administration of CSH, surgical interventions) of the current draft guideline are listed and commented on or categorized according to the respective evidence and knowledge base.

Before listing the recommendations, the current draft guideline contains the following statement:

**Statement VII.E1:** There is evidence from uncontrolled follow-up studies that patients diagnosed with persistent gender dysphoria in adolescence, who receive a staged body-modifying treatment in connection with socially supported transition, show long-term improvement in quality of life and mental health in adulthood → low level of evidence (2 studies with different cohorts from the same center) → References: Cohen-Kettenis & van Goozen, 1997; de Vries et al., 2014.

**Comment and context:** Taken alone, this claim or assumption is not scientifically tenable in this particular form. None of the studies mentioned here (Cohen-Kettenis & van Goozen, 1997; de Vries et al., 2014) have been considered in the context of recent high-ranking and high-quality NICE reviews (NICE 2020a/b) as well as relevant topic-specific follow-up analyses with NICE or Modified GRADE methodology (Zepf et al., 2024) since they both have significant flaws and do not meet minimum standards such as minimal PICO criteria. The current review articles (NICE 2020a/b; Thompson et al., 2023; Zepf et al., 2024) refute the assumption articulated here while maintaining appropriate minimum standards (PICO, NICE, Modified GRADE). Therefore, from the perspective of the authors of the present commentary, this statement should be removed or fundamentally revised.
Following is the statement regarding "Consensus-based recommendations":

**Recommendation VII.K0:** Specialized expertise and several years of experience in guiding the process and treating adolescents with gender incongruence are required for proper indication. Professionals without sufficient specific knowledge and experience in this area should consult an adequately experienced professional or a specialized outpatient clinic or treatment center to ensure professional confirmation of indication.

**Comment and context:** Once again, in the current draft guideline, the term "indication" is used in a misleading manner. Medical indication refers to the proven, sufficiently justified reason for a diagnostic or therapeutic intervention or measure in an affected individual. This intervention or measure must be actually and demonstrably appropriate or justified for a specific clinical condition based on medical evidence (analogous to the definition of the term "indication" according to Psychrembel online, 2024: "Criterion for the sufficiently justified application of a specific clinical procedure, drug, or therapy, with the basic obligation to inform the patient"). Therefore, the term "indication" used here is not appropriate in the current context and should be removed. From the perspective of the authors of the present commentary, the current evidence base, at least regarding the administration of PB and CSH in minors with GD, does not justify such an indication in most cases.

Furthermore, it is unclear what is meant by "specialized expertise" at this point. It is also not apparent whether the term "specialized expertise" implies knowledge of the actual current evidence base (including the works of Bachmann et al., 2024; Cass, 2024; Jorgensen et al., 2024; NICE 2020a/b; Rawee et al., 2024; Ruuska et al., 2024; Thompson et al., 2024; Zepf et al., 2024) on the topic at hand. If so, this recommendation would undermine other measures or interventions outlined in the current draft guideline, as many of the approaches outlined therein clearly contradict the current evidence base. From the perspective of the authors of the present commentary, the wordings that use the term "indication" should be removed without replacement, and the term "specialized expertise" should be more precisely defined. In the United Kingdom (UK), it is now required that a case-by-case decision be made by a multi-professional team (MPT), and somatomedical measures, such as puberty blockage, should only be carried out in a research context (see the current and final Cass review, [Cass, 2024]).
In Scotland, the Sandyford Clinic in Glasgow has stated that new clients seeking help aged 16 or 17 yrs. will not receive further PB until the age of 18 yrs. (BBC, 2024). Also, based on experiences from the USA and the UK, the authors of the present commentary believe that it is urgently necessary that individual, potentially self-appointed "professionals" or experts do not make this decision. An experienced MPT is currently considered the best standard within the context of child and adolescent psychiatric, psychosomatic, and psychotherapeutic diagnostics – according to Cass (2024), especially in the context of GI or GD.

Furthermore, there are new findings showing a significant harmful effect of puberty blockage on various testicular cell types in minors with GD (Murugesh et al., 2024).

**Specific Recommendations for Puberty Blockage**

**Recommendation VII.K1:** Indication for puberty blockade in adolescents with GI/GD should be dual-track and require interdisciplinary expertise and cooperation. A prerequisite for this indication is a child and adolescent psychiatric or psychological diagnostic assessment appropriate to the urgency and complexity of the individual situation. The somatomedical aspect of the indication should be contributed to by an experienced pediatric endocrinologist in terms of its prerequisites (pubertal stage of development, absence of somatic contraindications, etc.).

**Comment and context:** This recommendation disregards the current evidence base for the administration of PB in minors with GD (see Cass, 2024; NICE 2020a/b; Thompson et al., 2023; Zepf et al., 2024). There is currently no solid evidence that the GD symptoms and/or mental health of affected minors significantly and sustainably improve with PB administration (NICE 2020a/b; Thompson et al., 2023; Zepf et al., 2024). The studies presented by the authors of the current draft guideline were not considered in the last two NICE reviews (2020a/b) and relevant NICE- and Modified GRADE-based follow-up research (Zepf et al., 2024) due to significant qualitative deficiencies. Therefore, this recommendation should be removed or fundamentally revised.
**Recommendation VII.K2:** Here, the formal requirements for the expertise of individuals who provide the child and adolescent psychiatric-psychological-psychotherapeutic part of the indication for puberty blockage in adolescents with GI/GD are listed. The expertise of individuals who provide the child and adolescent psychiatric-psychological-psychotherapeutic part of the indication for puberty blockage in adolescents with GI/GD should meet the following formal requirements: specialist qualification in child and adolescent psychiatry and psychotherapy - specialist qualification in pediatrics with additional qualification in psychotherapy, license for child and adolescent psychotherapy.

**Comment and classification:** The term "indication" should be removed for the reasons stated above (see comment on Recommendation VII.K0. including evidence regarding puberty blockage in minors with GD). MPTs continue to be the highest standard in the field concerned here for gathering information and assessments regarding the symptoms of distressed children and adolescents and thus should be referred to as the "gold standard." Under no circumstances should a decision be made solely by one professional.

**Recommendation VII.K3:** The prerequisite for the indication of puberty blockage should be the presence of stable/persistent gender incongruence after the onset of puberty (according to the diagnostic criteria of GI in adolescence/ICD-11 HA60) with existing gender dysphoric distress. The diagnostic assessment should be carried out in collaboration between the psychiatric-psychological professional, the patients, and their legal guardians/caregivers based on careful exploration of the psychological findings and life history.

**Comment and context:** The term "indication" should be removed for the reasons stated above (see comment on Recommendation VII.K0. including evidence regarding puberty blockage in minors with GD). Furthermore, it remains unclear what exactly is meant by "stable" or "persistent." There is an urgent need for clarification, even though the terms "stable" and "persistent" are fundamentally derived from and translated formulations of the ICD-11. In the diagnostic assessment "... as a prerequisite for the indication of puberty blockage..." the condition "should" is used. It remains unclear how this should be justified, as there is a global consensus that considerations for the administration of PB – if considered at all for minors for non-somatic reasons – must start from a diagnosed GD. The current formulation of this
recommendation carries the risk of circumventing the collaborative approach intended by the text involving the stakeholders mentioned in this particular recommendation. Furthermore, the term "existing gender dysphoric distress" requires a precise definition, especially in differentiation from other subjective distresses experienced possibly concurrently, symptoms of possibly accompanying mental disorders, and their respective causes, manifestations, and presentations. See also our comment or assessment regarding the role of an MPT.

**Recommendation VII.K4:** In individual cases, the progressing pubertal development may create time pressure, where to prevent irreversible bodily changes (e.g., male voice change, female breast growth), puberty blockage can be initiated promptly with provisional indication if the implementation of a child and adolescent psychiatric-psychotherapeutic (CAP) process guidance for indication would entail an unreasonable delay. In such a justified case, a diagnostic CAP process guidance to secure the indication should be carried out promptly afterward.

**Comment and context:** The term "indication" should be removed for the reasons stated above (see comment on Recommendation VII.K0. including evidence regarding puberty blockage in minors with GD). Furthermore, it remains unclear what constitutes "an unreasonable delay" in this context, and who can or should assess or determine this based on which criteria. What is a justifiable delay in this context, and what is meant by an unreasonable delay? In the light of the current evidence base regarding puberty blockage in minors with GD (Cass, 2024; NICE 2020a/b; Thompson et al., 2023; Zepf et al., 2024), it is generally questionable how (and if) "securing the indication" for this measure can be done according to which mode. However, it is agreed that in rare individual cases, after extremely critical consideration, puberty blockage in minors with GD may be considered after treating any existing mental disorders, and in such cases, it may be advisable to consult a clinical ethics committee. In these cases, there is no clear medical indication in the classical medical sense (see comment above on Recommendation VII.K0.), but rather it concerns the medical justifiability on a case-by-case basis after a profound individual risk-benefit assessment and after completing a child and adolescent psychiatric diagnostic assessment and treatment for any accompanying mental disorders. A pediatric endocrinological decision with the use of endocrinological treatments in this specific context without conducting child and adolescent psychiatric-psychotherapeutic
diagnostics and process guidance can cause irreversible mental and physical harm and thus constitutes a potential risk to child welfare. Therefore, this recommendation in its current form is to be rejected.

**Recommendation VII.K5:** The indication for puberty blockage in adolescents with gender incongruence or gender dysphoria should be made independent of a binary sense of belonging to a specific gender and independent of sexual orientation.

**Comment:** The term "indication" should be removed for the reasons stated above (see comment on Recommendation VII.K0.). See also our comments on binary concepts related to biological sex in section II of this commentary.

**Recommendation VII.K6:** The indication for puberty blockage in adolescents with gender incongruence or gender dysphoria should not be made before Tanner stage 2.

**Comment:** The term "indication" should be removed for the reasons stated above (see comment on Recommendation VII.K0. including evidence regarding puberty blockage in minors with GD). Furthermore, it is noted that Tanner stage 2 represents a very early stage of puberty, meaning in reality, this would include minors as young as approximately 10.5-11 years old (spanning approximately 8-13 years; Girls: Breast buds begin to develop, and breast tissue becomes palpable; Boys: First onset of testicular enlargement). Considering the current evidence base (Cass, 2024; NICE 2020a/b; Zepf et al., 2024; Cass, 2024), there is currently no established evidence for this approach. Therefore, this recommendation, in its current form, is not scientifically and clinically justifiable.

**Recommendation VII.K7:** The indication for puberty blockage can be made at a later stage of puberty if desired. This may be appropriate for minors without an indication for gender-affirming hormone treatment to provide time for decision-making regarding further treatment steps and to alleviate distress.

**Comment and context:** The term "indication" should be removed for the reasons stated above (see comment on Recommendation VII.K0. including evidence regarding puberty blockage in minors with GD). Furthermore, it is critically noted that puberty blockage does not, as claimed
here, buy time, as this measure often leads to further interventions in many cases (Brik et al., 2020; Carmichael et al., 2021; Chen et al., 2023; de Vries et al., 2011). Additionally, the peers of individuals undergoing puberty blockage continue to progress through puberty, potentially leading to increased social isolation and additional distress. Moreover, the term "gender-affirming" may be perceived by some readers as a linguistic euphemism for potentially irreversible somatic medical interventions without clear evidence for their safe benefit concerning GD or mental health (NICE 2020a/b; Zepf et al., 2024), especially concerning PB and CSH. The commonly used term "affirming" implies a certain normalization, which may not be justified, particularly in the context of potentially irreversible somatic medical interventions in physically healthy minors. It is pertinent to clarify that the term "affirming" refers to the subjective self-description of identity experiences by minors with GD, which may change over time, particularly considering the presence of accompanying psychopathology.

Current research from Germany demonstrates overall weak stability of the diagnosis in question (Bachmann et al., 2024). In this new study by Bachmann and colleagues (2024), a ten-year increase in the prevalence of F64 diagnoses was shown in insured individuals aged 5–24 years, with the prevalence likely underestimated due to the absence of inpatient and outpatient data. Possible reasons for the increased frequency of F64 diagnoses (e.g., real prevalence increase, increased awareness, decreased stigma, improved healthcare, social contagion, overdiagnosis) could not be determined. The diagnosis persistence under 50% in all age groups in the five-year follow-up likely reflects the fluidity or variability of the concept of gender identity in childhood and adolescence. This new German study is complemented by other recent data from the Netherlands, which reveal the following trends regarding the course of such symptoms in a study with over 2,700 participants (Rawee et al., 2024):

- Gender dissatisfaction was most common around the age of 11, decreasing with age.

- Three different trajectories regarding the development were identified:

  1. The clear majority (78% of the sample) consistently showed no further gender dissatisfaction.
2. Another group experienced gender dissatisfaction in early adolescence but not in adulthood (19% of the sample).

3. Only a very small group (2% of the sample) exhibited increased gender dissatisfaction over time.

Taken together, these findings indicate that only about 2% of the cohort examined in this study exhibited ongoing or increased gender dissatisfaction in adulthood, while 98% did not exhibit this symptomatology in adulthood (Rawee et al., 2024). In the light of such findings, it is problematic to make assumptions about the unequivocal existence of a fundamental, innate "identitarian disposition" or a "primarily ubiquitous identity" that persists indefinitely and unchangeably, especially in minors concerning gender and their own experiences (see again Section II of this commentary). Such an assumption lacks empirical support. If an innate and enduring identity were indeed empirically demonstrable, its limits would need to be clearly defined (i.e., which aspects of identity are innately determined and to what extent, and which are not). However, this is not feasible. Throughout the current draft guidelines, there is no indication of the theoretical identity model or concept used in each argument or recommendation, or how these aspects of "identity" or "gender identity" may change or occur depending on the life and developmental phase, and to what extent, based on other variables, or not change. Therefore, there is a lack of an evidence-based conceptual framework regarding the definition of "identity" or "gender identity" in affected minors.

Such an empirically unverifiable "primary ubiquitous identity," which necessarily leads to or could lead to GD in such cases, and if it actually exists, should primarily be altered through potentially irreversible somatic medical measures because identity, according to such considerations, is an expression of one's own individual human nature, should not be the basis for such drastic, potentially irreversible somatic medical interventions in physically healthy minors without clear evidence of their safe clinical benefit or long-term safe benefit. Any supportive psychotherapy that might occur would thus be suspected of following the principles of so-called "conversion therapy" if the "feeling of being in the wrong body" itself became the subject of therapy. Ultimately, such a view arises from a fundamentally naturalistic perspective of the species Homo sapiens. It is widely known that humans, unlike animals, interpret themselves and can, in most cases, reflect on themselves to a greater or
lesser extent at various times (sometimes even differently at each time). Such reflective thoughts and individually perceived feelings cannot be understood as causally determined in self-interpretation, especially in minors in development, both with and without any accompanying psychopathology. Otherwise, a critically important element in terms of subjective knowledge gain and personal behavior modification following self-reflection, present in almost all established and recognized psychotherapy methods used in other conditions with potential psychological distress according to existing guidelines from our own and neighboring disciplines dealing with mental disorders, would be negated. This is particularly true if one does not understand the species Homo sapiens as a "biological apparatus" in which no self-change through reflection is possible and which would be entirely determined by, for example, genes or their expression, gene-environment interactions, and even the environment itself.

From the perspective of the authors of this commentary, the term "gender-affirming," despite all understanding and goodwill towards those affected, should not be used in any context within the current draft guidelines, and should be replaced, for example, with a non-discriminatory, non-stigmatizing, and at the same time factual-descriptive term such as "to alter outward appearance visually." Ultimately, all somatomedical measures outlined in the current draft guidelines aim to change the appearance according to a subjective (potentially only temporary) ideal among minors with primarily physiologically healthy bodies, with an actual change of biological sex (here then in the sense of altering the fundamental predisposition of the body's ability, for biologically born females after a change, to produce sperm, or for biologically born males, the fundamental interpretation of the body after its change for the ability to produce human egg cells for a part of life) not being medically possible according to current knowledge. However, the linguistic expression of "alignment" leads to such a scientifically unfounded assumption, and this should be avoided at all costs in the interest of the affected minors in the current draft guidelines and should not be used at any point.

**Recommendation VII.K8:** A previously initiated or completed social role change should not be considered as a necessary criterion in the assessment for puberty suppression.
Commentary and context: The term "assessment" should be removed for the reasons mentioned above (see comment on Recommendation VII.K0. regarding evidence regarding puberty suppression in minors with GD). The removal of this criterion poses a particular danger, as it may lead to temporary, extremely fleeting "identity states" (potentially temporally and also contextually circumscribed or limited), which may occur due to other mental disorders that cannot be identified without appropriate child and adolescent psychiatric diagnostics, serving as the basis for deriving medically irreversible measures (cf. Bachmann et al., 2024; Rawee et al., 2024).

Recommendation VII.K9: Before considering puberty-blocking treatment with GnRH analogs in adolescents, discussions with the patient and caregivers regarding the potential effects of the treatment on future fertility, as well as potential future gender-affirming somatic medical treatment steps, should take place. They should be informed about the possibilities of fertility-preserving medical measures and provided access to specialized counseling for this purpose. The assessment for puberty suppression should include an evaluation of the patient's capacity to consent (D) / capacity to judge (CH) / decision-making capacity (A) by a child and adolescent psychiatric or psychological specialist. In cases of insufficient capacity to consent / capacity to judge / decision-making capacity, the minor should be supported in acquiring these abilities.

Comments and context: The term "assessment" should be removed for the reasons mentioned above (see comment on Recommendation VII.K0. regarding evidence regarding puberty suppression in minors with GD). Furthermore, it is unclear why the softened "should" wording was chosen regarding the effects of the measures in question, rather than a wording associated with higher recommendation level in accordance with the German guideline assessment tool (Deutsches Leitlinien-Bewertungsinstrument, DELBI). The same question arises regarding wording related to the assessment of consent capacity. Moreover, it is not apparent how informed consent for the administration of PB can be obtained in minors with GD given the current evidence, especially when this issue is currently highly controversial even within the informed medical community and there is no clear evidence for a sustained and significant clinical benefit of PB administration regarding target variables such as GD itself or mental health.
At this point, it is worth asking: Can affected and burdened physically healthy minors, potentially also in a crisis situation with or without accompanying psychopathology, consent to potentially irreversible somatic medical interventions for which there is no clear and unequivocal evidence of a significant and sustainable improvement in GD or mental health? From the perspective of the authors of this commentary, such an attempt to obtain informed consent from the affected minors would fail already at the term "informed," as the actual and assured information regarding any potential benefits is currently not available and not supported by solid medical evidence for these measures in question. In many cases abroad, the administration of PB is being scaled back (see, for example, the analysis of the Scientific Services of the German Bundestag, 2023). The mention of enabling specialized counseling regarding fertility-preserving measures initially implies protection of the affected individuals from irreversible consequences, but it is misleading as there are currently no established minimum standards for fertility counseling in minors with GD in Germany. The sentence "In cases of insufficient capacity to consent / capacity to judge / decision-making capacity, the minor should be supported in acquiring these abilities." falsely suggests that such capacity to consent could be achieved in most minors with sufficient effort within a more or less manageable timeframe. The current draft guidelines lack clear guidance on how a thorough fertility counseling for minors with GD can be conducted based on evidence, and how these affected individuals can provide informed consent in the context of the current evidence, especially with potentially accompanying psychopathology, which can further complicate the burden on the affected individuals. Established minimum standards for fertility counseling in minors with GD are not available in Germany.

**Recommendation VII.K10:** If there is capacity to consent (D) / capacity to judge (CH) / decision-making capacity (A) in the minor, a consensus among caregivers should be sought.

**Comments and context:** Please refer to the commentary and context regarding Recommendation VII.K9. From the perspective of the authors of this commentary, a clear consensus cannot be reached, as most affected minors with GD (with or without accompanying psychopathology) cannot provide clear, sufficiently informed consent in the context of the current evidence (see above remarks). Furthermore, it raises the question why a wording associated with higher recommendation level in accordance with the German
guideline assessment tool (Deutsches Leitlinien-Bewertungsinstrument, DELBI) when aiming for consensus among caregivers was not chosen.

**Recommendation VII.K11:** In cases where there is no consensus between the patient and caregivers, intensive process support of the family system by a suitable professional with family therapy expertise should\(^a\) be offered with the aim of enabling support for the patient. Such process support is only recommended if it is not expected to have harmful effects on the patient's health/mental well-being. In such cases, an assessment of the child's welfare is indicated.

**Comments and context:** Please refer to the comments and contexts regarding Recommendations VII.K9 and VII.K10, including evidence regarding puberty suppression in minors with GD. The term "process support" should be further clarified, as the definition in the glossary of the current draft guidelines is not sufficiently precise and not specifically outlined. Affected minors with GD (with or without accompanying psychopathology) generally cannot provide clear informed consent for such measures in the context of the current evidence (see above remarks). It also remains unclear what is meant by "child welfare" specifically in the context of this recommendation, or what approach in such a case would be most in line with the welfare of the child regarding GD and potential desired changes in outward appearance. Furthermore, it remains unclear who defines child welfare according to what standards or criteria. Therefore, this recommendation, in its current form, is to be rejected as it contains too many ambiguities that cannot be sufficiently resolved.

**Recommendation VII.K12:** The indication for gender-affirming hormone treatment in adolescents with gender incongruence or gender dysphoria should\(^a\) be approached in a dual-track manner and requires interdisciplinary expertise and cooperation. A prerequisite for indication is a psychiatric or psychotherapeutic diagnostic assessment appropriate to the urgency and complexity of the individual situation. The somatic aspect of the indication should\(^a\) be conducted by an experienced endocrinologist with expertise in treating adolescents, considering factors such as pubertal stage of development, absence of somatic contraindications, etc.
**Comments and context:** The term "indication" should be removed for the reasons mentioned above (see comment on Recommendation VII.K0 regarding evidence regarding hormone treatment in minors with GD). For evidence-based reasons, this recommendation, in its current formulation, is to be rejected. Once again, there is a question why a wording associated with higher recommendation level in accordance with the German guideline assessment tool (Deutsches Leitlinien-Bewertungsinstrument, DELBI) was not chosen here. Furthermore, the term "gender-affirming" is also to be rejected for the reasons mentioned above.

**Recommendation VII.K13:** The expertise of individuals responsible for the psychiatric-psychological-psychotherapeutic part of the indication for gender-affirming hormone treatment in adolescents with gender incongruence/gender dysphoria should meet the following formal requirements:

*One of the following specific qualifications for childhood and adolescence:*

**D:** Specialist designation in child and adolescent psychiatry and psychotherapy or specialist designation in pediatrics with additional qualification in psychotherapy or license for child and adolescent psychotherapy;

**CH:** Specialist title in child and adolescent psychiatry and psychotherapy (Foederatio Medicorum Helveticorum/FMH) or federally recognized psychotherapist;

**A:** Specialist in child and adolescent psychiatry or specialist in child and adolescent psychiatry and psychotherapeutic medicine or registration as a psychotherapist with further training in infant, child, and adolescent psychotherapy;

Alternatively, with corresponding clinical expertise in the diagnosis and treatment of children and adolescents:

**D:** Specialist designation in psychiatry and psychotherapy, psychotherapeutic medicine, or psychosomatic medicine and psychotherapy or license for psychological psychotherapy;
CH: Specialist title in psychiatry and psychotherapy (FMH);

A: Specialist in psychiatry and psychotherapeutic medicine or specialist in psychiatry and neurology or registration as a psychotherapist, registration as a clinical psychologist.

Comments and context: The term "indication" should be removed for the reasons mentioned above (see comment on Recommendation VII.K0 regarding evidence regarding hormone treatment in minors with GD). The term "gender-affirming" is also to be rejected for the reasons mentioned above. For evidence-based reasons, this recommendation, in its current formulation, is to be rejected.

Recommendation VII.K14: A prerequisite for indicating gender-affirming hormone treatment should be the presence of stable/persistent gender incongruence (according to the diagnostic criteria of gender incongruence in adolescence/ICD-11 HA60) with the onset or increased distress of gender dysphoria after puberty and the accompanying desire for the expected gender-specific physical changes resulting from hormone treatment. The diagnostic assessment should be conducted collaboratively between a psychiatric-psychological specialist and the patients and their caregivers/significant others, based on the exploration of psychological findings and life history.

Comments and context: The term "indication" should be removed for the reasons mentioned above (see comment on Recommendation VII.K0 regarding evidence regarding hormone treatment in minors with GD). It is also unclear what constitutes "stable" or "persistent" (see above remarks). See also our commentary or assessment regarding the role of an MDT as the best standard in the context of comprehensive diagnostic assessment. The term "gender-affirming" is also to be rejected here for the reasons mentioned above. For evidence-based reasons, this recommendation, in its current formulation, is to be rejected.

Recommendation VII.K15: The indication for gender-affirming hormone treatment should be made regardless of the polarity or binary nature of gender identity and regardless of the sexual orientation of the patients.
Comments and context: The term "indication" should be removed for the reasons mentioned above (see comment on Recommendation VII.K0 regarding evidence regarding hormone treatment in minors with GD). The term "gender-affirming" is also to be rejected for the reasons mentioned above. Furthermore, reference to aspects of binary nature in Section II of this commentary.

**Recommendation VII.K16:** The indication for gender-affirming hormone treatment in adolescents should not assume that puberty suppression has been previously conducted.

Comments and context: The term "indication" should be removed for the reasons mentioned above (see comment on Recommendation VII.K0 regarding evidence regarding hormone treatment in minors with GD). The term "gender-affirming" is also to be rejected for the reasons mentioned above. For evidence-based reasons, this recommendation, in its current formulation, is to be rejected.

**Recommendation VII.K17:** To prepare for gender-affirming hormone treatment, a social trial of the desired gender role should be conducted, provided it is compatible with anti-discrimination protection. In cases where social support from the environment is insufficient, psychotherapeutic support should be offered for the transition process.

Comments and context: It is worth noting that the term "gender-affirming hormone treatment" (referring to hormone therapy) is generally to be rejected (see previous remarks). Regarding the outlined psychotherapeutic support, it's important to mention that within psychotherapy, the principle of abstinence applies. It is not the task of medical professionals in therapy to unquestionably and unconditionally affirm individuals in all aspects. Critically questioning potential motivations or motives is an essential part of all currently established diagnostic and psychotherapeutic procedures. Thus, the current guideline contradicts essential therapeutic principles.

On pages 95-96 of the current guideline draft, the following statement regarding therapeutic principles is found: "We have refrained from providing consensus-based specific recommendations on therapeutic attitude, as this ultimately lies within the reflective self-
responsibility of each psychotherapeutic professional and cannot and should not be regulated by a guideline."

In the view of the commentators, such a statement cannot be used as a basis to partially or fundamentally circumvent established therapeutic principles within a guideline context or to not consider them. Furthermore, the question arises as to why a "should" formulation was not chosen here.

**Recommendation VII.K18:** If there is a coincident mental disorder beyond gender dysphoria that interferes with gender-affirming hormone treatment, an appropriate psychiatric-psychotherapeutic intervention should be recommended and offered within an integrated or networked treatment concept. Treatment steps should be prioritized in dialogue with the patient.

**Comments and context:** The term "indication" should be removed for the reasons mentioned above (see comment on Recommendation VII.K0 regarding evidence regarding hormone treatment in minors with GD). Furthermore, the question arises here as well why a wording associated with higher recommendation level in accordance with the German guideline assessment tool (Deutsches Leitlinien-Bewertungsinstrument, DELBI) was not chosen here. The term "gender-affirming" is also to be rejected for the reasons mentioned above.

**Recommendation VII.K19:** Before indicating gender-affirming hormone treatment in adolescence, adolescents and their legal guardians should be informed about the potential effects of treatment on sexuality, fertility, relationship experiences, body experiences, possible experiences of discrimination, and other gender-affirming body-modifying treatment steps. They should also be informed about the options for fertility-preserving medical measures and provided access to specialized counseling for this purpose.

**Comments and context:** The term "indication" should be removed for the reasons mentioned above (see comment on Recommendation VII.K0 regarding evidence regarding hormone treatment in minors with GD). Furthermore, this recommendation gives the false impression that obtaining informed consent regarding the points concerned can be determined without
major problems for all affected minors. The term "gender-affirming" should also be rejected for the reasons mentioned above. Moreover, the effects on the aspects outlined here (sexuality, fertility, relationship experiences, body experiences, possible experiences of discrimination, and other gender-affirming body-modifying treatment steps) are not fully or adequately researched. Therefore, it cannot be adequately and especially not informed about in a manner appropriate for children. New research findings indicate that hormone treatment was associated with increased BMI and insulin resistance in individuals with GI/GD. Individuals undergoing male-to-female transition (biologically male at birth) showed a higher susceptibility to insulin resistance compared to those undergoing female-to-male transition (biologically female at birth) (Panday et al., 2024).

**Recommendation VII.K20:** The psychiatric-psychotherapeutic part of the indication for gender-affirming hormone treatment should include an assessment of the minor’s capacity for consent (D) / judgment (CH) / decision-making (A) - regarding the specifically planned treatment - by the indicating specialist. In case of insufficient capacity for consent / judgment / decision-making, the minor should be supported in acquiring this capacity.

**Comments and context:** The term "indication" should be removed for the reasons mentioned above (see comment on Recommendation VII.K0 regarding evidence regarding hormone treatment in minors with GD). Furthermore, this recommendation gives the false impression that obtaining informed consent regarding the points concerned can be determined without major problems for all affected minors and falsely suggests that such capacity for consent can be established in most minors with sufficient effort in a more or less manageable period. See also further comments above regarding informed consent. The term "gender-affirming" should also be rejected for the reasons mentioned above.

**Recommendation VII.K21:** In case of the minor’s capacity for consent (D) / judgment (CH) / decision-making (A) regarding the implementation of gender-affirming hormone treatment, a consensus among the legal guardians should be sought.

**Comments and context:** See also the commentary and assessment of Recommendation VII.K9, including the evidence regarding hormone treatment in minors with GD. From the
perspective of the authors of this commentary, a clear consensus cannot be reached because all affected minors with GD (with or without accompanying psychopathology) typically cannot provide clear informed consent in the current evidence context (see above comments). Furthermore, the question arises why a wording associated with higher recommendation level in accordance with the German guideline assessment tool (Deutsches Leitlinien-Bewertungsinstrument, DELBI) was not chosen here. The term "gender-affirming" should also be rejected for the reasons mentioned above.

**Recommendation VII.K22:** In cases where there is no consensus between the patient and legal guardians, intensive process support for the family system should be offered by a qualified professional with expertise in family therapy, aiming to support the patient. Such process support is only recommended if no harmful effects on the patient's health/psychological well-being are expected. In such cases, an assessment of the child's welfare is indicated.

**Comments and context:** See also the comments and assessments of Recommendations VII.K9, VII.K10, and VII.K11, including evidence regarding hormone treatment in minors with GD. Affected minors with GD (with or without accompanying psychopathology) typically cannot provide clear informed consent for such measures in the current evidence context (see above comments). It remains unclear what is meant by "child welfare" specifically in the context of this recommendation, or what would best serve the child's welfare regarding GD and potentially desired changes in external appearance. Furthermore, it is unclear who determines child welfare in this particular context according to which standards or criteria. Therefore, this recommendation, in its current form, is medically untenable and should be rejected due to too many uncertainties that are not sufficiently resolved.

**Specific recommendations regarding so-called "gender-affirming" surgeries in adolescence:**

**Recommendation VII.K23:** The assessment for gender-affirming mastectomy or breast reduction surgery in adolescents with gender incongruence or gender dysphoria should be approached from two angles and requires interdisciplinary expertise and collaboration. A prerequisite for assessment is an appropriate psychiatric or psychotherapeutic diagnostic evaluation considering the urgency and complexity of the individual situation. The somatic
aspect of the assessment should be conducted by an experienced specialist in operative medicine regarding its prerequisites.

**Comments and context:** The term "assessment" should be substituted for "indication assessment" for the reasons mentioned above. Due to evidence-based and conceptual reasons (lack of persistence of GD diagnosis or related symptoms in many cases, see Bachmann et al., 2024; Rawee et al., 2024), this recommendation in its current formulation is rejected.

**Recommendation VII.K24:** The qualification of professionals for the psychiatric-psychological-psychotherapeutic part of the assessment for gender-affirming mastectomy or breast reduction (or possibly genital-affirming) surgery in adolescents with GI/GD should meet the following requirements: One of the following qualifications specific to childhood and adolescence: D: Specialist title in child and adolescent psychiatry and psychotherapy or specialist title in pediatrics with additional qualification in psychotherapy or license for child and adolescent psychotherapy; CH: Specialist title in child and adolescent psychiatry and psychotherapy (Foederatio Medicorum Helveticorum/FMH) or federally recognized psychotherapist; A: Specialist in child and adolescent psychiatry or specialist in child and adolescent psychiatry and psychotherapeutic medicine or registration as a psychotherapist with further training in infant, child, and adolescent psychotherapy; Alternatively, with appropriate clinical expertise in the diagnosis and treatment of children and adolescents: D: Specialist title in psychiatry and psychotherapy, psychotherapeutic medicine, or psychosomatic medicine and psychotherapy or license for psychological psychotherapy; CH: Specialist title in psychiatry and psychotherapy (FMH); A: Specialist in psychiatry and psychotherapeutic medicine or specialist in psychiatry and neurology or registration as a psychotherapist, registration as a clinical psychologist.

**Comments and context:** Analogous commentary to Recommendation VII.K23.

**Recommendation VII.K25:** A prerequisite for indicating surgical breast removal or reduction (or possibly genital-affirming) surgery should be the presence of stable/persistent gender incongruence (according to the diagnostic criteria of GI in adolescence/ICD-11 HA60) with
gender dysphoria-associated distress coupled with a clear desire for a change in the organ or characteristic to be operated on. The assessment of the stability/persistence of gender incongruence and the treatment desire should\textsuperscript{a} be conducted through collaboration between psychiatric-psychological professionals together with the patients and their caregivers based on careful exploration of psychological findings and life history.

Comments and context: Analogous commentary to Recommendation VII.K23. The terms "stable" and "persistent" are not clearly defined (see above explanations). Furthermore, the question arises here as well why "must" formulations were not chosen. The term "gender-affirming" should also be rejected for the reasons mentioned above.

Recommendation VII.K26: The indication for gender-affirming mastectomy or breast reduction should\textsuperscript{a} be made independent of the polarity or binary nature of gender identity and regardless of sexual orientation.

Comments and context: Analogous commentary to Recommendation VII.K23.

Recommendation VII.K27: Prior to undergoing gender-affirming mastectomy or breast reduction surgery in adolescents with gender incongruence or gender dysphoria, a social trial of the desired gender role should\textsuperscript{a} be conducted, provided it is compatible with anti-discrimination laws. In cases where social support from the environment is insufficient, psychotherapeutic support should\textsuperscript{a} be offered during the transition process.

Comments and context: Analogous commentary to Recommendation VII.K23. Additionally, the question arises here as well why a wording associated with higher recommendation level in accordance with the German guideline assessment tool (Deutsches Leitlinien-Bewertungsinstrument, DELBI) was not chosen here. The term "gender-affirming" should also be rejected for the reasons mentioned above.

Recommendation VII.K28: If gender-affirming hormone therapy is already being administered, a period of at least 6 months for reflection on the experiences gained should\textsuperscript{a} be
recommended before proceeding with subsequent gender-affirming mastectomy or breast reduction.

**Comments and context:** Analogous commentary to Recommendation VII.K23. This recommendation pertains to two consecutive, potentially irreversible somatic medical interventions in physically healthy minors, for both of which there is no clear basis (e.g., low stability of GD diagnosis or related symptoms, see Bachmann et al., 2024; Rawee et al., 2024; see also Cass, 2024) and insufficient medically established evidence. The question also arises here why a wording associated with higher recommendation level in accordance with the German guideline assessment tool (Deutsches Leitlinien-Bewertungsinstrument, DELBI) was not chosen. The term "gender-affirming" should be rejected for the reasons mentioned above.

**Recommendation VII.K29:** In justified individual cases, gender-affirming mastectomy or breast-reducing surgery may be considered in adolescents with gender incongruence or gender dysphoria without prior gender-affirming hormone therapy.

**Comments and context:** Analogous commentary to Recommendation VII.K23. Current evidence does not support the general application of the measures described here in minors with GD. The term "gender-affirming" should also be rejected for the reasons mentioned above.

**Recommendation VII.K30:** If there is a concurrent psychiatric disorder beyond gender dysphoric distress that interferes with the treatment before indicating gender-affirming mastectomy or breast reduction, a specialized psychiatric-psychotherapeutic intervention should be recommended within an integrated or networked treatment concept.

**Comments and context:** The term "indication" should be omitted for the reasons mentioned above (see comment on Recommendation VII.K0). Likewise, the term "gender-affirming" should be omitted for the reasons mentioned above. Concurrent psychiatric disorders or symptoms should be diagnosed and treated based on evidence. Furthermore, the question arises here as well why a wording associated with higher recommendation level in accordance with the German guideline assessment tool (Deutsches Leitlinien-Bewertungsinstrument,
DELBI) was not chosen here. This seems urgently appropriate from the perspective of the authors of the present commentary, as otherwise it may contradict other existing guidelines.

**Recommendation VII.K31:** The assessment for surgical interventions for gender affirmation in adolescents with gender incongruence or gender dysphoria should include an evaluation of the patient's capacity for consent (D) / judgment (CH) / decision-making (A) by a specialist in child and adolescent psychiatry, psychotherapy, or psychology. In cases of insufficient capacity for consent / judgment / decision-making, the minor should be supported in developing this capacity.

**Comments and context:** Analogous commentary to Recommendation VII.K23, and further reference to the low persistence of GD diagnosis or related symptoms (see Bachmann et al., 2024; Rawee et al., 2024). Furthermore, this recommendation falsely suggests that informed consent regarding these points can be easily determined for all affected minors. Additionally, it incorrectly implies that such capacity for consent can be established with sufficient effort within a more or less manageable timeframe for most minors, which is not accurate. See also further above comments regarding informed consent. The term "gender-affirming" should also be rejected for the reasons mentioned above.

**Recommendation VII.K32:** If the minor is deemed capable of consent (D) / judgment (CH) / decision-making (A), a consensus among the legal guardians should be sought.

**Comments and context:** Please refer to the comments and context provided for Recommendations VII.K9 and VII.K21. From the perspective of the authors of this commentary, a clear consensus cannot be reached because all affected minors with GD (with or without accompanying psychopathology) cannot provide clear informed consent given the current evidence (see above comments). Additionally, reference is made to the low persistence of GD diagnosis or symptoms (Bachmann et al., 2024; Rawee et al., 2024). Furthermore, the question arises here as well why a wording associated with higher recommendation level in accordance with the German guideline assessment tool (Deutsches Leitlinien-Bewertungsinstrument, DELBI) was not chosen.
**Recommendation VII.K33:** In cases where there is no consensus between the patient and legal guardians, intensive process support for the family system should be offered by a qualified professional with expertise in family therapy, aiming to facilitate support for the patient. Such process support is only recommended if no harmful effects on the health/mental well-being of the patient are expected. In such cases, an assessment of the child's welfare is warranted.

**Comments and context:** Please refer to the comments and context provided for Recommendations VII.K9, VII.K10, VII.K11, and VII.K22. Minors affected by GD (with or without accompanying psychopathology) generally cannot provide clear informed consent for such measures given the current evidence (see above comments), and there is no classical medical "indication." It remains unclear what is actually meant by "child welfare" in the context of this recommendation, or what child welfare should entail in such a case with regard to GD and, potentially, desired changes in appearance. Furthermore, it remains unclear who determines the child’s welfare in this particular context and according to what standards or criteria. Therefore, this recommendation in its current form is not sustainable and should be rejected as it contains too many uncertainties that are not adequately addressed.

**Specific recommendations regarding somatic aspects of hormonal interventions**

**Recommendation VIII.K1:** Prior to commencing puberty-blocking or gender-affirming hormone treatment, individuals should be informed about the potential future fertility limitations and the possibility of fertility preservation measures.

**Comments and context:** The term "gender-affirming" is to be rejected for the reasons mentioned above. Informed consent for such measures, including their impact on aspects of fertility, may not be reliably obtained from all affected minors. In Germany, there are currently no established minimum standards for fertility counseling for affected minors with GD (with or without accompanying psychopathology). Furthermore, the question arises as to why a "must" formulation was not chosen here.
**Recommendation VIII.K2:** Prior to treatment with GnRH analogs for puberty suppression, individuals should be informed about potential side effects, such as hot flashes and, with long-term treatment, the possible development of osteoporosis.

**Comments and context:** Agreement regarding addressing and informing (to the extent possible, see below and previous comments and context) regarding these aspects. However, serious doubts about the ability to obtain informed consent from affected children and adolescents are warranted here as well, especially considering the very poor evidence base, the low persistence of the diagnosis of GD or related symptoms (Bachmann et al., 2024; Rawee et al., 2024), and other currently unknown sequelae of the measures in question (lack of long-term data). Furthermore, reference to previous discussions and comments on these measures. Additionally, the question arises as to why a "must" formulation was not chosen here.

**Recommendation VIII.K3:** In Trans* boys with largely completed puberty development, progestin-containing preparations in long-term cycles can be used to suppress menstrual bleeding.

**Comments and context:** For such an approach, a clear and sustained benefit is not reliably established. Furthermore, reference is made to the above discussions as well as to the low persistence of the diagnosis of GD and related symptoms (Bachmann et al., 2024; Rawee et al., 2024) and the poor evidence base. See also the current final Cass review (Cass, 2024) for further information.

**Recommendation VIII.K4:** To reduce androgen effects in gender dysphoric Trans* girls with largely completed puberty development, anti-androgens can be used.

**Comments and context:** A clear and sustained benefit for such an approach is not reliably established. Furthermore, reference is made to the above discussions as well as to the low persistence of the diagnosis of GD and related symptoms (Bachmann et al., 2024; Rawee et al., 2024) and the poor evidence base. See also the current final Cass review (Cass, 2024) for further information.
**Recommendation VIII.K5:** Growth and skeletal age should be considered in gender-affirming hormone treatment with testosterone. In growing trans boys, the dosage of testosterone may be increased more slowly, taking growth prognosis into account, compared to fully grown adolescents.

**Comments and context:** Reference to the above comments and context regarding the administration of testosterone. Currently, there is no established evidence for the administration of testosterone in minors with GD regarding its actual benefit in terms of GD as a diagnosis or mental health or long-term safety. Furthermore, the question arises as to why a wording associated with higher recommendation level in accordance with the German guideline assessment tool (Deutsches Leitlinien-Bewertungsinstrument, DELBI) was not chosen here. The term "gender-affirming" is also to be rejected for the reasons mentioned above.

**Recommendation VIII.K6:** If bleeding occurs during testosterone treatment, the cause should be carefully evaluated. A progestin preparation or GnRH analog may be added overlappingly to suppress menstruation.

**Comments and context:** Such an approach appears medically feasible in principle, and it is essential to investigate the causes of bleeding (this is basic medical knowledge), although it is not specified here what type of bleeding is meant. Thus, the question arises again as to why a wording associated with higher recommendation level in accordance with the German guideline assessment tool (Deutsches Leitlinien-Bewertungsinstrument, DELBI) was not chosen here. The evidence base for the use of progestins in minors with gender identity issues is also very limited. Furthermore, reference is made to the above discussions as well as to the low persistence of the diagnosis of GD and related symptoms (Bachmann et al., 2024; Rawee et al., 2024).

**Recommendation VIII.K7:** High-dose ethinylestradiol may be used if there is a desire to limit final height by accelerating epiphyseal closure in non-adult Trans* girls.
Comments and context: This recommendation is also to be rejected. There is no clear and definitive evidence for such an approach in minors with gender identity or GD. Furthermore, reference is made to the above aspects regarding informed consent.

Chapter IX - Professional interaction and discrimination-sensitive handling of gender-nonconforming children and adolescents

Page 219
Here, a definition of discrimination is provided, which was created by one of the authors of the current guideline draft:

"Different treatment of members of a particular social group with a lower status in the structure of social power relations is understood as discrimination, which 'harms them, restricts their freedom rights, degrades them, or impairs their equality of opportunity.' (Hädicke & Wiesemann, 2021, p. 382-383). Intent is not a necessary condition (ibid.)."

Comments and context: Generally, any form of discrimination is to be rejected. It should be noted, however, that what exactly constitutes subjective "degradation" or what can be perceived as such (or not perceived as such) remains unclear in the context of this particular definition. Such experiences can be very subjective and influenced by specific contexts. Therefore, there is much room for interpretation, including in conversations with minors seeking help and who may need to answer important questions about their own identity in order to discuss potential further measures. It is unclear where the boundary may lie between professionals actively inquiring out of professional interest in providing the best possible care for the affected individuals, versus potentially being subjectively perceived as discrimination. Furthermore, it should be mentioned that for the handling of minors affected by GI or GD, there should be a scientifically based guideline that is based on clear and solid evidence evaluation. This is currently not the case for all relevant aspects (see current guideline draft). Withholding such a guideline with clear and scientifically comprehensible evidence evaluation and corresponding conclusions for safe counseling and support for affected minors with GD, as reflected in the current guideline draft due to various implausible conclusions and conceptual deficiencies as well as linguistic distortions, could also be understood by some
individuals as a form of discrimination against affected transidentifying minors (including applying the aforementioned definition of discrimination). Therefore, the current guideline draft can be viewed in this context with clear neglect of the evidence base for many aspects, also with regard to the definition of discrimination provided by the authors of the current guideline draft themselves. This contradiction remains unresolved and current. Therefore, this chapter, along with the entire current draft of guidelines and recommendations, must be thoroughly revised.

**Recommendation IX.K1:** Healthcare practitioners (members of all helping professions in healthcare) should⁰ be informed about the risks and forms of discrimination that minors who are transgender and their guardians may face. They should⁰ critically reflect on their own professional stance regarding potentially discriminatory aspects.

**Comments and context:** In principle, any form of discrimination is to be rejected (as above). The question arises as to why a wording associated with higher recommendation level in accordance with the German guideline assessment tool (Deutsches Leitlinien-Bewertungsinstrument, DELBI) was not chosen here. The statements made in the current draft guidelines are general and also constitute rather basic therapeutic knowledge, as young people with psychological symptoms and diagnoses, as well as their relatives, are frequently exposed to experiences of discrimination (see also our remarks on the WHO statement justifying depathologization, explicitly pointing out aspects of stigmatization in people with mental disorders). Critical self-reflection should generally be an important part of healthcare practitioners. Furthermore, reference is made to the aforementioned remarks and limitations in the definition of discrimination, which were made by one of the authors of the current guideline draft themselves.

**Recommendation IX.K2:** Healthcare practitioners (members of all helping professions in healthcare) should⁰, where possible within the scope of their work, contribute to reducing discrimination that may occur at structural or institutional levels.

**Comments and context:** In principle, any form of discrimination is to be rejected (as above, see previous remarks). The question arises again as to why a wording associated with higher
recommendation level in accordance with the German guideline assessment tool (Deutsches Leitlinien-Bewertungsinstrument, DELBI) was not chosen here. Reference is made to the aforementioned remarks and limitations in the definition of discrimination, which were made by one of the authors of the current guideline draft themselves (as above).

**Recommendation IX.K3:** Healthcare practitioners (members of all helping professions in healthcare) shouldª be informed about the psychological and health consequences of experiences of discrimination and should consider this knowledge in their work.

**Comments and context:** Analogous aspects to those in Recommendation IX.K2 apply here.

**Recommendation IX.K4:** Within the framework of psychological-psychotherapeutic diagnosis, counseling, and process support for children and adolescents presenting with gender incongruence/gender dysphoria, experiences of discrimination shouldª be explored and considered as factors promoting illness.

**Comments and context:** Analogous aspects to those in Recommendations IX.K2 and IX.K3 apply here. Furthermore, the term "factors promoting illness" is used here. What is meant by this? Does this imply that GI/GD is now to be understood as a disorder or illness? These points require clarification.

**Recommendation IX.K5:** Educational and informational resources shouldª be made available to the social environment (e.g., schools, educational institutions, sports clubs, youth facilities, church communities, etc.) for supporting minors who are transgender. These resources should also highlight information and counseling services provided by self-advocacy organizations of transgender individuals and their families.

**Comments and context:** Analogous aspects to those in Recommendations IX.K2, IX.K3, and IX.K4 apply here.

**Recommendation IX.K6:** Healthcare practitioners shouldª inquire about and, where feasible, use the preferred pronouns and names of gender non-conforming children and adolescents in
their interactions. Accordingly, in consultation with those seeking treatment, the same approach should⁹ be taken in professional communication with other involved professionals and institutions.

**Comments and context:** Analogous aspects to those in Recommendations IX.K2 through IX.K5 apply here. Regarding the use of pronouns, various considerations need to be weighed. The Society for Evidence Based Gender Medicine summarizes the following points:

The newly released final version of the Cass Review (Cass, 2024) positions social transition as an active health intervention because it may have significant effects on a child or young person in terms of their mental functioning and long-term outcomes. An increasing number of clinicians in the UK and other countries are using social prescription interventions to influence health outcomes. For young children, the Cass Review (Cass, 2024) strongly advises against social transition, noting that the "gender of rearing" can profoundly alter a child's developmental trajectory, with far-reaching consequences. Should parents insist, the review recommends involving a healthcare professional to help parents understand the risk-benefit ratio of such a profound and likely life-changing decision. For older teenagers, the Cass Review (Cass, 2024) acknowledges the autonomy of young people's self-realization but strongly recommends involving parents in the decision. It points out that secret transitions create a gap between teenagers and their families and destabilize support networks that are essential for the long-term well-being of young people.

In general, the final Cass Review (Cass, 2024) recommends that social transitions, if at all, should only be partially carried out and not fully, especially in younger children. It is noted how many children currently live in fear of being "discovered" regarding their identity. Adopting the use of preferred pronouns can turn such fear into certainty. Therefore, it would be extremely unwise for parents to create a situation in which a young child lives in a "stealth" mode. Hence, a very cautious approach is advisable here. These recommendations were supported by interviews with affected individuals and families as well as by a systematic review of the evidence for social transition in a peer-reviewed article in the BMJ Journal (Hall et al., 2024).
The review found a lack of evidence and concluded: Professionals working in the field of gender identity and those seeking support should be aware of the lack of robust evidence for the benefits or harms of social transition in children and adolescents. Recognizing not only the potential benefits but also the potential harms, as well as the unknown benefit-to-harm ratio of social gender transition, should be noted. Fundamentally, clinicians have the task of diagnosing and alleviating possible suffering, and using non-preferred pronouns can potentially drive vulnerable minors into a crisis situation of reactance or rejection of help. This should be avoided at all costs. However, no human person has their own individual grammar; that is, the language used is always an expression of the subjective perception of the speaking person within the framework of freedom of opinion and speech. Therefore, no apodictic regulations should be made in the context of the current draft guidelines.

Chapter X – Law and ethics – Legal foundations and ethical guidelines for the treatment of minors with gender dysphoria

General Aspects

Almost the entire legal and ethical reasoning regarding the capacity for consent of minors refers to a single unpublished source:


This is highly unscientific and does not meet the standards of an S2k guideline.

Furthermore, the following points should be noted: In Chapter X, concerning the German Ethics Council (2020), the statement or indication is made, "The law implements the central ethical challenge of 'supporting minors on the path to their own gender identity and at the same time protecting them from - sometimes irreversible - harm' (German Ethics Council, 2020, p. 2). It remains unclear what damages are actually meant here. This section can encompass, for example, risks before an inadequately initiated "therapy" or such intervention
programs, but also the administration of PB or CSH and possibly surgical interventions. Clarity on this matter is urgently needed.

Currently, there is no solid research with scientifically adequate methodology that clearly demonstrates a long-term and sustainable improvement in quality of life and mental health in adulthood for patients diagnosed with persistent GD in adolescence who receive staged body-modifying treatment in the context of socially supported transition. See also the final Cass Review (Cass, 2024). Conversely, many studies point to the risks of administering CSH (see, for example, Thompson et al., 2023). These risks include possible increases in blood pressure, an elevated risk of thromboembolism, unfavorable lipid profiles, changes in bone mineral density, and increases in insulin levels. Additionally, the aforementioned consequences regarding fertility should be mentioned here as well.

In forensic evaluations of young people aged between 18 and 21 years, in Germany young people belonging to this group can still be sentenced under juvenile criminal law (see Juvenile Courts Act § 1, para. 2). Recent findings from neuroscience and developmental psychology show that not only adolescents but also young adults up to the age of 25 generally still possess significant developmental resources (Röpcke et al., 2020). Thus, a significant change in GI or GD over the course of development, including identity development and maturity, is entirely possible for affected individuals. It remains incomprehensible, therefore, how the necessary maturity for the medically relevant, partly irreversible decisions should be present in this particularly vulnerable population of minors with GI or GD without clear evidence, especially considering that this adolescent level of maturity or "immaturity" can also be present during puberty or even post-puberty in certain cases.

Other developmental criteria, which are also used in forensic assessments with regard to maturity aspects, contradict the statements and assumptions made in the draft guidelines regarding informed consent in affected minors with GI or GD. The following maturity criteria (so-called Marburg Guidelines 1955, Esser et al., 1991) have often been primarily used in forensic contexts. These maturity criteria for the age range of 18 to 21 years are now considered outdated by some colleagues for specific forensic questions and have also been criticized in some forensic contexts, for example, because they disadvantage females.
However, considering maturity characteristics in the context of GI or GD in minors, for example, with regard to the ability to provide informed consent or the maturity to understand the implications of relevant irreversible medical interventions, is important. If, for example, maturity characteristics in the age range of 18 to 21 years are not yet fully developed and these same maturity characteristics are often relevant for corresponding aspects relevant to criminal acts carried out in the age range of 18 to 21 years in forensic questions, then these maturity characteristics, if not fully present in the age range of 18 to 21 years, are highly likely not to have been present, for example, in the age range of 14 to 15 years. Therefore, specific maturity aspects are very relevant for the assessment of affected minors with GI or GD.

The following are the aforementioned Marburg Guidelines briefly outlined:

- Integration of Eros and Sexus (including maintaining intimate relationships over a longer period)

- Realistic life planning vs. living in the moment

- Independence from parents vs. strong need for support and helplessness

- Serious vs. playful attitude towards work and school

- External impression (overall impression, face, figure, size)

- Realistic daily coping vs. daydreaming, adventurous actions, living in roles that enhance self-esteem

- Same-age or older vs. predominantly younger friends

- Capacity for attachment vs. instability in interpersonal relationships or attachment weakness

- Consistent predictable mood vs. adolescent mood swings without adequate reason
In the European General Data Protection Regulation (GDPR) of 2018, the minimum age for consent to any activities and interactions on the internet is set at the age of 16 years, meaning that minors under the age of 16 years require the consent of their respective legal guardians. Thus, it is assumed per se that adolescents under the age of 16 do not have the maturity to consent to the foreseeable consequences of activities or interactions on the internet. However, some countries have set a lower age limit, typically 13 years, but Germany has not.

Furthermore, the ability to consent includes being able to assess the consequences of irreversible medical interventions. It should be noted that in a study, almost 10% of those under 16 years of age revoked their decision regarding an optical gender transformation (Butler et al., 2022). This raises the question of how seriously clinicians can and should assess the capacity for consent of minors (possibly also in stressful life situations with or without accompanying psychopathology) in order to avoid harm. Additionally, the fundamental contradictions of the concept of gender identity in minors (see Section II of this commentary) should be considered, as these are partially used as a basis for potentially irreversible somatomedical measures in physically healthy minors with GD.

Current research data from Germany show an overall weak stability of the diagnosis in question (Bachmann et al., 2024). This finding is in line with new findings from the Netherlands (Rawee et al., 2024). From a conceptual perspective, the implicit and currently scientifically unjustifiable assumption of the existence of a naturalistic "identity disposition" or a "primarily ubiquitous identity" in minors with regard to gender is evident throughout the entire draft guideline and problematic. Unfortunately, it must be emphasized again at this point that no theoretical model or concept of identity, or understanding of identity, is mentioned anywhere in the entire current draft guideline, nor is it explained whether and how these aspects change or occur depending on the stage of life and development. Turban et al. (2021) also found that approximately 9% of N = 27,715 participants expressed a desire to detransition, i.e., return to their original gender after hormonal (CSH) and/or surgical gender-affirming interventions or similar visual changes.

Furthermore, it raises questions about how the assumptions and approaches outlined in the current draft guideline are to be implemented for significantly learning-disabled or
intellectually impaired minors, especially considering that the development of informed consent capacity is unlikely in these particular individuals. This group of vulnerable minors is not mentioned at all in the current draft guideline.

In section 3.2.3 of Chapter X of the draft guideline, the (presumably more common) scenario where the legal guardians (usually parents) may not consent to the administration of PB or surgery(ies) is avoided (see also the above comment on Recommendation III. K1.). It remains unclear how and according to what criteria the possibly involved Youth Welfare Office / Child or Youth Protection Services, which may be called upon by the minor or legal guardians, can or should bring about clarification. Additionally, Recommendation VI.K6. sidesteps this issue, besides being indefinable what exactly distinguishes a "suitable expert with family therapy expertise." Furthermore, it is questionable whether a child protection concern is implied here if PB or surgeries are not administered (see point 1. Regarding the listed potential dispute). If so, the proportionality is clearly not given. Should a highly contentious non-performed medical intervention without clear evidence base for its benefit or sustainability and its definition as, for example, endangering the child's welfare in an extreme case lead to a custody and execution against the will of the parents? An ethical and legal statement is missing in the current draft guideline on this issue.

Furthermore, it is questionable whether the welfare of the child is adequately reflected or represented by the current will of the child or adolescent. Since other measures of the Youth Welfare Office / Child and Youth Protection Services in cases of child endangerment must be reversible at any time, but irreversible medical interventions are not, the reference to the welfare of the child "in the future" is not logically justified here, as it is subject to many unforeseeable influencing factors and can fluctuate to a large extent. As explained in our comments on Chapter V, current works on the ethical complex related to this issue explicitly emphasize the right of children and adolescents to have an open future (Jorgensen et al., 2024), and the evidence and findings in adults are not transferable to the child and adolescent field. Therefore, the assumptions and approaches in the current draft guideline regarding current research findings (Bachmann et al., 2024; Cass, 2024; Rawee et al., 2024; Ruuska et al., 2024; Thompson et al., 2023; Zepf et al., 2024) are in contradiction with the ethical
fundamental principle regarding the right of children and adolescents to an open future (Jorgensen et al., 2024).

**IV. SUMMARY**

The current draft of the guidelines is a consensus document from various participating institutions and professional societies, which demonstrates engagement with the topic under consideration and thus represents a fundamentally commendable and important initiative in an area of medicine that is currently largely unregulated. However, the current guideline draft requires various substantial improvements, as detailed earlier. In some critical aspects, the current draft of the guidelines contradicts essential scientific, professional ethical, and psychotherapeutic principles. These profound deficiencies in the current guideline draft cannot be reconciled with a medical understanding in terms of evidence-based medicine in child and adolescent psychiatry, psychosomatics, and psychotherapy, as well as important psychotherapeutic principles such as the rule of abstinence. This particularly concerns a clear assessment of medical evidence or non-evidence and the recommendations and conclusions derived from it.

**Implications for the affected individuals and the provision of care**

For the handling of minors affected by GD, there should be a scientifically based guideline rooted in clear and robust evidence assessment, along with corresponding conclusions. Withholding such a guideline for safe counseling and support of affected minors with GD could potentially be perceived by some individuals as a form of discrimination against transgender minors. Additionally, the draft guideline could significantly undermine the fundamental trust in clinical and academic child and adolescent psychiatry, psychosomatics, psychotherapy, and other related guidelines, especially concerning their fundamental scientific basis and acceptance in the healthcare landscape. This should be avoided in the interest of all affected parties, and accordingly, these guidelines in question here should urgently and fundamentally be revised and rigorously evaluated for their fundamental medical as well as psychotherapeutic scientific basis, potentially with the involvement of an independent external mediation and documentation.
Furthermore, the authors of the present commentary are of the opinion that, as part of a structured and potentially externally moderated process, it should be investigated how the development of such a guideline draft, in which fundamental scientific principles were partially neglected or even ignored, could have occurred. This is of particular importance concerning the protection of all affected individuals, as well as existing and future guidelines in this and related areas.

**Consequences of the evidence base: Child and youth protection**

In other countries, it has been recognized that both the administration of PB and CSH to minors with GD are currently considered experimental medical interventions without clear evidence of their safe, substantial, and sustainable effectiveness, given the partially irreversible consequences, unknown risks, and lack of long-term data (see, for example, the report by the Scientific Services of the German Bundestag, 2023; Cass, 2024). Similar considerations apply to corresponding surgical medical interventions in minors with GD. From the perspective of the authors of the present commentary, the current guideline draft must be thoroughly revised, particularly in the context of profound child and youth protection, taking into account the actual current medical evidence. This is in the interest of the affected individuals, who must be protected from potentially hasty decisions, as they are not able, due to their ongoing development and the current evidence situation, to give their informed consent to potentially irreversible somatic medical interventions on their healthy bodies. In addition to the right to free development of personality, which of course applies to children and adolescents and is emphasized in the current guideline draft, the following aspects must also be considered from the authors' perspective:

- the still developing personality of minors, which compared to adults, exhibits higher volatility and lower validity in subjectively coherent interpretation of self-concept,

- thus, considering the rights (a) to physical integrity and (b) the medical-therapeutic principle of "primum non nocere – first, do no harm," making it more challenging to assess the risk-benefit ratio of a potentially irreversible somatic medical intervention,
the fundamental contradictions within the construct of transgender identity in minors (refer to Section II of this commentary),
and the tension between Article 6 Paragraph 2 of the German Basic Law (guaranteed right of the child to freely develop their personality) and Article 6 Paragraph 3 of the German Basic Law (parents have the right and duty to care for and raise their children).

**Principles of medical and therapeutic practice to be considered**

In the statute of the DGKJP (2019), under "Purpose of the Association" (§2), the following section is found:

*Recognizing the interconnectedness of child and adolescent psychiatry, psychosomatics, psychotherapy, neurology, and psychology of childhood and adolescence, as well as special education, in research, teaching, and patient care, the society serves the promotion of science and research, as well as the promotion of public health and public health care, and the promotion of education. Furthermore, the society promotes the practice of medicine in the field of medicine and its related areas, including the establishment and expansion of international relations. This also includes the promotion of quality assurance in research, teaching, and patient care, as well as adherence to guidelines for ethical conduct in child and adolescent psychiatry, psychosomatics, and psychotherapy."

The current guideline draft should unequivocally adhere to this understanding within a child and adolescent psychiatric, psychosomatic, and psychotherapeutic context, as well as to the principles articulated in the DGKJP statute, particularly focusing on the "promotion of science and research" and the "promotion of quality assurance in research, teaching, and patient care, as well as adherence to guidelines for ethical conduct in child and adolescent psychiatry, psychosomatics, and psychotherapy." This is because the current guideline draft draws clinically and scientifically implausible conclusions, and the current evidence base does not reliably support these conclusions.

In the United Nations Convention on the Rights of the Child (UNICEF, 2023), Article 24, paragraph 1, clearly articulates regarding health care, "States Parties recognize the right of
the child to the enjoyment of the highest attainable standard of health and to facilities for the
treatment of illness and rehabilitation of health." Specifically considering the potentially
changeable will of children and adolescents throughout development, extending into
adulthood, and variable aspects of identity in children and adolescents during development,
as well as their protection from discrimination, these aspects are also listed in the UN
Convention on the Rights of the Child and must be considered and protected in this context.
However, mentions of identity, protection from discrimination, and the will of the child or
adolescent in the UN Convention on the Rights of the Child (UNICEF, 2023) should not lead to
the potentially easy assumption or misjudgment that all children and adolescents always have
a fully and potentially naturalistically predetermined and unchangeable, and potentially
always stable identity, especially regarding their own gender or its experience, and that this
always leads to a constant and unchangeable will of the child or adolescent. This is not
scientifically well-established. Since there is no ubiquitous and naturalistically determined
sustainable identity (also because its boundaries cannot be clearly articulated), the will of the
child and adolescent is known to often change during development (a characteristic feature
of puberty and adolescence), the construct of transgender identity, especially in minors,
carries many intrinsic and unresolved contradictions, accompanying mental disorders can
influence the desire for a change of gender, and the evidence base for the here discussed
potentially irreversible somatic medical interventions is extremely deficient from a well-
founded medical perspective, some of the recommendations discussed in the current
guideline draft now clearly contradict the UN Convention on the Rights of the Child (UNICEF,
2023). Furthermore, they contradict the right of children and adolescents to physical as well
as mental integrity regarding the currently unpredictable mental consequences of potentially
premature decisions for potentially irreversible somatic medical interventions without clear
evidence of their sustained benefits.

Furthermore, the current guideline draft is not in line with the principle outlined in the Geneva
Declaration of Physicians, "I will practice my profession with conscience and dignity and in
accordance with good medical practice." This is because the existing scientific evidence is not
adequately considered, and medically implausible conclusions are drawn, thus making good
medical practice not reliably possible according to the guideline draft (see, for example, the
Medical Association of Hesse, 2024). Referring to so-called "best practice" in the preamble of
the guideline draft in question is not an adequate solution because in a consensus-based approach, and with insufficient consideration of the actual evidence regarding the interventions in question, an expert consensus that does not adequately assess or even goes against the evidence cannot replace the factually proven deficient evidence base. Additionally, parts of the guideline draft, regarding the conclusions and their contradictions to the evidence, cannot be reconciled with the Hippocratic Oath according to the principle stated therein, "I will prescribe regimens for the good of my patients according to my ability and my judgment and never do harm to anyone" (see, for example, the Medical Association of the German state of Hessen, 2024). The issue regarding psychotherapeutic rules concerning abstinence has already been pointed out, as well as the low temporal stability of corresponding diagnoses or related symptoms (Bachmann et al., 2024; Rawee et al., 2024).

**Necessary consequences**

Following these discussions, the consideration of current, solid, and proven medical evidence for potentially irreversible interventions in physically healthy minors with GD must also be reflected in the guidelines in question. This includes target variables such as GD itself, mental health, and other important medical accompanying aspects for the safety of these interventions. Examples include aspects such as bone density or potential risk for malignant diseases after CSH administration (see, for example, Thompson et al., 2023; Zepf et al., 2024). From the perspective of the authors of the present commentary, the current guideline draft is scientifically untenable in many aspects and does not withstand empirical scrutiny in many places, necessitating urgent improvements in the interest of the affected individuals and stakeholders on the points outlined here. Alternatively, this guideline should be withdrawn. Rectifying these outlined deficiencies in the current guideline draft is essential to avoid significant harm to these vulnerable minors with GD, which may result from the potentially harmful consequences of the current guideline draft if adopted in its current form. Furthermore, according to the authors of the present commentary, a profound and documented investigation of the guideline process that led to the submission of a largely unscientific guideline draft with potentially harmful and irreversible effects for physically healthy minors with GD is urgently needed.
As of April 2024, the situation regarding the current guideline draft and its alignment with the current practice and underlying documents, conventions, and standards in Germany is as follows:

- The current medical evidence clearly demonstrates a very deficient evidence base for the administration of PB and CSH in minors with GD, as shown in an updated systematic review published in the official organ of the DGKJP (Zepf et al., 2024). This study and its conclusions regarding the evidence have been referenced by the American College of Pediatricians (ACP, 2024) in a position paper. The European Society of Child and Adolescent Psychiatry (ESCAP) has also incorporated this new systematic review and its conclusions into the new "ESCAP statement on the care for gender incongruent children and adolescents" (publication imminent). The evidence base for potentially operative interventions in minors with GD is also very deficient internationally. The construct of transgender identity in minors has several intrinsic and unresolved contradictions. However, the interventions under discussion are based on this contradictory concept (see Section II).

- At the same time, the current guideline draft from this professional society, in which the associated evidence base has been summarized according to established criteria (Zepf et al., 2024), does not adequately consider this medical evidence (even though the deficient evidence regarding the relevant topics is partially explicitly acknowledged by the authors of the guideline draft themselves, which is also reflected in the downgrading of the guidelines to an S2k level) and draws partly incorrect and illogical or implausible conclusions. The current and final Cass review confirms the current factual situation (Cass, 2024). The guideline draft cites studies that, due to substantial deficiencies in the respective studies when applying established research standards (NICE, PICO, Modified GRADE), cannot be considered for any conclusions.

- The current guideline draft urgently needs to be modified in light of the essential scientific principles and conventions of responsible child and adolescent psychiatric, psychosomatic, and psychotherapeutic work, as reflected in the statute of the DGKJP (2019), the UN Convention on the Rights of the Child (UNICEF, 2023), the Hippocratic
Oath ("... according to my ability and my judgment ..."), and the Geneva Declaration of Physicians ("... in accordance with good medical practice ..."; see, for example, the Medical Association of the German State of Hessen, 2024), as well as in the context of therapeutic rules, since conclusions drawn from the current evidence base for the interventions in question are not comprehensible and may harm these young vulnerable individuals. Some approaches outlined in the current guideline draft are currently, in the view of the authors of the present commentary, not justified or do not present a favorable or clearly justifiable risk-benefit ratio for the affected individuals.

**How to proceed with rare individual cases**

In the view of the authors of the present commentary, the possibility should also exist for very rare cases, in which the administration of PB or CSH may be considered in cases of longstanding GI/GD symptoms with significant distress, following prior comprehensive child and adolescent psychiatric-psychotherapeutic and possibly somatic diagnostic assessments, involving a MDT for each individual case. In such instances, the involvement of a clinical ethics committee and the inclusion of several relevant disciplines (child and adolescent psychiatry, psychosomatics and psychotherapy, pediatrics, psychotherapists, endocrinology, reproductive medicine) could be particularly valuable in conducting a benefit-risk assessment in an interdisciplinary manner, and considering the current evidence base. However, according to the assessment of the authors of the present commentary, such an approach should be limited to individual case decisions, considering the preceding discussions, the current evidence base, as well as the recently published research findings (Cass, 2024; Jorgensen et al., 2024; Rawee et al., 2024; Zepf et al., 2024).

The discrepancy between the evidence base and the recommendations articulated in the guideline draft regarding the interventions in question, in the view of the authors of the present commentary, is unacceptable and indicative of an urgent need for revision of the guideline draft under discussion. In the interest of the affected minors with GD and all stakeholders, the current guideline draft in its present form should therefore be rejected and fundamentally revised. Alternatively, the present guideline should be withdrawn. Furthermore, the critical discussion of this issue underscores the ongoing urgent need for research in this field to enable the affected minors with GD to receive appropriate, evidence-
based care. The comments, assessments, and considerations presented here may be forwarded to the guideline group; in fact it is explicitly requested by the authors of the present commentary to do so at this point.

V. REFERENCES


APA Issues Official Positions Supporting Access to Care and the Rights of Transgender and Gender Variant Persons (http://www.apa.org/about/policy/chapter-12b.aspx#transgender)

Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften (AWMF). AWMF-Website, https://register.awmf.org/de/leitlinien/detail/028-014, last accessed on 26.03.2024, at 08:00 AM.


Psychrembel Online (2024). [https://www.psychrembel.de/Indikation/K0AQ8/doc/](https://www.psychrembel.de/Indikation/K0AQ8/doc/), last accessed on 06.04.2024, 12:16 PM.


Society for Evidence Based Gender Medicine (SEGM), SEGM-Website: https://segm.org/Final-Cass-Review-2024-NHS-Response-Summary, last accessed on 16.04.2024, 4:23 PM.


World Health Organization (WHO), WHO-Website https://www.who.int/standards/classifications/frequently-asked-questions/gender-incongruence-and-transgender-health-in-the-icd, last accessed on 06.04.2024, 6:12 PM.


VI. CONFLICTS OF INTEREST & DISCLOSURE STATEMENTS

Participation in guidelines:

FDZ: From mid 2020 until November 29th 2022 FDZ was a member of the steering group of the German AWMF-S3-Guidelines “Sex-incongruence and gender dysphoria in children and adolescents: Diagnosis and treatment” (adapted author-translated German title of the S3 guidelines, Register No. 028–014). Because of his professional and ethical doubts and concerns regarding these particular S3 guidelines as well as his concerns about the protection of health in children and adolescents in the light of these new S3 guidelines FDZ left the above-mentioned steering group and discontinued working on these particular guidelines.

Consultancy & Speaker-Honoraria (last 3 years):

FDZ: Consultancy and speaker-honoraria by Takeda / Shire. Consultancy was in the context of ADHD and co-morbid disorders. As regards speaker activities two presentations with an extended thematic reference to the topics of the current paper were supported by Takeda. In particular, one of these presentations was an overview on trans-identity and the evidence of blocking puberty including GnRH analogues and the use of hormones in minors with gender dysphoria. The other presentation was on the clinical implications on ADHD with co-varying trans-identity and included aspects of the evidence of using GnRH analogies and CSH. There was no consultancy or other speaker activity supported by Takeda in relationship to GnRH
analogies. Speaker honoraria also by Medice (context was only about ADHD and comorbidities). No ownership interests regarding pharmaceutical agents or medical products.

TB: Consultancy for Eye Level, Infectopharm, Medice, Neurim Pharmaceuticals, Oberberg-GmbH and Takeda (no consultancy or speaker activity for Takeda in relationship to GnRH analogues), and speaker-honoraria by Janssen-Cilag, Medice and Takeda. Author honoraria by Hogrefe, Kohlhammer, CIP Medien, and Oxford University Press.

There are no conflicts of interest / no disclosures with the remaining authors.