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**To the kind attention of
Italian Society of Paediatrics (SIP)
and Cultural Association of Paediatricians (ACP)**

Subject: Primum non nocere: science beyond appearances

Critical observations on the SIP–ACP guideline “Oltre lo sguardo” (“Beyond the Surface”)

With this letter, we intend to provide a critical response to the guideline “*Oltre lo sguardo*”, acknowledging its commendable aim of reducing stigma and discrimination, while at the same time highlighting certain scientific and clinical issues, which are particularly relevant when the recommendations address developmental age and the management of gender-related distress in children and adolescents.

The first major limitation, which inevitably gives the guideline an overly generic approach and may generate possible confusion, is its tendency to summarise rather than explore in depth distinct clinical areas and fields of paediatric intervention: on the one hand, sexual orientation, gender-related issues, and complex matters such as intersex variations; on the other hand, same-sex parent families and surrogacy, the latter being particularly critical from a biological, bioethical, and legislative perspective. Each of these topics, precisely in order to ensure genuine and profound respect for the individuals involved, would require a more thorough analysis of the scientific literature and clinical approaches, as well as intervention strategies based on established scientific evidence, which differ considerably across medical, psychological, social, and ethical domains.

Neurobiological studies show that sexual differentiation, mediated by the interaction between chromosomal, gonadal, and hormonal factors, contributes to the development of organs, physiological systems, the endocrine system, and the central nervous system from the earliest stages of embryonic life [1][2][3][4]. From this perspective, sex cannot be reduced to a simple definition “assigned at birth” [5], as it represents a fundamental biological component that influences the entire developmental process and interacts with environmental and relational contexts [6][7][8]. Neuroimaging studies and research on neurodevelopment show sex-related differences in specific brain regions and in the maturation of neural circuits involved in emotions, executive functions, and neuropsychiatric vulnerability, while also recognising a broad spectrum of individual variability [3][9][10][11]. It follows that the development of the self and of gender perception emerges from the interaction between a sexually differentiated neurobiological foundation, subjective experience, social context, and learning processes that accompany growth [6][11].

The reference to a “true essence” of sexual and gender identity introduces into the framework of the guideline a fundamentally non-scientific concept. Moreover, the guideline itself states in subsequent pages that sexual identity develops through the interaction of biological, psychological, and sociocultural factors. The precise causes underlying a specific sexual orientation are not yet fully understood, and no single factor is sufficient to explain it. Sexual identity and, within it, gender identity, like every other aspect of broader personal identity, gradually emerges through a complex process of construction. This process is initially grounded in the perception and representation of one’s own anatomical constitution (the primary sensorimotor foundation), then develops by being

shaped within the various relational and social experiences that children encounter in their developmental environment, and becomes consolidated only later through puberty and adolescence, often alongside a profound redefinition and elaboration of the entire identity framework. Recognising and respecting a person's lived experience does not therefore imply assuming that their current self-definition represents immediate access to an essential, innate, immutable, and definitively known core [12][13].

When an adolescent goes through a phase of identity exploration, which may be influenced by social dynamics and the search for validation within peer groups [14][15][16][17], the brain responds to these powerful environmental stimuli. Given the phenomenon of brain neuroplasticity, it is plausible to hypothesise that repeated experiences and specific relational and cultural contexts may influence the maturation of certain neural circuits involved in self-representation and emotional regulation [18][19][20][21].

The current critical and ethical issue arises precisely from the interaction between these two mechanisms: innate biological predispositions [22][23][24] and the plastic modifiability of the brain [25].

From a psychological perspective, initiating a child prematurely towards "social affirmation" (including the so-called "alias career" in the school context) cannot be considered a neutral act without potential developmental consequences, because it requires parents and teachers to permanently adopt a specific interpretation of identity while the developmental process is still ongoing. Social affirmation modifies the relational environment of the child during a phase of rapid brain development and marked plasticity, in which relational and social experiences may have particular significance [20][21][26][27]. However, its possible effects on subsequent identity development and decision-making trajectories remain insufficiently studied [28][29]. Since, in a large proportion of cases emerging before puberty, distress may diminish or fail to persist through the end of adolescence and into adulthood [30][31][32], its use requires particular caution. Indeed, such an intervention does not merely describe a subjective reality, but modifies the relational context in which the developmental trajectory unfolds and must therefore be coordinated with the diagnostic and therapeutic pathway to be undertaken [33].

On the other hand, data regarding pubertal-onset gender variance are currently heterogeneous and do not allow for unequivocal conclusions [34][35]. When addressing this phenomenon, the reality of detransitioners cannot be overlooked, namely individuals who discontinue or reverse a process of social and/or medical transition. It is important to distinguish between detransition, regret, and simple treatment discontinuation. This variability in definitions and clinical presentations makes it difficult to estimate the prevalence of the phenomenon and to identify associated factors [36][37][38][39].

Furthermore, the literature clearly highlights the frequent co-occurrence of psychiatric comorbidities and neurodevelopmental disorders, including autism spectrum disorders, attention-deficit/hyperactivity disorder, and personality disorders, all of which may complicate the clinical presentation of individuals experiencing gender variance [40][41][42][43][44][45][46]. There is a concrete risk of **diagnostic overshadowing**, namely reducing the entirety of a young person's distress to the sole dimension of gender, while overlooking other primary diagnoses that may require treatment [29][40][44][45][46][47]. In this context, an operational guideline encouraging paediatric practices to become an "affirmative space" risks, unless accompanied by precise safeguards, legitimising pathways that focus attention on a single dimension while losing sight of the overall clinical picture [48].

The literature indeed indicates that, in many cases, psychological distress and psychopathology precede or accompany the emergence of gender-related distress, making a simple linear causal interpretation inadequate. Similarly, suicidality cannot be directly and uniquely attributed to the reactions of significant others, as it is a multifactorial phenomenon [49][50]. From this perspective, the findings of the Finnish study [51] also call for caution when interpreting psychiatric outcomes among young people seeking gender reassignment pathways, as suicide risk appears closely intertwined with pre-existing comorbidities and other vulnerability factors, including neurodevelopmental disorders [52].

The issue of neurodevelopmental disorders (which cannot be explained through minority stress), as is well known, represents one of the most controversial and delicate areas of comorbidity. In this clinical context, the paediatrician's informational and supportive role becomes particularly important, since for some minors and their parents, a diagnosis of "gender dysphoria" may sometimes prevent the identification and further exploration of complex clinical situations that are difficult to recognise.

Early social transition (change of name, pronouns, clothing, and social role), as already mentioned, is not a neutral act of simple "acceptance", but rather a psychological intervention with a significant impact. The available evidence regarding its benefits, possible risks, and influence on identity trajectories remains very limited. In cohorts of children who underwent complete social transition, high rates of persistence of transgender identification and subsequent access to endocrine treatments have been observed; these findings demonstrate an association but do not establish a causal relationship [28][29][53]. In light of current evidence, the clinical effectiveness of early social transition followed by medical transition cannot be considered demonstrated solely on the basis of the minority stress model, as the guideline appears to suggest [54]. Indeed, available systematic reviews indicate that affirmative psychosocial and medical interventions have highly uncertain effectiveness [55][56][57][58]. As recognised by the **Cass Review** [29], commissioned by the English National Health Service, available systematic reviews highlight a weak and uncertain evidence base also regarding puberty blockers and subsequent hormonal treatments [59][60][61]. In light of these conclusions, several countries that had initially adopted rapid affirmative models (the United Kingdom, Sweden, Finland, and Norway) are now revising their guidelines towards a more cautious approach, centred on comprehensive psychological assessments, supportive interventions, and significant restrictions on the use of hormonal treatments in minors [62][63][64][65][66].

Attention to the prevention of stigma towards individuals with non-heterosexual sexual orientations is both necessary and commendable; however, it cannot translate into protocols that effectively restrict the paediatrician's clinical freedom, discouraging diagnostic exploration, the assessment of comorbidities, and the adoption of a differentiated, case-by-case approach. The ethical and legal responsibility of healthcare professionals, in light of current scientific evidence, entails not automatically accepting every self-defined identity as a definitive fact, especially during developmental stages, but rather accompanying the minor through a process of understanding and integrating their own psychophysical reality. In this regard, for example, the developmental concerns and potential risks associated with the rapid affirmative approaches through which the case of Anna, a three-year-old child, is addressed by the paediatrician as a possible case of early-onset gender incongruence in the "Oltre lo sguardo" guideline (p. 21) [54], appear evident.

Based on the evidence summarised above, a truly "welcoming" clinical setting should combine the rejection of all forms of discrimination with rigorous respect for current limits of knowledge and for the

risk profiles identified through systematic reviews. In this sense, we propose revising the “Oltre lo sguardo” guideline by more clearly incorporating the following key principles:

- Empathetic and non-judgemental acceptance

The minor and their family should find a space for genuine listening, in which distress is neither minimised nor ideologised, and in which the distinction between respecting the person and endorsing identity hypotheses that have not yet been consolidated is explicitly clarified. In light of current scientific knowledge, empathetic and non-judgemental acceptance means that the paediatrician should not prematurely recommend affirmative pathways whose safety and effectiveness outcomes remain unclear, but rather should create a context of suspended action and reflection, providing appropriate information, highlighting the necessary precautions, the potential risks associated with such pathways, and the important role of comorbidities in this field.

- Clarity regarding the role of biological sex

The guideline should explicitly recognise the central role of biological sex in brain development and in responses to diseases and treatments, in accordance with gender medicine, avoiding formulations that suggest a radical and arbitrary separation between mind and body. In this regard, it should also be the paediatrician’s role to welcome and discuss explanatory theories (sometimes rigid and slogan-like) presented by patients, such as “I was born in the wrong body” or, conversely, “Everyone can choose their own gender”. Such statements may prevent patients and their families from engaging genuinely in reflection and developing a deeper awareness of themselves.

- Complex diagnostic assessment and thorough screening for comorbidities

An entire chapter of the Cass Review [29] is dedicated to the diagnostic assessment of cases of gender incongruence or gender dysphoria, advocating not a simplistic symptom-based and descriptive approach, but rather a complex diagnostic framework defined as “holistic”, extending to the broader personality structure of the minor. It follows that the paediatrician’s role should primarily be to refer situations of gender incongruence or gender dysphoria for a comprehensive psychological and neurodevelopmental assessment, which also considers the various possible comorbidities, such as autism spectrum disorders, depression, anxiety, eating disorders, trauma, and family dynamics, preventing the focus on gender from overshadowing other treatable primary diagnoses. Therefore, multidisciplinary collaboration among paediatricians, child and adolescent neuropsychiatrists, psychologists, and psychotherapists is essential.

- Exploratory assessment and psychotherapy

In light of a systematic review highlighting the limited evidence available regarding psychosocial interventions [55], various clinical contributions [67][68][69][70][71][72][73][74][75][76], and two statements issued by the National Bioethics Committee in 2018 and 2024 [77][78], which recommend, alongside careful multidisciplinary assessment, psychological-clinical intervention as the first-line approach in these situations, a fundamental role of the paediatrician should be to sensitively and competently guide the minor and their family towards an exploratory psychotherapeutic pathway. This intervention, which must be clearly distinguished from so-called “conversion therapies”, is specifically tailored to the structural and developmental needs of the individual minor and aims to explore the meaning of gender incongruence within the broader organisation of the child’s self and relational context. The therapist does not decide or define from the outside, but helps the patient autonomously

understand whether their experience is sufficiently stable, integrated, and reflective to guide decisions of such importance. The therapist also helps the patient develop broader levels of self-awareness and therefore greater freedom and capacity for choice. Such a process preserves the possibility that developmental distress may evolve or resolve without the need for irreversible medical interventions.

- Caution regarding social transition and early medicalised pathways

Any recommendation regarding social transition (changes in name, pronouns, clothing, or social role, as well as requests for educational and school environments to implement such changes) should be considered a significant clinical-psychological intervention. Its appropriateness should therefore be assessed by the paediatrician on a case-by-case basis and with caution, informing families and patients about uncertainties regarding benefits, possible risks, and the potential influence of transition on subsequent identity development trajectories. Furthermore, the inclusion in the guideline of a section on “same-sex parent families” and “surrogacy” (gestational surrogacy) raises considerable concerns, given the complexity of these issues, not least because they would require a separate and in-depth examination of the literature, in contrast with the unequivocal conclusions drawn in the guideline itself. In particular, regarding so-called “surrogacy” or “gestational surrogacy”, while requiring the paediatrician’s “full protection of the newborn”, it is surprising that a professional guideline addressed to paediatricians does not acknowledge this practice as not only ethically controversial, but also prohibited and subject to criminal penalties under Italian law [79]. From a scientific perspective, the literature on perinatal psychology shows that the mother–infant bond, the maternal–foetal dyad, is a process that begins during pregnancy through prenatal bonding, mental representations of the foetus, and the progressive emotional involvement of the pregnant woman [80]. This relationship, which is fundamental for optimal health and developmental outcomes for the newborn, continues after birth through skin-to-skin contact, rooming-in, breastfeeding, and other practices [81][82]. From this perspective, pregnancy cannot be reduced to a mere interchangeable biological function, as it involves a structuring relational and psychological dimension from the very beginning. Consequently, surrogacy raises significant scientific and ethical questions because it intentionally separates the different dimensions of motherhood — biological, gestational, psychological, and social — and therefore requires careful evaluation of outcomes for the surrogate mother, the newborn, and the entire family configuration.

In conclusion, protecting the physical and mental health of children and adolescents requires reference to methodologically robust evidence, synthesised through systematic reviews and assessed using transparent tools such as the GRADE system, which distinguishes the quality of evidence from the strength of recommendations. When data are weak, heterogeneous, or at risk of bias, an automatic clinical recommendation in favour of an affirmative approach cannot be considered justified.

A genuinely child-centred approach protects the dignity of minors and their right to be welcomed within a multidisciplinary assessment, while avoiding premature anticipation of cognitive maturation processes or promoting early social or medical changes in the absence of solid and shared evidence.

With esteem and with the hope of an open and pluralistic scientific discussion,

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Attached is the list of the 302 signatories of this document.

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