Opinion no. 43/2024

Bern, 7 November 2024

Medical treatment for minors with gender dysphoria

Ethical and legal considerations

Swiss National Advisory Commission
on Biomedical Ethics

NEK CNE

Table of contents

1. Introduction

For most people, the gender which they were assigned at birth on the basis of their external sex characteristics* matches their gender identity: they feel themselves to be a boy/man or girl/woman and are also perceived as such by others. For some people, however, this is not so: the gender ascribed to them by others is felt to be alien, incorrect or inappropriate. This mismatch between the gender ascribed by other people and a person's subjective gender identity* is known as gender incongruence*.[1] How many people in Switzerland experience such an incongruence is not clear. No official statistics on gender identity are available for the Swiss resident population, and the results of surveys vary widely, depending on the methods employed, age group and time of data collection. In a representative survey on "Gender and identity" conducted by Sotomo in Switzerland in 2021, 5% of respondents reported identifying more closely with the other (binary) gender, and 0.4% described their gender identity as non-binary*, i.e. neither (exclusively) female nor male (Sotomo 2021). To deal with the specific challenges which may arise from gender incongruence for the individuals concerned, increasing numbers of people are also seeking medical assistance.[2] As, among children with persistent gender incongruence, the resultant distress, or gender dysphoria*, typically becomes more intense at the onset of puberty (Medico et al. 2020), those who seek help are often still minors (Sun et al. 2023).

While society's awareness of gender diversity is growing overall, this shift is accompanied by a degree of uncertainty or even unease. Particularly with regard to the medical treatment of minors with gender dysphoria, major reservations are repeatedly expressed among the public. In some countries, political efforts are therefore being made to restrict or to prohibit such treatments altogether.[3] Due to the heavy politicisation of this topic – also in Switzerland – the persons concerned, their families and the professionals providing care increasingly find themselves caught between the fronts of a highly polarised debate, and individual treatment decisions assume a political dimension (Leibowitz et al. 2020). For this reason, the Cantonal Medical Officers of Latin Switzerland requested the National Advisory Commission on Biomedical Ethics (NCE) to state its views on the question of medical treatment for minors with gender dysphoria from an ethical perspective. In particular, they wished to have a social, legal and ethical assessment of the issue, a clarification of the role to be played by medicine, and recommendations as to how the decision-making process should be structured in practice for minors, so as to ensure the best possible care.

The need for specific treatment guidelines for children and adolescents with gender dysphoria has also been recognised at the international level. Accordingly, for German-speaking countries, a guideline on "Gender incongruence and gender dysphoria in childhood and adolescence: diagnosis and treatment" was announced by the Association of the Scientific Medical Societies in Germany (AWMF) in December 2020. The as yet unpublished guideline (no. 028-014, classified as S2k) contains concrete recommendations for treatment which are supported by the delegates of the 26 societies

---

[1] Explanations of terms highlighted with an asterisk can be found in the Glossary on page 34–36.

[2] Despite growing numbers of consultations at healthcare facilities, not all of those concerned wish to receive gender-affirming care. According to a US study, 36% of transgender* and non-binary* youth surveyed were not interested in receiving gender-affirming care, while 14% were currently receiving hormone therapy. The other 50% were not receiving such therapy but would like to do so (Green et al. 2022).

[3] Cf. the trans legislation tracker for the US (https://translegislation.com), proposed legislation in Australia (the Childhood Gender Transition Prohibition Bill), or a bill presented in the Grand Council of Geneva on 9 May 2023 (*Interdiction des interventions de réassignation sexuelle destinées aux mineurs*; PL 13324).

involved, with a consensus strength of 90–100%.[4] It is based on currently available scientific evidence and is addressed to professionals in Germany, Austria and Switzerland. Editorial work on this guideline has been completed, and it is expected to be published in the first quarter of 2025.

Against this background, the NCE decided to focus, in its Opinion, on the ethical and legal challenges arising in connection with the medical treatment of minors with gender dysphoria. As treatment protocols for persons with gender dysphoria after completion of puberty differ in certain respects from those for the target group discussed here, the following considerations are not necessarily also applicable for the treatment of gender-dysphoric adults. For a detailed discussion – from a medical/specialist perspective – of the various treatment options for adults with gender dysphoria, readers are referred to AWMF guideline no. 138-001 (2018).

The Opinion is structured as follows: after this Introduction, Section 2 deals with the development, diagnosis and treatment of gender dysphoria in minors. Section 3 is concerned with legal considerations and with the ethical implications, based on the principles of biomedical ethics developed by Tom L. Beauchamp and James F. Childress. Finally, in Section 4, recommendations are formulated with the aim of ensuring that minors with gender dysphoria receive appropriate medical care.

---

[4] AWMF guidelines are based on a systematic review and appraisal of available evidence and are developed in collaboration with the relevant professional societies. They are categorised into various levels of evidence (S1–S3) and follow clearly defined methods. The guidelines are not legally binding, but describe current best practice. Over 100 member societies are involved in guideline development. See: www.awmf.org/leitlinien (4 November 2024, german only).

2. Gender incongruence and gender dysphoria in a medical context: diagnosis, support and treatment

Why certain people develop gender incongruence has yet to be definitively established (cf. Skordis et al. 2020). Relatively little research has been carried out on the development of gender identity in children and adolescents (Steensma et al. 2013). While most children can already ascribe a gender to themselves and others at the age of 18–24 months ("gender labelling"), it is only at the age of 4–6 years that they form a conception of gender as a (generally) constant attribute, which does not change even if a person behaves or dresses in a gender-atypical manner (Steensma et al. 2013; Trautner et al. 2003). Nonetheless, the experience of a mismatch between externally ascribed and felt gender can occur very early in children. Thus, in the literature, various cases are documented of children who, at the age of three years, have already clearly and emphatically communicated that they do not accept their assigned gender and wish to live in a different gender (Bockting 2008; Cohen-Kettenis 2005). In a study of 96 minors seeking care for gender dysphoria, the mean age at which they recognised their gender incongruence was reported to be 8 years.[5] In addition, a number of years elapsed between internal and external coming-out*[6] (Olson et al. 2015). In a study investigating the process of gaining awareness of their gender incongruence and external coming-out in ten children from French-speaking Switzerland, three typical developmental pathways were observed: a) children who affirm their gender identity very early and also express it, at least privately; (b) the "silent" children who spend their childhood in a state of internal tension without being able to label their feelings; and (c) children who only become aware of their gender incongruence at puberty. The third group mainly consisted of children who spent an unproblematic childhood as tomboys*, with gender dysphoria only developing at puberty. A considerable time lapse between internal and external coming-out (2–7 years) was also documented in this study (Medico et al. 2020).

2.1 Diagnostic criteria according to ICD-11

While children frequently experiment with different roles and sometimes disregard social expectations concerning typically "girlish" or "boyish" behaviour, gender nonconforming* or gender variant* behaviour is not in itself a reliable indicator of gender incongruence or a transgender* identity. Gender variance may, for example, also indicate a non-heterosexual orientation.[7] For diagnostic purposes, therefore, what is crucial is not the person's behaviour, but their experienced gender.

This is reflected by the new classification in the eleventh revision of the International Classification of Diseases (ICD-11) diagnostic manual, which explic-

---

[5] However, the age range was very wide – up to 22 years (Olson et al. 2015).

[6] Internal coming-out refers to the time of personal recognition, while external coming-out involves communication with others. Internalised norms or fear of rejection may lead those concerned to reject or seek to suppress feelings regarded as inappropriate. Internal coming-out thus marks the step of acknowledging to oneself e.g. a transgender identity or homo- or bisexuality.

[7] In a Dutch study involving 54 gender-dysphoric children, the probability of homo- or bisexuality developing in the course of puberty – without a transgender identity – was almost 50% for children assigned male at birth (Wallien & Cohen-Kettenis 2008). However, if it is found that a person is sexually attracted to others of the same sex that they were assigned at birth, this by no means excludes a transgender identity. Cf. Nieder et al. (2016).

itly states that gender-variant behaviour alone is not a basis for assigning the diagnosis of gender incongruence. Rather, there must be a strong desire to live permanently and be socially accepted as a person of the experienced gender.

The diagnosis as formulated in ICD-11 is now "Gender incongruence of adolescence or adulthood" (HA60), or "Gender incongruence of childhood" (HA61), replacing the outdated diagnosis of "Transsexualism" (ICD-10: F64.0), or "Gender identity disorder of childhood" (ICD-10: F64.2). In addition, these diagnoses have been moved from the "Mental disorders" to the "Conditions related to sexual health" chapter. It is not yet clear when ICD-11 will come into effect in Switzerland.[8]

ICD-11 (2022)

Gender incongruence
Gender incongruence is characterised by a marked and persistent incongruence between an individual's experienced gender and the assigned sex. Gender variant behaviour and preferences alone are not a basis for assigning the diagnoses in this group.

HA60 – Gender incongruence of adolescence or adulthood
Gender incongruence of adolescence and adulthood is characterised 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 to the onset of puberty. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis.

---

[8] Cf. the interpellation 23.4184 submitted by National Councillor Manuela Weichelt on 28 September 2023: https://www.parlament.ch/de/ratsbetrieb/suche-curia-vista/geschaeft?AffairId=20234184 (21 August 2024); a report published in April 2024 on the introduction of ICD-11 in Switzerland estimates that six years will be required for preparatory work alone: https://www.bfs.admin.ch/bfs/de/home/statistiken/gesundheit/nomenklaturen/medkk/icd-11.html (21 August 2024).

HA61 – Gender incongruence of childhood
Gender incongruence of childhood is characterised by a marked incongruence between an individual's experienced/expressed gender and the assigned sex in pre-pubertal children. It includes a strong desire to be a different gender than the assigned sex; a strong dislike on the child's part of his or her sexual anatomy or anticipated secondary sex characteristics and/or a strong desire for the primary and/or anticipated secondary sex characteristics that match the experienced gender; and make-believe or fantasy play, toys, games, or activities and playmates that are typical of the experienced gender rather than the assigned sex. The incongruence must have persisted for about 2 years. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis.

As the care provided for prepubertal children with gender incongruence, unlike that for adolescents and adults, does not involve surgical or hormonal interventions, the diagnostic category of "Gender incongruence of childhood" has been criticised by some representatives of civil society as unduly pathologising (cf. GATE 2013). It is argued that any need for psychosocial support can already be adequately met through existing diagnostic codes.[9] In the case of adolescents and adults, the situation is different: in order to ensure that they can access medical services for the treatment of gender incongruence, an ICD classification is helpful. The WHO (2022) thus justifies the decision to include the gender incongruence diagnosis in ICD-11 as a means of ensuring access to and financing of specific health services for this group.[10]

2.2 Medical support and treatment

In its Standards of Care (SOC-8), the World Professional Association for Transgender Health (WPATH) explicitly states that expressing a transgender identity or experiencing gender incongruence "should not be seen as inherently negative or pathological."[11] However, the alienation from one's own body associated with marked gender incongruence may cause great distress in those concerned and lead to a desire to undergo gender-affirming treatment, so as to reduce the discrepancy between experienced gender and physical appearance. As, in minors, this discrepancy becomes increasingly acute with the onset of puberty, the associated distress – gender dysphoria – also typically increases at this stage. For this reason, the individuals concerned or their caregivers often consult medical professionals at this time, expressing a desire for the process of sexual maturation to be temporarily halted. In prepubertal children, however, care provision is restricted to psychosocial or psychological counselling and support. Prepubertal children are not eligible for gender-affirming treatments and no such interventions are performed at this stage (Coleman et al. 2022, S64).

---

[9] "Children facing challenges such as family opposition, bullying at school, or social rejection due to gender variance should be able to access services through codes that address these hostile environments without pathologizing the child. Parents, other family members and other relevant individuals, such as teachers and social workers, should similarly be able to access information, counseling, and support through codes that target their specific needs, without projecting their own distress on the child." GATE (2013)

[10] "Inclusion of gender incongruence in the ICD should ensure transgender people's access to gender-affirming health care, as well as adequate health insurance coverage for such services." WHO (2022)

[11] Coleman et al. (2022), S6.

2.2.1. Psychological, systemic and psychotherapeutic support

Children with gender-nonconforming behaviour often experience criticism and social rejection. It is thus conveyed to them that their "being different" is undesirable, and they are frequently subject to intense pressure to conform to conventional gender norms and the associated expectations with regard to appearance, behaviour and preferences.[12] While a (tom)boyish manner in children read as girls tends to be socially tolerated, children read as boys are rapidly subjected to social sanctions (i.e. bullying, exclusion, scolding or humiliation) if their behaviour or clothing is perceived as "girlish" (Jewell & Brown 2014; Pauli 2017).[13] The experience of being rejected for expressing their felt identity has an impact on these children's psyche and self-esteem. Pressure to conform, in particular, adversely affects their psychological welfare: whereas children who rate themselves as gender atypical do not necessarily fare worse, in terms of mental health, than children who score higher in terms of gender tipicality*, a clear negative influence on psychological welfare and self-esteem is observed when they also report high pressure for conformity (Perry et al. 2019).[14]

This prompts the conclusion that the high prevalence of concomitant mental disorders – such as depression, anxiety or suicidality – in individuals with gender dysphoria is not (solely) related to gender incongruence (Garcia Nuñez et al. 2024, Krüger et al. 2023).[15] It is also substantially influenced by social pressure for gender-conforming behaviour, as well as experiences or fears of exclusion, disparagement and rejection by peers and the wider social environment if these expectations are not met.[16] Of particular importance for children and adolescents are parental attitudes (Grossman et al. 2021; Simons et al. 2013). In providing support and treatment for minors with gender dysphoria, systematic consideration must therefore be given to the social and systemic dimension (family, school, sports club, etc.).[17] A supportive family environment has been shown to be an important protective factor for the mental health and well-being of children and adolescents with gender dysphoria (Campbell et al. 2023; Başar et al. 2016; Davey et al. 2014), thus significantly improving the prospects of successful treatment (cf. De Lara et al. 2020). Close involvement of and support for family members, including family therapy in the event of conflict, is to be recommended (cf. Pauli 2017).

If signs of psychological stress are seen in minors, psychological or psychiatric assessment and support

---

[12] "Generally, a child's gender expression may vary depending on the perceived expectations of emotionally significant people. If a parent for example, does not want the child to express their felt gender, the child will reassure their parent by acting in a way as to confirm this significant adult's point of view. Children may therefore seem ambivalent about their gender while they are in fact navigating a stressful situation and managing fear of rejection." Medico et al. (2020), p. 1006.

[13] This difference in reactions is also reflected in clinical practice: in cases of gender variance, parents tend to seek professional help earlier for children assigned male at birth than for those assigned female at birth (cf. Pauli 2023).

[14] "Indeed, children who have any of several reasons to question their fit with their gender – who feel dissatisfied with their own gender, who feel different from same-gender peers, who feel similar to the other gender, or who are overtly gender nonconforming – tend to experience adjustment difficulties (e.g., depression, low self esteem) mainly to the extent that they feel pressure for gender conformity […]. This is important because it underscores the severe harm that gender self-discrepancies can cause children, indicates that children who question their gender fit are not inevitably handicapped, and carries implications for parents, teachers, and other socializing agents." Perry et al. (2019), p. 300. For a cross-national overview of the relationship between gender conformity and self-esteem, see Zentner & von Aufsess (2022). For a qualitative study from Switzerland, see Medico et al. (2020).

[15] There is an almost complete lack of statistical data on suicidality and attempted suicide in trans youth in Switzerland (cf. Pfister et al. 2019, Krüger et al. 2023). In 2022, according to a survey of the adult Swiss resident population conducted by the Swiss Health Observatory (Obsan), 8% of cisgender and 29% of transgender/non binary respondents reported suicidal thoughts. 3.8% of cisgender and 9.7% of transgender/non-binary respondents had already attempted suicide at least once (Peter & Tuch 2024). While the relatively small numbers of cases need to be borne in mind when interpreting the data for transgender/non-binary people, the figures largely correspond to those from international studies (cf. Surace et al. 2021).

[16] This effect has been termed "minority stress", referring to the chronic stress to which minorities are exposed as a result of experiences and expectations of rejection, stigmatisation, discrimination and violence (cf. Meyer 2003). For a study relating to Switzerland, see Garcia Nuñez et al. (2024).

[17] "These [results] demand that the transition process should not be considered a solely 'medical' matter, but a multifactorial one including psychological, physical and social processes. Therefore, more systemic interventions (e.g., involvement of family members, school, employers) provided by the care system but also by peers are needed." Garcia Nuñez et al. (2024), p. 7; Cf. also Başar et al. (2016) and Campbell et al. (2023).

should be offered (Michaud et al. 2024; cf. AWMF guideline, IV.K1.). If a mental disorder requiring treatment is diagnosed, appropriate therapy should be initiated promptly. Psychiatric problems may arise either as adjustment reactions to gender incongruence and the associated stressful experiences, or independently thereof. For this reason, it is recommended that diagnostic instruments be used which take account of psychological stress associated with experiences of stigmatisation and discrimination (Garcia Nuñez et al. 2024). Whether a specific mental health crisis or condition represents a contraindication with regard to medical treatment for gender dysphoria needs to be assessed in each case by a specialist (cf. Michaud et al. 2024).

If there are signs of autism spectrum disorder (ASD), an appropriate assessment is recommended. Gender incongruence or gender dysphoria is overrepresented in people with ASD (Hisle-Gorman et al. 2019). Even below the diagnostic threshold for ASD, a clear statistical association can be demonstrated between ASD traits, gender-dysphoric feelings and cross-gender behaviour (Kallitsounaki et al. 2021). The prevalence of ASD among people seeking treatment for gender dysphoria varies from one study to another, but is generally around 10% (de Vries et al. 2010; Kallitsounaki & Williams 2023). It is thus considerably higher than in the general population (around 1%) (Roy & Strate 2023).

An ASD diagnosis does not represent a general contraindication for medical treatment of gender dysphoria. However, people on the autism spectrum frequently require more time for decision-making, as well as specific support (Pauli 2017). In cases where ASD has been diagnosed, specialists from this area should be consulted, as appropriate expertise is essential to ensure the best possible medical care (cf. AWMF guideline, IV.K6. & IV.K7.).

For many people with gender incongruence, inadequate expertise or a lack of experience on the part of professionals in providing appropriate support and treatment continue to pose a barrier to access to healthcare. In a study on the health of LGBT[18] people in Switzerland, 35.6% of trans/non-binary respondents reported having chosen not to utilise health services for fear of discrimination based on their gender identity or sexual orientation (Krüger et al. 2023). Inadequate knowledge and skills in the management of gender variant people were identified as an important reason for these negative experiences (Ayhan et al. 2020). This is also the case for minors in Switzerland (Medico et al. 2020). It is thus crucial that support and treatment for people with gender dysphoria should be provided by professionals with appropriate training and experience in trans health (cf. AWMF guideline, VII.K0; Coleman et al. 2022).

Aims of psychological care

Psychological or psychiatric care can offer support in coping with stressful experiences such as family conflicts, discrimination or social exclusion (bullying, etc.). It can help individuals to explore their gender identity in more depth, or to reflect on and deal with internalised stigma (transphobia). In addition, psychological or psychiatric support can be provided to facilitate the process of social or medical transition* (cf. AWMF guideline, V.K4).

In the long term, despite having (on average) a markedly higher risk of mental disorders, gender-incongruent adolescents and adults can attain a quality of life similar to that of the cisgender* population (Durwood et al. 2017, de Vries et al. 2014), especially if they have a supportive environment (De Lara et al. 2020). In addition, protection against discrimination and access to appropriate medical care can substantially reduce the risk of suicide and depression (cf. Green et al. 2022; Tordoff et al., 2022; Bauer et al. 2015).

2.2.2. Puberty suppression

The administration of drugs that stop the progress of puberty (puberty blockers) is one of various medi-

---

[18] LGBT: lesbian, gay, bisexual and transgender.

cal interventions currently used for the treatment of gender dysphoria in adolescents. This treatment was originally developed to delay sexual maturation in children with early-onset (precocious) puberty, and it has been employed in this indication for many years. Here, so-called GnRH analogues[19] are used to substantially reduce the production of endogenous sex hormones, thus interrupting puberty. Biological maturation processes which have already taken place (e.g. breaking of the voice) cannot, however, be reversed. The administration of GnRH analogues to adolescents with gender incongruence is an instance of off-label use.[20]

In the context of gender dysphoria, according to current best practice, puberty suppression, if indicated, is not to be initiated before Tanner stage* 2. This means waiting until breast or testicular growth has begun.[21] Puberty blockers can also be used later, although the desired effect – preventing the development of secondary sex characteristics – will be less marked as puberty advances. The adolescents are usually aged between 12 and 16 at the start of treatment (Coleman et al. 2022, S65). Puberty suppression is always a temporary measure. Once the GnRH analogue is discontinued, puberty resumes. According to current scientific knowledge, this measure is completely reversible, and in the context of precocious puberty it is well researched and established (Hembree et al. 2017). Since, in the case of adolescents with gender dysphoria, a different age group is involved, consideration needs to be given in this context not only to the physical effects but also to the psychological and social dimensions of delayed puberty. While treatment for precocious puberty results in alignment with the physical development of one's peers, this is not the case for adolescents undergoing puberty suppression. Virtually no robust data from scientific studies is currently available on the psychosocial implications of delaying puberty (Coleman et al. 2022, S66).

Aims of treatment

The use of puberty blockers can, firstly, prevent the development of unwanted physical sex characteristics (e.g. voice change, beard or breast growth) which are irreversible and would adversely affect the outcome of a subsequent transition. In addition, time can be gained to allow a careful assessment of the adolescents' needs and wishes, and to create space for a process of reflection involving not only the adolescents themselves but also those closest to them. In addition, if the adolescents do not yet have capacity to consent in relation to further medical interventions, puberty suppression can provide them with more time for developing the relevant abilities without being exposed to the stress of puberty in an undesired gender.

As puberty suppression merely arrests sexual maturation, without however causing any physical development in the direction of the desired gender, it is not to be expected that the distress of existing gender dysphoria can be reduced by this intervention alone. The aim is rather to prevent an exacerbation of gender dysphoria due to unwanted physical changes. Since puberty represents a massive stress factor for adolescents with marked gender dysphoria, puberty suppression may provide relief and thus have positive effects on their general mental welfare by averting a scenario which they find barely tolerable (cf. Rew et al. 2021).

Risks and adverse effects

As well as having temporary adverse effects, such as hot flashes or mood swings,[22] puberty blockers can

---

[19] Gonadotropin-releasing hormone analogues are hormone-like substances which bind to and, with prolonged use, downregulate GnRH receptors, so that the release of sex hormones is reduced.

[20] Off-label use means that the treatment or substance/product in question is not officially approved for this specific indication or patient group. As children are generally excluded from registration studies for ethical reasons, off label use is widespread in paediatrics (approx. 40% to 90% of drugs prescribed) (Cuzzolin et al. 2003; Kimland & Odlind 2012).

[21] AWMF guideline, VII.K6; Coleman et al. (2022), S111.

[22] Menopausal symptoms of this kind occur primarily at the start of treatment if puberty is already advanced, and they are generally temporary (cf. AWMF guideline, pp. 229f.). Nonetheless, attention should be paid to deterioration of mood, especially in transmasculine* individuals.

also affect bone density. As sex hormones influence bone metabolism, bone development may be inhibited during treatment with puberty blockers, which needs to be taken into account particularly with prolonged use. According to current research, if puberty suppression is stopped, or if it is followed by cross-sex hormone therapy, bone density will return to normal in most cases (cf. Taylor et al. 2024b).[23] Adequate exercise and a balanced diet also contribute to bone health (Ciancia et al. 2022) and may partly offset the adverse effects of treatment with GnRH analogues (Bergström et al. 2005).

Whether treatment with puberty blockers has an influence on cognitive development has yet to be established. Based on current knowledge of the effects of puberty on brain maturation, the possibility that puberty suppression also influences brain development cannot be ruled out. Empirical evidence of specific behavioural effects in mouse models have not been confirmed to date in human studies (Anacker et al. 2020). In a study examining the association between pre-treatment IQ and post-treatment educational achievement, no differences were found between people who had undergone a medical transition (gender-affirming treatment including puberty suppression) and comparison groups. Indeed, compared with the general population in the Netherlands, the educational achievement of the former group was on average slightly higher, despite similar initial IQ values (Arnoldussen et al. 2022). In a neuroimaging study, brain activation patterns were investigated in gender-dysphoric adolescents with (n=20) and without (n=20) puberty suppression, and in a control group of adolescents without gender dysphoria (n=45), on tasks involving various cognitive (e.g. planning) functions (Staphorsius et al. 2015). No significant differences in performance (reaction times, accuracy) were found between the two (treated and untreated) groups with gender dysphoria. Adolescents with puberty suppression showed sex differences in brain activation similar to their natal sex control groups. However, the untreated adolescents with gender dysphoria showed markedly divergent brain activation, both compared to the treated adolescents and to the control group. The reason for this is not clear, although it could be a result of the small sample size.[24]

2.2.3. Gender-affirming hormone therapy

In order to experience puberty in the desired gender, the use of cross-sex (masculinising or feminising) hormones is necessary. As a result of these hormones, the body is altered in the direction of the desired gender, with certain changes being irreversible, i.e. largely persisting even when the hormones are no longer used. This applies, for example, to breast or beard growth, voice change or body hight. Other changes (e.g. distribution of fat or muscle mass) are, however, largely reversible. The hormones must therefore be taken throughout life in order to maintain the desired effects. Establishment of an indication requires a diagnosis according to the ICD (or DSM-5) and thus marked and persistent gender incongruence (or gender dysphoria), together with a desire for gender-affirming hormone therapy.

In addition, hormone therapy affects the fertility of the persons treated. While reactivation of oocyte or sperm production of adequate quality may be possible after cessation of hormone therapy (Cheng et al. 2019), fertility – especially oocyte quality – may be permanently impaired after prolonged hormone therapy (Moravek et al. 2020). It is therefore recommended to provide information on options for fertility preservation – in particular, gamete cryopreservation (i.e. freezing and storage of egg or sperm cells). However, this procedure requires that puberty suppression – or, if puberty blockers are not administered, gender-affirming hormone therapy – be delayed until fertile egg or sperm cells have been formed. This occurs at Tanner stage 3–4 for sperm cells, and at Tanner stage 4 for egg

---

[23] Below-average bone density existing at the start of treatment may be a casual factor, and should be taken into account when treatment is given.

[24] To ensure the quality of future research on neurodevelopmental effects of puberty suppression, recommendations for study design were produced by a team of 24 international experts (Chen et al. 2020).

cells. Alternatively, testicular or ovarian tissue can be retrieved before gametes have developed, for transplantation at a later date. However, the prospects of success are lower than with direct retrieval of mature gametes (Feil et al. 2023).[25]

Aims of treatment

The use of gender-affirming hormone therapy leads to the alignment of physical characteristics with the individual's gender identity, thus potentially reducing gender incongruence and dysphoria.[26] Ideally, levels of psychological distress can thus be reduced to those experienced by the cisgender population (De Lara et al. 2020). For individuals identifying with one of the binary genders (male/female), so-called "passing"*, i.e. being perceived by others as a person of the gender one identifies with, can be an important aim of treatment in addition to increased body satisfaction. As this ascription is generally made on the basis of external sex characteristics, visible physical changes such as beard growth or breast development, or a change in voice pitch, are important milestones for many people within the transition process.

Risks and adverse effects

Apart from the above-mentioned effects of hormone therapy on fertility, attention has focused in particular on adverse effects for bone health and the risk of thrombosis and cancer. Available scientific evidence indicates that, in healthy people, hormone therapy generally does not cause any serious health problems (cf. Hembree et al. 2017). The risk of breast cancer is slightly increased by the administration of estrogens, but it is lower than in cisgender women. Likewise, the risk of thrombosis is slightly increased by the administration of testosterone (cf. AWMF guideline, p. 238.). Also reported are typical hormone-related adverse effects such as acne, breast tenderness, mood swings, increased appetite or hormonal hair loss (alopecia), with the prevalence being comparable to that in respective cisgender counterparts (Taylor et al. 2024b). Deviations in the area of bone density which may arise as a result of puberty suppression usually return to normal with the administration of gender-affirming hormones (Taylor et al. 2024b).

2.2.4. Surgical interventions

In Europe, surgical interventions – for example, the construction of a vagina or penis (vagino- or phalloplasty), removal of the uterus (hysterectomy), laryngeal or facial surgery – are generally only performed in adulthood (Brierley et al. 2024); accordingly, they are not discussed in detail here. An exception to this is breast removal (mastectomy): breasts are a readily visible sex characteristic, commonly used by others as a basis for the ascription of gender. Breast development begins early in puberty (Tanner stage 2), often causing considerable distress in the individuals concerned. The visibility of breasts complicates the process of social transition, or increases the likelihood of being recognised as transgender and thus the risk of discrimination where social transition has already taken place (cf. AWMF 2018, p. 46; Miller & Grollman 2015). For these reasons, mastectomy may already be indicated in minors. Alternatively, the breasts may be bound using specially designed binders. However, these may cause pain in many cases and, more rarely, also physical injuries such as rib fractures, especially when used for an extended period (i.e. several years) (Peitzmeier et al. 2021). In people with male sex characteristics, as an alternative to removal of the testicles and penis (orchidectomy/penectomy), so-called "tucking" may be employed, i.e. the practice of securing the penis and scrotum between the legs, so that the typical bulge is no longer visible, even with tight clothing. In the long term, this practice may have adverse effects on fertility (Feil et al. 2023).

According to systematic reviews, general satisfaction with gender-affirming surgery is high, irrespective of gender and type of procedure (Ren et al. 2024, Javier

---

[25] Cf. also the following information from Zurich University Hospital (USZ) on fertility preservation prior to treatments causing damage to gametes: https://www.usz.ch/fertilitaetserhalt-bei-keimzellschaedigenden-behandlungen (21 August 2024).

[26] "In our study, all [23] trans participants experienced gender dysphoria at T0, which had resolved in all at 1 year of CSHT [cross-sex hormone treatment], which demonstrates that this dysphoria is not a necessary condition in transgender individuals […]." De Lara et al. (2020), p. 46.

et al. 2022), and – according to a follow-up study – sustained, with values between 94% and 100% four to six years after first clinical contact (Van de Grift et al. 2018).[27] In addition, the outcome is generally more favourably rated by those undergoing surgery than by medical professionals.[28]

The prevalence of regret after surgery is low. According to a meta-analysis in which data on satisfaction after various types of gender-affirming surgery was analysed for around 8000 people, a total of 77 regretted having had surgery (approx. 1%) (Bustos et al. 2021). The reason most frequently given by those who decided after surgery to revert to living in their birth-assigned gender (34 people) was a lack of social acceptance (work, family, partnership). Other reasons frequently reported for regret were unsatisfactory aesthetic or functional outcomes and medical complications; however, these did not generally lead to a detransition* (Bustos et al. 2021; cf. also Wiepjes et al. 2018). Satisfaction with surgical outcomes tends to be higher in more recent surveys and for interventions performed in the United States (Ren et al. 2024), which suggests differences and improvements in surgical techniques over time. To promote standardisation and quality assurance for gender-affirming surgical interventions, an AWMF guideline is currently being developed in Germany.[29]

The surgical procedures mentioned are irreversible.[30] They are subject to the usual risks of surgical interventions, such as allergic reactions to substances used, nerve damage and associated sensory disturbances, risk of infection or wound-healing complications. In addition, the removal of reproductive organs (e.g. hysterectomy, orchidectomy) leads to permanent infertility.

---

[27] In contrast to the systematic review by Javier et al. (2022), the case numbers in van de Grift et al. (2018) were sometimes very low (n between 3 and 71).

[28] "The clinicians rated the global outcome as favorable in 62% of the cases, compared to 95% according to the patients themselves." Johansson et al. (2010), p. 1429.

[29] AWMF guideline no. 043-052: Geschlechtsangleichende chirurgische Maßnahmen bei Geschlechtsinkongruenz und Geschlechtsdysphorie.

[30] Irreversible here means that the original condition cannot be fully restored. Artificial breast reconstruction can be carried out, for example, even after a mastectomy.

3. Legal and ethical considerations

Decisions concerning medical treatment for minors with gender dysphoria involve numerous ethical dilemmas and therefore require a complex process of deliberation, making extremely high demands on the judgement of health professionals and all other parties involved in the decision. If institutional ethics support bodies are available, they can serve as a valuable resource for decision-making.

In many cases the high level of distress of the adolescents concerned asks for urgent action, while at the same time the fact that the development of their personality and maturity is as yet incomplete would argue for a more cautious approach – especially in the case of minors who still lack capacity to consent. The urgency of the decision is further intensified by the fact that, as puberty progresses, physical changes occur which cannot be reversed even by gender-affirming hormone therapy and which, in the event of subsequent medical transition, would necessitate more, and more invasive, surgical interventions. To be set against this are the physical changes – many of them also irreversible – and the risk of a permanent loss of fertility associated with gender-affirming hormone therapy.

Finally, the assessment of all these aspects is complicated by the fact that, while the currently available empirical evidence on the effects, adverse effects and (positive or negative) long-term results of various measures provides important hints and in some cases also shows clear trends, the quality of the existing data does not (yet) meet the high demands which would need to be placed on evidence-based decision-making in view of the wide-ranging and partly irreversible consequences of treatment (cf. Taylor et al. 2024a&b). In addition, all these deliberations take place in a context in which the minors concerned cannot always be confidently assumed to have capacity and yet – given the strictly personal nature of the decisions – their representation by caregivers appears to be problematic.

It is therefore not surprising that the question of appropriate medical care for minors with gender dysphoria has given rise to controversy within society and to a certain extent also within the medical field itself. Important goods are at stake which need to be carefully weighed up against each other – in the knowledge that there can be no perfect, risk-free decision. In what follows, the dilemmas outlined above will be presented and discussed in more detail with reference to the principles of biomedical ethics developed by Beauchamp & Childress (2019).

3.1 Respect for autonomy

3.1.1. The child’s right to an open future

Minors are, like adults, bearers of fundamental and human rights. With the adoption of the UN Convention on the Rights of the Child in 1989, children were for the first time explicitly recognised as legal persons. The Convention “protects and recognises children as independent persons with their own aims and their own will and calls for the welfare of children to be given priority consideration in all decisions which concern them.”[31] Decisions with long-term, irreversible effects on a child’s subsequent life should therefore, whenever possible, be made by the child themselves. In connection with the treatment of minors with gender dysphoria, the European Academy of Paediatrics (EAP) refers to the child’s right to an open future, which is compromised both by exeriencing puberty in a gender the child does not identify with and by a medical transition which is subsequently regretted. The aim should therefore be to keep open and permit

---

[31] The legal framework for child and youth policy in Switzerland: https://www.bsv.admin.ch/bsv/de/home/sozialpolitische-themen/kinder-und-jugendfragen/grundlagen-gesetze/gesetze.html (21 August 2024).

the exploration of various options until the child can decide for themselves.[32]

While the claim to an open future is not fully realisable, respect for the autonomy of minors requires that, whenever possible, they should make key life choices themselves. However, the onset of puberty comes at an age when it is not immediately clear whether the individuals concerned already have capacity in relation to the question of a possible medical transition. An autonomous decision is only assured if they are able to assess the longer-term personal, social and health consequences associated with their decision. At the same time, a cautious approach adopted in the presence of a desire to transition means that the minor will have to live through puberty in the undesired gender, and that a subsequent transition would be complicated by the physical changes that have already occurred, which is also problematic from the viewpoint of autonomy. The use of puberty suppression in minors with gender dysphoria can therefore be seen as an attempt to resolve this dilemma by delaying the commitment – occasioned by puberty – to a particular gender-related future. The right to an open future also explains the major relevance attaching from an ethical perspective to the distinction between reversible and irreversible physical developments and medical interventions in this context. The less an individual is able to subsequently correct their decision (i.e. after attaining capacity), the more seriously is their open future restricted.

3.1.2. Capacity and proxy decisions

Irrespective of whether the minor has capacity or not, gender dysphoria will only be medically treated if the individual concerned so wishes. If the minor has capacity, only they are legally entitled to consent to, or to refuse, medical interventions. In purely legal terms, the caregivers or persons with parental authority have no say in, or right to veto, such a decision. Empirical studies show, however, that a supportive social environment represents an important protective factor for the mental health of minors with gender dysphoria, and is associated with more positive long-term treatment outcomes (Simons et al. 2013; Turban et al. 2021; Campbell et al. 2023). From a therapeutic perspective, therefore, it does not appear to be appropriate or in the interests of the person seeking help to engage in confrontation with their caregivers or to exacerbate an existing conflict.[33] Rather, it is recommended that the caregivers should be continuously involved in treatment decisions from an early stage, and that – whenever possible and in the interests of the individual concerned – a shared consensus should be sought. Here, according to the AWMF guideline, such a consensus is all the more important, "the more serious the decision to be taken is, and the more difficult it is to determine the capacity of the person concerned to consent" (AWMF guideline, p. 274). If a minor lacks capacity, decisions on medical interventions are normally taken by the authorised representatives. However, this is only possible if the decision does not concern strictly personal rights, which preclude proxy decisions.[34] How is the treatment of gender dysphoria to be assessed in this regard?

Of central concern in the medical treatment of minors with gender dysphoria is their gender identity. For many people, gender identity is an important element of their personality, intimately bound up with their own self-concept. The question thus arises whether decisions in this matter even admit of representation, or whether the right in question here – as, for example, in

---

[32] "A further consideration is the child's right to an open future, which protects the child against having life choices made for them until they choose for themselves. A child entering puberty in a gender they do not identify with has their right to an open future compromised, but a child on a path to transition they may later regret is equally compromised. An alternative approach that better retains options and permits more fluidity of gender expression and identity seems preferable despite its essential ambiguities and difficulties in balancing competing rights." Brierley et al. (2024), p. 5.

[33] While the individuals concerned will often have already grappled with their gender identity for a long time, relatives may sometimes be surprised when a desire to transition is first expressed. They often require more time to engage with the question and to understand that this desire is the result of a lengthy internal process (Pauli 2023). This is also shown by the fact that the proportion of parents showing positive responses to their trans youths' gender identities increases with time from coming-out (cf. Grossman et al. 2021).

[34] Paradigm cases of strictly personal rights are, for example, the right to marry or the right to make a will.

the case of marriage – is a strictly personal one, to be exercised only by the person concerned. Supporting this view is the fact that questions of gender, gender identity and sexuality are highly intimate and personal matters which cannot be adequately assessed by third parties. In addition, gender as a category permeates almost every area of life, compelling individuals to be permanently accountable to others for their gender in their everyday lives. Therefore, as experience shows, decisions of this kind have a profound influence on a person's lived experience and self-determination. For this reason, the NCE takes the view that, in the case of gender-affirming medical measures and interventions which have a profound and permanent impact on a person's appearance, or irreversible consequences for their fertility, proxy decision-making is not permissible where the individual concerned lacks capacity. This applies both to gender-affirming hormone therapy and to surgical procedures. To be distinguished from these are interventions and measures which are temporary and largely reversible, such as puberty suppression. Here, it is possible for the individual, on attaining capacity, to decide for themselves whether the measure should be continued or discontinued. The right to an open future is thus essentially assured. While representation is possible in principle in this situation, the individual concerned is to be closely involved in the decision-making process, and any treatment requires their consent. In addition, a minor who does not yet have capacity should be actively supported in developing the relevant abilities.

3.1.3. Right to participation and shared decision-making

Irrespective of age, minors have a right to participation, even if they do not yet have capacity. This right derives, in part, from Article 12 of the UN Convention on the Rights of the Child (CRC) and comprises various forms of participation, such as the right to be informed, to be present, and to form and express their own views freely, or the right to be heard (cf. Swiss Centre of Expertise in Human Rights/SKMR 2020). The perspective and wishes of children and adolescents are therefore to be duly considered in the decision-making process, in accordance with their age and maturity.[35] As an inner psychological certainty, gender identity is not readily amenable to objective measurement or test methods (Turner et al. 2020), so that authority as to one's own experience and feelings must always ultimately rest with the individual concerned (Wiesemann 2020). The aim of treatment should therefore be to support the minor in exploring their gender identity in an open-ended process, and to facilitate an autonomous decision on whether or not to undergo possible treatments (cf. AWMF guideline no. 028-014, V.K3.; Ashley 2019). At the same time, the individuals concerned may be overwhelmed by the complexity of the decision – not least because the level of distress is typically high, and these minors will in many cases fear or experience incomprehension and rejection by those close to them (Grossman et al. 2021), which can make decision-making emotionally challenging. Therefore, in accordance with the notion of relational autonomy, the support provided by a trusted interlocutor is of great importance in this situation.[36]

To provide the best possible support for minors in this process, shared decision-making is to be recommended. This approach involves dialogue-based, patient-centred decision-making on the basis of a context-specific evaluation of all the necessary information, appropriately prepared.[37] This requires a dialogue of equals between treatment providers and the individual concerned (and possibly also, in the case

---

[35] Art. 12 para. 1 CRC: States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

[36] According to the concept of relational autonomy, which emphasises the relational aspect of the exercise of self-determination, autonomy always requires an interlocutor. In contrast to individualistic conceptions of autonomy, this concept focuses on the social context within which decisions are made and discusses the familial, societal and cultural prerequisites of human autonomy. Cf. Swiss Academy of Medical Sciences/SAMW (2016).

[37] As far as possible, information should be provided in the form of evidence-based decision aids. Cf. Lühnen et al. (2015). Guideline evidence-based health information. URL: https://www.leitlinie-gesundheitsinformation.de (19 September 2024).

of minors, their caregivers or authorised representatives). It is assumed that the individual concerned – in relation to the development and nature of their gender dysphoria, their preferences, values, life goals and lived experience – can offer unique expertise which, together with the treatment providers' medical expertise, permits the best possible decision for addressing the specific medical challenge. In an iterative process, possible treatment options are assessed in the light of the preferences, values and life goals of the individual concerned, and a joint decision is made as to the medical treatment appropriate to the situation. Irrespective of whether they have capacity or not, the individual concerned participates, as far as possible, in all stages of the decision-making process. With this approach, too, the right to consent to or refuse a medical measure rests with the individual concerned or, if they lack capacity, with their authorised representative.

The shared decision-making approach implies that the treatment process is guided by the particular situation and specific needs of the individual concerned, and not by a predefined social ideal, such as that of a "perfect" transition. Wherever possible and appropriate, rather than predetermined treatment pathways, individualised treatment goals should be agreed on (cf. De Lara et al. 2020). The option of discontinuing treatment, or subsequently adapting a treatment pathway, must also be available at all times, without this having any negative consequences for future treatment.

3.1.4. Open-endedness and room for doubts

High-quality treatment requires a relationship of trust between treatment providers and the individual concerned. This is all the more important, the more personal, intimate and shame-ridden the matter to be dealt with is. Previous negative experiences with health professionals can further impede the development of a trusting relationship. In addition, creating a space in which the individual can explore their gender identity in an open-ended process also means that the expression of doubts or changes of view by the individual concerned is understood as part of the process and does not automatically impede the chances of receiving medical treatment. Otherwise, there is a risk of self-censorship, i.e. that the individuals concerned will seek to conform to the expectations of health professionals and will feel under pressure to provide a narrative which the latter find credible (cf. Howell & Maguire 2023). Here it should be borne in mind that gender incongruence can be expressed in various ways, and that stereotypical ideas of how "genuine" trans persons have to look or behave do not do justice to the great diversity of manifestations and experiences. A treatment environment which makes the individuals concerned feel that they must fit a certain pattern in order to be taken seriously is thus not conducive to an open-ended and self-critical exploration of their own gender identity.

At the same time, the process of providing careful and responsible support for minors also involves, if necessary, critically examining their desires and conceptions, without this having to be interpreted as a vote of no confidence. If risks are underestimated or the benefits of treatment are overestimated, the health professional has a duty to correct these expectations. Support for minors with gender incongruence thus requires not only considerable expertise and experience, but also the necessary sensitivity and an awareness of their daily reality, which is often shaped by stigmatisation and external constraints (cf. Garcia Nuñez et al. 2024). Accordingly, appropriate training of all professionals involved in treatment is crucial for high-quality and non-discriminatory care (cf. Krüger et al. 2023).

3.2 Nonmaleficence

3.2.1. Indication and risk assessment

A medical intervention will be contemplated if it is medically indicated. This means, firstly, that a condition requiring treatment is present, and that medicine can offer measures apt to alleviate this condition. It also means that the individual risk-benefit ratio of the measure is favourable for the person concerned, and that alternative treatment options are either ruled out or are considered less appropriate for the person's specific situation. Since the medical measures available for the treatment of gender dysphoria include interventions with serious and in some cases irreversible consequences, the assessment of risks and benefits is of particular importance in the decision-making process. Unlike in the case of adults, treatment for minors involves intervening in as yet incomplete processes of biological maturation, which can have undesired effects, for example on their bone health or future fertility. In this context, a high price is paid for the wrong decision. At first glance, this might appear to argue for an extremely cautious treatment practice, as exemplified by the "watchful waiting" approach.[38] However, this is to ignore the fact that delayed or belated medical intervention can be very harmful, for example because, with a later medical transition, extensive surgical interventions become necessary which could otherwise have been avoided, or because the symptoms of gender dysphoria are increasingly aggravated by the progress of puberty and, as a result, the distress of the individuals concerned can become more acute, even to the point of suicidality (cf. Bauer et al. 2015). For the treatment decision, it is therefore of major importance to be able to predict with sufficient confidence whether gender incongruence will prove to be persistent or merely temporary. If gender incongruence and an associated desire for medical transition turn out to be persistent, treatment beginning as early as possible in puberty to limit subsequent harm would be medically advantageous,[39] while in the event of a subsequent detransition – especially with regard to fertility – the opposite is true (Taylor et al. 2024b). The risks of treatment must therefore be carefully weighed up against the risks of non-treatment in each individual case,[40] with the decision being further complicated by a lack of sound evidence in certain areas.

3.2.2. Scientific evidence and gaps in research

The availability of data concerning medical treatment for minors with gender dysphoria is inadequate in a variety of areas. There are various reasons for this situation: the quality und comparability of available data are impaired by small case numbers; limited possibilities (also on ethical grounds) for conducting randomised controlled double-blind studies;[41] heterogeneous, non-randomly selected samples; and the use of different instruments for scientific analysis, and non-standardised treatment protocols. In addition, long-term data is lacking given the comparatively recent origins of this treatment practice.[42] While some of these methodological weaknesses could and must be addressed in future by more robust research designs, the problem of control groups remains largely unresolved for ethical reasons.

Further complicating matters is the fact that the prospects of success demonstrably depend not only on the treatment protocol itself, but also on the social environment of the person treated (Simons et al. 2013). While social factors play a role in many medical treatments, this interaction is rarely so clearly marked. In the present context, it is therefore recommended that differences in social support and discrimination experiences should be systematically included in the analysis when the effectiveness of particular treatment

---

[38] This approach involves monitoring the course of a disease or a development without intervening medically. Cf. AWMF guideline, p. 112.

[39] With the exception of vaginoplasty, for which as a result of puberty suppression less penile skin is available to construct the neovagina (Taylor et al. 2024a).

[40] "In deciding on somatic medical treatment measures for puberty suppression or gender affirmation in adolescence, the expected benefits and risks must therefore be carefully weighed up. The possible consequent risks to health arising from a decision to proceed with somatic medical treatment subsequently regretted by the individual concerned, or from treatment which for other reasons proves not to have been soundly indicated, are thus to be weighed against the health risks which may arise from delaying or failing to initiate somatic medical treatment." AWMF Guideline, p. 34.

[41] Not only because the visible physical changes caused by hormone therapy make blinding impossible, but also because it seems unacceptable from an ethical viewpoint to provide the control group only with a placebo or alternative treatment (e.g. psychotherapy), while at the same time puberty in the undesired gender progresses.

[42] In a number of countries, gender-affirming medical treatments have been administered and also scientifically evaluated since the 1980s or even earlier. In the Netherlands, for example, data on the treatment of transgender people is available from 1972 onwards (Wiepjes et al. 2018). However, many of these datasets concern adults.

methods is studied (cf. De Lara et al. 2020; Campbell et al. 2023).

If evidence is lacking or inadequate, the risk of poor decisions is increased. This involves a risk not only of over- or undertreatment but also of inappropriate care. Deficiencies or uncertainties in the data must therefore be taken into consideration in the risk-benefit assessment. Also relevant here is whether evidence of particular harmful side-effects exists, whether the effects of treatment are disputed, whether the results of studies are contradictory or no robust data is available whatsoever. With regard to hormone therapy (puberty suppression, gender-affirming hormones) for minors with gender dysphoria, the treatments in question have already long been used in other contexts (precocious puberty, differences of sex development, and specific hormonal disorders such as hypogonadism) and are considered safe with appropriate adverse-effect monitoring (cf. Hembree et al. 2017). As the treatments are administered to a different target group, these results are not directly applicable to the treatment of minors with gender dysphoria, but they do provide valuable evidence of possible risks and adverse effects. At the same time, non-treatment also involves considerable health risks, which likewise need to be taken into consideration in the assessment. Overall, it can be concluded that the adverse effects and long-term consequences which are possible and to be expected on the basis of current knowledge from research and practice, as well as the prognostic uncertainty associated with treatment, are not such as to generally preclude – with reference to the precautionary principle[43] – medical treatment with puberty blockers or gender-affirming hormones in minors with gender dysphoria. In the absence of effective alternative options, and in view of the promising results of treatment in terms of mental health and quality of life (cf. Tordoff et al. 2022; Nobili et al. 2018), and the presence of sometimes massive distress, the threshold for the ethical justification of a general rejection of treatment is particularly high (cf. de Lara et al. 2020). The decisive factor for treatment should always be, as explained above, the individual indication, involving a comprehensive individual risk-benefit assessment. Here, due consideration is to be given to new scientific evidence.

Scientific evidence of the highest quality (i.e. randomised controlled trials) is indisputably desirable, but it represents the exception in medical care. Such a quality standard is not always attainable and, if rigorously applied, would rule out a substantial proportion of established treatments in current medicine. In the treatment of minors with gender dysphoria – as in all other areas of medical care – consistent efforts should be made, in line with evidence-based medicine, to improve the quality of therapies through more robust research results and to continuously evaluate the effectiveness of treatment methods. In particular, as mentioned above, the search for reliable predictors of persistent gender incongruence should be intensified, so as to prevent harms arising from misdiagnosis.

In addition, as part of the information provided for patients, it must be transparently communicated where uncertainties exist with regard to the effects of the desired treatment, as well as concerning possible short- or long-term adverse effects (cf. Taylor et al. 2024b, p. 7). However, the application of double standards of evidence cannot be justified from an ethical perspective.

3.2.3. Weighing of goods and harm reduction in individual cases

Overall, from the perspective of the nonmaleficence principle, knowledge of the – in some respects – irreversible consequences of gender-affirming hormone therapy or a surgical intervention suggests the need for a cautious approach to treatment, as well as close monitoring of the effects and any adverse effects.

---

[43] The precautionary principle is applied particularly in environmental law in cases where there are plausible indications of serious and irreversible damage, but a reliable quantitative risk assessment is not possible (inadequate evidence). In such situations, the precautionary principle requires that uncertainties are to be taken into account by adopting a safety margin, provided that this does not involve the acceptance of comparable risks or the violation of overriding private and/or public interests (cf. Rütsche 2024).

Accordingly, from an ethical viewpoint, routine treatment without careful evaluation of the individual risk-benefit ratio is just as unacceptable as the withholding of treatment which is medically indicated and desired by a person with capacity. Of particular importance here are the provision of comprehensive information about possible risks and adverse effects, effective monitoring, additional harm-reduction measures (e.g. to improve bone density) and regular evaluation – conducted jointly with the individuals concerned – of the effects of treatment.

In addition, from the perspective of nonmaleficence, particular attention should be paid to fertility preservation. Before hormone therapy is initiated, the individuals concerned must be comprehensively informed about the possibilities and limits of fertility preservation. Of particular interest for research in this context is the development of reliable methods allowing fertility to be preserved even in cases where gametes are not fully matured.

Finally, given the widespread controversy, it should not be overlooked that, across different studies, levels of subjective satisfaction with treatment are high and the proportion regretting an intervention is very low.[44] While these results mainly concern adults who have completed gender-affirming treatment, the findings are – prospectively – also highly relevant for the treatment decisions of minors. Here, too, further surveys are required to permit a better assessment of satisfaction over the long term.

3.3 Beneficence

Under Art. 11 of the Swiss Federal Constitution, children and young people have a right to special protection of their integrity and promotion of their development. They require these because often they cannot yet exercise their rights to the same extent as adults, on whom they are dependent. Until they attain capacity, minors can only exercise their rights with “allies” (cf. SAMW 2016, p. 31). To uphold their interests, they are reliant on support from parents or persons with parental authority. Particularly for younger people, access to medical services often depends in practice on the support provided by caregivers. At the same time, for a minor with gender incongruence, coming out generally represents a crucial test for their relationship with the people closest to them (cf. Grossman et al. 2021). In this respect, medical treatment for gender dysphoria differs substantially from treatment associated with other medical diagnoses. Such a disclosure – particularly if it is unexpected from the viewpoint of other family members – can give rise to major upheavals within the family, which may cause profound and long-term impacts on the minor’s welfare (Campbell et al. 2023). While the individuals concerned will normally have already been grappling with their gender identity for some time, this is unexplored territory for many caregivers. They need time and ideally professional support to familiarize themselves with it. At the same time, the welfare of children in this situation is known to depend to a large extent on the quality of their family relationships and on the support and acceptance they receive from those close to them.[45] Because gender identity is – and is felt to be – intimately bound up with one’s own personality, a negative response from within the family is particularly devastating. For the minors concerned, this creates a position of intense vulnerability, manifested in many cases not least through increased psychological stress or social withdrawal (cf. Campbell et al. 2023; Medico et al. 2020).

Furthermore, minors with gender dysphoria are in a highly vulnerable position not only in the private sphere. Their identity, their suffering and their deci-

---

[44] For all treatments carried out in the Netherlands between 1972 and 2015 for which data on “regret” is available (n=2627), a total of 14 people who underwent gender-affirming surgery – 11 transwomen (0.6%) and 3 transmen (0.3%) – regretted their decision. The reasons given were a lack of social acceptance in five cases, feeling non-binary in two cases, and “true regret” in seven cases (i.e. not identifying as trans anymore). With one exception, the treatments in question had taken place before 2000 (Wiepjes et al. 2018).

[45] “Whereas family support is generally understood to play a protective role in the lives of adolescents, parents of transgender youth may have a crucial opportunity to offset the mental health impact of societal harassment and discrimination their children receive” (Simons et al. 2013, p. 793). Cf. also Campbell et al. (2023).

sions are debated in public on a daily basis – often by people who themselves have neither the necessary expertise nor the relevant experience. The social climate thus created runs blatantly counter to the special protection to which children and adolescents are entitled on account of their particularly vulnerable position. From the perspective of beneficence, therefore, it is incumbent not only on the immediate social environment but also on society as a whole not to increase the distress of minors with gender dysphoria through pressure to conform – based on stereotypical notions of gender – social disparagement and exclusion, and media outrage and stigmatisation.

Reference to the particular vulnerability of children and adolescents does not provide a direct answer to the question of concrete treatment measures. These can only be determined on a case-by-case basis. Conclusions can, however, be drawn as regards the approach to be taken and the responsibilities borne by caregivers, health professionals and society: neither purely paternalistic treatment, which fails to take into account the experiences of the minors concerned, nor turning away from or ignoring their distress can fulfil the special responsibility owed to children and adolescents. Since viable and trusting relationships are of the greatest importance for them during this challenging period, the cultivation and maintenance of relationships plays a key role both within the family and in the therapeutic setting. The special need for protection of those concerned is further underlined by the high degree of distress they may experience and the fact that, during this profoundly personal and challenging process of transition, the children and adolescents have to exposed themselves to their environment. For this reason, the social and family environment should be systematically involved in the support and treatment provided for minors with gender dysphoria (cf. Section 2.2.1). Protection against social discrimination and stigmatisation and protection of privacy should be accorded the highest priority throughout the treatment process (cf. Garcia Nuñez et al. 2024; Turban et al. 2021).

3.4 Justice

The bioethical principle of justice calls for an equitable distribution of benefits and burdens in the health system (Beauchamp & Childress 2019). This means, for example, that healthcare resources should be equitably allocated[46] and that non-discriminatory access is to be assured. Legally, the prohibition on discrimination is enshrined in various international agreements, as well as in Article 8 of the Federal Constitution.[47] The state thus has a duty to ensure that structural and financial barriers impeding equal access are eliminated. It also has a responsibility to ensure, together with health professionals, that the rights and dignity of minors with gender dysphoria are safeguarded when decisions concerning their treatment are made.

In practice, structural and financial barriers are widespread. As the treatment of people with gender dysphoria involves various medical disciplines (child and adolescent psychiatry, paediatrics, gynaecology/urology, endocrinology, possibly surgery, etc.), a multidisciplinary approach is essential in order to ensure comprehensive medical care. This makes the provision of care for people with gender dysphoria a complex matter. In a number of countries, competence centres

---

[46] As the group of persons concerned here is relatively small and the treatment costs are financially sustainable, the question of equitable allocation of health services among different groups of patients plays a minor role.

[47] Article 24 of the CRC: Enshrined in this article is the right of the child to the highest attainable standard of health and access to high-quality healthcare services. States Parties are required to ensure that access – especially to existing services – is provided in a non-discriminatory manner.

Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR): This article recognises the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, including non-discriminatory access to existing medical services. The Committee on Economic, Social and Cultural Rights (CESCR) has noted that this involves an obligation for states to ensure equal access to healthcare for everyone, irrespective of gender, and to take positive steps to eliminate any barriers to such access.

Article 8 of the Federal Constitution: This article protects the principle of non-discrimination by prohibiting any discrimination, in particular on grounds of gender, age, or other personal situation. In connection with healthcare for minors with gender dysphoria, this article creates an obligation for authorities and health service providers to ensure equal access to treatments and to avoid any form of unjustified exclusion or differentiation.

have therefore been established which bring together the various disciplines under one roof, or have a network of specialists available to ensure comprehensive care. Nonetheless, surveys show that barriers to the utilisation of medical services remain high. Among the reasons for this are previous negative experiences or fear of discrimination.[48] In a study on the health of LGBT people in Switzerland, 35.6% of transgender or non-binary respondents reported having chosen in the past not to access health services out of fear of discrimination (Krüger et al. 2023). Appropriate training and regular continuing education for all professionals involved in treatment is therefore crucial – in addition to sufficiently large caseloads – to ensure high-quality care.

Further complicating matters for minors is the fact that access generally involves the parents or others with parental authority. This means that children and adolescents are dependent on their caregivers recognising their distress and taking it seriously as such. Low-threshold facilities for minors can help to reduce this barrier to access. But even within the health system, so-called gatekeeping may occur, whereby access to information or resources is controlled by certain individuals or groups. In Switzerland, for example, there is a requirement for a referral by a psychiatrist or psychologist, who also assesses the minor's capacity. While it is medically appropriate for a psychiatric specialist to be involved in treatment, it must be ensured that the specified procedure does not in practice lead to long waiting times. Especially as puberty progresses, this may be highly stressful for the individuals concerned. The new AWMF guideline therefore recommends that, in urgent cases, rapid care should be assured by means of prioritisation for adolescents with gender incongruence and a high level of distress (cf. AWMF guideline, p 176).

Discrimination also occurs if certain groups of people are automatically excluded from medical treatment in the absence of an appropriate contraindication. Accordingly, the general exclusion of individuals from medical treatment for gender dysphoria based on a psychiatric diagnosis or an autism spectrum disorder is potentially discriminatory, even though a contraindication may be present in particular cases. General exclusion from treatment on grounds of age is likewise unacceptable. Rather, the decisive factors are the individual medical indication and the capacity and autonomous wishes of the person concerned. As a matter of principle in basic care, the withholding of treatment which is medically indicated and desired by a person with capacity is ethically and legally impermissible, although professionals may refuse to carry out treatment on conscientious grounds, as long as care is assured elsewhere.

Treatment costs can pose an additional access barrier. In Switzerland, medically indicated treatments for gender incongruence are, in principle, to be covered by compulsory health insurance. In practice, however, this is not always automatically the case, necessitating additional administrative efforts for the individuals concerned and for treatment providers. Long waiting times may also lead those concerned to opt for private clinics, if they are in a position to pay for treatments themselves.

As a result of all the barriers mentioned, disparities in access to care arise on various levels, which are problematic from the perspective of justice unless they can be justified on legitimate grounds such as, for example, clear contraindications.

As well as the assurance of equal, non-discriminatory access to medical services, the principle of justice also requires that legitimate interests of third parties should be taken into account. This concerns in particular the interests of the closest family members. Even if they do not have a legal right to a say in decisions, their questions, anxieties and fears are to be appropriately addressed. Relatives should therefore be given access to suitable sources of information and support and, whenever possible, be closely involved in the decision-making process.

---

[48] "The following factors which tend to restrict access to medical care for trans people are mentioned in the literature: discrimination in the health system, professionals with a lack of knowledge of trans-specific health issues, previous negative experiences in healthcare, but also inadequate coverage of necessary services by health insurers, including refusal of treatments." Krüger et al. (2023), p. 41.

4. Conclusions and recommendations

From the above discussion, it can be concluded that medicine has an important but also a limited role to play in the treatment of (legally minor) people with gender dysphoria. While body dysphoria* can often be successfully medically treated, the desire for recognition and acceptance in one's experienced gender identity cannot be addressed (solely) by medical means. Here, a substantial role is played by deeply embedded social norms and expectations concerning the appearance and behaviour of persons of a particular gender. In the past, as a result, the medical treatment of people with gender incongruence generally aimed to achieve – as far as possible – a "perfect" medical transition, i.e. a convincing adaptation to the new (binary) gender (Nieder et al. 2020; Brierley et al. 2024). This goal was guided mainly by the requirements of society and less, or only indirectly, by the needs of the person seeking help. But even if treatment options are more varied today, the pressure to conform remains operative: the more closely social acceptance of the individual gender identity is tied to a binary-coded, gender-conforming appearance, the greater is the pressure for the people concerned to opt for body-modifying treatments. From this it also follows that the suffering of people with gender dysphoria not only represents suffering caused by their own body but must also be understood as suffering caused by a social order in which gender is ascribed primarily on the basis of physical sex characteristics and where deviations from the associated expectations still attract strong sanctions (Miller & Grollman 2015). From an ethical perspective, therefore, it is incumbent not only on medicine and the immediate social environment of the individuals concerned but also on society as a whole to engage in critical reflection on established notions of gender and to avoid increasing the distress of people with gender dysphoria through social disparagement and exclusion based on stereotypical conceptions of gender, excessive pressure to conform, and public outrage and stigmatisation. For this reason, the NCE sees a need for action not only in the area of medical care, treatment and research, but also with regard to the general social framework.

1) Medical care and treatment

a) Access to high-quality interdisciplinary care and counselling must be assured

Access to comprehensive, expert and non-discriminatory medical care must be assured for minors with gender incongruence or gender dysphoria and their relatives. Prerequisites for ensuring high quality in counselling, support and treatment are appropriate training and regular continuing education of the professionals involved, as well as close interdisciplinary collaboration between the disciplines concerned (child and adolescent psychiatry, paediatrics, endocrinology, gynaecology, surgery, etc.). The current guidelines and recommendations of professional societies are to be taken into account.

b) Treatment decisions are to be based on the individual indication

All treatment decisions should be made on the basis of the individual indication, taking into account the specific situation of the person concerned. The general exclusion of individuals with a psychiatric diagnosis or autism spectrum disorder from body-modifying treatments is discriminatory, unless an absolute contraindication is present in a particular case. Withholding treatment which is medically indicated and desired by a person with capacity is ethically unacceptable in basic care.

c) No proxy consent for irreversible body-modifying treatments

Body-modifying treatments with irreversible consequences (i.e. gender-affirming hormone therapy and surgical interventions) are only permissible if the minor has capacity in relation to the proposed intervention and has given their informed consent. In cases of incapacity, a proxy decision is excluded for both minors and adults, given the strictly personal nature of the decisions in question. If the individual concerned has not yet attained capacity, psychosocial care and support should be offered which is designed to strengthen their autonomy with regard to their gender identity, with the aim of promoting capacity. In the case of reversible treatments, a proxy decision is in principle possible, but only until the minor has attained capacity. The use of puberty suppression is thus also possible in a minor who has not yet attained capacity, provided that it is medically indicated and desired by the individual concerned and consent has been given by the parents or others with parental authority.

d) The decision-making process is to be open and participatory (shared decision making)

If a minor has capacity, they alone are entitled to consent to, or to refuse, medical interventions. Legally, the parents have no say in such a decision. In most cases, however, it is appropriate from a therapeutic perspective for the parents or other caregivers to be closely involved in the decision-making process, with the aim of reaching a consensus. During counselling, it is essential to present a variety of medical and non-medical options in order to permit an open decision-making process. The proposed measures should be adapted to the individual situation of the person seeking help and should be determined together with the health professionals in a participatory process (shared decision making). The right of the individuals concerned to participate in this process is not dependent on age or capacity and is protected as a human right.

e) Pathologisation of the people concerned is to be avoided

Assignment of a diagnosis inevitably involves a degree of pathologisation of the people concerned. At the same time, it is necessary, within Switzerland's health system, to ensure access to medical services and, if appropriate, the coverage of costs by health insurers. While psychiatric counselling and support can be helpful, mandatory psychotherapy as a prerequisite for somatic medical treatment is ethically unacceptable and not medically appropriate in the absence of a psychiatric indication. In addition, with the introduction of ICD-11, gender incongruence is no longer classified as a mental disorder, which can be considered an important step in the direction of destigmatisation. In prepubertal children, who do not require any medical interventions beyond, possibly, psychosocial support, the benefits of having a diagnosis of their own (ICD-11: HA61) may be called into question and criticised as unnecessary pathologisation of gender diversity.

f) If necessary, institutional clinical ethics bodies should be used to support decision-making

Decisions on medical treatment relating to transition in minors are generally made at clinical centres. Many such centres have clinical ethics bodies designed to provide support for ethically complex decision-making processes. These resources should be used, if necessary, since in many cases an external perspective and structured ethical deliberation can help to bring the positions of all parties closer together, thus promoting ethically responsible decisions which will stand the test of time.

2) Scientific evidence and research

a) Existing gaps in research should be identified and closed

The data currently available in relation to the medical treatment of minors with gender dysphoria is in various respects inadequate. In particular, there are gaps in research with regard to possible long-term consequences. In addition, more robust research designs are needed to improve the quality of the data available on the effectiveness of the various treatment options, and thus also of the individual risk-benefit assessment. However, the demands placed on the quality of the evidence base should not be higher than in the case of comparable interventions for which randomised double-blind studies are likewise not possible or justifiable.

Of major relevance for the treatment decision is the assessment of whether the occurrence of gender dysphoria in adolescence is likely to persist into adulthood or whether it is only of a temporary nature. Future research projects should therefore specifically investigate questions of particular relevance for treatment practice – the predictors of persistent gender incongruence, the effects of hormone therapy on fertility and bone health, and risk reduction measures.

b) The precautionary principle does not justify rejection of treatment on principle

Overall, knowledge of the irreversible consequences of gender-affirming hormone therapy suggests the need for a cautious approach to treatment, as well as close monitoring of the effects and any adverse effects. However, in the absence of concrete signs of previously unknown, serious long-term damage, and in view of the promising results of current treatment practice with regard to mental health, a general rejection of treatment cannot be justified on the basis of currently available evidence. The basis for treatment is the individual indication, which must include a comprehensive individual risk-benefit assessment. Here, new scientific evidence is to be duly considered. In addition, as part of the information provided for patients, it must be transparently communicated where uncertainties exist with regard to the effects or possible adverse effects of the desired treatment.

c) Social factors are to be systematically taken into account in studies of the effectiveness of treatment

The prospects of success of medical treatment for a minor with gender dysphoria demonstrably depend not only on the treatment protocol itself, but also on the social support received by the person treated. Because of this close interaction, it is therefore recommended that, in the context of gender dysphoria, differences in social support and discrimination experiences should be systematically included in the analysis when the effectiveness of particular treatment methods is studied.

3) Social context

The complex question of the causes and psychological consequences of gender incongruence can only be understood and discussed in the context of social norms concerning gender-conforming appearance and behaviour. The weight attached to these norms in the form of role assignments and expectations should therefore not be neglected in the debate on the medical treatment of minors with gender dysphoria. The renunciation of social gender stereotypes and narrowly defined gender roles could make a significant contribution towards reducing the distress of the people concerned. Here, the following points in particular should be taken into consideration:

a) Gender is to be understood as a graded spectrum

A strictly binary conception of gender leads to an unjustified restriction of the options for action and for treatment of gender-variant individuals. An alternative conception of gender as a spectrum not only more accurately reflects the experienced reality of numerous people but also has the potential to reduce pressure to conform and the associated risks for the mental health of people who do not fulfil binary gender role expectations.

b) Social recognition of a specific gender identity should be decoupled from body-modifying treatments

The more closely social acceptance of the individual gender identity is tied to a gender-conforming appearance, the greater is the pressure for the people concerned to opt for body-modifying treatments. This is ethically problematic: no one should have to undergo body-modifying interventions to have their personality recognised.

c) Public outrage over this issue harms the people concerned and jeopardises evidence-based medical care

Not only do minors with gender dysphoria have to cope with the personal challenges of finding their identity, they also find themselves at the centre of a highly polarised public debate. Their identity, their suffering and their personal decisions are debated in public on a daily basis – often by people who themselves have neither the necessary expertise nor the relevant experience. The social climate thus created runs blatantly counter to the special protection to which these individuals are entitled on account of their particularly vulnerable position, and it impedes objective and evidence-based discussion of the social and medical framework required to ensure that they receive the best possible support and care.

5. References

Anacker, C., Sydnor, E., Chen, B. K., LaGamma, C. C., McGowan, J. C., Mastrodonato, A., … & Denny, C. A. (2021). Behavioral and neurobiological effects of GnRH agonist treatment in mice—potential implications for puberty suppression in transgender individuals. *Neuropsychopharmacology*, 46(5), 882–890.

Arnoldussen, M., Hooijman, E. C., Kreukels, B. P., & de Vries, A. L. (2022). Association between pre-treatment IQ and educational achievement after gender-affirming treatment including puberty suppression in transgender adolescents. *Clinical child psychology and psychiatry*, 27(4), 1069–1076.

Ashley, F. (2019). Thinking an ethics of gender exploration: Against delaying transition for transgender and gender creative youth. *Clinical child psychology and psychiatry*, 24(2), 223–236.

AWMF (2018). Geschlechtsinkongruenz, Geschlechtsdysphorie und Trans-Gesundheit: S3-Leitlinie zur Diagnostik, Beratung und Behandlung, AWMF-Register-Nr. 138|001.

AWMF (n.d.). Geschlechtsinkongruenz und Geschlechtsdysphorie im Kindes- und Jugendalter: Diagnostik und Behandlung, S2k-Leitlinie, AWMF-Register-Nr. 028|014. (forthcoming).

AWMF (n.d.). S2k-Leitlinie Geschlechtsangleichende chirurgische Massnahmen bei Geschlechtsinkongruenz und Geschlechtsdysphorie, AWMF-Register-Nr. 043|052. (forthcoming).

Ayhan, C. H. B., Bilgin, H., Uluman, O. T., Sukut, O., Yilmaz, S., & Buzlu, S. (2020). A systematic review of the discrimination against sexual and gender minority in health care settings. *International Journal of Health Services*, 50(1), 44–61.

Başar, K., Öz, G., & Karakaya, J. (2016). Perceived discrimination, social support, and quality of life in gender dysphoria. *The journal of sexual medicine*, 13(7), 1133–1141.

Bauer, G. R., Scheim, A. I., Pyne, J., Travers, R., & Hammond, R. (2015). Intervenable factors associated with suicide risk in transgender persons: a respondent driven sampling study in Ontario, Canada. *BMC public health*, 15, 1–15.

Beauchamp, T., Childress, J. (2019). *Principles of biomedical ethics*. 8th Edition. Oxford University Press: Oxford.

Bergström, I., Freyschuss, B., Jacobsson, H., & Landgren, B. M. (2005). The effect of physical training on bone mineral density in women with endometriosis treated with GnRH analogs: a pilot study. *Acta obstetricia et gynecologica Scandinavica*, 84(4), 380–383.

Bockting, W.O. (2008). Psychotherapy and the real-life experience: from gender dichotomy to gender identity. *Sexologies*, 17, 211–224.

Brierley, J., Larcher, V., Hadjipanayis, A. A., & Grossman, Z. (2024). European Academy of Paediatrics statement on the clinical management of children and adolescents with gender dysphoria. *Frontiers in Pediatrics*, 12, 1298884.

Brinkman, B. G., Rabenstein, K. L., Rosén, L. A., & Zimmerman, T. S. (2014). Children's gender identity development: The dynamic negotiation process between conformity and authenticity. *Youth & Society*, 46(6), 835–852.

Bustos, V. P., Bustos, S. S., Mascaro, A., Del Corral, G., Forte, A. J., Kim, E. A., ... & Manrique, O. J. (2021). Regret after gender-affirmation surgery: a systematic review and meta-analysis of prevalence. *Plastic and Reconstructive Surgery – Global Open*, 9(3), e3477.

Campbell, T., Mann, S., Rodgers, Y. V. D. M., & Tran, N. (2023). Family Matters: Gender Affirmation and the Mental Health of Transgender Youth. Available at SSRN 4503648.

Chen, D., Strang, J. F., Kolbuck, V. D., Rosenthal, S. M., Wallen, K., Waber, D. P., ... & Garofalo, R. (2020). Consensus parameter: Research methodologies to evaluate neurodevelopmental effects of pubertal suppression in transgender youth. *Transgender health*, 5(4), 246–257.

Cheng, P. J., Pastuszak, A. W., Myers, J. B., Goodwin, I. A., & Hotaling, J. M. (2019). Fertility concerns of the transgender patient. *Translational Andrology and Urology*, 8(3), 209.

Ciancia, S., Dubois, V., & Cools, M. (2022). Impact of gender-affirming treatment on bone health in transgender and gender diverse youth. *Endocrine Connections*, 11(11).

Cohen-Kettenis, P. T. (2005). Gender identity disorders. In: Gillberg, C. (Ed.), *A Clinician's Handbook of Child and Adolescent Psychiatry*. Cambridge University Press, Cambridge, pp. 695–725.

Coleman, E., Radix, A. E., Bouman, W. P., Brown, G. R., De Vries, A. L., Deutsch, M. B., ... & Arcelus, J. (2022). Standards of care for the health of transgender and gender diverse people, version 8. *International journal of transgender health, 23*(sup1), S1–S259.

Cuzzolin, L., Zaccaron, A., & Fanos, V. (2003). Unlicensed and off-label uses of drugs in paediatrics: a review of the literature. *Fundamental & clinical pharmacology*, 17(1)f, 125–131.

Davey, A., Bouman, W. P., Arcelus, J., & Meyer, C. (2014). Social support and psychological well-being in gender dysphoria: A comparison of patients with matched controls. *The journal of sexual medicine*, 11(12), 2976–2985.

De Lara, D. L., Rodríguez, O. P., Flores, I. C., Masa, J. L. P., Campos-Muñoz, L., Hernández, M. C., & Amador, J. T. R. (2020). Psychosocial assessment in transgender adolescents. *Anales de Pediatría* (English Edition), 93(1), 41–48.

De Vries, A. L., McGuire, J. K., Steensma, T. D., Wagenaar, E. C., Doreleijers, T. A., & Cohen-Kettenis, P. T. (2014). Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics*, 134(4), 696–704.

De Vries, A. L., Noens, I. L., Cohen-Kettenis, P. T., van Berckelaer-Onnes, I. A., & Doreleijers, T. A. (2010). Autism spectrum disorders in gender dysphoric children and adolescents. *Journal of autism and developmental disorders*, 40(8), 930–936.

DiDonato, M. D., & Berenbaum, S. A. (2013). Predictors and consequences of gender typicality: The mediating role of communality. *Archives of Sexual Behavior*, 42(3), 429–436.

Drescher, J., Cohen-Kettenis, P. T., & Reed, G. M. (2016). Gender incongruence of childhood in the ICD-11: controversies, proposal, and rationale. *The Lancet Psychiatry*, 3(3), 297–304.

Durwood, L., McLaughlin, K. A., & Olson, K. R. (2017). Mental health and self-worth in socially transitioned transgender youth. *Journal of the American Academy of Child & Adolescent Psychiatry*, 56(2), 116–123.

Egan, S. K., & Perry, D. G. (2001). Gender identity: a multidimensional analysis with implications for psychosocial adjustment. *Developmental psychology*, 37(4), 451.

Eyssel, J., Koehler, A., Dekker, A., Sehner, S., & Nieder, T. O. (2017). Needs and concerns of transgender individuals regarding interdisciplinary transgender healthcare: A non-clinical online survey. *PLoS One*, 12(8), e0183014.

Feil, K. (2023). Fertilität, Kontrazeption und Fertilitätsprotektion bei Transpersonen. *Dtsch Arztebl Int*, 120, 243–50.

Fuss, J., Auer, M. K., & Briken, P. (2015). Gender dysphoria in children and adolescents: a review of recent research. *Current opinion in psychiatry*, 28(6), 430–434.

Garcia Nuñez, D., Frigerio, G., Perler, L. D., Jäggi, T., Schönbucher, V., & von Känel, R. (2024). Quality of life and associated factors in Swiss trans people: a cross-sectional study. *Frontiers in Psychiatry*, 14, 1233625.

GATE (2013). Critique and Alternative Proposal to the "Gender Incongruence of Childhood" Category in ICD-11. GATE Civil Society Expert Working Group, Buenos Aires, April 4–6.

Green, A. E., DeChants, J. P., Price, M. N., & Davis, C. K. (2022). Association of gender-affirming hormone therapy with depression, thoughts of suicide, and attempted suicide among transgender and nonbinary youth. *Journal of adolescent health*, 70(4), 643–649.

Grossman, A. H., Park, J. Y., Frank, J. A., & Russell, S. T. (2021). Parental responses to transgender and gender nonconforming youth: Associations with parent support, parental abuse, and youths' psychological adjustment. *Journal of Homosexuality*, 68(8), 1260–1277.

Hembree, W. C., Cohen-Kettenis, P. T., Gooren, L., Hannema, S. E., Meyer, W. J., Murad, M. H., Rosenthal, S. M., Safer, J. D., Tangpricha, V. & T'Sjoen, G. G. (2017). Endocrine treatment of gender-dysphoric/gender-incongruent persons: an endocrine society clinical practice guideline. *The Journal of Clinical Endocrinology & Metabolism*, 102(11), 3869–3903.

Hisle-Gorman, E., Landis, C. A., Susi, A., Schvey, N. A., Gorman, G. H., Nylund, C. M., & Klein, D. A. (2019). Gender dysphoria in children with autism spectrum disorder. *LGBT health*, 6(3), 95–100.

Howell, J. D., & Maguire, R. (2023). Factors associated with experiences of gender-affirming health care: A systematic review. *Transgender Health*, 8(1), 22–44.

Javier, C., Crimston, C. R., & Barlow, F. K. (2022). Surgical satisfaction and quality of life outcomes reported by transgender men and women at least one year post gender-affirming surgery: A systematic literature review. *International Journal of Transgender Health*, 23(3), 255–273.

Jewell, J. A., & Brown, C. S. (2014). Relations among gender typicality, peer relations, and mental health during early adolescence. *Social Development*, 23(1), 137–156.

Johansson, A., Sundbom, E., Höjerback, T., & Bodlund, O. (2010). A five-year follow-up study of Swedish adults with gender identity disorder. *Archives of sexual behavior*, 39, 1429–1437.

Kallitsounaki, A., Williams, D. M., & Lind, S. E. (2021). Links between autistic traits, feelings of gender dysphoria, and mentalising ability: replication and extension of previous findings from the general population. *Journal of Autism and Developmental Disorders*, 51, 1458–1465.

Kallitsounaki, A., & Williams, D. M. (2023). Autism spectrum disorder and gender dysphoria/incongruence. A systematic literature review and meta-analysis. *Journal of Autism and Developmental Disorders*, 53(8), 3103–3117.

Kimland, E., & Odlind, V. (2012). Off-label drug use in pediatric patients. *Clinical Pharmacology & Therapeutics*, 91(5), 796–801.

Kornienko, O., Santos, C. E., Martin, C. L., & Granger, K. L. (2016). Peer influence on gender identity development in adolescence. *Developmental psychology*, 52(10), 1578.

Krüger, P., Pfister, A., Eder, M., & Mikolasek, M. (2023). *Gesundheit von LGBT-Personen in der Schweiz*. Nomos.

Leibowitz, S., Green, J., Massey, R., Boleware, A. M., Ehrensaft, D., Francis, W., ... & WPATH, USPATH, and EPATH Executive Committee and Board of Directors. (2020). Statement in response to calls for banning evidence-based supportive health interventions for transgender and gender diverse youth. *International Journal of Transgender Health*, 21(1), 111–112.

Lühnen, J., Albrecht, M., Hanssen, K., Hildebrandt, J., & Steckelberg, A. (2015). Leitlinie evidenzbasierte Gesundheitsinformation: Einblick in die Methodik der Entwicklung und Implementierung. *Zeitschrift für Evidenz, Fortbildung und Qualität im Gesundheitswesen,* 109(2), 159–165.

Mahfouda, S., Moore, J. K., Siafarikas, A., Zepf, F. D., & Lin, A. (2017). Puberty suppression in transgender children and adolescents. *The Lancet Diabetes & Endocrinology*, 5(10), 816–826.

Medico, D., Pullen Sansfacon, A., Zufferey, A., Galantino, G., Bosom, M., & Suerich-Gulick, F. (2020). Pathways to gender affirmation in trans youth: A qualitative and participative study with youth and their parents. *Clinical Child Psychology and Psychiatry*, 25(4), 1002–1014.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychological bulletin*, 129(5), 674.

Michaud, L., Stiefel, F., Jox, R., J., Pamfile, D., Brovelli, S., Pécoud, P., Plessen, K., J., Harari, M., M. (2024). Transidentités : pertinence de l'implication des psychiatres. *Rev Med Suisse*, 20(872), no. 872, 894–898.

Miller, L. R. and Grollman, E. A. (2015), The Social Costs of Gender Nonconformity for Transgender Adults: Implications for Discrimination and Health. *Sociological Forum*, 30, 809–831.

Money, J. (1975). Ablatio penis: normal male infant sex-reassigned as a girl. *Archives of sexual behavior*, 4(1), 65–71.

Moravek, M. B., Kinnear, H. M., George, J., Batchelor, J., Shikanov, A., Padmanabhan, V., & Randolph, J. F. (2020). Impact of exogenous testosterone on reproduction in transgender men. *Endocrinology*, 161(3), bqaa014.

Nationale Ethikkommission im Bereich der Humanmedizin (2020). Die amtliche Registrierung des Geschlechts. Ethische Erwägung zum Umgang mit dem Geschlechtseintrag im Personenstandsregister. Stellungnahme Nr. 36/2020.

Nieder, T. O., Elaut, E., Richards, C., & Dekker, A. (2016). Sexual orientation of trans adults is not linked to outcome of transition-related health care, but worth asking. *Int Rev Psychiatry*, 28(1), 103–11.

Nieder, T. O., Eyssel, J., & Köhler, A. (2020). Being trans without medical transition: Exploring characteristics of trans individuals from Germany not seeking gender-affirmative medical interventions. *Archives of Sexual Behavior*, 49, 2661–2672.

Nieder, T. O., Mayer, T. K., Hinz, S., Fahrenkrug, S., Herrmann, L., & Becker-Hebly, I. (2021). Individual treatment progress predicts satisfaction with transition-related care for youth with gender dysphoria: a prospective clinical cohort study. *The Journal of Sexual Medicine*, 18(3), 632–645.

Nieder, T. O., & Strauss, B. (2019). S3-Leitlinie zur Diagnostik, Beratung und Behandlung im Kontext von Geschlechtsinkongruenz, Geschlechtsdysphorie und Trans-Gesundheit. *Zeitschrift für Sexualforschung*, 32(02), 70–79.

Nobili, A., Glazebrook, C., & Arcelus, J. (2018). Quality of life of treatment-seeking transgender adults: A systematic review and meta-analysis. *Reviews in Endocrine and Metabolic Disorders*, 19(3), 199–220.

Olson, J., Forbes, C., & Belzer, M. (2011). Management of the transgender adolescent. *Archives of pediatrics & adolescent medicine*, 165(2), 171–176.

Olson, J., Schrager, S. M., Belzer, M., Simons, L. K., & Clark, L. F. (2015). Baseline Physiologic and Psychosocial Characteristics of Transgender Youth Seeking Care for Gender Dysphoria. *Journal of adolescent health*, 57(4), 374–380.

Panagiotakopoulos, L., Chulani, V., Koyama, A., Childress, K., Forcier, M., Grimsby, G., & Greenberg, K. (2020). The effect of early puberty suppression on treatment options and outcomes in transgender patients. *Nature Reviews Urology*, 17(11), 626–636.

Pauli, D. (2017). Geschlechtsinkongruenz und Genderdysphorie bei Kindern und Jugendlichen. *PSYCH up2date*, 11(06), 529–543.

Pauli, D. (2019). Nicht-binäre Geschlechtsorientierung bei Kindern und Jugendlichen: Eine Herausforderung für die Betroffenen, das Umfeld und die Behandelnden. *Kinderanalyse*, 27(1), 53–64.

Pauli, D. (2023). *Die anderen Geschlechter: Nicht-Binarität und (ganz) trans* normale Sachen*. CH Beck.

Peitzmeier, S. M., Silberholz, J., Gardner, I. H., Weinand, J., & Acevedo, K. (2021). Time to first onset of chest binding–related symptoms in transgender youth. *Pediatrics*, 147(3).

Perry, D. G., Pauletti, R. E., & Cooper, P. J. (2019). Gender identity in childhood: A review of the literature. *International Journal of Behavioral Development*, 43(4), 289–304.

Peter, C. & Tuch, A. (2024). Suizidales Erleben und Verhalten – In der Bevölkerung der Schweiz 2022 (Obsan Bulletin 08/2024). Neuchâtel: Schweizerisches Gesundheitsobservatorium.

Pfister, A., & Mikolasek, M. (2019). *Suizidversuche von LGBT-Jugendlichen und jungen Erwachsenen. Einschätzung der Machbarkeit einer qualitativen Untersuchung in der Schweiz.* Luzern: Hochschule Luzern – Soziale Arbeit.

Puckett, J. A., Tornello, S., Mustanski, B., & Newcomb, M. E. (2022). Gender variations, generational effects, and mental health of transgender people in relation to timing and status of gender identity milestones. *Psychology of Sexual Orientation and Gender Diversity*, 9(2), 165.

Ren, G. N., McMorris, B. J., Gower, A. L., Coleman, E., & Eisenberg, M. E. (2018). Health and care utilization of transgender and gender nonconforming youth: A population-based study. *Pediatrics*, 141(3).

Ren, T., Galenchik-Chan, A., Erlichman, Z., & Krajewski, A. (2024). Prevalence of Regret in Gender-Affirming Surgery: A Systematic Review. *Annals of Plastic Surgery*, 92(5), 597–602.

Rew, L., Young, C. C., Monge, M., & Bogucka, R. (2021). Puberty blockers for transgender and gender diverse youth – a critical review of the literature. *Child and Adolescent Mental Health*, 26(1), 3–14.

Ristori, J., & Steensma, T. D. (2016). Gender dysphoria in childhood. *International Review of Psychiatry*, 28(1), 13–20.

Roy, M., & Strate, P. (2023). Autism spectrum disorders in adulthood – symptoms, diagnosis, and treatment. *Deutsches Ärzteblatt International*, 120(6), 87.

Ruble, D.N., Taylor, L.J., Cyphers, L., Greulich, F.K., Lurye, L.E. and Shrout, P.E. (2007). The Role of Gender Constancy in Early Gender Development. *Child Development*, 78, 1121–1136.

Rütsche, B. (2024). Zwischen Rationalität und Werturteil: Begriff und Methodik der Interessenabwägung. Schweizerischer Juristentag 2024, ZSR 143 II 5–99, S. 75 f.

Schweizerische Akademie der Medizinischen Wissenschaften (2016). Autonomie und Beziehung. Selbstbestimmung braucht das Gegenüber, Bericht zur Tagung vom 7. Juli 2016 des Veranstaltungszyklus «Autonomie in der Medizin». *Swiss Academies Communications*, 11 (12).

Simons, L., Schrager, S. M., Clark, L. F., Belzer, M., & Olson, J. (2013). Parental support and mental health among transgender adolescents. *Journal of adolescent health*, 53(6), 791–793.

SKMR (2020). Kinderrechte in der Schweiz: Die Umsetzung des Partizipationsrechts des Kindes nach Art. 12 UN-Kinderrechtskonvention. Schweizerisches Kompetenzzentrum für Menschenrechte. URL: https://skmr.ch/publikationen-dokumentationen/studien-gutachten/kinderrechte-in-der-schweiz (20 June 2024).

Skordis, N., Kyriakou, A., Dror, S., Mushailov, A., & Nicolaides, N. C. (2020). Gender dysphoria in children and adolescents: an overview. *Hormones*, 19(3), 267–276.

Sotomo (2021). Geschlechtergerechter: Studie #1 Geschlecht und Identität.

Staphorsius, A. S., Kreukels, B. P., Cohen-Kettenis, P. T., Veltman, D. J., Burke, S. M., Schagen, S. E., ... & Bakker, J. (2015). Puberty suppression and executive functioning: an fMRI-study in adolescents with gender dysphoria. *Psychoneuroendocrinology*, 56, 190–199.

Steensma, T. D., Kreukels, B. P., de Vries, A. L., & Cohen-Kettenis, P. T. (2013). Gender identity development in adolescence. *Hormones and behavior*, 64(2), 288–297.

Sun, C. F., Xie, H., Metsutnan, V., Draeger, J. H., Lin, Y., Hankey, M. S., & Kablinger, A. S. (2023). The mean age of gender dysphoria diagnosis is decreasing. *General psychiatry*, 36(3).

Surace, T., Fusar-Poli, L., Vozza, L., Cavone, V., Arcidiacono, C., Mammano, R., ... & Aguglia, E. (2021). Lifetime prevalence of suicidal ideation and suicidal behaviors in gender non-conforming youths: a meta-analysis. *European Child & Adolescent Psychiatry*, 30, 1147–1161.

Tate, C. C., Bettergarcia, J. N., & Brent, L. M. (2015). Re-assessing the role of gender-related cognitions for self-esteem: The importance of gender typicality for cisgender adults. *Sex Roles*, 72(5–6), 221–236.

Taylor, J., Mitchell, A., Hall, R., Heathcote, C., Langton, T., Fraser, L., & Hewitt, C. E. (2024a). Interventions to suppress puberty in adolescents experiencing gender dysphoria or incongruence: a systematic review. *Archives of Disease in Childhood*, 109, 33–47.

Taylor, J., Mitchell, A., Hall, R., Langton, T., Fraser, L., & Hewitt, C. E. (2024b). Masculinising and feminising hormone interventions for adolescents experiencing gender dysphoria or incongruence: a systematic review. *Archives of Disease in Childhood*, 109, 48–56.

Tordoff, D. M., Wanta, J. W., Collin, A., Stepney, C., Inwards-Breland, D. J., & Ahrens, K. (2022). Mental health outcomes in transgender and nonbinary youths receiving gender-affirming care. *JAMA network open*, 5(2), e220978–e220978.

Trautner, H. M., Gervai, J., & Németh, R. (2003). Appearance-reality distinction and development of gender constancy understanding in children. *International Journal of Behavioral Development*, 27(3), 275–283.

Turban, J. L., King, D., Li, J. J., & Keuroghlian, A. S. (2021). Timing of social transition for transgender and gender diverse youth, K-12 harassment, and adult mental health outcomes. *Journal of Adolescent Health*, 69(6), 991–998.

Turner, D., Briken, P., & Nieder, T. O. (2020). Geschlechtsinkongruenz, Geschlechtsdysphorie und Trans-Gesundheit. *PSYCH up2date*, 14(04), 347–363.

Van de Grift, T. C., Elaut, E., Cerwenka, S. C., Cohen-Kettenis, P. T., & Kreukels, B. P. (2018). Surgical satisfaction, quality of life, and their association after gender-affirming surgery: a follow-up study. *Journal of sex & marital therapy*, 44(2), 138–148.

Wallien, M. S., & Cohen-Kettenis, P. T. (2008). Psychosexual outcome of gender-dysphoric children. *Journal of the American Academy of Child & Adolescent Psychiatry*, 47(12), 1413–1423.

Wiepjes, C. M., Nota, N. M., de Blok, C. J., Klaver, M., de Vries, A. L., Wensing-Kruger, S. A., ... & den Heijer, M. (2018). The Amsterdam cohort of gender dysphoria study (1972–2015): trends in prevalence, treatment, and regrets. *The journal of sexual medicine*, 15(4), 582–590.

Wiesemann, C. (2020). Trans-Identität bei Kindern und Jugendlichen: Medizinethische Grundsätze für individuelle Behandlungsentscheidungen. *Praxis der Kinderpsychologie und Kinderpsychiatrie*, 69(6), 517–523.

Yunger, J. L., Carver, P. R., & Perry, D. G. (2004). Does gender identity influence children's psychological well-being? *Developmental psychology*, 40(4), 572.

Zentner, M., & von Aufsess, C. (2020). Is being gender nonconforming distressing? It depends where you live: gender equality across 15 nations predicts how much gender nonconformity is related to self-esteem. *Psychological medicine*, 52(10), 1857–1865.

Zitelny, H., Dror, T., Altman, S., & Bar-Anan, Y. (2021). The relation between gender identity and well-being. *Personality and Social Psychology Bulletin*, 48(4), 495–515.

Internet sources

PES (2020). Transgender Health - An Endocrine Society Position Statement. URL: https://www.endocrine.org/advocacy/position-statements/transgender-health (16.08.2024).

WHO (2022). WHO/Europe brief – transgender health in the context of ICD-11. URL: https://who-sandbox.squiz.cloud/en/health-topics/health-determinants/gender/gender-definitions/whoeurope-brief-transgender-health-in-the-context-of-icd-11 (16.08.2024).

6. Glossary

Assigned gender
The gender assigned to an individual at birth – generally on the basis of external sex characteristics. This is specified in the birth certificate and is thus the officially recorded gender

Body dysphoria
In the context of gender dysphoria, body dysphoria refers to the distress which may be caused by the experience of a mismatch (incongruence) between physical characteristics and the self-perceived gender identity.

Cisgender, cis
Individuals who identify with their birth-assigned gender are called cisgender or cis (opposite: transgender).

Coming-out/outing
In coming out (originally, "out of the closet"), a person who is queer communicates their sexual orientation or gender identity for the first time to their private circle or publicly. External coming-out is generally preceded by an internal coming-out – the process whereby a person becomes aware of their sexual orientation or gender identity, but does not initially disclose it. The term "outing" is used to describe a situation in which a queer person's sexual orientation or gender identity is made public by third parties, without their consent.

Gender conforming or nonconforming behaviour
Gender expression is considered to be gender conforming if it is in line with social expectations concerning a particular gender. If it deviates from such expectations, it is referred to as gender nonconforming behaviour. What is regarded as conforming or nonconforming is culturally variable and may change over time.

Gender dysphoria
The distress which may be caused by a mismatch (incongruence) between an individual's gender identity and their assigned gender is known as gender dysphoria. It may be induced by physical characteristics as well as by other people's perceptions and social expectations concerning behaviour conforming to that of the assigned gender.

Gender expression
Clothing, hairstyle, appearance (e.g. make-up), facial expressions, gestures and social behaviour are often gender-coded as "typically feminine" or "typically masculine". Gender expression describes how someone presents themselves within this coding scheme. It may, but need not, coincide with the individual's gender identity. It can be constant or variable, clear, ambiguous, or gender-neutral.

Gender identity
The personal sense of one's own gender (e.g. male, female, non-binary).

Gender incongruence
Gender incongruence is a mismatch between an individual's gender identity and their assigned gender.

Gender typicality

In psychology, gender typicality refers to the extent to which one perceives oneself as a typical member of one’s assigned gender, i.e. as having abilities and interests similar to those of one’s same gender peers.

Gender variant

Individuals whose gender expression and behaviour does not match social expectations for their assigned gender are said to be gender variant. They may be transgender, gender-fluid or non-binary, but they may also be cisgender. Gender variance is not in itself a reliable indicator of a transgender identity (see **Gender expression**).

Non-binary

Individuals who do not, or do not exclusively or fully, identify with one of the binary gender categories (“male” or “female”) are called non-binary.

Passing

If a person is perceived and addressed by others as being of the gender they identify with, this is known as “passing”.

Persisters/desisters

Individuals whose gender incongruence persists beyond childhood into adolescence or adulthood are known as “persisters”. In “desisters”, gender incongruence remits either during childhood or at the onset of puberty.

Sex characteristics

Among the biological sex characteristics are the sex chromosome patterns (e.g. XY, XX, XXY, X0), the primary reproductive organs (e.g. testicles, penis, uterus, vagina), the secondary sex characteristics (e.g. breasts, facial hair, Adam’s apple) and the individual’s hormone status.

Tanner stages

The Tanner scale is used to describe the various stages of sexual development associated with puberty. Tanner stage 1 indicates the prepubescent child’s body, while stage 5 signifies the completion of physical maturation.

Tomboy

A child assigned female at birth whose gender expression (clothing, play preferences and/or social behaviour) matches social expectations for males and is therefore often taken for a boy.

Transgender, trans, trans*

Individuals who do not (fully) identify with their birth-assigned gender are called transgender or trans (opposite: cisgender). The spelling trans* (with an asterisk) is used to indicate the inclusion of non binary identities; however, not all non-binary people describe themselves as trans*.

Transition

The process by which a transgender person undertakes social or medical changes to express their own gender. A distinction is made between social transition (e.g. changing one’s gender expression, first name, or officially recorded gender) and medical transition (body-modifying measures, e.g. hormone therapy or surgical procedures).

Transmasculine/transfeminine

Transgender individuals who identify on the male spectrum are known as transmasculine. Transgender individuals who identify on the female spectrum are known as transfeminine.

This document was unanimously approved by the Swiss National Advisory Commission on Biomedical Ethics on 7 November 2024.

Members of the National Advisory Commission on Biomedical Ethics:

Chair
Prof. Dr. theol. Markus Zimmermann

Vice Chair
Prof. Dr. med. Samia Hurst-Majno

Members
PD Dr. Iren Bischofberger, Prof. Dr. phil. Christine Clavien,
Prof. Dr. iur. Stéphanie Dagron, Prof. Dr. med. Karin Fattinger,
Prof. Dr. med. Dr. phil. Ralf Jox, Prof. Dr. med. Dipl. Soz. Tanja Krones,
Prof. Dr. iur. Mélanie Levy, Dr. med. Roberto Malacrida,
Prof. Dr. theol. Frank Mathwig, Dr. phil. Simone Romagnoli,
Dr. med. Benno Röthlisberger, Prof. Dr. iur. Bernhard Rütsche

Design and Layout
Terminal8 GmbH, Monbijoustrasse 99, 3007 Bern, www.terminal8.ch

Translation
Jeff Acheson, Bottmingen

Executive Office
Dr. phil. Anna Zuber, Executive Secretary
Dr. phil. Elodie Malbois, Scientific Collaborator

Swiss National Advisory Commission
on Biomedical Ethics
CH-3003 Bern
Tel. +41 58 469 77 64
info@nek-cne.admin.ch
www.nek-cne.admin.ch

This Opinion is available in English, French and German. The German version is the original version.