

## **Gender dysphoria, gender incongruence and gender nonconformity in adolescence – changes and challenges in diagnosis**

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### **Summary**

Psychiatrists, psychotherapists and sexologists specializing in therapy and support of teenage patients have noticed a significant rise in reports of lack of acceptance of the gender assigned at birth, questioning it, rejecting it, and various ways of experiencing it. Although the history of work with transgender adults goes back to the 1920s, gender dysphoria in adolescents remains a complex phenomenon, and any attempts at standardization of approaches and protocols have so far been unsuccessful. The controversies associated with the issue often result in hasty conclusions and the false – according to the authors of the present paper – assumption that the population of adolescents who experience gender dysphoria or gender incongruence is homogenous. The present article reviews the changes in the diagnoses associated with gender identity made in the DSM and ICD classifications in recent decades, psychological health and neurodiversity of patients reporting gender dysphoria, most common models of treatment, including their advantages and disadvantages, as well as the challenges for diagnosis and treatment in work with this population.

**Key words:** DSM-5, ICD-11, gender dysphoria, sexology

### **Introduction**

Both centers specializing in the health of transgender persons and institutions of wider patient profile and various referral levels have been reporting a significant rise in the number of children and adolescents showing discomfort towards the gender they were assigned at birth. The growing social acceptance of this stigmatized condition, wider access to information and the opportunities for contact through social media have definitely play a role in the process. Still, many questions remain unanswered.

The discomfort associated with the body and social roles is reported by teenagers on a scale that surpasses all previous statistics, especially in case of patients assigned female at birth [1]. The average age of first visit to a specialist is becoming lower, a majority of patients experience coexisting affective and behavioral difficulties, and the symptomatology of developmental disorders on the autism spectrum is several times higher in this group than in the general population [2]. Moreover, there are no extensive studies on gender dysphoria in Polish literature at all, and the few publications on the subject focus on the experience of adults. The authors of the present article aim to address this gap by providing a framework for readers who, if they have not met adolescents reporting gender dysphoria in their psychiatric, psychological and/or psychotherapeutic practice yet, are very likely to encounter the phenomenon in the near future. It is a largely specific and unique phenomenon and, as a consequence, it poses numerous difficulties in terms of diagnosis and therapy. The following aspects in particular require special attention and explanation:

- fundamental changes in diagnoses associated with gender identity made in recent decades in the Diagnostic and Statistical Manual of Mental Disorders (DSM) and International Statistical Classification of Diseases and Related Health Problems (ICD);
- high levels of anxiety, depression, nonsuicidal self-injury, suicidal ideation and suicide attempts in the population of teenagers reporting gender dysphoria;
- higher than in the general population prevalence of disorders of autism spectrum and of broadly understood neurodiversity;
- selection of appropriate forms of treatment, as well as recognition of their advantages and disadvantages;
- rapidly growing number of youth reporting gender dysphoria to mental health professionals, and the associated question of the role of sociocultural factors in the genesis of the phenomenon.

### **Historical background**

The terms ‘transvestitism’ and ‘transsexualism’ entered the discourse of Western medicine in 1910 and 1923 respectively thanks to the German doctor and sexologist Magnus Hirschfeld [3, 4], who, in 1919, established the first Institute for Sexology in the world (German: *Institut für Sexualwissenschaft*), collecting in its library 20,000 volumes of publications, case studies and patient observation notes. Around the same time, David Cauldwell was developing his sexology practice in the USA. He popularized the term ‘transsexualism’ in the English language with his 1949 essay *Psychopatia Transsexualis* [5]. The destruction of Hirschfeld’s work in 1933 by the Nazis, his death, and the World War II ravaging Europe all contributed to Cauldwell being hailed as the author of the term, and the center for research on

transsexuality moving to North America. The endocrinologist and sexologist Harry Benjamin, born in 1885 – like Hirschfeld – in Berlin, became an emblematic figure for the modern understanding of transgenderism. By combining endocrinology and sexology, he became a leading clinician for transgender people, and by the end of the 1970s he cared for over 1,500 patients [6]. His book *The Transsexual Phenomenon* [7] and the introduction to *Transsexualism and Sex Reassignment* [8] established his position as a pioneer of a holistic and affirmative approach to the issue, already then reported also by young persons. Among the 800 letters written to Benjamin by transgender people, 21 are from 14–18-year-olds [6]. The correspondence he collected is a reflection of his pioneering work with transgender youth, who Benjamin helped to the best of his ability, according to the legal regulations and medical practice of the time, inspiring many other specialists to adopt affirmative approach. In 1978, Harry Benjamin Gender Dysphoria Association was established, and a year later it published the first standards of care in the world [9]. The association transformed in 2007 into the World Professional Association for Transgender Health (WPATH). The current version of standards of care, published in 2011, is currently being revised for the eighth edition [10].

### **Gender identity of children and adolescents in medical classifications**

DSM-III [11] is the most often mentioned source in literature as an introduction to the category of ‘disorders’ of gender identity in children and adolescents. Still, the ninth edition of the ICD [12] was published already three years earlier. The chapter “Sexual deviations and disorders” includes, for the first time, “Disorders of psychosexual identity,” defined as “behavior occurring in preadolescents of immature psychosexuality which is similar to that shown in the sexual deviations described under transvestism and transsexualism”. In 1980, the American Psychiatric Association in turn, in the chapter “Psychosexual disorders”, introduced the diagnosis of “Gender identity disorder of childhood”, changing it in a later revision to “disorders usually first evident in infancy, childhood, or adolescence” [13]. In 1990, the World Health Organization adopted, in ICD-10, the wording of the DSM category, at the same time creating the new category of “Gender identity disorders”, which also included “transsexuality”, referring to adults. DSM-IV and DMS-IV-R retained the code from the earlier editions, but moved it to the new category of “Sexual and gender identity disorders”, along with sexual dysfunctions and paraphilias [14, 15]. In 2013, the publication of the fifth edition of the DSM brought a breakthrough as “Gender identity disorders”, following the recommendations of Cohen-Kettenis and Pfafflin [16], were replaced with “Gender dysphoria”, which included separate categories of “gender dysphoria in children” and “gender dysphoria in adolescents and adults” [17]. Although reasons for this have been described at length [18], it is worth emphasizing here that the discussion on whether diagnoses associated with gender identity in children should exist at all has been going on since the 1990s. The opponents point to the unnecessary medicalization of gender diversity in children.

As no hormonal or surgical interventions are used in case of children, diagnosis is not justified by the need to gain access to treatment. Another argument that is sometimes voiced is that considering childhood gender nonconformity as a problem may in consequence lead to pathologizing homosexuality again, especially male homosexuality, which often manifests this way in boys. Proponents of retaining the diagnosis talk of the need to provide professional support and education for parents, and the need to identify the subpopulations of gender nonconforming children for whom it is not a passing developmental variant and who experience or will experience discomfort or suffering because of it [19].

In the proposition of DSM-5 regarding adolescents, the axis of the change is depathologization of various forms of gender identity, but it is noted that dysphoria, that is a lasting suffering and discomfort stemming from the divergence between the gender assigned at birth and gender identity, is a problem which requires clinical interventions. This is why the diagnosis of gender dysphoria in a teenage person requires fulfilling two criteria. Criterion A: “A marked incongruence between one’s experienced/expressed gender and assigned gender, of at least 6 months’ duration, as manifested by at least two of the following:

- (1) a marked incongruence between one’s experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics);
- (2) a strong desire to be rid of one’s primary and/or secondary sex characteristics because of a marked incongruence with one’s experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics);
- (3) a strong desire for the primary and/or secondary sex characteristics of the other gender;
- (4) a strong desire to be of the other gender (or some alternative gender different from one’s assigned gender);
- (5) a strong desire to be treated as the other gender (or some alternative gender different from one’s assigned gender);
- (6) a strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one’s assigned gender)”.

Criterion B is as follows: “The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning” [17].

Reformulating the diagnostic criteria and the name itself was intended by the authors to contribute to removing the odium of pathology from diverse forms of experiencing one’s gender identity, at the same time leaving space for clinical interventions for people who suffer because of it [20]. Therefore, the aim of the interventions is not to change one’s gender identity, but to reduce the suffering brought by the experienced incongruence. Moreover, the term dysphoria implies the character of

the phenomenon as a non-binary spectrum or continuum. Contrary to gender identity disorder, which one might have or not, dysphoria can fluctuate in time, intensify and diminish, similarly to physical pain. It is worth noting that diagnoses associated with gender identity remain the only psychiatric diagnoses where hormonal and surgical interventions – partly or completely irreversible – are included as recommended forms of treatment.

A few months before the publication of DSM-5, which took place on 18 May 2013, a meeting took place between representatives of the WPATH and WHO to work on a consensus in the process of preparing the eleventh, fundamentally revised ICD classification [21]. The twenty-three years which had then passed since the publication of ICD-10 brought, apart from ample research and clinical data, a range of socio-cultural changes which the WHO had to acknowledge. One of the postulates included removing the category F66, that is “Psychological and behavioral disorders associated with sexual development and orientation” [22], removing the codes F64.1, that is “Dual-role transvestism” and F65.1, that is “Fetishistic transvestism”, and, most importantly, changing the name of code F64.0 “Transsexualism” and moving this diagnosis from the section “Disorders of adult personality and behavior” to another one, not related to psychological health [22]. A substantial majority of the postulates was introduced, and the final wording of ICD-11 was agreed on 18 June 2018. Issues associated with gender identity were placed in a new chapter “Conditions Related to Sexual Health”, where “transsexualism” was replaced with “gender incongruence of adolescence and adulthood”, according to the description provided by the authors characterized by “a marked and persistent incongruence between an individual’s experienced gender and the assigned sex, which often leads to a desire to ‘transition’, in order to live and be accepted as a person of the experienced gender, through hormonal treatment, surgery or other health care services to make the individual’s body align, as much as desired and to the extent possible, with the experienced gender. The diagnosis cannot be assigned prior the onset of puberty. Gender variant behavior and preferences alone are not a basis for assigning the diagnosis” [22].

Despite many similarities, ‘gender dysphoria’ from DSM-5 and ‘gender incongruence’ from ICD-11 are not interchangeable terms. The new WHO definition stresses the individual and subjective experience of incongruence between the assigned and experienced gender. The incongruence may cause significant clinical suffering and impairment of functioning, that is fulfill the criterion B for gender dysphoria according to DSM-5, especially in face of social disapproval, but neither the suffering nor the impairment of functioning is necessary for diagnosis. Gender incongruence is then a diagnosis of a state of incongruence between individual aspects of gender identity, anatomy and social roles, which may but does not have to imply discomfort. The definition with the aspect of suffering removed is not only a natural consequence of removing the diagnosis from the area of psychopathology, but, above all, it reflects the idea of depsychiatrization of various forms of experiencing one’s gender more clearly than the DSM-5 definition. If the incongruence is accompanied by the

wish to transition, it is recommended that medical and formal actions should be undertaken to achieve possibly full cohesion between psychological identity, body and legal situation.

### **Psychological health of adolescents reporting gender dysphoria**

Research on psychological health of persons experiencing gender dysphoria focuses on adults, with few exceptions [23], and almost always shows alarmingly high rates of anxiety, depression, nonsuicidal self-harm, suicidal ideation and suicide attempts. Various authors [24–28] see the reasons for this primarily in the suffering associated with experiencing one's gender identity as different from the gender assigned at birth, the changes in one's body during puberty, stigmatization, prejudices and rejection from friends and family, as well as minority stress, that is a unique, chronic and socially conditioned tension associated with belonging to a discriminated group. There are significantly fewer reports focusing solely on teenagers, and they refer mainly to the last two decades, which makes this population a minority of a minority. An additional difficulty is the fact that the data are limited to the subpopulation of teenagers where at least one of their carers agrees to consultations, assessment of psychosexual development and potential medical intervention. Most research, some of which is quoted below, comes from institutions specializing in gender identity, where parents report in the initial stages of recognizing the problem and actively seek help for their children [29]. It could be then assumed that a significant number of teenagers who do not have access to such care are included in the data much later, as young adults beginning the process of diagnosis and assessment only after reaching the age of majority. Methods for assessing psychological health of teenagers reporting gender dysphoria vary significantly between institutions, which excludes the possibility of comparing samples. There are also no systematic literature reviews in this regard. Readers interested in reviews of literature on adults should refer to the work of Dhejne et al. [28]. In one of the available studies on teenagers conducted by Spack et al. [27], 44.3% adolescents had a history of at least one psychiatric diagnosis, 37.1% had taken medicines prescribed by a psychiatrist and 21% reported past or present suicidal ideations. A team in one of Canadian clinics [30] studied a sample of 84 adolescents, where 44% of those assigned female gender at birth and 33% of those assigned male gender at birth matched the criteria for anxiety disorders. Ten persons in this study had tried to commit suicide at least once. In turn, each of the 21 adolescents qualified for hormonal therapy in 2011 by the Australian team of Hewitt et al. reported symptoms of anxiety and depression [31]. A team from Finland, studying a similar sample of teenagers evaluated before medical transition reported treatment for depression in the history of 64% of patients, and suicidal ideation and nonsuicidal self-harm in 53% of patients [32]. In a sample of 218 patients of Tavistock Clinic in London, which treats both children and adolescents, 42% reported low mood and 39% reported practicing nonsuicidal self-harm [33]. There is only one study comparing

results of the MMPI administered to 86 adolescent and 293 adult transgender persons who had not undergone social or medical transition. The adult group showed much higher rates of psychopathology [32], which – as the authors of the study suggest – may point to psychological health benefits of early coming-out.

Although there are cases where the severity of internalizing and externalizing symptoms is such that it makes the assessment of stability of gender identity and gender dysphoria in time virtually impossible, as well as impairs the patient's ability to express informed consent to hormonal treatment, it should be emphasized that those cases are not the norm, nor do they have to indicate the diagnostic criteria for dysphoria are not met. Gender dysphoria is in a sense an egalitarian experience: it does not discriminate based on one's background, intrapsychic and interpersonal resources, intelligence, level of emotional development, and so on. Thus, persons experiencing dysphoria, especially at the developmental crisis of adolescence, are capable of verbalizing and bearing it to different degrees, using defense and coping mechanisms of various levels of adaptability.

### **Gender dysphoria and neurodiversity**

Another challenge in providing care for teenagers reporting gender dysphoria (GD) is individualizing the diagnostic process in the case of patients showing symptoms of autism spectrum disorders (ASD). Both clinical practice and research point to an increasing number of patients with this problem. A systematic review of medical databases in this respect by Van Der Miesen et al. [34] quotes studies where coexistence of GD and ASD varies from 3.8% [35] to 21.3% [36], depending on the inclusion criteria. Still, even the more conservative estimates are higher than the estimated prevalence of ASD in the general population, which is 1% [37]. The authors see the reason for this in interactions of biological, social and psychological factors, at the same time pointing out the limitations associated with excessive attachment to individual conceptions, as well as their speculative nature [38]. Despite the difficulties of diagnosing neuroatypical teenagers reporting gender dysphoria, there is nothing in the literature to suggest that ASD could be a factor excluding the possibility of diagnosing GD. The most common recommendation is lengthening the observation process and individualizing it in a way that takes into consideration the patient's level of development [38]. Turban [39] goes even further, questioning the method of assessing ASD in adolescents experiencing gender dysphoria and suggesting that the scales used for assessment, in the case of 80% of young people experiencing anxiety and depression, yield results within the reference range, and thus generate artifacts in the form of overrepresentation of ASD diagnoses in adolescents with GD. The author suggests considering the hypothesis of quasi-autism, that is social deficits following high exposure to stress, lack of contact with peers, or rejection by family.

## **Diagnosis and treatment of children and adolescents – the Dutch model**

The range of interventions offered for children and adolescents with gender dysphoria was examined in a 2012 report by Byne et al. [40] for the American Psychiatric Association. Therapeutic approaches designed for children were categorized into three main groups. The first focused on the reduction of experienced gender dysphoria, as well as strengthening identification with the assigned gender. The second focused on supporting children in their natural development, including the natural development of their gender identification and behaviors. The third focused on early affirmation of the child's identification with the experienced gender. Literature on each of these approaches is limited, and each has been criticized as well as argued for. The Dutch model presented here integrates approaches of the second and third group, with emphasis on “watchful waiting” in reference to children and “affirmation” in reference to adolescents.

The first clinic in the world which specializes in gender dysphoria in children and adolescents was established in 1987 at the medical center of Utrecht University (currently the University of Amsterdam), but it should be noted that the team who created it started their work in this field already at the beginning of the 1970s. The number of patients grew consistently, from 34 in 1980 to 686 in 2015 [41]. Although the data for the years 2016–2018 are not available yet, an upward trend can be expected. To compare, another pioneering institution specializing in dysphoria in children and adolescents, the Gender Identity Development Service for Children at the Tavistock Center in London, had 97 new patients in 2009 and as many as 2,519 from the beginning of 2017 to April 2018 [42]. Insufficient knowledge, as well as lack of studies and recommendations, combined with the dramatically growing need for instructions or guidelines, inspired the pioneering team working in Amsterdam to create the so-called Dutch protocol – a complex, long-term procedure for observation, treatment and evaluation of minors reporting gender dysphoria [43]. The program is widely cited and has a relatively large scientific basis, which is why it is discussed here in more detail. Nevertheless, it is also worth learning about models of care used in other leading centers, such as the abovementioned Gender Identity Development Service for Children at the Tavistock Center in London or Gender Identity Service, Child, Youth, and Family Program at the Center for Addiction and Mental Health in Toronto [44–47].

The authors of the Dutch protocol emphasize the difference of approach depending on the age of patients, who fall into two groups: children up to 12, and adolescents between 12 and 18 years of age [41]. Observation of children should lead to a precise determination whether the gender nonconforming behaviors are a passing developmental variant which does not cause discomfort or, on the contrary, whether they have the characteristics of persisting gender dysphoria. If possible, every aspect of the child's functioning is assessed, including their cognitive level, social functioning and learning outcomes, as well as current and past family situation. The dysphoria itself is an important but not central element, and the therapeutic

interventions do not focus on it. If the assessment of the child's functioning reveals coexisting developmental or family problems, they are treated first. If such problems are not identified, parents are offered psychoeducation and support to help them in the difficult situation they found themselves in. The uncertainty as to the way their child's gender identity will develop may cause various adjustment disorders, and as a result decrease the parents' functioning levels to a more significant degree than the dysphoria affects their child's. The uncertainty may be increased by the fact that studies of childhood dysphoria yield largely divergent results. The available studies currently encompass 317 children observed until adolescence or early adulthood and estimate the rate of dysphoria persisting from childhood to adolescence or early adulthood at between 2% and 39% [43]. Various interpretations of this phenomenon have been offered. One of them emphasizes the importance of long-term observations, as some persons whose dysphoria had seemingly subsided may experience it again and seek help later. This does not change the final conclusion that childhood gender dysphoria desists in most cases [43–45]. At the same time, so far there has been no method to accurately predict further development of a child who identifies with the opposite sex or does not identify with their assigned sex, although research points to such factors as the severity of gender dysphoria in childhood and the scope of cross-gender behaviors. Other factors include female gender assigned at birth, later age of assessment of childhood gender dysphoria, lower social class, and social transition in childhood, especially in children with male gender assigned at birth. Additionally, children whose gender dysphoria persisted more often stated explicitly that they felt they were persons of another gender, while those whose dysphoria desisted said that they would like to be of another gender. The age when changes associated with puberty intensify, both in the psychosocial environment as well as in the body (10–13 years) has been deemed key for gender dysphoria persisting or ceasing, and the available data suggest that the probability of persisting of gender dysphoria presenting at this age is high [48]. In light of the above, the authors of the Dutch protocol do not recommend full social transition, that is the solution where the child receives a new name, different pronouns are used in reference to them, and people around them are not informed of the gender the child was assigned at birth. The authors argue that this would be too great a burden in the development of these children who may want to go back to identifying with their natal gender and perhaps abandon it for fear of rejection. Moreover, young children, after a prolonged period of functioning in a social role, may not realize the biological path of their development and, as a result, be unprepared for the typical changes of puberty. Instead a full social transition, it is proposed that a child should be encouraged to try various behaviors and games regardless of the gender they are stereotypically assigned. Parents are also taught how to support the child's gender identity and encourage other aspects of their development at the same time.

In the case of adolescents, however, the protocol is different. The assessment of persons above 12 years of age itself is similar, regardless of whether they were ob-

served earlier in connection of gender dysphoria experienced in childhood or reported to the clinic only during puberty, the only difference being that in the former case the period of re-evaluation may be somewhat shorter [41]. After conversations with the parents and the adolescent, there is a series of individual consultations during which the diagnostician collects information on the patient's psychosexual development, their sexual experiences, behaviors, preferences and fantasies, as well as the perception of their body, the severity of the dysphoria, and the context in which it appeared. After the extended history is taken, an individualized process of assessing the developing personality takes place, including the assessment of possible psychopathology, which involves additional consultations with a psychiatrist, an evaluation of the family situation and the factors which influence experiencing dysphoria and the motivation for undertaking measures leading to medical sex reassignment. Further interventions, over a few years, are paramount for the patients' future and can be grouped into reversible (suspension of puberty), partly reversible (hormonal therapy) and completely irreversible (surgical procedures). An adolescent qualifies for these interventions if they: 1) fulfill the criteria for gender dysphoria according to the DSM, 2) live in a supportive family and social environment, 3) do not have coexisting psychological or psychosocial conditions which would make diagnosis and treatment more difficult. Detailed psychoeducation of both the patient and their carers, biochemical tests, assessment by a pediatric endocrinologist, and reaching by the patient stage 2 or 3 on the Tanner scale all precede treatment with gonadotropin-releasing hormone agonist (GnRHa) aimed at suppressing puberty. The requirement to reach a specific stage of biological development is especially important for diagnosis, since it is only after the onset of puberty that it is possible to subjectively experience it (not just anticipate it) and react to the experience. The main premise for puberty suspension is providing the patient time for exploring their identity while relieving them from the need to experience their body becoming more masculine or feminine. As a result, gender dysphoria and its behavioral and affective components should diminish, making more harmonious development possible for the teenage person. Another premise for puberty suspension is that if the patient eventually qualifies for hormonal therapy, early suppression of such sex characteristics as facial hair, breaking of the voice and proliferation of muscular tissue in persons with assigned male gender, or the development of breasts, hips and adipose tissue in persons with assigned female gender results in hormonal therapy bringing significantly better results and make it possible for patients to achieve the silhouette they want. Introducing sex hormones then triggers biological puberty congruent with the experienced gender, which makes it a partly irreversible process. Patients qualified for it must be at least 16 years of age [41, 43]. Decisions to undergo any surgical procedures are taken after reaching the full legal age.

### Challenges in diagnosis and treatment

Studies on treatment of adolescents experiencing gender dysphoria largely focus on cases where dysphoria begins in childhood and persists or intensifies during puberty. Therefore, it seems that the Dutch protocol is especially useful, or actually created, for this group. There are few reports in literature on teenagers who started experiencing incongruence during puberty, especially in the case of persons with assigned female gender. The many unknowns, combined with the gaps in literature and research, may contribute to the feelings of helplessness and frustration among clinicians, and they in turn may lead to overly simplified hypotheses and diagnostic artifacts, as was the case with the widely criticized *rapid onset gender dysphoria* authored by Lisa Littman [48–50]. The hypothesis presented in this widely cited and criticized 2018 study suggested the significance of “trends” and “social contagion” in the “spread” of reporting experiences of gender dysphoria by teenage girls. The methodology of the study the hypothesis was based on has been severely criticized. Although the reasons for the rise in reports of gender dysphoria are still not fully understood, it is thought that the wider access to the internet and social media allows adolescents to better understand their experience, find a name for it, and seek support.

There is no doubt that more empirical studies focusing on gender dysphoria in adolescents as broadly as possible are needed. It seems unlikely that coexisting psychopathology results from gender dysphoria in all cases and as such subsides as a desired result of social and medical transition. Despite this, in connection to the abovementioned egalitarianism, persons with personality disorders or schizophrenia-spectrum disorders may also experience persisting gender dysphoria. This means that in some cases a successful treatment may require two diagnoses and two treatments which will complement each other.

It is rather common that the significance of issues associated with identity reported by teenage patients is marginalized and treated from the start as one of the undesirable symptoms of psychopathology. In many places, teenagers are refused to function in society under the name they chose, with the explanation that it may strengthen “something that may not be true at all”. This doubt is in many ways understandable – the lack of standards and literature based on studies conducted in Poland, very limited availability of such content in curricula of studies and seminars, and lack of systemic solutions translate into the need for increased caution and avoidance of any treatment for fear of strengthening the teenage patient’s wish to transition. However, this approach assumes, although it has not been confirmed by research, that using forms of address congruous with the patient’s identity equals a diagnosis and has a similar effect as hormonal therapy. Refraining from doing something is not ethically neutral; lack of action is also action. Refusal to use their preferred pronouns may be treated by the patient as invalidating their identity, and as a result take on an iatrogenic character and contribute to aggravating their minority stress and dysphoria, as well as psychopathology in form of internalizing and externalizing disorders, suicidal

ideation and suicide attempts. Both in the process of psychotherapy and diagnosis, the therapeutic alliance is of paramount importance and respecting the patient's identity or gender identification, even if it is temporary, seems to be essential in obtaining it. Adjusting the pronouns and the name to the patient's experience of themselves may bring positive results in the long run even if the original problem disappears or changes character with time.

The rate of suicidal tendencies and attempts in the general population of adolescents and young adults is alarmingly high and rising [51], resulting in a growing need for psychiatric and psychotherapeutic care for children and adolescents, as well as the shortage of specialists in this area. Transgender persons think about suicide or attempt suicide twice as often as non-heterosexual persons [51, 52]. This rate is even higher in the population of adolescents. In light of this, gender dysphoria has become one of those psychological health issues whose appropriate diagnosis and treatment may save lives. It should be noted here that treatment in this context is a very broad category, including the obvious hormonal and surgical interventions, which, as noted above, do not always align with the patients' wishes, but which actually start with an extremely delicate diagnostic situation: noticing the issue, describing and assessing its advancement, and finally accepting the identified dysphoria and experienced identity in the form, shape and nature they present in at the moment. It seems that there are only few other medical situations where the role of language and the choice of words play an equally important role from the first moment of contact between the professional and the patient. In this case, even the first words said during the consultation have a therapeutic or antitherapeutic character and, chosen carelessly, they may break the rule of *primum non nocere*.

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