SEGM
SOCIETY FOR EVIDENCE BASED GENDER MEDICINE

February 27, 2022

Summary of Key Recommendations from the Swedish National Board of Health and Welfare (Socialstyrelsen/NBHW)

February 2022 update

Background

In February 2022, the Swedish National Board of Health and Welfare (NBHW) issued an update to its health care service guidelines for children and youth <18 with gender dysphoria / gender incongruence. This update contains 14 distinct "recommendations," with justification for each, referencing a recently completed systematic review of evidence. Three of the recommendations provide guidance for social support for gender dysphoric youth and their families; nine focus on the assessment of gender dysphoria/gender incongruence; and two target hormonal interventions: puberty blockers and cross-sex hormones. Additional updates are anticipated later in 2022.

Key Changes in the Updated Guidelines

Following a comprehensive review of evidence, the NBHW concluded that the evidence base for hormonal interventions for gender-dysphoric youth is of low quality, and that hormonal treatments may carry risks. NBHW also concluded that the evidence for pediatric transition comes from studies where the population was markedly different from the cases presenting for care today. In addition, NBHW noted increasing reports of detransition and transition-related regret among youth who transitioned in recent years.

NBHW emphasized the need to treat gender dysphoric youth with dignity and respect, while providing high quality, evidence-based medical care that prioritizes long-term health. NBHW also emphasized that identity formation in youth is an evolving process, and that the experience of natural puberty is a vital step in the development of the overall identity, as well as gender identity.

In light of above limitations in the evidence base, the ongoing identity formation in youth, and in view of the fact that gender transition has pervasive and lifelong consequences, the NBHW has concluded that, at present, the risks of hormonal interventions for gender dysphoric youth outweigh the potential benefits.

As a result of this determination, the eligibility for pediatric gender transition with puberty blockers and cross-sex hormones in Sweden will be sharply curtailed. Only a minority of gender dysphoric youth—those with the "classic" childhood onset of cross-sex identification and distress, which persist and cause clear suffering in adolescence—will be considered as potentially eligible for hormonal interventions, pending additional, extensive multidisciplinary evaluation.

For all others, including the now-prevalent cohort of youth whose transgender identities emerged for the first time during or after puberty, psychiatric care and gender-exploratory psychotherapy will be offered instead. Exceptions will be made on a case-by-case basis, and the number of clinics providing pediatric gender transition will be reduced to a few highly specialized centralized care centers.

Summary of Key Points (NBHW February 2022 Update)

Following a rigorous analysis of evidence base, there has been a marked change in treatment recommendations. The guidance has changed from a previously strong recommendation to treat youth with hormones, to new caution to avoid hormones except for "exceptional cases." A more cautious approach that prioritizes non-invasive interventions is now recommended, due to recognition of the importance of allowing ongoing maturation and identity formation of youth.

Currently, the NBHW assert that the risks of hormonal treatments outweigh the benefits for most gender-dysphoric youth:

Poor quality/insufficient evidence: The evidence for safety and efficacy of treatments remains insufficient to draw any definitive conclusions;

Poorly understood marked change in demographics: The sharp rise in the numbers of youth seeking to transition and the change in sex ratio toward a preponderance of females is not well-understood;

Growing visibility of detransition/regret: New knowledge about detransition in young adults challenges prior assumption of low regret, and the fact that most do not tell practitioners about their detransition could indicate that detransition rates have been underestimated.

Psychological and psychiatric care will become the first line of treatment for all gender dysphoric youth <18.

A substantial focus is placed on gender exploration that does not privilege any given outcome (desistance or persistence).

The presence of psychiatric diagnoses will lead to prolonged evaluation to ensure that these conditions are under control and that gender transition does not do more harm than good.

The diagnosis of ASD (autism spectrum disorder) will necessitate additional evaluation.

The well-known lack of adherence to gender norms among ASD individuals could lead them to misattribute their experience to being "transgender" and inappropriately transition.

The guidelines also posit that some youth on the autism spectrum who are suffering from gender dysphoria may not come across as genuinely suffering because they take little care to present in ways consistent with the gender they identify with.

Access to hormonal interventions for youth <18 will be tightly restricted. The goal is to administer these interventions in research settings only, and to restrict eligibility criteria to mirror those in the "Dutch protocol."

The key prerequisite for hormonal treatment of youth is the ***prepubertal*** onset of gender dysphoria that is long-lasting (5 year minimum is mentioned), persists into adolescence and causes clear suffering.

Some exceptions apply. Puberty blockade can be offered in extreme circumstances to those with post-pubertal onset of gender dysphoria, especially for biologically male patients. However, it does not appear that cross-sex hormones can be offered to the <18 youth with no childhood history of gender dysphoria.

Social transition may be recommended to some youths. Social transition may be recommended at the latter stage of assessments. The health care service may accommodate these young people by providing them with "aids" such as packers, binders, tucking devices, and breast and genital prosthesis.

Most youth will receive psychotherapeutic care in their home regions. Gender-affirming interventions will be provided at few highly specialized centers and in the context of research.

Home regions will need to develop competence in managing gender dysphoria with psychological and psychotherapeutic interventions.

Centers offering "gender-affirming" interventions will be centralized, and their number reduced.

Treatment eligibility will be based on the criterion of "distress," and not "identity."

The DSM diagnosis of "gender dysphoria" will be a prerequisite for eligibility for "gender-affirming" hormonal interventions.

The presence of a transgender identity that is not causing distress or functional impairments is not sufficient.

At the current time, youth who identify as nonbinary will not be eligible for hormonal interventions even in research settings. Future updates to these guidelines will address appropriate treatments for this patient population.

Limitations of the NBHW's Updated Guidelines

The updated guidelines leave several key questions open to interpretation. While more responsibility has been placed on local health services to provide gender exploration and psychotherapy, it is not clear how this expertise will be developed and scaled. Similarly, it is uncertain how the presence of autism-spectrum disorders, which are highlighted as cause for significant caution, will impact eligibility for hormonal interventions. Further, is it not readily apparent how the guideline's requirement to provide pediatric transitions only in research settings will be practically implemented, given that there are no ongoing research trials in Sweden.

Another significant gap in the current guidelines is that they do not address the care for 18–25-year-olds. Like the 13–17-year-old cohort, which is the focus on the current update, the cohort of gender-dysphoric 18-25 year-olds with significant mental health comorbidities has risen rapidly in recent years as have reports of regret and detransition from this group. The need to safeguard this vulnerable cohort requires careful consideration because though they are recognized as "young adults," this cohort is distinctly different from mature adults due to differences in terms of brain maturity and life experiences.

Comparison to WPATH Draft SOC8 Guidelines

There are several important differences between hormonal treatment eligibility criteria outlined by Sweden's NBHW and those put forth by WPATH in their recently released draft SOC 8 guidelines.

Some of the key differences are highlighted in a table below:

	Swedish National Board of Health and Welfare (NBHW), February 2022 update	World Professional Association for Transgender Health (WPATH), SOC8 draft
Management of gender dysphoria in youth	First line of treatment is mental health support and exploratory psychological care. Hormonal interventions can be a last resort measure for some youth (see p.43, NBHW guidelines). Hormonal interventions should be restricted to research settings. Eligibility for hormonal treatment and ability to consent will be assessed by an interdisciplinary clinical team, with only a minority of patients expected to be treated hormonally.	There should be a general assumption to treat with hormones and surgeries. Mental health assessments are important but can also be abbreviated (see SOC8 draft "Assessment" section). Hormonal interventions should be widely available in general medical practice. Patient desire is the ultimate eligibility criterion. While ability to consent is important, inability to consent is not always a barrier to receiving "gender-affirming" interventions.

	Only “gender dysphoria” (DSM-5) will qualify for hormonal interventions. A transgender identity or “gender incongruence” without distress is not sufficient.	All forms of gender incongruence are eligible for interventions, and all interventions should be available to bring the body in congruence with identity.
Eligibility for hormonal interventions based on timing of gender dysphoria onset	Prepubertal onset of gender dysphoria is required for eligibility for hormonal (GnRHa and cross-sex hormones) interventions. An exception may be made for selected post-pubertal onset cases for pubertal suppression, but not for cross-sex hormones.	The importance of long-lasting gender dysphoria is acknowledged, the timing of prepubertal vs post-pubertal onset is noted. However, hormonal transition is allowed even for those with post-pubertal onset for eligibly.
Minimum age for puberty blockers (GnRH analogues)	Tanner Stage 3; suggested minimum age of 12.	Tanner Stage 2; no minimum age suggested.
Minimum age for cross-sex hormones (estrogen, testosterone)	Minimum age 16.	Minimum age 14.

SEGM Take-away

The update to the Swedish treatment guidelines represents an impressive step toward safeguarding the growing numbers of gender dysphoric youth from medical harm arising from inappropriate gender transition.

SEGM hopes that other countries will follow Sweden’s example, independently examining the body of evidence and issuing evidence-based guidelines for medical care that respects young people’s dignity, provides relief from suffering, safeguards them from medical harm, and ultimately, prioritizes long-term mental and physical health.

The official English translation of Sweden's updated guidelines is available here.