

Abstract

Reviews of treatment outcome studies of medically transitioned young people have raised concerns about the methodological problems of these studies and the treatments they support. These concerns include small sample size, lack of control groups, sample selection bias, lack of long-term follow-up data, and heavy attrition rates at follow up. Despite these limitations, major mental health associations including the American Psychological and American Psychiatric Associations continue to support medical transitioning of gender dysphoric youth. This article raises questions for psychologists (and mental health professionals in general) about the theory, research, and practice behind this diagnosis and such life-changing interventions. For these reasons, it's important to press for higher quality research, specifically mental health research and re-imagine Gender Affirming Care of trans-identified youth as an actual psychotherapeutic endeavor. This proposed approach involves an empirically supported and broadly-based process of informed consent, and maintains an affirming, client-centered stance that envisions multiple treatment options and pathways to gender dysphoria.

Keywords: Transgender, Transitioning, Detransitioning, Gender-Affirming Care

Issues surrounding gender non-conforming children and gender dysphoric adolescents are emotional, complex, and controversial. These issues have divided professionals providing medical interventions to trans-identified young people from professionals who are concerned that the safety, reliability, and validity of these treatments have not been sufficiently established. One result of this divide is a system of care where clinical research is not leading, but following, mainstream clinical practices associated with the transitioning of gender dysphoric young people¹. Further, the social, emotional and political controversies that have accompanied this divide have also discouraged scientific and clinical efforts intended to examine currently accepted beliefs and treatment of gender dysphoria (Cass, 2024b). As a result, psychology's contributions to the theory, research, and psychotherapeutic practice with gender dysphoric and trans-identifying youth have been largely inconsequential.

A variety of pressures have led to practice preceding research in contemporary approaches to transgender care including the sincere desire to help the growing numbers of young people presenting for treatment. Yet, this lack of adequate research and a research base that leads treatment may cause providers to underestimate the attendant risks. One egregious historical example of underestimating risk is the surgical lobotomy, for which Moniz won the only Nobel prize in psychiatry for an intervention that was later considered extremely harmful after closer scientific scrutiny (Ables, 2023).

While scientific evidence for medical interventions with young people experiencing gender dysphoria remains incomplete (Abbruzzese, Levine, & Mason, 2023; Cass, 2024b; and Thompson et al., 2023), and the consequences of misdiagnosis and unnecessary treatment are potentially harmful, psychologists may need to reconsider their support of social and medical transitioning in youth until after nonmedical issues and options have been

thoroughly explored. This could involve an effort to re-imagine a different form of Gender Affirming Care, assist in the development of higher quality research, and reintroduce psychological, psychiatric, and family systems thinking into the treatment paradigm of gender non-conforming and gender dysphoric youth. A broader and deeper role for mental health professionals may help clarify the role anxiety, depression, eating disorders, trauma, peer pressure, social isolation, personality disorder, autism, and autism spectrum disorders play in the experience and expression of identity in general, and gender identity in particular.

It is the intent of this paper to explore the relationship between research and practice in the understanding and treatment of young people with gender dysphoria and encourage the involvement of mental health professionals in the development of empirically derived standards of care for them. In a more general sense, it is about humility and caution. Humility about what we know regarding gender dysphoria and caution when making claims about the success of medically transitioning young people. There is no intent to deny or disavow the pain trans-identified persons live with and face while trying to find peace within themselves and happiness in their lives. Nor is there any desire to discourage or impede the pursuit of individual rights, calls for social justice, or demands for personal safety. Scientifically based health care and empirically derived health care interventions are fundamental rights for everyone.

Concerns Regarding Empirical Support for Medical Transitioning of Young People

As concerns about the quality of research supporting the medical treatment of gender non-conforming children and gender dysphoric adolescents continue to intensify, (particularly in Europe) it is striking that many healthcare providers in the United States seem undeterred by these concerns (Cohen, 2023). Extensive reviews of medical interventions and their treatment outcomes reveal consistently unclear, underwhelming, and unfavorable results (Abbruzzese,

Levine, & Mason, 2023; Cass, 2024b; Thompson et al., 2023). Further, the safety and potential side-effects of puberty blockers, cross-sex hormones, and reassignment surgery for young people yield significant concerns, yet to be resolved by research (Akhaven, Sandhu, & Ogunleye, 2021; Alzahrani et al., 2019; Baxendale, 2024; Cheng, Pastuszak, Myers, Goodwin, Hotaling, 2019; Hembree, et al., 2017; Joseph, Ting, & Butler, 2019; Schneider et al., 2017; Taylor, et al., 2024; Yelehe, Klein, Layal, Maurier, & Fiegerlova, 2022). At present, what can be said for the medical transitioning of young people, is while many patients report being helped (Olsen, Raber, & Gallagher, 2024), others believe they have been harmed (Littman, 2021 Littman, O'Malley, Kerschner & Bailey, 2024).

Many clinicians and medical providers throughout North America have failed to seriously consider research-based criticism of the Dutch protocol, which is a series of studies that form the empirical foundation of medical transitioning (de Vries & Cohen-Kettenis, 2012; Gooren & Delemarre-van de Waal, 1996). These criticisms come from national health services and medical organizations in Sweden, Finland, Norway, and the United Kingdom, all former proponents of medical transitioning (Davis Jr., 2023; Kaltiala, 2023). The Dutch protocol studies have been profoundly influential. They have shaped the discussion and directed the treatment of trans-identified patients around the world. Yet, these studies have been found to suffer from significant methodological problems including small sample size, lack of control groups, sample selection bias, heavy rates of attrition at follow-up, and reaching large conclusions from small effects (Abbruzzese et al., 2023; Cass, 2024b). What's more, these studies rely on time-limited follow-up data to understand and explain ongoing interventions with lifelong impact for patients who are still physically developing and emotionally maturing. Unfortunately, similar problems are identified in the methodology and conclusions of studies that have followed the Dutch protocol,

including, Carmichael et al., (2021), Costa et al., (2015), and Tordoff et al., (2022). These studies have been criticized by Abbruzzese et al., (2023) and Biggs (2019) for framing minimal results, no results, and even negative results as positive outcomes.

In an extensive independent review, commissioned by the NHS England, Cass (2024) and colleagues outline their concerns and conclusions: 1) while a great deal of research has been published in this area, it has been of poor quality and provides no solid evidence for transgender patients, their families, or clinicians to draw from in their personal or professional decision-making; 2) this low quality research has frequently been overstated and misrepresented in social discourse and scientific publications; 3) social and political controversies have affected clinical decision-making and negatively impacted individual and individualized care of these patients; 4) the impact of puberty suppression on patients' gender dysphoria, social or emotional health is weak and inconclusive; 5) long-term follow-up on cross-sex hormones with young people remains inadequate, inconclusive and in need of more research; 6) clinicians remain unable to predict transitory from enduring trans-identification. In her forward, Dr. Cass (2024a) writes:

This is an area of remarkably weak evidence, and yet results of studies are exaggerated or misrepresented by people on all sides of the debate to support their viewpoint. The reality is that we have no good evidence on the long-term outcomes of interventions to manage gender-related distress. (p. 13)

Social Transitioning of Children

The limited quality of research that currently surrounds gender dysphoria and its medical treatment, complicates the support of social transitioning of gender non-conforming and gender dysphoric children. The social transitioning of young children such as changing names, pronouns, and manner of dress appears to be a passive process that buys children and their

families time to experiment in this new identity. However, research has shown that social transitioning functions as a very powerful intervention that reinforces trans-identification and directs many children and their families into future medical treatments (Olson, Durwood, Horton, Gallagher, & Devor, 2022). Of concern is these children and their families are being directed into medical treatments that have side-effects, can be irreversible, and have yet to empirically demonstrate their long-term effectiveness in relieving gender-dysphoria, or improving social and emotional functioning (Cass, 2024b). Further, social transitioning may be a premature intervention that overlooks the transitory nature of gender identification as well as ignores the incomplete nature of a child's developing identity and self-concept. It is an intervention that can eclipse a child and his/her family's consideration of non-medical options and the potential benefits of time, patience and acceptance, on social, emotional, and gender identity development. Researchers, including some in the original Dutch studies, recommend that adults refrain from early social transitioning of children in favor of a stance aligned with watchful waiting, an approach to gender non-conforming children that emphasizes empathy and patience, until early puberty at which time decisions can be made about additional interventions (Cohen-Kettenis, Delemarre-van de Waal, & Gooren, 2008; de Vries & Cohen-Kettenis, 2012).

In their review, Ristori & Steensma (2016) suggest 80% of gender dysphoric and gender incongruent children will eventually return to identifying with their natal sex. In other studies, between 50% and 90% of gender non-conforming and gender dysphoric children desisted from trans-identification (Cantor, 2020; Korte et al., 2008; Singh, Bradley, & Zucker, 2021; Zucker, 2018). By late adolescence and early adulthood, these "desisters" tend to accept their birth sex, are seen to be well adjusted and navigating their way through life, many as gay and lesbian adults (Hembree et al., 2017; Korte et al., 2008). In contrast, Olson, et al. (2022) finds that 94%

of children in their study who socially transition between the ages six and seven, went on to identify as transgender by age 12; with 60% of them (by age 12) having already begun puberty blockers or cross-sex hormones. Once started, puberty blockers function as a pathway to further treatment since 95% of adolescents who begin puberty blockers go on to additional medical interventions (van der Loos, Hannema, Klink, den Heijer, & Wiepjes, 2022).

Together, these studies reveal a path that many gender non-conforming, and gender dysphoric children follow when not socially transitioned. Many accept their birth sex and avoid medical interventions all together. Further, studies of social transitioning point to the critical role of adults, and how they can alter the course of children's lives in general and gay children's lives in particular; first, by socially transitioning them into transgender identities, and second, by directing them into medical treatment (Cantor, 2020; Zucker, 2018).

This is not a judgement about the relative merit or worth of being trans-identified or non-trans-identified. It is an accounting of the risks and benefits for patients who undergo medical interventions versus those who do not. It represents the desire to scientifically establish the etiology and course of these children's concerns, identify the safest way forward for them, and discern the most effective steps to be taken on their behalf by parents, teachers, and health care professionals. According to Cass (2024b), we are currently unable to identify transient from enduring trans-identification in children or adolescents. Yet built into social transitioning is the assumption that we can in fact make this distinction. Without the ability to distinguish transient from enduring trans-identification and proceeding to socially transition gender non-conforming or dysphoric youth, we risk directing significant numbers of children experiencing transitory gender dysphoria toward medical interventions. Such interventions can be irreversible, involve adverse side-effects such as sexual dysfunction and infertility, require lifelong involvement with

the medical system, and include the risk of enduring such procedures while not receiving the anticipated social or emotional benefits (Littman, 2021).

Re-Imagining Gender-Affirming Care

Gender Affirming Care is the current standard of treatment for gender dysphoria in the United States. Gender Affirming Therapy is described by the American Psychiatric Association (2024), as “a therapeutic stance that focuses on affirming a patient’s gender identity and does not try to ‘repair’ it.” Through Gender Affirming Care, children are to be supported, believed, and accepted in their thoughts and feelings about their sense of being male or female, both, or neither (U.S. Department of Health & Human Services, 2023). Under the auspices of Gender-Affirming Care, mental health interventions with trans-identified young people have evolved from consultations, extensive evaluations, and psychotherapy (Cohen-Kettenis, Steensma, & de Vries, 2011), to very brief interactions intended to direct children and families into medical treatment (Kaltiala, 2023; Edwards-Leeper & Anderson, 2021). Currently, to provide Gender-Affirming Care one must believe children and adolescents, take their claims at face value, and presume they possess the self-understanding to know, and the cognitive capacity to communicate, the breadth and depth of their feelings and transgender identity. Gender-Affirming Care as currently conceptualized and practiced, is to assist children and adolescents in social transitioning and prepare them to deal with the challenges of the social environment, medical system, and future medical interventions (U.S. Department of Health & Human Services, 2023).

Some clinicians are concerned that Gender Affirming Care has framed mental health providers as unnecessary and as unwanted gatekeepers. They report many patients are being diverted from mental health treatment directly into medical transitioning (Edwards-Leeper & Anderson, 2021; Ghorayshi, 2023; Kaltiala, 2023; Levine, Abbruzzese, & Mason, 2022; Reed,

2023). The downsizing of genuine mental health services is occurring despite the significant role of psychotherapy in the Dutch studies (Cohen-Kettenis et al., 2011), despite the findings of Churcher Clarke & Spiliadis (2019), who underscore the effectiveness of brief exploratory interventions with trans-identified patients and despite moves in the United Kingdom, Finland, Sweden, and Norway to restrict medical transitioning of minors and to rely more heavily on mental health interventions for treatment of gender dysphoric young people (Abbruzzese et al., 2023; Davis Jr., 2023; Kaltiala, 2023).

As with Gender Affirming Care, all psychotherapy should be affirming, yet affirming in psychotherapy is not the same as promoting, just as validation is not the same as agreement, nor empathy the equivalent of approval. The assertion that one has been born into the wrong body (an assertion that is frequently accompanied by other emotional concerns), might reasonably be seen as the beginning not the end of a young person's involvement with mental health treatment.

Our re-imagined approach to Gender Affirming Care would be guided by what Jorgensen, Athea and Masson (2024) have discussed as a child's right to an open future. Namely, that children do not possess the capacities to make decisions in the present while at the same time fully grasping the implications of these decisions for the future. Therefore, children must be protected in the present in order to preserve their right to explore options and make decisions for themselves once they reach adulthood. As such, we oppose Gender Affirming Care as described above and widely practiced throughout North America. As adults, health care providers are charged with protecting children's rights to an open future, a future which is not foreclosed upon in childhood and which remains open to them in their adulthood.

This re-imagined approach to Gender Affirming Care would be grounded in what is already understood about child and adolescent psychology, psychopathology, and psychotherapy.

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It would be guided by psychotherapeutic principles and delivered in an intellectually honest way about what we do and do not know regarding gender dysphoria and its treatment. This re-imagined approach to gender non-conforming and gender dysphoric young people would draw from what data exist to provide an experience of informed consent where both parents and children would be made aware of the risks and benefits of medical and non-medical approaches to gender dysphoria. Such discussions would include our inability to distinguish transitory from enduring gender dysphoria, the many possible pathways of trans-identification, and the lack of long-term studies demonstrating our ability to relieve gender dysphoria or improve social or emotional functioning through medical interventions (Cass, 2024b).

A re-imagined Gender Affirming Care would also recognize our limited understanding of the role emotional disturbance and neurodiversity play in the cause, course, and treatment of gender dysphoria including these patients' responses to medical transitioning. Re-imagined Gender Affirming Care would affirm the gender dysphoric experience without promoting or impeding patients or families discussing or taking additional steps toward or away from medical transitioning. It would function as an approach to self-understanding that validates the patient's struggles as well as each patient's potential for growth, growth that may or may not lead to trans-identification or future medical treatment. Last, re-imagined Gender Affirming Care would be sensitive to and continually refined by future clinical research.

Medical Transitioning of Emotionally Disturbed Children and Adolescents

Mental health interventions with transgender youth are frequently seen as an affront to patient autonomy, and the current values of Gender Affirming Care (Edwards-Leeper & Anderson, 2021; Reed, 2023). As a result, the understandings, interventions and research of mental health providers are underutilized in the care of trans-identified young people (Littman,

2021; Littman et. al. 2024). We believe the lack of mental health involvement leaves trans-identified and particularly emotionally disordered trans-identified young people at risk for misdiagnosis, receiving life-altering treatment, and unfortunately, receiving treatment they may later regret (Littman, 2021).

Insufficient mental health involvement in transgender care has opened the door to medically transitioning more young people with serious co-occurring mental health concerns (Kaltiala, 2023). These emotional difficulties range from autism and autistic spectrum disorders to anxiety, depression, self-harm, suicidality, eating disorders and trauma (Edwards-Leeper & Anderson, 2021; Kaltiala, 2023; Kaltiala-Heino, Bergman, Työlajärvi, & Frisé, 2018; Littman, 2018; Paz-Otero, 2021). Each of these difficulties is defined by, or is indicative of, profound disorders in self-understanding, emotion regulation, and/or social/emotional awareness. Patients with such significant mental health concerns were frequently considered inappropriate and excluded from medical transitioning in the original Dutch protocol (de Vries, Cohen-Kettenis, & Delemarre-van de Waal, 2006; Smith, van Goozen, & Cohen-Kettenis, 2001).

In a study of 100 detransitioners by Littman (2021), 65% of participants report the relationship between their mental health problems and their desire to transition were not assessed prior to transitioning. While most patients in the study detransitioned for several different reasons, a striking 60% included becoming comfortable with their birth sex as one of these reasons. In addition, 42% also explain their decision to detransition because they did not see the improvements in their mental health they had anticipated, and 38% went on to conclude that their gender dysphoria was due to pre-existing mental health conditions (Littman, 2021). Many of the findings by Littman (2021) and Littman, O'Malley, Kerschner, & Bailey (2024) are reflected in a lawsuit brought in the United States by a young woman with a number of mental health

diagnoses including gender dysphoria who claims that her treatment team rushed her into medical transitioning, ignored her mental health problems, and failed to disclose the short and long-term side-effects of these medical procedures. The American Academy of Pediatrics was also named in the suit as misrepresenting the level of existing empirical support for these treatments (Scher, 2023).

By medically transitioning patients with serious mental health problems, we potentially ignore that in some instances gender dysphoria may be less a cause of emotional disturbance and quite possibly an effect (Kaltiala, 2023). By ignoring the potential significance of pre-existing mental health concerns, we may be inadvertently placing primacy on gender dysphoria and overlooking more fundamental mental health problems such as a young person's own misogyny, homophobia or history of trauma (Littman et. al. 2024). Attempting to disentangle co-occurring emotional disorders from gender dysphoria is an important feature of our re-imagined approach to Gender Affirming Care and a critical area of inquiry for future research. If successful, such efforts might differentiate those who are likely to benefit from medical transitioning from those who are at risk for feeling harmed by it or who may have benefitted from other less invasive psycho-social approaches to their concerns.

The Impact of Social and Emotional Controversy on Clinical Research

The social and political controversy surrounding gender dysphoria has discouraged some clinicians from working with this population (Cass, 2024a) and has negatively affected research and researchers. The experiences of Lisa Littman, Michael Bailey and Ken Zucker are noteworthy. All three have made significant contributions to the scientific understanding and treatment of gender dysphoria. Yet, all three have been accused of bias in their research or of being transphobic in their beliefs. Littman and Zucker have lost jobs because of their research

activities (Kearns, 2018) and Bailey has recently had an article, Diaz & Bailey (2023), retracted following protests to the publisher (Wright, 2023). (This retracted article has recently been republished as Bailey & Diaz (2023) in the Journal of Open Inquiry in the Behavioral Sciences). Through their work, Littman, Bailey, and Zucker challenge several assumptions of Gender Affirming Care by attempting to understand the role of emotional disturbance and social contagion and the significant increases of trans-identified adolescent young women and young people (Littman, 2021; Muth, 2017). Drs. Littman and Bailey are actively researching Rapid Onset Gender Dysphoria (ROGD) a construct that has growing empirical support and has identified a unique subset of trans-identified adolescents (Leonhardt, Fuchs, Gander & Sevecke, 2024). Personal attacks on scientists are serious. They have the potential to harm the reputations and careers of individual researchers, but also hinder clinical research and negatively affect the development of patient care.

The personal attacks on Littman and her work are particularly concerning, because she leads the way in the study of desisters and detransitioners, two groups crucial to our understanding of gender dysphoria and the ultimate efficacy of trans-gender treatment. It is tragic that detransitioners are being maligned and ostracized by activists, and even parts of medical and mental health communities (Edwards-Leeper & Anderson, 2021; Paul, 2024; Vandebussche, 2022). This mistreatment may in part explain why as many 75% of these patients fail to report their decision to detransition to their health care providers (Edwards-Leeper & Anderson, 2021; Littman, 2021). With 75% of detransitioning patients failing to inform their providers of their decision to detransition, it is difficult to have confidence in the accuracy of reported treatment outcomes.

In their study of patient outcomes, Roberts, Klein, Adirim, Schvey, & Hisle-Gorman (2022) report at four-year follow-up, 70% of their patients continue to fill monthly prescriptions for cross-sex hormones. The authors reasonably contend this is a 70% persistence rate. This finding also suggests a 30% rate of desistance though not necessarily a 30% rate of regret or detransition. Littman and her colleagues are exploring why patients are stopping and, in some cases, attempting to reverse their treatments. Littman et al., (2024) report patients stopping treatment due to financial concerns, family and social pressure, having confused trauma with gender dysphoria, or coming to terms with their own misogyny or homophobia. Some of these reasons for desisting and detransitioning include misdiagnosis and unnecessary medical treatment. Others have nothing to do with such errors. The research of Littman and others is essential to parse these data and inform clinicians, parents, patients, and policymakers about success and failure surrounding medical transitioning, particularly in long-term outcomes among children and adolescents. As a matter of informed consent, transgender youth and their parents, have a right to know this information, before any steps are taken to transition.

Additional Questions and Concerns

The above discussion has not addressed several other difficult questions. Such as, can minors ever provide informed consent? Can severely emotionally disturbed people, of any age, provide meaningful consent given their level of personal vulnerability? Can parents, confronted by conflicting social, emotional, political, and apparent scientific messaging, make reasoned or reasonable decisions about medically transitioning their children? Nor does it deal with concerns related to medical side-effects of puberty blockers, such as issues with loss of bone density and interruption of neuropsychological development (Joseph et al., 2019; Schneider et al., 2017), the cardiovascular risks associated with cross-sex hormones (Alzahrani et al., 2019), and the

potential risks of sexual dysfunction (Kerckhof et al., 2019) and sterility (Cheng, Pastuszak, Myers, Goodwin, & Hotaling, 2019) that can accompany medical transitioning. Last, this discussion has not considered the potential for financial conflicts of interest in the proliferation of diagnoses and medical treatments of gender dysphoria (Muth, 2017).

Conclusion

In the absence of blood tests, brain scans, and biological markers for gender dysphoria, healthcare providers face difficult decisions about how best to help young transgender patients. However, medical transitioning with children and adolescents carries an extraordinary burden of proof, first of “no harm” and second of treatment efficacy. It is the seriousness of these patients’ problems, the growth in their numbers, and the irreversible nature of the interventions used to treat them, that requires clinical research take precedence over clinical practice. Such a shift will support the rights transgender people seek, as well as the quality of care they deserve.

Mental health professionals can facilitate research preceding practice by re-imagining Gender Affirming Care for young persons and making it an empirically supported psychotherapeutic activity. It can be care that draws from clinical research, emphasizes informed consent, and affirms, validates, and supports patients and their families. Re-imagined Gender-Affirming Care would approach gender dysphoria and medical transitioning in a manner not dissimilar from how psychotherapists approach many other patients facing life-altering decisions. It would not recommend or discourage one path or clinical intervention over another but support the exploration and implications of each.

In addition, mental health professionals can help create a more substantive role for high quality mental health research. This research would examine long-term follow-up, seek to distinguish transient from enduring gender dysphoria and inform various treatment pathways and

decisions for gender dysphoric youth and their families. Conflating emotional disturbance and gender dysphoria, giving in to social, political and family pressures, or compromising on the need for scientific data, followed by possibly unnecessary or ineffective or even harmful medical treatment are unsupportable outcomes for these patients. Such outcomes may be less likely if mental health professionals become re-engaged and insist that for these powerful interventions, there be equally powerful scientific evidence to justify their use.

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Footnotes

¹ For purposes of this discussion, “child or children” refers to a prepubescent individual or group, “adolescent(s)” refers to an individual or group capable of, experiencing, or having gone through puberty and under the age of eighteen, “minor(s)” refers to an individual or group of

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individuals under the age of eighteen years of age, and “youth” or “young people” refer collectively to a person or persons under the age of twenty-one.