VIEWPOINT

Understanding Pediatric Patients Who Discontinue Gender-Affirming Hormonal Interventions

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It is estimated that as many as 1% of American adolescents have a gender identity that is not congruent with their sex assigned at birth.[1] Guidelines developed in the Netherlands and then adopted throughout the world allow clinicians to prevent physical changes of puberty with the use of gonadotropin-releasing hormone analogs (GnRHa) when the first signs of puberty have manifested, a point at which the patient's dysphoria surrounding gender often intensifies. This may be followed with exogenous testosterone or estrogen therapy at ages as young as 14 years, but more typically at approximately 16 years of age, to more closely align the adolescent's body with their inner sense of their gender.[2,3]

Despite widespread use of these treatments, there is to our knowledge currently only 1 published longitudinal study that follows up transgender adolescents into adulthood.[4] In that study of 55 adolescents, psychiatric symptoms improved over the period of the protocol, and none of the adolescents changed their minds or chose to discontinue the gender affirmation process.

In our clinical experience, nearly all adolescents who initiate treatment with a GnRHa maintain a transgender identity and continue hormone treatment in adulthood. Occasionally, some adolescents discontinue hormones. Here we present one of those cases, along with a discussion of how clinicians can better understand and support these youths.

Case Presentation

A patient was assigned male sex at birth and initially identified as female on presentation to our program. At the time, the patient's pronouns were *she*, *her*, and *hers*, which we therefore use here. Throughout her prepubertal years, she had minimal interest in gender-typical activities, recalling that she disliked sports, dolls, and dress-up. Her friends were both boys and girls. She knew she was "supposed to be a boy," as she put it, but she reported that this gender did not seem to fit. With pubertal onset, she had increasing distress about her masculinizing body and developed anxiety at the prospect of becoming a man. She started wearing more gender-neutral clothing, applied makeup, and was pleased when strangers perceived her as a girl. In addition to she-series pronouns, she adopted a traditionally female name and came out to her friends as transgender at boarding school in the ninth grade. The biological parents of the patient, as well as her stepmother, were hesitant to embrace the patient's transgender identity, declining to use her declared pronouns and discouraging her from leaving the house in feminine clothing. Despite this, the family sought help from a licensed psychologist with expertise working with gender-diverse youths. After comprehensive evaluation, the patient received a diagnosis of gender dysphoria and was deemed to have capacity to provide informed assent for gender-affirming hormone therapy.

At age 15 years, the patient presented to a multidisciplinary gender clinic. At that time, she wore gender-neutral clothing and had stereotypically feminine gestures. She had minimal voice deepening and a testicular volume of 15 mL. Despite initial hesitation, her parents provided consent for her to receive a puberty blocker (ie, a histrelin GnRHa implant). The patient and family were reminded that the implant can be removed at any time and that, if removed, the patient would progress through male puberty.

At age 16 years, she started estrogen therapy at a small dose, with a plan to escalate to adult dosing over a prolonged period of time. Four months later, the patient adopted the nonbinary pronouns *they*, *them*, and *their* (which are used henceforth in this article). They did not wish to increase the dose of estrogen any further, nor did they wish to stop estrogen. In therapy, they explored their feelings of discomfort and feeling like an outsider while living in a girls' dormitory, despite being accepted as a girl and having a private room. After several months of weekly psychotherapy, the patient decided that they did not identify as a boy or a girl and chose to discontinue estrogen therapy. After several discussions, the patient and their physician agreed that the best course of action would be to remove their puberty blocker with the understanding that they would progress through male puberty as a result; they continue to be followed in the gender clinic and identifies as gender nonbinary. The patient sometimes expresses a desire to not have any secondary sex characteristics but overall reports that their anxiety and depression are controlled and that they are happy with their decision. They were recently accepted to college and are looking forward to enrolling in the next academic year.

Discussion

This case highlights the sometimes dynamic nature of gender identity among youths. In this case, the patient met all published standards for treatment of gender dysphoria,[2,3] and their gender identity evolved to a point at which they no longer felt that hormones were appropriate for them. Through extensive engagement in psychotherapy with a skilled clinician specialized in gender-associated dynamics, this patient expressed that

gender-affirming hormone therapy was vital for consolidating their gender identity and did not regret this treatment.

Some adolescents who endorse a clear desire for gender-affirming hormones may change their mind after receiving them. While this may be uncomfortable for prescribing clinicians, we have observed that some gender-questioning adolescents benefit from a period of exploration that includes hormonal intervention in order to consolidate their gender identity. In this case, the patient reported conviction that the experience of living as a girl and also undergoing estrogen therapy served to clarify that male puberty was a better fit. It is likely that as the medical field's appreciation of nonbinary and/or fluid gender identities expands, we will see more adolescents who elect to discontinue gender-affirming hormones after receiving just enough treatment to relieve and make sense of their dysphoria. While it would be more clinically straightforward for every adolescent's gender identity to be fully developed prior to initiating gender-affirming medical therapy, in our experience this is not always the case, and gender identity may continue to evolve subsequent to medical intervention initiation.

Though less prominent in this case, extrinsic factors must also be considered when a patient expresses a desire to stop gender-affirming hormones. Transgender youths have high rates of rejection by their families and peers; rejection is a primary driver of anxiety, depression, and suicidality in this population.[5,6] Transgender adolescents who initiate gender affirmation and later find themselves in a rejecting environment may feel compelled or coerced to discontinue hormones. It is vital that treatment teams understand these social determinants to support and protect patients in physically and emotionally unsafe environments. Discrimination in schools, public accommodations, and employment settings continues to negatively affect these individuals. Though there has been a relative increase in insurance coverage for gender-affirming hormone treatment, financial barriers to care are often another major concern among transgender youths.[7] Short-term and long-term gaps in insurance coverage can jeopardize access to interventions like puberty blockers, which can cost thousands of dollars.[7] Legal barriers, like incarceration or requirements for guardian consent, can also cause patients to fall out of care and detransition involuntarily.[8]

Conclusions

Nearly all gender-questioning youths who begin gender-affirming hormone therapy will continue to identify as transgender in adulthood. We are learning, however, that gender is often less binary and more dynamic than previously thought. Clinicians must be open to each individual's gender exploration and allow this path to unfold in the manner that feels most comfortable for the patient, within the boundaries of safe prescribing. Gender-affirming care ought to have no prespecified identity-associated outcome (transgender, cisgender, or otherwise) as the goal of treatment. Rather, health care teams ought to work with gender-exploring youths to relieve dysphoric distress without restricting these youths to only binary or unalterable gender options. For some percentage of youths, this path may involve detransition.

ARTICLE INFORMATION

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