

A Clinical Guide for Therapists Working with Gender-Questioning Youth

Version 1



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Introduction to Exploratory Therapy for Gender Dysphoria

This is a guide for psychotherapists, counselors, and clinicians who work with adolescents and young people from puberty to age 25. It is intended to provide an overview of the main premises of exploratory psychotherapy for gender dysphoria. This approach is exploratory and, therefore, does not favor any particular outcome. Instead, it aims to ameliorate the distress experienced by young people with gender dysphoria using a whole-person approach.

The **exploratory approach** outlined here stands in contrast to the “**gender-affirmative approach**,” which has gained popularity in recent years. The gender-affirmative approach assumes that minors presenting with a wish to live in a gender role different from their sex are transgender, and that the primary role of the therapist is to help minors transition. Transition consists of varying combinations of social transition, medical interventions, and surgical procedures.

The gender affirmative-approach is relatively new. It gained popularity after the publication of the “Dutch Studies” in 2011 and 2014. These two studies showed that high-functioning Dutch minors with an early-childhood onset of persistent and consistent gender dysphoria, who were medically transitioned after reaching mid-puberty, functioned well after their final surgery at the average age of 21. An attempt to replicate the successes reported by the Dutch researchers was undertaken at the world’s largest pediatric clinic in the UK, but failed to demonstrate the psychological improvements reported by the Dutch (Carmichael et al., 2021). There are also significant uncertainties about whether the findings of the Dutch studies are applicable to the current cohort of youth presenting with gender dysphoria.

There is general scientific consensus that the two Dutch studies, as well as several other studies that followed them, suffer from serious methodological problems, including a high risk of bias due to small sample sizes, lack of control groups, and poor study designs. Consequently, the body of evidence for hormonal interventions for minors has been rated as “low” to “very low” quality by

several systematic reviews of evidence, including a review commissioned by the Endocrine Society on which the current treatment recommendations rest (Hembree et al., 2017). Several other more recent reviews of evidence, including one commissioned by the UK National Health Service, confirmed this finding (National Institute for Health and Care Excellence, 2020a; National Institute for Health and Care Excellence, 2020b; Baker et al., 2021). The “low quality” rating indicates that it is unclear whether the benefits of interventions outweigh the risks (Balslem et al., 2011).

Early gender transition, promoted by the “gender-affirmative” model, can be associated with potential short-term benefits, including reduced feelings of anxiety and depression or fewer reported thoughts of self-harm (Baker et al., 2021). However, it is also associated with significant risks. These risks include compromised bone density and brain development, cardiovascular complications, neoplasms, and other dangers (Alzahrani et al., 2019; Klink et al., 2015; Lin et al., 2020; Schneider et al., 2017). There is also a growing concern that many of the adverse effects of these interventions will emerge in years to come (Malone et al., 2021). Further, recent research suggests that between 10-30% of young people and adults who undergo gender transition discontinue it within 16 months to 5 years, sometimes experiencing significant regret over the irreversible physical changes (Boyd et al., 2022; Hall et al., 2021; Littman, 2021; Vandembussche, 2021; Roberts et al., 2022). Clinical experience, media coverage, and online testimonials, where thousands of young people share tragic stories of inappropriate gender transitions, show that this is an uncertain, rapidly evolving and understudied issue (r/detrans Detransition Subreddit, n.d.).

Early gender transition also poses a key ethical dilemma: according to the treatment protocol outlined by the Endocrine Society (which is supported by only low quality evidence), minors undergoing gender transition are likely to be infertile for life, with little opportunity for fertility preservation. There is also emerging concern about future sexual dysfunction (Bowers, 2021). This means that children as young as 9-12 may be waiving their future right to sexual function and reproduction long before they are mature enough to comprehend the importance of these functions. This is especially alarming since gender-related distress is a common developmental phase of many pre-gay youth who may not discover their sexual orientation until they are more mature.

In view of the heavy medical burden and risks associated with medical transition, the uncertain long-term benefits, and low-quality evidence base, a growing number of public health authorities

internationally are recognizing that less invasive approaches, such as exploratory psychotherapy, should be the first line treatment for youth with gender distress. These international recommendations are highlighted below:

International Guidance for Gender Dysphoria in Youth

Sweden: National Board of Health and Welfare

Based on a review of the literature, it was concluded that the evidence is not sufficient to show that the benefits of gender-affirming treatments outweigh the potential risks for youth with gender incongruence. Further, the reasons for the continued increase in the number of youth presenting with gender dysphoria are not clear, further affecting the risk-benefit analysis for gender affirming treatments in this group. Therefore, gender-affirming hormonal treatments should only be offered in exceptional cases and only in research settings. The majority of young people with gender incongruence may be offered other forms of care instead of hormonal treatment. (Socialstyrelsen [National Board of Health and Welfare], 2022)

Finland: National Health Service

“The first-line intervention for gender variance during childhood and adolescent years is psychosocial support and, as necessary, gender-exploratory therapy and treatment for comorbid psychiatric disorders....In adolescents, psychiatric disorders and developmental difficulties may predispose a young person to the onset of gender dysphoria. These young people should receive treatment for their mental and behavioral health issues, and their mental health must be stable prior to the determination of their gender identity. Clinical experience reveals that autistic spectrum disorders (ASD) are overrepresented among adolescents suffering from gender dysphoria; even if such adolescents are presenting with gender dysphoria, rehabilitative interventions for ASD must be properly addressed.” (Council for Choices in Health Care in Finland (COHERE), 2020)

Royal Australian and New Zealand College of Psychiatrists

“Evidence and professional opinion is divided as to whether an affirmative approach should be taken in relation to treatment of transgender children or whether other approaches are more appropriate....Approaches which don’t include medical treatments may focus on utilizing psychotherapy to aid individuals with Gender Dysphoria in exploring their gender identity, and

aid alleviation of any co-existing mental health concerns identified in screening and assessment.... Psychiatric assessment and treatment should be both based on available evidence and allow for full exploration of the person's gender identity.... It is important the psychological state and context in which Gender Dysphoria has arisen is explored to assess the most appropriate treatment.” (Royal Australian and New Zealand College of Psychiatrists, 2021b)

United Kingdom: The Cass Review

“There is a lack of agreement...about the extent to which gender incongruence in childhood and adolescence can be an inherent and immutable phenomenon for which transition is the best option for the individual, or a more fluid and temporal response to a range of developmental, social, and psychological factors.” (The Cass Review, 2022, p.16)

“Primary and secondary care staff have told us that they feel under pressure to adopt an unquestioning affirmative approach and that this is at odds with the standard process of clinical assessment and diagnosis that they have been trained to undertake in all other clinical encounters.” (The Cass Review, 2022, p.17)

“Assessments should be respectful of the experience of the child or young person and be developmentally informed. Clinicians should remain open and explore the patient's experience and the range of support and treatment options that may best address their needs, including any specific needs of neurodiverse children and young people.” (The Cass Review, 2022, p.71)

Each of these recommendations highlights the importance of a person-specific approach, of which exploratory therapy is a key part. Exploratory therapy for gender dysphoria draws on the established principles of psychological engagement that most clinicians already utilize in their practices. Any clinician with training and experience in psychotherapy or counseling—who approaches their practice with careful exploration of the client's unique personal experience, developmental history, and current life context—has the requisite skills to undertake work with young people with gender dysphoria. It is our hope that this guide will show clinicians how to apply the skills they already possess to treat the rapidly growing numbers of gender dysphoric minors in a compassionate, empathic and thoughtful manner, helping them navigate the often tumultuous years of adolescence and young adulthood and the developmentally-appropriate tasks of identity exploration.

What Exploratory Therapy Is:

- 1. It is open to a range of outcomes.** Exploratory therapy does not have a fixed outcome, such as identification with natal sex, as its goal. Instead, it is a patient-centered process which aims to explore, understand and address the multiple, intersecting factors generating distress in the young person's life. One possible outcome is that the individual may come to identify with their birth sex and accept their body as is. Or, they may decide to find non-medical ways to live a better life while still honoring their unique gendered experience. Or, they may decide to go ahead with gender transition and medical/surgical interventions even if they have a greater understanding of the complex sources of their distress. These outcomes are equally valid and equally legitimate.
- 2. It understands that gender dysphoria emerges in a context.** Gender-related distress, just like any other form of distress, occurs in a context. It cannot be understood without exploring the developmental, familial, relational and social context within which it occurs. Gender dysphoria or gendered experience is but one aspect of the complex tapestry of each unique human life. Exploratory therapy seeks to explore not just the person's gendered experience, but the entire landscape of their current life and lived experience. It seeks to understand how this person came to develop negative feelings about their sexed body, or that the gender they were assigned is wrong.
- 3. It is developmentally informed.** Gender dysphoria in young people is invariably embedded in larger developmental processes and struggles, including separation/individuation and identity formation. Trans identification can be recruited to manage crucial developmental challenges and conflicts. A clinical understanding of the gender-questioning young person should always consider how developmental processes are being managed by the family system and how gendered experience is both impacting and being shaped by developmental struggles.
- 4. It considers and addresses comorbid conditions.** Comorbidities such as ASD, ADHD, social anxiety, depression, suicidality, and eating disorders are common in young people with gender dysphoria and good clinical care includes a comprehensive exploration of how these conditions intersect with the young person's gendered experience. Viewing

gender dysphoria as an encapsulated, stand-alone condition that can be treated without considering comorbid conditions, is reductionistic and leads to inadequate clinical care. Comorbid conditions frequently overlap and usually represent dimensions or strands of the person's unique response to their life context and history.

5. **It acknowledges the complex interplay of sexual development and gender identity.** Sexual identity (which includes sexual orientation) and gender identity development influence each other but represent separate aspects of adolescent development. Adolescents may experience struggles in either or both areas. Anxiety and conflict around emerging adult sexuality are common in teens. Gender distress can sometimes be generated by underlying anxieties regarding adult sexuality. In some cases, shame around same-sex attraction may lead young people to question their gender identity and conclude that they are trans.
6. **It is a process that occurs over an extended time.** Exploratory therapy requires an extended period of regular contact. The complex issues which almost always constitute the lives of young people with gender dysphoria cannot be identified, let alone understood and dealt with, in a handful of sessions.
7. **It maintains an evidence-based approach to suicidality.** It is often claimed that gender questioning young people are at extreme risk of suicide. The data instead suggest that the risk in this cohort is similar to the suicide rate in young people experiencing a range of mental health issues (Carmichael, 2017; Zucker, 2019). Suicidality in young people with gender-related distress should be managed in the same way that it is managed in all other situations. There is little to no evidence that transition reduces the risk of completed suicide and clinicians should be aware that this risk remains elevated post-affirmation and/or medical transition.
8. **It promotes true informed consent.** True informed consent is not possible without adequate self-awareness, including an appreciation of unconscious motivations, hopes, and fears. Further, informed consent requires honest and accurate discussion of the current state of outcome research and careful consideration of the risks and benefits of transition. Exploratory therapy provides the optimal frame for both careful exploration of the realities of transition and for expanded self-reflection.

What Exploratory Therapy *Is Not*:

- 1. It is not conversion therapy.** Conversion therapy is traditionally understood as an approach to treating same-sex attracted individuals which aims to produce a heterosexual orientation. There is considerable debate about whether this notion is applicable to gender identity. Nevertheless, attempts to force a normative gender identification and expression have no place in health care. Gender-exploratory therapy does not aim for any fixed outcome in regard to how one experiences or expresses their gender. A normative, cis-gender identification is not its goal. Rather, it seeks to understand and ameliorate gender-related distress noninvasively, whilst respecting the individual's freedom to express themselves freely and authentically.
- 2. It does not assume that trans identification is universally adaptive.** A trans identity can allow some people to flourish, providing greater freedom, autonomy and a sense of authenticity. However, for others it can be embraced as a solution to psychological pain, ultimately failing to provide the solution that was hoped for. Therapists aim to help clients explore the sources of pain and distress in a wide-ranging way so that the client can become clearer about the function of a trans identity for them. Exploratory therapy seeks to help young people determine for themselves whether trans identification is adaptive or whether it is a response to pain, trauma or other issues. It is essential that clinicians are mindful that patients may not always be conscious of the range of factors leading to their desire to transition.
- 3. It does not assume that gender-affirming interventions are universally helpful.** Although the affirmative approach is often presented as the gold standard treatment for gender dysphoria, there is no robust evidence to justify this assertion. Affirmative approaches accept expressions of a transgender identity at face value, and generally assume that gender affirmative treatments will be helpful if they are strongly desired by the young person. Exploratory therapy, by considering the many unique possible meanings, origins, and functions of gender distress, accepts that gender-affirming interventions can be helpful for some individuals but may be unhelpful, or even harmful, for others.

4. **It does not encourage the obfuscation of biological facts.** Some young and vulnerable people believe that they can fully change sex and that medical and surgical treatment will transform them entirely into the desired sex. Exploration of the hoped for benefits of transition should occur in tandem with an age appropriate discussion of the reality of biology and sex. Additionally, biological realities need to be disentangled from culturally-constructed gender role stereotypes.

Background:

Youth Transition Today

The rapidly changing landscape of gender dysphoria in youth

Until very recently, gender identity issues in children and adolescents were thought to be exceedingly rare. The incidence in youth was so rare that there were no official counts, though in adults it was estimated at 2-14 per 100,000 (American Psychiatric Association, 2013, p. 454). But, beginning in 2006, the incidence among young people began to rise, with a sharp increase observed in 2015 (Aitken et al., 2015; de Graaf et al., 2018). By 2021, a staggering 2-9% of U.S. high school students identified as transgender, and in college-aged youth, 3% of males and 5% of females identified as gender-diverse (American College Health Association, 2021; Johns et al., 2019; Kidd et al., 2021).

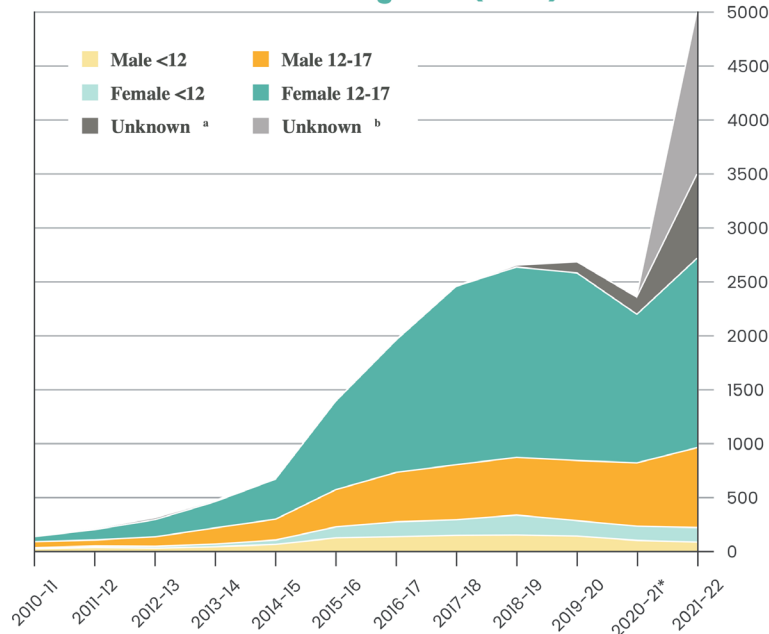
By 2021, a staggering 2-9% of U.S. high school students identified as transgender, and in college-aged youth, 3% of males and 5% of females identified as gender-diverse.

Growing rates of transgender identification are reflected in the numbers of youth seeking help from medical professionals. For example, in the UK there were just 51 requests for services in 2009 (de Graaf et al., 2018). In 2019-2020, there were 2,728 referrals for care—a 53-fold increase in about a decade (Tavistock and Portman NHS Foundation Trust, 2020). Rapid growth in the number of urban transgender health centers in recent years (Human Rights Campaign, n.d.) reflects the increased demand for gender-related medical care among young people in North America, Europe, and Australia.

Along with the rapid increase in the number of young people seeking care, the youth seeking this care also changed markedly in the past two decades. Historically, pediatric gender dysphoria occurred primarily in males. Although the incidence of natal males asserting a trans identity in adolescence significantly increased, the dramatic increase observed in the past two decades is attributable to an increase in natal females seeking services (Zucker, 2017). Many suffer from significant comorbid mental health disorders, have neurocognitive difficulties, such as attention

deficit hyperactivity disorder (ADHD) or autism spectrum disorder (ASD), or have a history of trauma (Becerra-Culqui et al., 2018; Kozłowska, McClure, et al., 2021). Moreover, in the past most gender dysphoric youth identified as the opposite sex, but today youth are more likely to identify as non-binary: neither male nor female, or both male and female (Chew et al., 2020). In fact, a recent study reported that the majority of transgender-identifying youth (63%) identify as non-binary (Green et al., 2021).

Child and Adolescent Referrals for Gender Dysphoria United Kingdom (GIDS)



*Referral activity to GIDS/Tavistock was sharply limited in 2020-2021 due to COVID-19.

^aBeginning in 2018-19, increasing numbers of referrals are not reported by sex.

^bBeginning July 2021, referrals made directly to GIDS are reported separately from those handled by the Arden & GEM referral management service. The Tavistock reports that Arden & GEM handled over 1500 additional referrals in 2021-22 (age and sex not reported separately).

Source: segm.org

As this new cohort of youth with pediatric gender dysphoria has grown, our healthcare systems have endorsed and promoted gender-affirmative interventions as the optimal treatment for these children and adolescents. Social transition of gender dysphoric youth now begins as early as preschool or grade school. Preteens and teens are prescribed puberty blockers, cross-sex hormones, and surgical interventions in adolescence and early adulthood. In the U.S., college students can obtain hormones and surgery without their parents' knowledge and potentially even without a formal

Psychiatric evaluations are not always performed prior to gender affirming interventions, and when they are performed, they are often perfunctory and inadequate.

psychiatric evaluation (under informed consent protocols). Psychiatric evaluations are not always performed prior to gender affirming interventions, and when they are performed, they are often perfunctory and inadequate (Anderson & Edwards-Leeper, 2021).

This wholesale adoption of the affirmative care model of treatment for gender dysphoric youth occurred despite the widely acknowledged deficiencies in the evidence supporting gender-affirmative interventions (National Institute for Health and Care Excellence, 2020a; National Institute for Health and Care Excellence, 2020b). This chapter offers an overview of what is known and what is, as yet, unknown about gender dysphoria and transition of youth today.

Aetiology, Natural History and Rates of Desistance of Gender Dysphoria

The origins of childhood or adolescent onset gender incongruence have not yet been fully elucidated; imaging studies of the brain have yet to identify a structure that produces an atypical gender identity, after controlling for sexual orientation and exposure to exogenous hormones (Frigerio et al., 2021). Twin studies find that biology contributes to the experience of “gender incongruence,” however it is far from deterministic (Diamond, 2013). **Today, there is no credible evidence for the widely held notion that youth with gender dysphoria are “born in the wrong body.”** Current thinking is that gender and gender dysphoria result from a complex interplay of biological, psychological, social, environmental and cultural factors.

Clinicians and researchers report that the skyrocketing number of teens declaring a trans identity appears to be fueled by peer influence (Anderson, 2022; Hutchinson et al., 2020; Littman, 2018, 2020; Zucker, 2019). Some observed that another surge of trans-identified youth appeared during the COVID-19 pandemic, and have hypothesized that the combination of heightened isolation and heavy internet exposure may be causal or contributing factors (Anderson, 2022). Littman (2018) described a new phenomenon of adolescents, who previously had no feelings of gender dysphoria, suddenly expressing dysphoria and the desire to transition. She found that social influence appeared to be implicated in these cases and coined the term Rapid

Multiple research studies to date indicate a high rate of resolution of gender incongruence in children by late adolescence or young adulthood without any medical interventions.

Onset Gender Dysphoria (ROGD) for this presentation. Research into the role of social influence as a contributor to trans identification of youth has just begun and is strongly contested by clinicians and others that encourage youth transition.

Multiple research studies to date indicate a high rate of resolution of gender incongruence in *children* by late adolescence or young adulthood without any medical interventions (Cantor, 2020; Ristori & Steensma, 2016; Singh et al., 2021). Although attempts have been made to discredit the applicability of this research, suggesting that the studies were based on gender non-conforming, as opposed to gender dysphoric children (Temple Newhook et al., 2018), a rigorous review of the data confirmed the finding that among children meeting the diagnostic criteria for “Gender Identity Disorder” in DSM-IV (currently “Gender Dysphoria in DSM-5), 67% were no longer gender dysphoric as adults and the rate of natural resolution for gender dysphoria was 93% for children whose gender dysphoria was significant but did not meet the DSM diagnosis (Zucker, 2018). High rates of resolution of childhood-onset gender dysphoria were recorded before the practice of social transition of young children was endorsed by the American Academy of Pediatrics (Rafferty et al., 2018). It is possible that social transition will predispose young people to persistence of transgender identity long-term (Zucker, 2020).

Information about how often resolution of gender dysphoria occurs in youth with adolescent-onset gender dysphoria, which is today’s principal presentation, is less clear. Emerging evidence suggests that for many adolescents and young adults, post-pubertal onset of transgender identification may be a temporary or fleeting phase of identity exploration, rather than a permanent identity, as evidenced by the growing number of young detransitioners (Entwistle, 2020; Littman, 2021; Vandenbussche, 2021). Historically, rates of detransition and regret were thought to be very low, however, these estimates likely underestimated and undercounted desistance, detransition, and regret (D’Angelo, 2018).

A recent UK study found that about 7% of those treated with gender-affirmative interventions detransitioned within a scant 16 months of commencing treatment, and another 3.4% had healthcare utilization associated with detransition, suggesting a rate of detransition of more than 10%. Another 21.7% of patients disengaged from care without completing their treatment plan (Hall et al., 2021).

“detransitioning might be more frequent than previously reported”

Although some patients ultimately re-engaged with the gender clinic, the investigators concluded, “detransitioning might be more frequent than previously reported.” Another study from a UK primary care practice found that more than 12% of those who began hormone treatment either detransitioned or documented regret, and one in five stopped treatment for a wider range of reasons (Boyd et al., 2022). The mean age of presentation with gender dysphoria was 20 years and the patients had been taking gender affirming hormones for an average of 5 years (17 months-10 years) before stopping this treatment.

These high rates of treatment discontinuation and detransition prompted the researchers to observe, “...the detransition rate found in this population is novel and questions may be raised about the phenomenon of overdiagnosis, overtreatment, or iatrogenic harm as found in other medical fields” (Boyd et al., 2022, p.15). Since it is known that regret may take up to 8-11 years to emerge (Dhejne et al., 2014; Wiepjes et al., 2018), we will likely see many more detransitioners in the foreseeable future. Detransitioner research has just begun; two recent studies considering detransitioner experiences report that many recent detransitioners believe they were rushed to medical and surgical gender-affirmative interventions with irreversible effects, often without adequate, or in some instances any, psychological exploration or evaluation (Littman, 2021; Vandenbussche, 2021).

Today, there is no reliable way to predict which young people will persist in their transgender identification as they mature and attain adulthood (Ristori & Steensma, 2016). Families should be informed that a period of strong cross-sex identification in childhood is commonly associated with future homosexuality (Korte et al., 2008). Research confirms that the majority of youth whose gender dysphoria resolves naturally will identify as gay, lesbian, or bisexual when they are adults (Cantor, 2020, Appendix; Singh et al., 2021).

Inadequate Evidence Base for Gender-Affirmative Care

The premise of the gender-affirmative model of care is that children should be “allowed to live in the gender that feels most real or comfortable to that child and to express that gender with freedom from restriction, aspersion or rejection” (Hidalgo et al., 2013). Gender-affirmative interventions are social transition, which entail a change of name, pronouns, documents, dress, and other outward gender cues; medical interventions, primarily puberty blockers and cross-sex hormones; and surgical procedures including genital, breast, facial and other cosmetic surgeries.

Some gender-affirming clinicians contend that children and teens know best what they need to live happy, productive lives (Ehrensaft, 2017).

Most clinicians who provide gender-affirmative care mistakenly believe that it is the accepted standard of care (Malone, D'Angelo, et al., 2021; Malone, Hruz, et al., 2021). Although the safety and efficacy of pediatric gender transition have been endorsed by several professional medical societies, the best available evidence suggests that the benefits of gender-affirmative interventions are of very low certainty (Clayton et al., 2021; National Institute for Health and Care Excellence, 2020a; National Institute for Health and Care Excellence, 2020b) and must be thoughtfully and deliberately weighed against known risks to fertility, bone, and cardiovascular health (Alzahrani et al., 2019; Biggs, 2021; Getahun et al., 2018; Hembree et al., 2017; Nota et al., 2019). In addition to these known physiological risks, there are psychosocial risks and as yet unknown long-term medical risks (Malone, D'Angelo, et al., 2021).

Gender transition outcome research suffers from serious methodological problems and limitations that compromise its reliability, validity, and applicability. As early as 2010, a meta-analysis (Murad et al., 2010) cautioned that the available evidence for adult transition at that time was of very low quality. These studies lacked control groups, relied on self-report and were at high risk for reporting bias. Today, the quality of evidence supporting pediatric gender transition is widely recognized as very low quality (Hembree et al., 2017). Systematic reviews of endocrine treatment of gender dysphoric young people note the scarce and poor quality evidence base (Clayton et al., 2021). Baker et al. (2021); Chew et al. (2018); Mahfouda et al. (2017); National Institute for Health and Care Excellence (2020a and 2020b); and Rew et al. (2021a) observe that the studies are plagued by bias and confounding and assert that more rigorous evidence is needed. These reviews are often erroneously cited as strong evidence in favor of youth gender transition, when in fact, they acknowledge that the evidence for these treatments is low quality and unreliable.

The best available evidence suggests that the benefits of gender-affirmative interventions are of very low certainty.

A systematic review performed by the National Institute for Health and Care Excellence (National Institute for Health and Care Excellence 2020a, 2020b) concluded that any reported positive impacts of puberty blockers and cross-sex hormones are of very low certainty using modified

GRADE [Grading of Recommendations, Assessment, Development and Evaluations]¹. The NICE review of evidence for puberty blockers describes the studies as “all small, uncontrolled observational studies, which are subject to bias and confounding. All the included studies reported physical and mental health comorbidities and concomitant treatments very poorly” (National Institute for Health and Care Excellence, 2020a, p.13). Importantly, there are no long-term follow-up studies that have evaluated outcomes of youth transition beyond very early adulthood. Not only are existing studies deemed low quality but also none have collected or reported data to indicate whether children and adolescents who transition do well one, two, or three decades post-transition.

In terms of administering puberty blockers and cross-sex hormones, the designation of “very low certainty” indicates that evidence asserting the benefits of these interventions is extremely unreliable.

In contrast, several serious risks and negative outcomes are confirmed by data as certain. For example, puberty blockade followed by cross-sex hormones results in infertility and sterility (Laidlaw et al., 2019). Invasive surgeries to remove breasts or sex organs can lead to serious complications and are irreversible. Other health risks, including risks to bone and cardiovascular health, are not fully understood and are uncertain, but the emerging evidence is troubling (Alzahrani et al., 2019; Biggs, 2021).

There are no long-term follow-up studies that have evaluated outcomes of youth transition beyond very early adulthood.

To date, research about other approaches, such as psychotherapy or watchful waiting, suffers from similar methodological problems and limitations as research considering more invasive interventions: neither employs control groups, nor is there systematic follow-up at predetermined intervals with predetermined means of measurement (Bonfatto & Crasnow, 2018; Churcher Clarke & Spiliadis, 2019; Spiliadis, 2019).

Rationale for Pediatric Transition

Until the 1990s, gender transitions were almost exclusively initiated in mature adults (Dhejne et al., 2011). During this period, it was observed that for natal male patients especially, hormones and

¹ GRADE is the most widely adopted tool for grading the quality of evidence and for making treatment recommendations worldwide. GRADE has four levels of evidence, also known as certainty in evidence or quality of evidence: very low, low, moderate, and high (BMJ Best Practice, 2021). When evidence is assessed to be “very low certainty,” there is a high likelihood that the patients will not experience the effects of the proposed interventions (Balshem et al., 2011).

surgery often failed to achieve satisfactory results, and patients had a “never disappearing masculine appearance” (Delemarre-van de Waal & Cohen-Kettenis, 2006). Inadequate cosmetic results were thought to contribute to the often disappointing outcomes of medical gender transition, evidenced by unrelentingly high rates of mental illness and suicidality post-transition (Ross & Need, 1989; Delemarre-van de Waal & Cohen-Kettenis, 2006; Dhejne et al., 2011).

In the mid-1990s, a team of Dutch researchers hypothesized that by carefully selecting a subset of gender dysphoric children, who would likely be transgender-identified for the rest of their lives, and by taking action early, they could improve mental health outcomes. They theorized that by medically intervening before puberty altered the children’s bodies, cosmetic outcomes would be improved—and this would result in better mental health outcomes, as well. (Gooren & Delemarre-van de Waal, 1996).

The Dutch Study: The Questionable Basis for the Gender-Affirmative Model of Care for Youth

Most clinicians who administer gender-affirmative interventions, and nearly all patients and families, are unaware that the foundation for all subsequent developments in the practice of medically transitioning youth was a single Dutch proof of concept study, the outcomes of which were reported in two papers (de Vries et al., 2011; de Vries et al., 2014). The first (de Vries et al., 2011) described patients who underwent puberty blockade, and the second (de Vries et al., 2014) focused on a subset of patients who had genital surgeries.

The entire evidence base for medically transitioning youth was a single Dutch proof of concept study.

In the 2014 study, the Dutch research team reported mental health data and outcomes of 55 youths who had undergone medical and surgical transition (de Vries et al., 2014). The 2014 paper (commonly termed the “Dutch Study”) reported that for youth with severe gender dysphoria, which presented in early childhood and persisted into mid-adolescence, a sequence of puberty blockers, cross-sex hormones, and breast and genital surgeries (including mandatory removal of the ovaries, uterus and testes), with ongoing intensive psychological counseling, produced positive mental health and improved overall function 1.5 years post-surgery.

The Dutch reported resolution of gender dysphoria post-surgery in study subjects based on

the Utrecht Gender Dysphoria Scale (UGDS), but the psychological improvements were quite modest (de Vries et al., 2014). Of 30 psychological measures, there was no statistically significant improvement in nearly half of the measures, and the balance only evidenced small changes of questionable clinical relevance (Malone, D'Angelo, et al., 2021). Importantly, there was no improvement in anxiety, depression, and anger scores. The Children's Global Assessment Scale, showed one of the largest changes—but it, too, remained in the same range band pre- and post-treatment (de Vries et al., 2014).

The Dutch study reported high levels of psychological functioning at the study endpoint, 1.5 years after surgery, which sounds like a notable outcome. But because these two studies were non-randomized case series—one of the lowest levels of evidence—both suffer from a high risk of bias (Mathes & Pieper, 2017; National Institute for Health and Care Excellence, 2020a). The studies also have limited applicability to the populations of adolescents presenting today (de Vries, 2020). The interventions described in the Dutch study are currently being applied to adolescents who were not cross-gender identified prior to puberty, and youth with significant mental health problems, as well as those with non-binary identities. Despite its many limitations and exclusion of patients resembling those presenting for care today, the Dutch experiment has become the basis for the practice of medical transition of minors worldwide and is the basis for the 2017 Endocrine Society guidelines (Hembree et al., 2017).

It is important to fully appreciate the strengths and the weaknesses of these two studies since, to date, the Dutch experience offers the best available evidence in support of pediatric gender transition. **Nevertheless, the Dutch studies have been misunderstood and misrepresented as evidence of the safety and efficacy of youth gender transition.**

Reduced Gender Dysphoria Does Not Equate to Meaningful Improvements in Psychological Measures

The discord between the pronounced reduction in gender dysphoria measured by the UGDS (Utrecht Gender Dysphoria Scale), and the absence of meaningful changes in psychological function using standard measures, warrants investigation. There are three possible explanations for this lack of concurrence. All three call into question the widely assumed notion that medical interventions significantly improve mental health or lessen or eradicate gender dysphoria.

One possible explanation is that gender dysphoria, as measured by UGDS, and psychological function, as measured by most standard instruments, are not correlated. This challenges the primary justification for providing gender-affirmative treatments for youth, which is to improve psychological functioning. Another plausible explanation is the high psychological function of the study subjects pre-treatment at baseline; subjects were selected because they were free from significant mental health problems (de Vries et al., 2014). For these subjects, there was little room for meaningful improvement. This explanation calls into question the wisdom of applying the study's results to the majority of today's gender dysphoric youth, who often present with comorbid mental illness (Becerra-Culqui et al., 2018; Kozłowska, McClure, et al., 2021).

A third possible explanation for the discordance between the observed minor changes in psychological outcomes and the significant drop in gender dysphoria emerged after an examination of the UGDS scale itself and how it was used by the Dutch researchers. This 12-item scale, designed by the Dutch to assess the severity of gender dysphoria and to identify candidates for hormones and surgeries, consists of “male” (UGDS-M) and “female” (UGDS-F) versions (Iliadis et al., 2020). At baseline and after puberty suppression, biological females were given the “female” scale, while males were given the “male” scale. However, post-surgery, the scales were flipped: biological females were assessed using the “male” scale, while biological males were assessed on the “female” scale (de Vries et al., 2014). Flipping the scales may have obscured, or severely compromised, the study's assessment of how gender dysphoria was affected throughout treatment.

For example, at baseline, a gender dysphoric biological female would have high scores for statements on the “female” scale such as: “I prefer to behave like a boy” (item 1); “I feel unhappy because I have to behave like a girl” (item 6) and “I wish I had been born a boy” (item 12). Positive responses to these statements would have resulted in a high baseline gender dysphoria score. Post-surgery, however, the same patient would be asked to rate items from the “male” scale, including the following: “My life would be meaningless if I had to live as a boy” (item 1); “I hate myself because I am a boy” (item 6) and “It would be better not to live than to live as a boy” (item 12). A gender dysphoric female would not endorse these statements at any stage of the intervention, which would produce a lower gender dysphoria score.

As a result of using this measure, the detected drop in gender dysphoria scores may have had less to do with the success of the interventions, and more to do with switching the scale from the “female”

to the “male” version and vice-versa between the baseline and post-surgical period. This also may explain why there were no changes in gender dysphoria noted between baseline and the puberty blockade phase, and changes were only detected and reported after the final surgery, when the scale was switched.

Had the researchers used the “flipped” scale earlier, at the completion of the puberty blocker stage but before surgery, the UGDS scale may still have registered the reduction in gender dysphoria. It’s also possible that had both sets of scales been administered to the same individuals at baseline, a “reduction” in gender dysphoria might have been noted upon switching the scale, well before any interventions was undertaken. Unfortunately, it is unclear whether the reduction of gender dysphoria was an artifact of whichever scale was used.

It is important to bear in mind that the UGDS measure was designed to effectively differentiate between clinically referred gender dysphoric individuals, non-clinically referred controls, and participants with disorders of sexual development; it was not intended to detect changes in gender dysphoria during treatment (Steensma et al. 2013). Statements such as “I dislike having erections” (item 11, UGDS-M), when presented to birth-females, and “I hate menstruating because it makes me feel like a girl” (item 10, UGDS-F), when presented to birth-males, could not be meaningfully scored at any stage of the interventions, further calling into question the UGDS’s validity for detecting changes in gender dysphoria following medical and surgical treatment.

The updated UGDS scale (UGDS-GS), developed by the Dutch after the publication of their seminal study, replaced the two-sex versions with a single battery of questions applicable to both sexes (McGuire et al., 2020). This change may more reliably measure treatment-associated changes in future research. Other gender dysphoria scales also exist (Hakeem et al., 2016; Iliadis et al., 2020) and may be better suited for measuring the outcome of medical interventions on underlying gender distress. Gender dysphoria may, however, prove to be a more complex concept than can be measured by any scale.

Other Limitations

Both Dutch studies lacked a control group (de Vries et al., 2011; de Vries et al., 2014) and the researchers did not control for mental health treatment, which all study subjects received along with hormones and surgery. The Dutch researchers only evaluated mental health outcomes and

did not consider the physical health effects of hormones and surgery. Their sample size was small: the final study reported the outcomes of just 55 children, and only 32 of these were evaluated on key measures of psychological outcomes.

Bear in mind that the Dutch sample was carefully selected, which introduced a source of bias, and also challenges the study's applicability. Nearly 200 adolescents were initially referred; of these, 111 were deemed eligible to start puberty blockers, and of this group, only the 70 who were most mature and mentally stable, and who advanced to cross-sex hormones, were included in the study (de Vries et al., 2011). Of interest, 97% of the selected cases were attracted to members of their natal sex at baseline. All were cross-sex identified, with no cases of non-binary identities. The 2014 study only followed 55, rather than the original 70 subjects, which effectively excluded subjects who experienced adverse events, including: one death from surgery-related complications, and three instances of serious complications such as obesity and diabetes that rendered subjects ineligible for surgery. Three additional study subjects refused to be contacted or dropped out, which also may have camouflaged adverse outcomes (de Vries et al., 2014).

We do not know how the 126 patients who did not participate in the study fared and we do not know the long-term outcomes of the subjects who did participate. We are aware of only one case of long-term follow-up for a female-to-male patient treated by the Dutch team in the 1990s. The case study describing the subject's functioning at the age of 33 found that the patient did not regret gender transition. However, he reported struggling with significant shame related to the appearance of his genitals and his inability to function sexually; he reported problems maintaining long-term relationships; and experienced depressive symptoms (Cohen-Kettenis et al., 2011). These issues had not yet arisen when this patient was evaluated at age 20, when he reported high levels of satisfaction in general, and was "very satisfied with the results [of the metoidioplasty]" in particular (Cohen-Kettenis & van Goozen, 1998, p.248). **Because the last round of psychological outcomes of the individuals in the Dutch study was obtained when the subjects were around 21 years of age (de Vries et al., 2014), it raises questions about how they will fare in their 20s and 30s, when new developmental tasks, such as career development, forming long-term intimate relationships and friendships, or starting families come into focus.**

One study reported on 14 adolescent patients deemed ineligible for early sex reassignment and

disqualified from treatment due to “psychological or environmental problems” (Smith et al., 2001, p. 473). The study found that 1-7 years after their original applications to participate in the study 11 of 14 no longer wished to transition, and 2 others only slightly regretted not transitioning (Malone, D’Angelo, et al., 2021; Smith et al., 2001). This further underscores the importance of conducting research utilizing control groups and following subjects for an extended period.

A recent attempt to reproduce the results of the first Dutch study (de Vries et al., 2011) found no demonstrable psychological benefit from puberty blockade, but did report that the treatment adversely affected bone development (Carmichael et al., 2021). There have been no other attempts to replicate final Dutch study (de Vries et al., 2014) with or without a control group.

The Application of the Dutch Protocol Beyond Original Indications

The medical and surgical sequence of the Dutch protocol was rapidly adopted worldwide, without the careful evaluations and rigorous inclusion and exclusion criteria used by the Dutch researchers. The protocol’s original investigators recently expressed concern that the interventions they described were widely adopted on four continents without several of the protocol’s essential discriminatory features (de Vries, 2020).

The protocol’s original investigators recently expressed concern that the interventions they described were widely adopted on four continents without several of the protocol’s essential discriminatory features.

The extensive multi-year, multidisciplinary evaluations of the children have been abbreviated or simply bypassed. The medical sequence is routinely used for children with post-pubertal onset of transgender identities complicated by mental health comorbidities (Kaltiala-Heino et al., 2018), rather than exclusively for high-functioning adolescents with persistent early life cross-sex-identifications, as was required by the Dutch protocol (de Vries & Cohen-Kettenis, 2012). It also has become increasingly common to socially transition children before puberty (Olson et al., 2016), even though this was explicitly discouraged by the Dutch protocol (de Vries & Cohen-Kettenis, 2012).

Today, medical transition is frequently initiated much earlier than recommended by the original protocol (de Vries & Cohen-Kettenis, 2012). The authors of the protocol were aware that most children would have spontaneous resolution of gender dysphoria by transiting the early- to mid-

stages of puberty (Cohen-Kettenis et al., 2008). The average age of initiating puberty blockade in the Dutch study was around 15. In contrast, currently the age limit has been lowered by the Endocrine Society to the age of Tanner stage II, which can occur as early as 8-9 years (Hembree et al., 2017). Cross-sex hormones, which often have irreversible consequences, were initiated in the Dutch study at an average age of nearly 17; today, they are commonly prescribed to 14-year-olds, and this lower age threshold was recommended in the initial draft of the WPATH Standards of Care 8. In the final SOC 8, age minimums were removed, entirely. Transitioning children before the natural resolution of gender dysphoria has had a chance to occur is a major deviation from the original Dutch protocol.

Even the Dutch researchers have called for further research into the novel presentation of gender dysphoria in youth (de Vries, 2020; Voorzij, 2021) and question the wisdom of administering hormones and surgical treatment protocols to the newly presenting cases. Unfortunately, many recently trained gender specialists mistakenly believe that the Dutch protocol proved the concept that its sequence helps all gender dysphoric youth. They appear to be unaware of its acknowledged limitations, and the Dutch clinicians' discomfort that most new trans-identified adolescents presenting for care today significantly differ from the population the Dutch originally studied.

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Assessment of Young People with Gender Dysphoria

Before embarking on exploratory therapy, a thorough biopsychosocial assessment should be undertaken. This assessment often extends over several appointments and may involve parent and/or family interviews. The aim is to generate a preliminary formulation of the person's difficulties, to understand what the patient hopes to achieve in therapy, and to determine whether this particular patient-therapist dyad is a good fit. Therapy is a collaborative process and therapists should engage the patient in a way that allows these decisions to be made jointly and cooperatively.

For individuals with gender dysphoria, the starting point is to document the history of their gendered experience to begin to understand what the person is feeling and how these feelings may have arisen. This includes clarifying what they are doing and plan to do regarding their dysphoria, e.g. social, medical or surgical transition. For some individuals, the goal may be to go forward with medicalized gender-affirming treatment as quickly as possible and it may seem that they are not open to exploratory therapy. In situations like these, therapists need to carefully explore what the resistances to therapy are so that a decision can be made about whether exploratory therapy is possible.

All psychological experience, including gendered feelings and gender distress, emerges in a context and so it is vital to take a comprehensive developmental, family, social and sexual history. Effective therapeutic work begins with a biopsychosocial formulation, which situates the presenting problem in the context of the individual's relational (including family and peer relations) world, previous formative experiences, and the social/political world within which they live. It can be helpful to have a framework for thinking about developmental processes and stages. Erik Erikson's framework is one such model of development, which posits eight developmental challenges we all must meet over the course of our lives (Mcleod, 2018).

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It is important to assess for comorbid conditions, as sometimes gender dysphoria can be a secondary phenomenon when other conditions are actually more primary.

These include anxiety disorders (particularly social anxiety disorder), autism spectrum disorders, depression, personality difficulties, and trauma. Therapists may refer the person to a psychiatrist, psychologist or physician for diagnostic clarification and/or specific treatment of underlying conditions if indicated. In some cases, targeted treatments such as medication for depression or CBT for obsessive-compulsive disorder may be required before the person is able to fully participate in exploratory therapy. It is also possible that treatment of the underlying condition may result in amelioration of gender distress.

In contrast, rapid evaluations which disregard the complex factors contributing to the development of gender dysphoria in youth are widespread. In November 2021, two prominent clinicians associated with the World Professional Organization for Transgender Health (WPATH) warned the medical community that “the mental health establishment is failing trans kids” (Anderson & Edwards-Leeper, 2021). Frequently, the primary purpose of evaluations provided by gender clinicians is to establish whether the diagnosis of gender dysphoria (DSM-5), or its ICD-11 counterpart gender incongruence, is present. Some form of screening for conspicuous mental illness prior to recommending hormones and surgeries is also usually undertaken. These limited, abbreviated evaluations overlook, and as a result fail to explore, the complex psychological, family, and social factors that may have shaped the young person’s current gender identity or their desire to transition.

Confirming the young person’s self-diagnosis of gender dysphoria or gender incongruence is easy. Clarifying the developmental forces that have influenced it and determining an appropriate intervention are not. Identifying these forces involves an understanding of child and adolescent developmental processes, childhood adversity and trauma, co-existing physical and cognitive disadvantages, problematic parental or family circumstances (Levine, 2021), as well as the role of social influence (Anderson, 2022; Anderson & Edwards-Leeper, 2021; Littman, 2018; Littman, 2021).

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The poor quality of mental health evaluations has been a point of significant discontent for a

growing number of parents of gender dysphoric youth. These distressed parents, recognizing that their son or daughter may eventually decide to present to others as a trans person, want a psychotherapeutic exploration to understand what contributed to the development of this identity coupled with a consideration of noninvasive treatment options. Frequently, they cannot find anyone in their community who does not recommend immediate affirmation.

This section will outline what is required to perform an adequate assessment of a person with gender dysphoria and will highlight the complexity of issues that may be at play.

Sample Assessment Protocol

Identifying Data

Including sex identified at birth, current gender identity (male, female, non-binary, genderqueer, genderfluid, etc), age, living situation, educational, and occupational activities, etc.

History of Presenting Problem

In clients with gender dysphoria, clinicians should explore the history of their gender experience alongside a general history of the presenting problem:

- * When did they first become aware of gender distress or begin to question their gender and how did it feel? What was happening at the time (home/school/friendships)? Were they gender non-conforming and was there any experimentation with cross-gender play or dress in childhood? How did these gendered feelings evolve over time? How much did social media have an impact on their gender identity? Did their gendered feelings remain stable, did they change? How did they conclude that their gender is different to their natal sex? How do they currently identify? What does female/male/non-binary/genderfluid mean to them? What is it about being male or female that is particularly distressing to them and what is it about being female/male/non-binary/genderfluid that feels right or desirable? How do they feel about their body? What aspects of the body are particularly troubling and why? How do they manage their bodily and gender distress?
- * What are the positives associated with what they are doing and are there any negatives? What are they more able to do in their new gender that they were not able to do previously? Is there

anything they miss about the old gender? How do they think about their previous self: do they feel he/she is gone/dead, do they feel a sense of continuity with their past self, do they like the past self or feel hatred or shame towards that person, is there any compassion towards the previous self? Do they feel safer, more confident, stronger, less vulnerable, more able to be vulnerable, more able to connect with others, more or less self-conscious? Has it improved or worsened relationships with family, peers and others? How does gender dysphoria affect their life at school, with friends and at home? How have family and friends responded?

- * How much time do they spend thinking about/researching their gender dysphoria? How much time on social media, and what kind of social media? Do they have friends, either online or real-time who are trans? How have these friends responded to their gendered feelings and what have they recommended?
- * Are they living socially as the desired gender? Do they live in the desired gender in all settings (home/school/work) i.e., are they “out”? If not, why not? What changes have they made since identifying as trans?
- * What physical interventions are helping them manage their gender dysphoria e.g. tucking penis and testicles for natal males, binding breasts for natal females, hair removal, voice change (on their own, or via a speech and language pathologist), change of gait, mannerisms, behaviors, make-up and clothing
- * What is the history of their romantic and sexual relationships? How do they see their sexual orientation (gay/bi/asexual)? Have they had any sexual experiences and what was their nature? Do they masturbate? What kinds of sexual fantasies do they have, if any? When was their first sexual experience? How do they feel about sexuality and sexual contact? Are they interested in sexual contact or do they find it frightening or abhorrent? If they are sexually active, who do they prefer to have sexual contact with and is this consistent with their stated sexual orientation? What kinds of sexual activities do they prefer (being active, passive, dominant, submissive, kinks, etc.)? How did family and peers respond to their sexual orientation? Is there any internalized homophobia? Have they had any adverse sexual experiences including non-consensual contact, abuse or sexual assault?

- * What would they like to do in terms of further steps in their transition (name and document changes, changes in appearance, hormones, cosmetic procedures, surgery). What is their understanding of what these interventions will achieve? Do they believe they will become a man/woman just like cis-men or cis-women, or is there an awareness that this can never be fully achieved? Is there any magical thinking associated with what these interventions might achieve? What is their level of understanding of the risks of the interventions they would like to undertake?

Symptom Review

Assess for symptoms of anxiety, depression, autism spectrum disorder, ADHD, OCD, psychosis, suicidal ideation (see below for a detailed discussion of suicidality in trans youth) and self harm, behavioral problems, interpersonal difficulties etc.

Past Psychiatric History

Hospitalizations, previous suicide attempts (assess lethality/intent), self harm, previous episodes of psychological distress or mental illness, previous psychiatric consultations and diagnoses, medication trials and efficacy/side effects, forensic history, substance use.

Past Medical History

Any significant current or past medical problems, including surgery. Do they have a good relationship with their primary care physician?

Medications

Type, dose, duration, response.

Substance Use

Type, route of use, amount, frequency, and any recent changes.

Family History

Who makes up the family, who do they live with? Any history of mental health issues, substance use issues, psychiatric hospitalization and suicide in the family (including in first degree relatives, plus more distant relatives such as grandparents, aunts, uncles and cousins)?

Social/Personal History

- * Identify parents and siblings (+/- genogram), parent's marital/relationship status, occupations.
- * Developmental history including normal developmental milestones (talking, walking etc).
- * School history, including academic performance, peer group and friendship experience, experience with sports, school behavior problems, suspensions or expulsions from school, evidence of attention problems or hyperactivity, learning problems, difficulty with peer relations and social cues.
- * Forensic history: illegal activities such as shoplifting, theft, or any contact with police.
- * The nature of the relationship and attachment to each parent. Who were they closer to and why? The dynamics of the parent-child interaction: were they accommodating and compliant or oppositional? How were limits set at home? Who did they feel close to? Is there evidence of parentification of the child? How was distress responded to? Was the child's individuality honored or were they expected to comply with parental expectations?
- * Sibling relationships, including any perceived favoritism, or sibling rivalry.
- * History of adverse experiences and trauma. Was there any domestic violence, emotional, physical or sexual abuse in the home? Any abuse experiences outside of the home? History of school bullying or victimization? Separation, divorce, loss of a family member, illness in a family member, mental illness, or substance abuse in a family member.
- * Activities as a child: explore talents and capacities as well as involvement in activities that are traditionally considered gendered. Was there a preference for sex-congruent activities or opposite sex activities? How did peers and family respond to this? Were friendships mostly with same sex or opposite sex peers?

Suicide in Trans-Identified Youth

Suicidality among trans-identified youth is significantly higher than that observed in youth who are not trans-identified (Biggs, 2022; de Graaf et al., 2020). However, the “transition or die” storyline, in which parents are informed that they must choose between a “live trans daughter or a dead son” or “live trans son or dead daughter,” is not only factually inaccurate but, also, ethically questionable. Broadcasting such an exaggerated and hysterical rhetoric harms the majority of trans-identified youth who are not at risk for suicide. It also hurts those at risk, who may decline evidence-based suicide prevention and intervention measures because of the misguided belief that transition will eliminate their suicidal ideation.

The “transition or die” storyline, in which parents are informed that they must choose between a “live trans daughter or a dead son” or “live trans son or dead daughter,” is not only factually inaccurate but also ethically questionable.

The premise that trans-identified youth are at exceedingly high risk of suicide typically references online surveys of self-reported suicidal ideation, self-harm, and suicide attempts (James et al., 2016; D’Angelo et al., 2020; The Trevor Project, 2021), and considers suicidal thoughts, self-harm, serious suicide attempts, and completed suicides as equally important measures of suicidality.

Data from the largest pediatric gender clinic in the world, the UK’s Tavistock Gender Identity Development Service, reports a 0.03% rate of completed youth suicides over a 10-year period, which is an annual rate of 13 per 100,000 (Biggs, 2022). Although this rate is higher than that observed in the general population of adolescents, it is far from the epidemic of trans suicides described in headlines and public discourse. In fact, there were just four completed suicides in this very large sample.

The “transition or die” storyline considers suicidal risk in trans-identified youth as distinct from suicidal risk among other youth. This distinction implicitly and incorrectly promises that immediate

transition will reduce or eliminate the risk of suicidal ideation or attempts. Trans patients themselves complain about the “trans broken arm syndrome”—the tendency for physicians to attribute all of a patient’s problems to their trans identity, and as a result, fail to identify, diagnose, and appropriately address other physical and mental health issues (Paine, 2021). Clinicians caring for trans-identified youth should be reminded that suicide risk in all patients is a multi-factorial phenomenon (Mars et al., 2019). Treating trans youths’ suicidality as entirely attributable to their identity may prompt clinicians to overlook other contributing factors.

A recent study concluded that suicidality of trans-identifying teens is only somewhat elevated compared to that of youth referred for mental health issues unrelated to gender identity or gender dysphoria (de Graaf et al., 2020). Another study found that transgender-identifying teens have comparable rates of suicidality as teens who are gay, lesbian, and bisexual (Toomey et al., 2018). It is important to bear in mind that depression, eating disorders, autism spectrum disorder, and other mental health conditions are common comorbidities in transgender-identifying youth (Kaltiala-Heino et al., 2018; Kozłowska, McClure, et al., 2021; Morandini et al., 2021) and independently increase the risk of suicide (Biggs, 2022; Simon & VonKorff, 1998; Smith et al., 2018).

The “transition or suicide” premise implies that transition will prevent suicides. While in the short-term, gender-affirmative interventions can lead to improvements in some measures of suicidality (Kaltiala et al., 2020), neither hormones nor surgeries have been found to reduce suicidality long-term (Bränström & Pachankis, 2020a; Bränström & Pachankis, 2020b). A longitudinal study from

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Sweden that followed study subjects for more than 30 years found that adults who underwent surgical transition were 19 times more likely than their age-matched peers to commit suicide, with female-to-male participant subjects’ risk 40 times the expected rate (Dhejne et al., 2011, Table S1). Another study from the Netherlands concluded that suicides occur at similar rates at all stages of transition, from pre-treatment assessment to post-

transition follow-up (Wiepjes et al., 2020). Data from the Tavistock clinic did not reveal a statistically significant difference between completed suicides in the “waitlist” and the “treated” groups (Biggs, 2022). Fortunately, in both groups, completed suicides were rare.

In 2021, an editorial in the *Lancet* asserted that puberty blockers reduce suicidality (The *Lancet*, 2021). But there is no convincing evidence that puberty blockers reduce suicidality or suicide rates (Biggs, 2020; Clayton et al., 2021). Many letters to the editor challenged the editorial's assertion. Following a critical review of their methodology, the authors clarified that they were not making a causal claim that puberty blockers decreased suicidality (Clayton et al., 2021; Rew et al., 2021). Another paper from the University of Melbourne claimed that barriers to gender-affirming care increased suicidality, but the authors ultimately retracted this claim and substantially revised their paper (Zwickl et al., 2021a & b).

We believe the “transition or die” storyline is worse than mistaken; it is unethical. Unquestionably, any increased suicidality and suicide risk is worrying, and any at-risk adolescents should be carefully evaluated and treated by capable mental health professionals. But we aver that the hyper-focus on heightened suicide risk promulgated by clinicians and the media may create an injurious nocebo effect, inadvertently exacerbating suicidality in vulnerable youth (Biggs, 2022; Carmichael, 2017).

When working with trans-identified youth, we have found that an adolescent's suicidality sometimes occurs in response to parental distress, resistance, or skepticism. When mental health professionals or other clinicians fail to acknowledge the validity of parental concerns, or label parents as transphobic, intrafamilial tension may intensify. Clinicians should be aware that rapid gender transition is not an appropriate response to suicidal intent or threat, because it ignores the larger mental health and social context of the young patient's life—the entire family is often in crisis. Trans-identified adolescents should be screened for self-harm and suicidality, and when suicidal ideation or behaviors are identified then an appropriate, evidence-based suicide prevention plan should be enacted (de Graaf et al., 2020).

Rapid gender transition is not an appropriate response to suicidal intent or threat, because it ignores the larger mental health and social context of the young patient's life.

Mental health clinicians are generally familiar with managing suicidality. The strategies and approaches used to detect and manage suicidality for other clinical issues are applicable when working with clients with gender dysphoria. The following are the key steps in the management of suicide risk:

1. **Perform a careful assessment of suicide risk.** Exploring suicidal ideation, the formulation of plans, any actions that have been taken to prepare for suicide, past history of suicide attempts, etc.

If the risk is assessed to be high or imminent, appropriate steps should be taken, such as referral for further assessment or inpatient treatment.

2. **Assess and treat comorbid mental health conditions.** In many cases, suicidality may be due to mental health conditions other than gender dysphoria. For example, depression, psychotic disorders, eating disorders, substance use, and personality disorders are all associated with increased risk of suicide and self harm. If these conditions are present, they should be treated appropriately with psychological interventions, pharmacological treatment, if indicated, and any other interventions which may ameliorate the underlying mental health condition.
3. **Assess and manage psychosocial stressors.** Suicidality is often a response to psychosocial adversity. In youth, this may include a dysfunctional or stressed home environment, trauma and abuse, social difficulties (including marginalization and bullying), academic and learning difficulties, problematic parent-child or sibling-sibling interactions, etc. Addressing these environmental difficulties, which might potentially involve family and school interventions, can sometimes dramatically reduce suicidality.
4. **Provide a safe and consistent therapeutic relationship.** Suicidal ideation often reduces when young people are engaged in an empathic and supportive therapeutic relationship in which they feel seen and understood. The power of the therapeutic relationship in suicidal patients should not be underestimated.
5. **Psychological intervention.** There are many forms of psychological intervention that may be helpful with suicidal youth. These include psychotherapy, CBT and DBT, particularly in terms of helping young people develop stress tolerance and more adaptive ways of managing emotional distress and interpersonal difficulties. Clinicians may also help to support and develop the young person's strengths and established resources and coping strategies. This might include helping the young person develop more effective communication with peers and family and helping them deal with interpersonal conflict.

6. Safety Plans. A safety plan may be useful and can be created in conjunction with the youth during the appointment time. This should be recorded either on paper or electronically (i.e., in the youth's phone). For example, the patient should list:

- *Warning signs (signs that a crisis may be developing, including possible thoughts, images, moods, situations, and actions).*
- *Coping strategies (things that can be done that help the patient take their mind off their problems).*
- *Social settings and places that provide distraction or a feeling of calm.*
- *Ways to make the environment safe.*
- *Names of family/friends who can be contacted for help.*
- *List at least one thing that is worth living for.*

Patients can also be instructed to use “in the moment” tools that can stimulate the parasympathetic nervous system, as this can help them regulate distressing emotions and get into a frame of mind where they can use other coping tools. For example, a cold shower, holding their face in a bowl of ice water and regulating breathing, and/or a gel ice pack (or zip lock baggie with cold water and ice cubes) held over the cheek bones, face or back of neck. In addition, paced breathing (where the exhale is deliberately longer than the inhale, such as inhale for a count of 5 and exhale for a count of 7) done for 4-5 minutes can be helpful.

There are also many apps based on distress tolerance and coping skills that abound, and can be downloaded onto patients' phones.

A Psychotherapeutic Approach to Gender Dysphoria

Young people with gender dysphoria experience distress about, and preoccupation with, their natal sex or assigned gender, often especially about the physical sexed body. Individuals commonly report distress about a sense of misalignment between their experienced gender and their natal sex. Commonly, two approaches to treatment are considered. The first involves aligning the body with the mind and involves medical and surgical treatment to alter the body so that it is felt to be consistent with the experienced gender of the individual (Coleman et al., 2012; Hidalgo et al., 2013). This is the gender-affirming approach. A second involves aligning the mind with the body and involves helping the person become comfortable with their body as-is and with the gender they have been assigned. This approach is increasingly considered “conversion therapy” and is prohibited in various jurisdictions around the world.

Current thinking about treatment for gender dysphoria is structured by a binary that considers only two possible approaches: *affirmation or conversion*. Both affirmation and conversion represent extreme positions, which impose predetermined notions of cure on the patient. Influencing patient outcomes in this way is arguably a violation of appropriate therapeutic principles and boundaries. Therapeutic interventions structured by affirmation or conversion fundamentally foreclose the possibility of a genuine psychotherapeutic process.

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A third therapeutic approach is not constrained by the affirmation-conversion binary but is open to a range of outcomes, including gender outcomes. It aims to address the distress of gender dysphoric youth rather than correcting any sense of misalignment. Neither consolidating a trans identity nor working to establish a cis identity are goals of treatment. Thus, it bears no relation to conversion therapies which presume that non-normative gender identification is a pathology to be corrected. **Instead, psychotherapy facilitates a process of curiosity, exploration, and psychological growth, by opening up new areas of inquiry.** Effective psychotherapy can lead to greater freedom and agency by helping

young people with gender dysphoria discover creative solutions to their problems, solutions that are safer and potentially more liberating than gender affirming treatments.

Currently, there is insufficient evidence to determine which treatment approach is most likely to achieve durable, long-term resolution of gender dysphoria while minimizing the risk of iatrogenic harm. The gender-affirming approach, which involves varying combinations of social transition, endocrine treatment (puberty blockade and cross-sex hormones), and surgical interventions, has increasingly become the predominant treatment paradigm (Coleman et al., 2012; Telfer et al., 2018). However, the data validating its effectiveness and risks is scant and of poor quality (Heneghan & Jefferson, 2019; National Institute for Health and Care Excellence, 2021a, 2021b). On the other hand, evidence supporting psychotherapy for GD consists only of case reports and small case series. Yet many reports suggest that psychotherapy can ameliorate gender dysphoria in some individuals (Ahumada, 2003; Bonfatto & Crasnow, 2018; Chiland, 2000; Churcher Clarke & Spiliadis, 2019; Coates et al., 1991; D'Angelo, 2020a; Davenport & Harrison, 1977; Di Ceglie, 2009; Evans & Evans, 2021; Forester & Swiller, 1972; Greenson, 1966; Hakeem, 2012; Kirkpatrick & Friedmann, 1976; Lemma, 2018; Levine & Lothstein, 1981; L. R. Loeb, 1992; L. Loeb & Shane, 1982; L. Lothstein, 1988; L. M. Lothstein, 1980; L. M. Lothstein & Levine, 1981; Pfäfflin, 1994; Shane & Shane, 1995; Spiliadis, 2019; Stein, 1995; Zients, 2003). A detailed review (Zucker, 2001) cites 49 case reports on the treatment of children with GD using psychotherapy or psychoanalysis and concludes that psychotherapy can benefit children with GD.

Despite the limited evidence for their efficacy for gender dysphoria, individual and family psychological interventions, particularly systemic and psychodynamic therapies, are well established as the basic framework of child and adolescent psychiatric care (Carr, 2006; Thapar et al., 2015). They are effective when applied to a range of psychological difficulties, including those characterized by distress about the body and psychological problems related to identity confusion. Importantly, psychodynamic psychotherapy is now backed by a compelling and rigorous evidence base (Leichsenring et al., 2015; Leichsenring & Steinert, 2018; Royal Australian and New Zealand College of Psychiatrists, 2021a; Shedler, 2010; Steinert et al., 2017). This also applies to work with children and adolescents (Midgley et al., 2021). Psychotherapy is a unique therapeutic approach in

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that it is “transdiagnostic,” rather than diagnosis-specific, with demonstrated efficacy in a range of emotional disorders (Leichsenring & Steinert, 2018).

Critics of psychotherapy often conflate ethical, exploratory psychotherapy with conversion or reparative therapy. Conversion therapies are broadly defined as practices that attempt to change or suppress same-sex attraction or non-normative gender identity. Therapies designed to change or suppress same-sex attraction have indeed been shown to be harmful (American Psychological Association, Task Force on Gender Identity and Gender Variance, 2009; Beckstead, 2012; Drescher, 2015; Serovich et al., 2008). It is frequently assumed that the same-sex literature applies equally to gender identity, leading to claims that attempts to change gender identity are harmful (American Psychological Association, Task Force on Gender Identity and Gender Variance, 2021). While this may seem plausible, there is no credible evidence to support such a claim. A study purporting to link attempts to change gender identity with poor psychological outcomes (Turban, Beckwith, et al., 2020) was discredited due to serious methodological flaws (D’Angelo et al., 2020).

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Conceptualizing Gender Identity

Gender identity is a *highly personal and idiosyncratic way of conceptualizing and experiencing the self* that is infused with historical, relational, and socio-political residues. When viewed in this way, it becomes a rich source of meaning and data to be explored, rather than a pseudo-biological structure that can only be responded to in concrete, medicalized ways. Gender has been referred to as a “pattern in time” (Fausto-Sterling, 2012) a description which captures the infinite variability of this experience for each individual.

From a psychotherapeutic perspective, gender is helpfully viewed as an emergent phenomenon arising at the intersection of multiple mutually influencing systems (individual, historical, family, social, political, etc.) (D’Angelo, 2020b). This way of conceptualizing gender dysphoria is consistent with recent research examining the attachment classifications and developmental experiences of gender dysphoric youth (Kozłowska, Chudleigh, et al., 2021; Kozłowska, McClure, et al., 2021). The authors emphasize “the importance of conceptualizing gender dysphoria by using a broad lens that takes into account the multiple factors that contribute to

the child's distress, difficulties with adaptation, multimorbidity, and loss of health and well-being.”

There is no one-size-fits-all explanation for the development of gendered experience: each individual's pathway to the development of gender dysphoria is unique and can only be discovered through careful exploration. Transgender identification may represent a healthy development that allows greater freedom and authenticity. Alternatively, trans identification may be a carrier for other struggles, which may be experienced as being located in the body. Trans identification may also be a way of eliminating and disowning unwanted aspects of the self. These distinctions cannot be made in a routine psychological evaluation and only become apparent in the process of an evolving, detailed psychological exploration.

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A gender-affirming approach is based on a fundamentally different conceptualization. At its heart is a reification: namely, that gender identity is an irreducible core essence that simply is. Searching for its origins makes no sense in the same way that we would not investigate why someone has blond hair or left-handedness. This assumption has problematic consequences that impact how we understand individual subjective experience. It reduces the unique, complex shape of individual lives to a simple concrete construct. Subjective psychological experience cannot be understood without considering the context within which it emerges. Gender identification is a unique, personal experience that emerges and exists in a context. Viewing a young person's stated gender identity as a simple, concrete reality, without understanding the complex systems within which it has emerged, neutralizes personal meaning and ignores the context in which personal identity has taken shape and in which it has a specific personal meaning.

Young people are increasingly experiencing distress about gendered aspects of their experience, as reflected in the exponential increase in referrals to youth gender clinics worldwide (Aitken et al., 2015; Wood et al., 2013; Zucker, 2019). The reification of gender identity outlined above explains this distress in physical terms, namely as a result of being born in the wrong body, and closes down space for imagining creative solutions to gendered distress. It posits that the solution is to alter and align the body with the experienced gender. There are potentially many more ways to reject gender stereotypes and creatively live in a gendered world, which may not be considered when the solution is seen to reside in the reconfiguration of the body.

When gender identity is seen as a complex, emergent, and therefore fluid phenomenon, on the other hand, therapist and patient will be open to the possibility of as-yet unimagined solutions that truly dismantle the constraints of culturally sanctioned gender roles.

Comorbidity in Gender-Distressed Youth

Our diagnostic systems, DSM and ICD, whilst helpful as classifications of syndromes, have created a fragmented perception of mental illness and emotional distress. Shedler (Shedler, 2021) argues that DSM presents psychiatric diagnoses as “encapsulated conditions,” separate from the overall psychological and emotional life, and real world experiences, of the individual. Young people with gender dysphoria often meet criteria for a range of other mental health diagnoses (Gijs et al., 2014; Kaltiala-Heino et al., 2015; Spack et al., 2012; Steensma et al., 2014) such as anxiety disorders, depression, eating disorders and autism spectrum disorders. We are trained to think about the clinical presentation as consisting of separate illnesses or conditions that simply coexist, or where one may be primary and another secondary.

This results in a narrow focus on diagnoses, rather than a broad holistic view that considers the person in their specific life context and history. All of the difficulties in a person’s life are likely intertwined in

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complex ways, and our diagnostic focus reduces our capacity to consider the big picture. For example, social difficulties and gender dysphoria are very commonly comorbid in young people. We might speculate that the young person’s interpersonal difficulties have led to trans identification as a way of managing their social anxiety. Another formulation might hypothesize that trans

identification has led to social anxiety as a consequence of adverse experiences of discrimination. The latter often leads clinicians to assume that gender dysphoria is the primary problem requiring clinical attention. Clinicians may believe that gender-affirming treatments will resolve comorbid problems such as social anxiety, deliberate self-harm, or eating disorders. These simplistic conceptualizations are unable to comprehensively address the person’s specific mental health needs.

Rather than a hierarchical formulation in which one diagnosis is primary, and the other is secondary, a more complex understanding may consider these experiences as components of a complex system

of interacting psychological phenomena. Questions which might illuminate how the components of the system fit together include the following: What is the history of their emergence over time? How does transgender identification impact social interactions? How does interpersonal vulnerability relate to the person's gender expression? Are both gender distress and social anxiety different facets of a complex response to family, developmental or other contextual issues? The interaction between the two concerns could be multi-directional and not linear as in the “primary/secondary” model outlined above. Focusing on one aspect of a person's experience without considering its place in the complex system of an individual life leads to fragmented and inadequate care.

This does not mean that significant comorbid psychiatric difficulties may require specific interventions. Treatments that provide symptom reduction, by reducing the overall burden of distress for that young person, may have an impact on other components of their presenting difficulties. Sometimes treatment of coexisting mental illness even leads to the reduction or resolution of gender distress.

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The minority stress theory is often used to explain the high rate of co-occurring psychiatric problems in gender dysphoric individuals. This theory argues that these problems are caused by prejudice and discrimination as a result of being gender non-conforming (Rood et al., 2016; Zucker, 2019), leading to the assumption that gender transition will ameliorate these difficulties. It has been claimed, for example, that gender-affirmative care will successfully treat not only depression and anxiety, but will also resolve neurocognitive deficits such as autism spectrum disorders in gender dysphoric individuals (Turban, 2018; Turban & van Schalkwyk, 2018; Turban, King, et al., 2020).

These latter claims are contentious and are disputed by respected proponents of gender-affirmative interventions (Strang et al., 2018; van der Miesen et al., 2018). **Further, some researchers have found that psychiatric symptoms frequently pre-date the onset of gender dysphoria** (Bechard et al., 2017; Kaltiala-Heino et al., 2015; Kozłowska, Chudleigh, et al., 2021), **casting doubt on the minority stress hypothesis as the main driver of psychiatric difficulties in this group.** Recent research has found that youth with underlying psychiatric issues are likely to continue to struggle post-transition (Kaltiala et al., 2020), showing that psychiatric difficulties are unlikely to be helped by gender transition.

Basic Principles of Individual Psychotherapy for Youth with Gender Dysphoria²

The Importance of Context

What does it mean when a 13-year-old natal female suddenly announces that she is a boy? A gender affirming therapist may view this as a straightforward expression of gender identity which should be accepted so that options to help the patient to live as a male can be explored. The gender-affirming paradigm does not consider that these statements may have complicated origins and meanings, some of which the teen may not be aware of. Although gender affirmation may represent an immediate tangible solution to gender distress, psychotherapy seeks to identify and address the often complex causes of this distress. Importantly, gender identity and gender distress are understood to emerge in a context. Viewed this way, gender distress is not an individual's sole defining characteristic; instead, it is but one dimension of the complex array of qualities, abilities, and challenges that comprise an individual's life.

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However, **adolescents often fixate on gender transition as the best and sole solution for their distress. Psychotherapy can help them understand the nature of their distress differently.** One of the overarching aims of exploratory psychotherapy is to shine a light on aspects of experience that may be outside of awareness, dissociated, or disavowed. As a result, problems are understood in more complex and nuanced ways. On occasion it turns out that the presenting problem has little or no relationship with more fundamental issues and sources of pain.

² Some of the general principles of psychotherapeutic treatment of gender dysphoria outlined will be more relevant for adolescents than children, and clinicians should formulate a treatment approach that is developmentally appropriate for their patient.

Understanding the experience of gender dysphoria in the context of family and other environmental influences can be challenging, at least in part because **our diagnostic systems, healthcare providers, and culture advance a rigid, decontextualized version of gendered experience.** Such decontextualization can obscure other problems and limit self-awareness. Elucidating the context is a process that examines multiple, previously unexplored areas of inquiry to expand self-awareness. This can be challenging and uncomfortable, and it's often viewed with suspicion, especially by adolescents with deeply held convictions that transition is the only possible solution. **The challenge is to understand the presenting gender distress while concurrently exploring the entire landscape of the young person's life and subjective experience,** with the aim of identifying the foundational difficulties.

Psychotherapeutic inquiry does not simply accept that a person has the wrong body or gender, it explores why and how a young person came to have negative feelings about their sexed body or that their body or gender is “wrong.” This involves exploring relational and developmental history, the quality of relationships with parents, any traumas or losses that have affected the family, the presence of marital dysfunction, domestic violence, sexual abuse or other detrimental interpersonal dynamics. It also involves exploring social relationships with friends and peers.

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Importantly, it helps patients gain greater clarity about how they feel and why, tracing feelings of alienation, unworthiness, and self-hatred in context.

Today, young people live in an environment that supports and reinforces trans-identification. Social influences must not be underestimated; they have important implications for the therapeutic process. Many young people present

their gender identification with absolute certainty, which poses difficulties for the therapist. Therapists may find that even their most sensitive attempts to question and explore gender-related feelings are reflexively dismissed or elicit a defensive reaction. It may feel like any exploration of gender issues is off-limits. Therapists may be frustrated or confused when they confront areas that are off-limits. When these areas can eventually be opened up, they sometimes reveal pivotal and potentially traumatic material (see D'Angelo 2020 for a description of this process).

Clinicians also may become preoccupied by gender issues, distracting their attention from other, potentially more pressing problems. Gender dysphoria can create a sense of urgency in response to acute distress in the family, which may be intensified by suicidal ideation. Young people who are highly distressed often mistakenly believe that embarking on social or medical transition as soon as possible will relieve their distress. Therapists may feel a similar urgency to act to relieve this distress while also being aware that the underlying issues have not yet been sufficiently examined. Patients' frustration, disappointment, or anger may surface when the therapist conveys that the issues have not yet been adequately explored and understood. Psychotherapy attempts to explore what is driving the sense of urgency rather than simply acquiescing to relieve it. Therapists can acknowledge the patient's distress whilst holding the patient's stated gender identity lightly, expressing curiosity about its meaning and origins.

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Family Processes and Development Issues

To work effectively with young people, clinicians must consider family dynamics and developmental processes. Childhood and adolescence are ongoing processes of development and psychic growth. Clinicians working with gender dysphoria need to explore how developmental issues are managed by the family system. **Gender struggles are nearly always inextricably interwoven with developmental and family processes; they do not occur in a vacuum.**

An example of this involves separation-individuation processes. As young people enter and progress through adolescence, they navigate a complicated tension between maintaining family bonds while investigating greater separation and autonomy. Gender often becomes entangled with these struggles, becoming the medium through which this developmental struggle is negotiated. Many adolescents with gender dysphoria have been compliant and cooperative before identifying as trans. Proclaiming a trans identity, which often ignites parental distress, may be the first time these young people have opposed their parent(s).

It may seem that encouraging the young person to assert their gender identity more emphatically to their parents is the appropriate way to support their developing autonomy. But this belies a

decontextualized understanding that ignores the centrality of developmental issues often present in gender dysphoria. A more nuanced approach would identify the separation/individuation struggle as the primary problem, understanding the young person's gender-related interactions with parents as a way of having their own voice. The initial assertion, "I am trans and my parents do not understand," might, over time, give rise to other questions such as, "Why am I still so worried about upsetting people and unable to be myself in so many relationships? Why is my gender identity the only thing I feel able to assert when I generally do not speak my mind for fear of upsetting others?"

Exploring these issues entails identifying the developmental and family issues that color the adolescent's current challenges and their gender struggles, focusing the clinical work on those family and relational difficulties. The family dynamics that may be involved are not unlike those of young people struggling with other issues. For example, aspects of the relationships with one or both parents may cause or exacerbate pain, rejection, or confusion. Trans identification may serve to reject, control, distance, punish, or usurp the parent. On the other hand, it may be a plea for attention and recognition, an attempt to bridge distance, or a way to become someone who will be more lovable. Sibling relationships may be competitive such that the patient perceives herself as inferior or less favored by the parents. The potential dynamics in which the gender issues are emerging are multiple and unique to each case.

In some instances, traumatic relationships such as the loss of a parent or sibling, domination or aggression at home or school, or physical or sexual abuse may be key. Trans identification may be a compensatory strategy for loss; a way to gain feelings of strength, control, and power; an attempt to dissociate from feelings of vulnerability; or a way to bury the version of the self that was violated or victimized. Through careful exploration of these experiences, patients often recognize that hatred of their natal sex is related to feelings about a parent or peer. Establishing temporal links between the onset of gender difficulties and relational dynamics is often sufficient to illuminate their interconnectedness, without any need to infer a causal relationship.

Because the family is one of the most critical aspects of the context in which gender dysphoria arises, family therapy should be a vital component of the comprehensive treatment of gender dysphoria in young people. Family difficulties may be evident at the initial assessment or may be uncovered over time. Problematic family dynamics may contribute to the young person's distress

and may exacerbate or even drive gender issues. Clinicians need to determine the appropriate amount of family intervention for each patient based on the extent of family distress or pathology and the developmental stage of the young person.

Discovery of the True Self

One of the critical tasks of adolescence and early adulthood is to explore the question, “Who am I?” For some adolescents, this involves exploring whether they identify as male or female or another gender. Developing a sense of authentic “me-ness” is arguably fundamental to happiness and mental health and involves cultivating a sense of freedom and agency. One of the arguments for the gender-affirming approach is that the process of coming out as trans involves a liberation from a false gender self and so should be encouraged and supported. This is a simplistic and formulaic application of the notion of true and false self, which overlooks the complexity and nuances of how we come to discover our authentic selves.

The discovery of the “true self” and authenticity is one of the central goals of psychotherapy and was extensively described by Laing (1960), Sullivan (1953), and Winnicott (1971). They argued that false self is protective, insulating the true self from potential threats. The false self involves an accommodation to the other, with the result that the true self is safely concealed. One of the consequences of the false self is that it limits the degree to which closeness between the self and others is possible, often leading to a deep sense of aloneness. It can be a way of hiding and protecting the self from the risks of interpersonal closeness.

Young people with gender dysphoria frequently present their experience in these terms, stating that they can now finally be themselves rather than being what their parents want them to be. **One of the central tasks of work with gender dysphoric youth is to consider whether trans identification really is an expression of the true self or whether it is something else.** Is trans identification a liberation from the previous false self, or is it a new false self that has been appropriated as a protective strategy? Is it about having a voice, or is it a new way of hiding? Does identifying as another gender represent full acceptance of the self, or does it involve a rejection of feared and hated parts of the self and an attempt to become someone else and start again? Is gender dysphoria an understandable response to feeling trapped in a gender that does not feel authentic, or a consequence of deep self-hatred? Does expressing a trans identity involve

dismantling a compliant false self, or does it entail accommodation to culturally determined gender roles?

The answers to these questions are crucial because they help determine whether gender change will be growth-promoting or whether it will limit the developmental possibilities, including the

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capacity to know oneself, to connect with others authentically and the capacity for creativity. A psychotherapeutic process can help illuminate whether trans identification is an important developmental attainment or whether gender is being recruited to solve other difficulties. Making this distinction is complex and can only occur in the context of an ongoing therapeutic

relationship in which the subtleties and less apparent aspects of experience can be explored.

Exploring and Establishing Sexual Identity

Adolescence is a pivotal period of exploration and identity formation. Feelings of sexual attraction and sexual fantasies arise and adolescents experiment with and experience sexual pleasure via masturbation or sexual contact. Sexual identity may be understood as comprised of three interconnected dimensions: gender identity, sexual orientation and intention—meaning the kind of sexual activities the person wishes to engage in with sexual partners (Levine, 2020). Sexual identity exploration also encompasses novel sexual identities such as asexual orientations and paraphilias, including BDSM and autogynephilia (a persistent pattern of sexual arousal in a male to imagining or experiencing himself as a woman). Exploring aspects of sexual identity helps young people better understand how transitioning might play out in their sexual lives, but it also may highlight anxiety, conflict, or confusion that may contribute to gender dysphoria.

While the current premise is that gender and sexual orientation are separate and distinct constructs and that gender identity does not determine sexual object choice, these dimensions often overlap. It has been noted that **sexual orientation conflicts, often associated with shame or disgust, are a central dynamic for many young people with gender dysphoria** (D'Angelo, 2020a; Evans & Evans, 2021; Greenson, 1964; Morgan, 1978; Patterson, 2018). Trans identification may be a strategy aimed at addressing issues described as manifestations of internalized homophobia. In

the west, gay male culture has increasingly rejected gender non-conformity and glorified normative masculinity (Valentine, 2007). Boys who are feminine may feel rejected by gay men and may feel that identifying as a trans person is a more palatable alternative.

Interestingly, many young people with gender dysphoria have not had any sexual experiences and disavow sexual fantasies or masturbating. These young people may suffer feelings of disgust about their developing sexed bodies and/or dissociation from the erotic body. Alternatively, shutting out sexual exploration may occur in response to more complex fears surrounding sexual relationships and intimacy. These issues require sensitive exploration, particularly when gender-affirming treatments may compromise the capacity to experience sexual pleasure and orgasm. **While the desire for gender-affirming surgery may seem understandable, it may also be an expression of complex unconscious feelings about sexuality.**

Exploring these issues entails consideration of how the young person's attitudes to same-sex attraction and adult sexuality were shaped. Family attitudes about sexuality and sexual orientation may be crucial, as are religious or cultural values. Often, there are important issues to explore in relation to developmental sexual experiences, and the extent to which sexuality has become conflated with shame or fear. It is also vitally important to uncover experiences of sexual boundary violations and sexual abuse, which are often associated with inhibited sexual desire.

Decoding the Meaning of Gender

What does identification as male, female, non-binary, genderqueer, or another gender identity mean? When exploring issues related to gender dysphoria it is imperative to determine whether the

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young person is motivated by a desire to flee from the natal sex/gender, a compelling identification with another gender, or both. The particular, idiosyncratic meanings associated with the rejected/feared gender/sex and the idealized/desired gender/sex are complex. Shaped by a range of influences and imbued with relational, historical, and traumatic residues, these

meanings only emerge over time. What is possible in one gender that is impossible in the other? What dreams, aspirations, and plans are associated with the new gender? Which experiences,

meanings, and parts of the self are contained in the old gender and why must these need to be altered, disavowed, or excised?

It is important not to overlook the influence of stereotypes that shape how young people, and the broader society, define gender. The majority of young people have not considered the extent to which their gendered experience results from the way gender is understood in the family and how our culture defines, prescribes, and regulates how one lives as a man or a woman.

It is important not to overlook the influence of stereotypes that shape how young people, and the broader society, define gender.

For example, upon inquiry, some natal female teens who identify as male have deeply held patriarchal and misogynistic beliefs. They may feel that women passively accommodate to men's wishes; that men are strong and women are emotionally weak and labile; and that men command respect while women are often ignored or discounted. Similarly, natal male teens who identify as women may feel that they are different from cis males because they are quiet or timid and uncomfortable with aggression. Observing these views is a powerful reminder of the pervasiveness of patriarchal gender regulation; though certain stereotypes have been challenged, others persist.

Young people often internalize their family's gender-related beliefs and stereotypes, even when they are not overtly expressed. For example, some families view emotional expression and vulnerability as undesirable qualities and associated with a debased version of femaleness. In this environment, a girl may feel ashamed of her emotionality and wish it away. She may believe that as a boy, she will be more welcome in a culture in which men are stereotypically not emotionally sensitive or vulnerable. On the other hand, a natal male may manage the shame induced by his family about his emotional vulnerability by identifying as female, since it is permissible for women to be emotionally vulnerable. Similarly, a parent with negative attitudes towards masculinity, who associates it with aggression, may prompt the child to fear or reject his natal sex.

It is important that therapists create a space in which together, patient and therapist can question the assumptions that explain why certain qualities, behaviors, identities, and sensibilities are associated with particular body types, clothing choices, and other gender signifiers. This exploration aims to help the patient understand the impact of being perceived as a particular gender and explore how gender perception increases or

limits personal freedom. It may be possible to reframe thinking so that instead of simply perceiving non-alignment as inherently distressing, the patient and therapist can explore why non-alignment is a distressing.

This kind of exploration, of the meaning of gender or the meanings attached to gender, is crucial. It enables young people to acquire a more nuanced understanding of how they understand themselves in gendered terms. It also can deepen an appreciation of the cultural context and the persistent inequities between the way men and women are treated. **Young people may not have considered the broader socio-political context and may be surprised to learn that they have inadvertently internalized toxic gender stereotypes.** Questioning whether transitioning really challenges gender norms or actually perpetuates the very norms the young person is trying to reject can be a pivotal point in treatment.

Therapists should aim to facilitate a process in which previously unimagined ways of understanding, navigating, and challenging gender constraints can emerge. Some young people may choose to live within their natal sex and gender but will reject gender norms in their behavior and dress, career choices, and how they present themselves in the world. Others may opt to identify in the gender of their choice without body modifying medical procedures.

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Informing Patients About the Realities, Risks, and Uncertainties of Transition

Therapists should be equipped with accurate information about the risks, benefits, and uncertainties of transition. Young people and their families should be informed of the ongoing controversy about the risks and benefits of youth transition. **Therapists have an ethical imperative to ensure that young people understand and appreciate the potential challenges of transition.** Young people heavily invested in transition often reflexively dismiss or reject any discussion of risks and uncertainties; however, the material they have read online generally downplays the realities and risks of transition. Sensitive exploration of the reality of adverse health, cosmetic, social, and interpersonal outcomes can prompt some young people to reconsider medical and surgical

interventions (Hakeem, 2012).

Ultimately, transition is one possible solution to distress, albeit one with numerous risks. The health risks include cardiac and endocrine disorders, surgical complications, and impaired fertility and sexual function. There also are psychosocial risks, such as discrimination and stigma; challenges with dating and in intimate relationships; changing family dynamics; and the consequences of not having adequately dealt with core psychological issues prior to transition (Levine, 2019).

The possibility of regret and detransition must also be considered. While regret has been thought to be low, it is likely that the true regret rate is higher than that reported in the literature since methodological limitations, such as high rates of loss to follow-up, call into question the low rates (D'Angelo, 2018). Most detransitioners report that they did not receive adequate evaluation before transitioning and only later realized that their gender dysphoria resulted from trauma or other mental health issues (Littman, 2021; Vandebussche, 2021).

Psychotherapeutic exploration is an essential aspect of fully informed consent. The issues that need to be considered are outlined in the following section.

Informed Consent

Consent for Any Form of Gender Transition Should be Explicit, Not Implied

Typically, medical procedures that involve little risk of harm do not require a formal, signed informed consent document; in most cases, consent is understood and implicit since the patient has sought the care. For example, when a patient arrives in the emergency department with chest pain, consent for an electrocardiogram and cardiac enzymes is assumed. When the patients in question are children, it is presumed that the parents or guardians agree to the proposed diagnostics and treatment and understand the benefits and risks. But when the risks associated with medical care are significant, such as those of surgery or cancer chemotherapy, explicit, or express informed consent is required.

In terms of treatment for gender dysphoria, the long-term outcomes, known risks, and as yet unknown consequences of puberty blocking, cross-sex hormones, and gender-affirmative surgeries have been acknowledged (National Institute for Health and Care Excellence, 2020a; National Institute for Health and Care Excellence, 2020b; Manrique et al., 2018; Wilson et al., 2018). Because of the complexity, uncertainty, and risks involved with these interventions consent should be explicit rather than implied.

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Should informed consent also be required for social transition? There is evidence that social transition may foster persistence of gender dysphoria (Hembree et al., 2017; Steensma et al., 2013). This indicates that social gender transition may be a psychological intervention with enduring effects (Zucker, 2020). We assert that although causality has not yet been confirmed, the potential for iatrogenesis and increased exposure to the risks of medical and surgical gender dysphoria treatments suggest that consent for social gender transition should be informed and explicit, rather than simply implied.

Truly Informed Consent Requires Complete and Unbiased Disclosure of Benefits, Risks, and Alternatives

When mental health professionals perform evaluations and issue recommendations, the informed consent process begins as part of an extended evaluation or is integrated in a psychotherapeutic process. When primary care physicians, pediatricians, physician assistants, or nurse practitioners perform the initial evaluation, the informed consent process is more likely to take place over the course of a series of visits.

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Across all settings, the informed consent process for gender-affirmative care should be guided by three key premises:

- 1. Choosing to initiate gender transition has the potential to result in long-term persistence of transgender identity.**
- 2. Many of the physical changes carried out are irreversible.**
- 3. There have not been quality, long-term studies to determine whether these medical and surgical interventions improve physical and mental health or social functioning, nor have their risks or harms been adequately investigated.**

The informed consent process, which culminates in a signed document, indicates that parents and patients have been fully apprised about the short- and long-term risks, benefits, and uncertainties associated with the proposed gender-affirmative interventions. The process must also inform patients and families about the full range of alternative treatments, including watchful waiting and the option to forego any treatment of the young person's gender dysphoria.

Capacity to Grant Consent Must be Assessed

Trans-identified youth usually express avid desire for hormones and surgery. But their enthusiasm is often greater than their capacity to carefully consider the long-term consequences of realizing their desires. Trans-identified youth younger than the age of consent should be included in the informed consent process, but they may not have sufficient maturity to recognize or admit their fears or reservations about the effects of the planned intervention. This is why the parents of

minors are responsible for completing an informed consent document.

At what age are adolescents sufficiently mature to consent to gender transition? In the United Kingdom and Australia the courts have been asked to determine whether youth have the capacity to consent to hormones (Ouliaris, 2021). In the United States, the legal age for medical consent for gender-affirmative interventions varies by state.

At what age are adolescents sufficiently mature to consent to gender transition?

Patients age 18 and older, and in some jurisdictions as young as age 15 (Right to medical or dental treatment without parental consent, 2010), do not legally require parental consent for medical procedures. But since an individual's gender transition exerts an impact on parents, siblings, and other family members, clinicians are advised to seek their involvement throughout the informed consent process.

A recent study by Dutch researchers aimed to assess the decision-making capacity of adolescents preparing to transition (Vrouenraets et al., 2021). Seventy-four study subjects with an average age of 14.7 years completed the MacCAT-T, which measures the ability to understand, appreciate, reason, and express a choice. The researchers found that the adolescents were competent to consent to pubertal suppression, and called for similar research for children less than age 12, particularly because they opined, "birth-assigned girls ... may benefit from puberty suppression as early as 9 years of age" (Vrouenraets et al., 2021, p.7).

This study suffers from two significant limitations. First off, it was not intended for use with children; it was designed to assess medical consent capabilities of adults suffering from psychiatric disorders such as dementia and schizophrenia. Secondly, it is unreasonable to assume that adults with cognitive

For example, we question whether even highly intelligent children can fully appreciate the loss of future sexual function and reproductive abilities.

impairments are comparable to healthy children with age-appropriate cognitive capacities but lacking the necessary life experience to evaluate profoundly life-changing medical interventions. For example, we question whether even highly intelligent children can fully appreciate the loss of future sexual function and reproductive abilities.

Furthermore, even for adults, the MacCAT-T has been faulted for its sole focus on cognitive aspects

of decision-making capacity, discounting or ignoring the non-cognitive aspects of decision-making such as values, emotions, and other biographic and context specific variables inherent in decision-making (Breden & Vollmann, 2004). It is widely understood that children's values and emotions change dramatically as they mature.

The authors' conclusion about their young patients' competence to consent is quite different from the opinion expressed by a panel of judges about the Tavistock treatment protocol (Bell v Tavistock, 2020):

...the clinical intervention we are concerned with here is different in kind to other treatments or clinical interventions. In other cases, medical treatment is used to remedy, or alleviate the symptoms of, a diagnosed physical or mental condition, and the effects of that treatment are direct and usually apparent. The position in relation to puberty blockers would not seem to reflect that description. (para. 135)

...we consider the treatment in this case to be in entirely different territory from the type of medical treatment which is normally being considered. (para. 140)

...the combination here of lifelong and life changing treatment being given to children, with very limited knowledge of the degree to which it will or will not benefit them, is one that gives significant grounds for concern. (para. 143)

Clearly, acceptability of the idea that children as young as age 10 are capable of granting informed consent varies by country and state, but also is influenced by the facility and by clinicians' beliefs about the long-term benefits of these interventions.

We believe that the premise that children have the capacity to provide meaningful consent to often irreversible life-changing interventions is basically a philosophical claim or perhaps even just wishful thinking (Clark & Virani, 2021). Our view is that consent is principally a parental function.

Informed Consent Should be a Process Rather than an Event

Most institutions and practices that care for transgender-identified youth have the requisite consent forms outlining the risks and uncertainties of hormones and surgery. However, signatures are often

collected in a perfunctory manner (Schulz, 2018), not unlike signatures collected in anticipation of routine surgical procedures. The purpose of these informed consent documents seems to be to shield institutions and practitioners from legal liability, rather than to fulfill the primary ethical obligation of fully informing patients and families of all that is known and that which is not yet known about the planned treatment.

Signed informed consent documents should document that the process of informed consent has been undertaken over an extended time period and is not simply quickly and thoughtlessly completed (Vrouenraets et al., 2021). The latter approach is ethically fraught (Levine, 2019).

Trans-identifying young people and their families vary considerably in terms of their expectations, capacities, and intrafamilial relationships, as well as their cultural, religious, and political sensibilities.

It requires a slow, patient, thoughtful question and answer period as the parents and patient consider what is known and what is not yet known about the planned treatment and determine which approach to take to manage gender dysphoria.

These factors and myriad others may influence the time necessary to complete a thorough and deliberate informed consent process. It is unwise to recommend a specific duration for the informed consent process, other than to reiterate that it requires a slow, patient, thoughtful question and answer period as the parents and patient consider what is known, and what is not yet known, about the planned treatment and determine which approach to take to manage gender dysphoria before the age of full

neurological maturity is attained. We believe that only when patients reach adulthood, and their mental health comorbidities have been effectively addressed is truly informed consent by patients possible.

Additional Thoughts

In recent years, there have been sweeping philosophical and logistical changes in health care for people with gender dysphoria or gender incongruity. Thinking and beliefs about who should be treated, when they should be treated, and how they should be treated continue to evolve. Today, we are challenged to treat unprecedented numbers of youth declaring a trans identity. As adolescents pursue social, medical, and surgical interventions, healthcare providers may feel uneasy about patients' cognitive and emotional capacities to make decisions with life-changing and often

irreversible consequences. An unhurried informed consent process helps the clinician, parents, and patient make thoughtful, deliberate choices.

Several issues have the potential to compromise the informed consent process: comorbid mental health problems, uncertainty about the minor's capacity to fully appreciate the irreversible nature of the interventions, and parental disagreement. Physical and psychiatric comorbidities can contribute to the formation of a new identity, develop as its consequence, or bear no relationship to it. Assessing mental health and the minor's functionality requires time, patience, and care; it cannot be achieved in a 20 minute visit. This is why rapid, rushed, or fast-tracked affirmative care may be precarious for patients and their families. For example, when other conditions or disorders are present such as autism, learning disorders, sexual abuse, attachment problems, trauma, separation anxiety, neglect, low IQ, past psychotic illness, eating disorders or parental mental illness, clinicians must decide whether to ignore these potentially causative or inter-related conditions and comorbidities or to provide timely and appropriate treatment before commencing affirmative care (D'Angelo et al., 2020).

For youth less than the age of majority, informed consent from the parents provides legal endorsement of treatment, but it does not make the decisions to transition, provide hormones, or surgically remove breasts or testes any less perilous, weighty, or uncertain. All that health professionals can do is to ensure that the consent process accurately and fully informs patients and parents about the current state of the science, which still sorely lacks quality research and reliable data analyses. It is healthcare professionals' responsibility to ensure that patients and parents understand the benefits, risks, and unknowns associated with transition as they prepare to make these life-changing and often excruciating decisions.

Young people who have reached the age of majority, but who have not attained full maturation of the brain represent a unique challenge. It is well-recognized that brain remodeling continues through the third decade of life, and that the pre-frontal cortex, where executive function and impulse reside, is the last to mature (Katz et al., 2016). The growing number of detransitioners who were old enough to legally consent to transition, but no longer identified as transgender by their mid-20s, heightens concern about the vulnerability of this group of late adolescents and young adults (Littman, 2021; Vandenbussche, 2021).

When the clinician is uncertain whether a young person is able to comprehend the implications of the desired treatment—when even the most thoughtful informed consent process cannot inform the patient—the clinician may need to spend more time with the patient. When parents or guardians disagree about whether to use puberty blockers or cross-sex hormones, clinicians are in an especially uncomfortable position (Levine, 2021). Australia has instructed clinicians facing these uncertainties to ask the court to decide (Ouliaris, 2021). In the UK, the court system has been wrestling with similar issues. While it is a rare case that ends up in a courtroom, clinicians devoted to providing and enabling deliberate informed consent processes are still likely to face ethical dilemmas and challenges that they alone are unable to satisfactorily resolve.

Case Study: Alina

Case studies represent a composite of several patients. Identifying details have been fictionalized.

Case Background: Alina is a 16-year-old ROGD (Rapid Onset Gender Dysphoria) adolescent from an intact family. She has one younger brother, Noah, aged 12. Alina is a high achiever, good at sports, and an elite swimmer. She plays guitar and writes songs, and is a member of a local theatre company.

Initial Interview with Parents Prior to Seeing Alina

Mr. and Mrs. J reported that for the past couple of years, Alina had been depressed, anxious, and skirting around developing an eating disorder. She had concerns about her developing body and spent a lot of time preening in front of the mirror, experimenting with hair styles, clothes, and overall appearance.

Alina's parents started noticing that these behaviors became exaggerated during the COVID-19 lockdown, during which children could not attend school and had to undertake their studies online. Alina spent a great deal of time in her bedroom online. She finished all her online schoolwork by 10:30 a.m. and was then at a loose end, with no swimming training, theatre group, or music lessons possible. She became miserable and couldn't get out of bed. Her father said that she "lost her mojo" and her friendship group.

When school resumed, Alina underwent a metamorphosis, and completely changed her appearance, clothing, and attitudes. She became "obsessed" with transgender thinking and this "became the focus of her being." Alina cut her long hair very short. Mother was not too concerned at that time as she herself had worn her hair short at Alina's age. She said that she did not realise at the time that it was related to Alina's "new identity as trans." Simultaneously, Alina started wearing boy-like clothes. She dressed in the girls' school uniform at home and changed clothes at school, wearing her father's shirts. Again, her parents were "not fazed by hair or clothing preferences." Mother stated that she used to wear army pants, herself, and thought that Alina was just experimenting with a new look.

Then Alina selected a new name—Nat (short for Nathan)—but her parents informed her that they would continue to address her by her given name, Alina. Her parents get a variable response from her if they call her Alina. If she is stressed, she is volatile and likely to react badly. She tells them they are deadnaming her. Father tries not to use her name because he doesn't want to confront her unnecessarily. She replies that if he can't see the world her way, they can't have a relationship. Her swimming coach calls her Alina, and she accepts that without reacting, but when meeting new people, she introduces herself as Nat.

Over the next few months, Alina became an active member of the LGBTQ club at school and was becoming more insistent on transition. Her parents treated Alina's "antics" as part of her adolescent rebellion until she told one of her teachers that she was thinking about suicide. The school immediately called her parents. They enlisted the assistance of a therapist, but after a few sessions, Alina said she wasn't getting what she wanted, and demanded a more gender-affirming therapist. Her parents took the extraordinary step of keeping Alina home from school for six weeks in order to remove her from the "toxic trans influencers" at school.

Alina adopted a position of authority on the matter and refused to discuss her gender concerns with her parents. Alina called her parents "transphobic" and told them that they were adversely affecting her mental health. Her father told her she had fallen prey to a cult, and he could never "subscribe to her religion." Alina was offended and a standoff between them ensued. When she returned to school, the teachers declined, at the request of her parents, to adopt her new name, so Alina did not respond to them if they did not call her Nat and threatened not to attend those teachers' classes. The following week, Alina spoke about wanting top surgery as soon as possible because her breasts "felt wrong."

Her mother tried to find her a group outside of school to broaden her friendship circle and reduce the influence of the LGBTQ club, and enrolled her in a swimming squad to which she became "immediately hooked."

I asked her parents whether Alina had ever been assessed for autism spectrum disorder (ASD). They replied that she had not but volunteered that their son, 12, was on the autism spectrum, but had not yet been formally diagnosed.

There seemed to be a great deal of complexity in this family, so I suggested that I meet again just with the parents to gain further understanding of Alina's early life and developmental history.

Session 2 and Subsequent Discussions with Parents

Neither parent expressed any concerns regarding Alina’s early childhood. They described her as a “wonder child”—fierce, affectionate, organized, gifted. Her parents gave her a lot of responsibility with which she always coped well. In hindsight, they recognized that they did not set boundaries for her, and she was left to self-regulate even basic matters like bedtime, screen time, when she ate and when she did her homework. Upon reflection, her parents then made the extraordinary comment, “We did not feature in her early life.”

This is an important clue about the emotional atmosphere of Alina’s early life, a declared absence of parental input.

Mr. and Mrs. J said their one major concern regarding Alina was her relationship with her brother, Noah. They said that she had always had a “standoffish” relationship with him and was intensely rivalrous with him. She was often “unpleasant” to him even though he loves her and “will do anything for her, this is not reciprocated”.

When working with gender dysphoric families, I listen for indications of identifications and dis-identifications i.e., the striving not to be like a significant figure. The ambivalent sibling relationship emerges early in this material and is likely important in the formation of a transgender identity in this family.

Alina’s Socialization History as Narrated by Her Parents

In primary school, Alina was not “super sociable”—that is, she was not “adroit” socially and was often ostracized. She could not understand “group machinations;” although she had friends, she “never got the hang of social games” which was distressing for her until she started swimming squad, now a strong part of her life. In year 5, Alina joined the netball team. She had never played netball and didn’t have ball skills, but she was “fierce and stuck with it.” On court, she felt like part of the team, but off court, she was not accepted by teammates.

Alina was always drawn to older children, and she would tell her parents, “I wish I had an older sister.”

A possible hypothesis for this wish is that Alina is searching for a positive female identification, which has not been possible with her mother, in order to relieve her

anxieties regarding her ambivalent identification with her male sibling.

Alina's transition to high school was "painless" as there were lots of students from her primary school who went to the same high school. In year 8, she felt a sudden pressure to have a boyfriend, but she couldn't find one.

This could be due to normal developmental strivings, peer group pressure—if other girls had boyfriends—or a confirmation of herself as female.

At the end of year 8, she started a friendship with Malcolm. They hung out during the Christmas school holidays but then she broke it off with him at the end of first term of year 9, which was when lockdown started. Her parents said Malcolm was "nice, friendly, came home a lot and then he was gone." They learned from Malcolm's mother that he was upset about the way that Alina had "dumped" him.

Alina went online during lockdown and discovered the "transgender cult." She received freely available "propaganda" distributed at school by *Transgender Agenda*. Her parents noticed the evolution of her vocabulary into the language of the movement. She talked incessantly of the need for safe spaces, social justice for minorities, transphobia, the harms of deadnaming and misgendering, and the many forms of transgenderism as exemplified in the gender spectrum flag and the transgender "dictionary."

According to her parents, Alina "redesigned her history," claiming her gender dysphoria was present very early in her life, rewriting her own story to fit with the online trans narrative. Her parents were adamant that it appeared during lockdown one year ago. Her father said that she had "read the playbook on how to become trans." When COVID permits school attendance, she "hangs out at Rainbow Club at school which she sees as a safe place to go, where she is sure to be treated nicely." Mother said that "this club has put a wedge between her and us. But it is not coming from her."

Father's Relationship with Alina:

Dad: Our relationship has evolved a lot. Before lockdown, she was Daddy's girl, we were very tight – she was keen to do things with me. It was an ideal relationship. She was very hurt when I didn't accept her transgenderism and refused to become her

ally. Now, our relationship is weird; there is still a foundation of affection and trust, but it is constantly sabotaged. She still wants my approval, but she is very surly and confrontational. When she is in a good mood, the older relationship re-emerges. A friend told me that fathers lose their daughters between 12 and 20 and then get them back. I worry that she will hurt herself by transitioning. We haven't lost anything yet, but Alina fantasizes about surgical mutilation. She told me that she wanted to slash her chest open and squeeze her breasts out. I remain detached and objective and reflect what she says back to her. I say, "Surgically mutilating yourself will not make you feel any better, you will just have two problems." I remain calm, and she finds that infuriating because she wants to have an argument. She responds with rage—"Get out of my room, fuck off!" For 24–48 hours, she is cold and rejecting and I have to keep my distance, then she wants a cuddle, reconnection, and apologizes.

Mother's Relationship with Alina:

Mom: Alina has always been my sunshine. I never felt that we had a bad relationship, but with Noah in the mix and very demanding of my time, I did not have as much time with her as she wanted. The best times we have is when she is alone with me but there are limited opportunities to do that. We have had lots of mother-daughter adventures—I took her to the hairdresser, to have manicures and pedicures, body waxing, shopping—we had fun being female. At some point, Alina started to spend more time with her dad. She was always a compliant child, but she gravitated to Dad because I was so taken up with Noah's demands. After lockdown, she asserted her independence and her transgender state. Communication deteriorated, she was very short, angry that I would not support her transition, and viewed disagreement as a breakdown in our relationship. She told me on the way to swimming that she was transgender, got out of the car and slammed the door. I had no opportunity to respond. I booked a weekend away with her—she told me to be a better parent and to hear her. I actively try to avoid conflict with Alina, she knows my position, but I stay away from it. Alina knows that we are opposed to puberty blockers and cross-sex hormones; she accepts that she can't do anything until she is 18. She is not pushing this boundary, but she is exploring different boundaries.

Here, we see the arrival of the preferred male child and a re-emergence of the theme of sibling rivalry. Mother behaves in a hyper-feminized way with her daughter and then transferred her attention to her son. Alina became more identified with her father when mother's attention was redirected to Noah. Are there "ghosts in the nursery?"

Session 1 with Alina

In response to an open-ended question about the issues that Alina is currently dealing with she replied: “A bunch of issues related to my parents, always feeling down, school is good, can’t focus on anything, very frustrating, home is not a fun environment, stuck in my room. Seeing different counselors—tried a lot of things, nothing worked.”

I was struck that Alina did not mention her gender identity struggles. Perhaps Alina realizes that her gender issues are not the main problems?

Therapist: That is a big list of issues. Let’s see if we can unpack some of those to understand them better. Which one would you like to begin with?

Alina: The counselors I have seen would ask the same questions over and over and I would give the same answers.

Therapist: You are worried that I will ask the same questions as the previous counselors, and you will give the same answers and it will feel like we are going round in circles, and nothing will work.

Alina: They said it was an environmental issue, change your environment, like getting away from my parents more by staying with friends or my grandmother. They would talk with Dad to see what options there were, like sending me to boarding school. He said no. I stayed with my grandmother sometimes, but Mum had a fight with her, so we don’t see her as much now. I said no to boarding school because I love school. I feel understood and supported at school but not at home. School is accepting, parents are supposed to do that, have unconditional love for their children, but they don’t do that. There have been big arguments that last for days at home. A year ago, I came out as trans to my parents. They said NO! “The trans community is a religion, a cult.” Before coming out to my parents there was a lot less arguing, Dad and I were close. Mum and Dad have a bad relationship—they argue all the time but not about trans. They both agree on that. They don’t think trans exists. We had a big argument last week. Two adults yelling at me, my voice was drowned out. They said, “Your friends are pressuring you to do this, this is not who you are.” Mum started crying. I felt frustrated, unloved, and lonely.

Hypothesis: Is there an Oedipal process occurring where Alina and Dad were close, and Mum was the rival fighting for her position in the marital dyad? With the onset of puberty, did Alina become uncomfortable with her burgeoning sexual feelings, and dealt with them by repudiating her femininity and her female sexed body? “The body is used

to act out something that cannot be accepted or processed by the mind” (Evans & Evans, 2021, Ch. 2, p. 28). Alternatively, Alina is repudiating the bad internal maternal object with whom she is “at war.”

Therapist: It sounds like you’re coming out as trans has changed the relationships within the family.

Systemically, the parental couple has realigned, and Alina has been ejected from the dad/daughter (pseudo-marital) dyad.

Alina: Lots changed around quarantine [lockdown]. I was left by myself in my room all day every day, with Mum and Dad arguing, and my brother really upset all the time. I started thinking about who I am. I am happy at school but then quarantine hit—it was scary, I felt alone. I don’t want to disappoint my parents and not be the person they want me to be, but I realized that I was meant to be a boy. My mental health is not good. I told my friends and teachers, I did not want to make a big deal out of it, but my parents found out and pulled me out of school for six months [it was, in fact, six weeks]. The school counselor advised them to let me go back to school, but they didn’t. I was depressed all the time, sat in my room, played guitar, watched videos, and read books. I tried to do schoolwork, but it only lasted for a couple of weeks. After that, I had no program of study. People stopped messaging me. My parents were told that they had to send me back to school or home school me, so they sent me back to school.

We have a repeat here of her parents again “not featuring in her ...life”, leaving her alone in her room all day every day.

Therapist: What was it like going back to school?

Alina: I found it really difficult to talk to people but it got easier after a while. My friends were happy to see me back. I saw the counselor for months but stopped because it wasn’t helping. My parents want me to move on, not to talk about trans stuff and focus on my mental health, but the lack of affection and support from family is really bad for my mental health.

Therapist: It sounds like you and your parents have a different perspective on how important your gender issues are to your mental health.

Alina: Yes, very different. But there are other issues, you know, red flags, besides my gender that I am worried about.

Therapist: I would like to hear about everything that worries you.

Alina: Well, I cannot remember anything that happened in my life before year seven which means that I had a bad childhood, so I have to focus very much on being myself, and support and love myself because my parents won't do that for me. The other big issue is that I can't focus. I have always had difficulty focusing throughout primary school. I told Dad in year 8 that I probably had ADD but he said, "You probably don't." My parents are dismissive of my feelings. They tell me how I should feel.

Therapist: You are struggling with many issues right now, and it is important to you that I don't tell you how you should feel or be dismissive of your feelings.

Alina: Dad told me that I might have bipolar, depression, BPD, and an eating disorder after I saw the psychiatrist. But it is not official. Mum thinks I have anorexia, but I don't—I don't have problems eating. I am a healthy weight, but I can't look at myself naked or wear tight clothes. I hate having to touch any part of my body; I have showers with the lights off. When I see my body, I have a sense of despair.

Therapist: It seems like Mum and Dad are focused on a whole range of possible mental health diagnoses but cannot recognize your concerns about your gender identity and your feelings about your body.

Hypothesis: Is Alina the scapegoat in this family where all the pathologies and diagnoses reside? Systemically, Alina's gender dysphoria appears to be a symptom of underlying conflict in the family's dynamics. There is also a tendency throughout for the parents and Alina to 'biologize' emotional difficulties. The 'anorexia,' 'bipolar,' and other ways of defending against emotional pain culminates in the biologizing of her gender identity issues and imagining surgery as a solution.

This appears to be borne out by Alina's account of her extended family.

Alina: My (paternal) grandmother is really nice. Mum doesn't like her because I like her more than my Mum. I feel more comfortable with her. Mum comes from [a Balkan country]. She didn't meet her dad until she was 21. There is a whole lot of BPD across generations. Her grandfather was a bully, a drunk, and beat his children. During one beating of my (maternal) grandmother (when she was five), he had a heart attack and died. My grandmother tried to kill herself, and Mum went

to live with neighbors for four months. Her Mum and my Mum came to Australia when she was 17. Her Mum went back to [a Balkan country] after an argument. They have not spoken since. We have never met them. Mum has been diagnosed with BPD. I know nothing about my dad, he is Australian. His parents are divorced.

Alina's father confirmed that her mother has serious mental illness (borderline personality disorder) and is volatile and unstable. The children call her "the monster."

In the following weeks, Alina was more focused on her mental health than her gender dysphoria. She continued to insist that she had attentional difficulties, so to keep faith with her, I did some screening to assess for possible ADD/ADHD, which were positive. I wrote to her parents suggesting a referral for further assessment and possible medication. They agreed to proceed. Our therapeutic relationship deepened. Alina felt heard and validated.

Sessions 8-16 with Alina

Alina: I had a big argument with Dad because I ordered a binder. Then Mum came into my room, and I had a major argument with her. I said, "Mum, I just want you to love me." She said, "I have nothing but love for you." But we were yelling at each other because I told her that her love was conditional. I stood up for myself but felt sad I had to. I asked her to leave, but Mum said, "First let me yell at you some more. When I was 16 my mother beat me up and called me names. You are lucky I don't do that to you. I am not going to call you Nat."

Therapist: You are struggling to find your true self and to be loved for who you are, but that struggle is complicated because your parents have their own view of who you are or who you should be.

Alina: This morning, Mum treated me nicely, got me a hot chocolate and a muffin—I felt strange because we were screaming at each other and then she wanted to treat me nicely the next day. I feel happy when she treats me nicely, but I am confused. I hate my mother when she screams at me. I tell her I need her help, but she says no, she will never accept me as a boy. I feel bad for standing up for myself. If she is angry or sad it is my fault. I asked her for one thing—just to change my name. She said no because if she does that, I will want more.

Therapist: It's confusing going from loving feelings to hurt and angry feelings towards your Mum and to be battling with her over who you really are.

Alina: Mum won't settle. They care about how I feel until I say how I feel and then they say, No, we don't care about that. My whole life I had to be who they wanted me to be so that Mum would be happy. When I went to high school, I decided to be myself and they flipped out and yelled at me.

***Hypothesis:** Alina is engaged in a developmentally normal process of separation/individuation that has become pathological because she is trying to achieve a separate identity in an extreme way—through transgendering her body.*

Therapist: You feel that she will only accept those parts of you that are like her.

Alina: Yes, I had to be girly, quiet, paint nails, go shopping, buy dresses. I would make her feel happy and then I would feel bad for not being myself. I couldn't wear what I wanted to wear, be with the friends I wanted to be with. I came out to my friends, who were very accepting—they were friends with the person, not the image. Mum likes the idea of having a daughter, but I say, I am not your daughter. She doesn't like the way I dress because I look boyish and that is associated with being transgender. She takes pride in having a daughter because I am a little piece of her, but I don't want to be a piece of her. If I say I am not, she withholds love until I act like an extension of her. I have always had to look after her feelings. If she is sad, I have to make her happy. I realized that I can't be myself because Mum won't love me, so I pretended to be someone that Mum could love. Then I got sick of suppressing myself and changed during high school. I have always felt more boyish. I hate that Mum wants me to be a girl. People say, "You are saying you're a boy to spite your Mum." My relationship with Mum is inconsistent. Sometimes we get along, other times we are at war.

Therapist: I wonder whether you are rebelling against your mother's rigid view of what it is to be female. You don't feel "female" in her terms, so perhaps you have gone to the opposite extreme to make your point—that maybe you are coming out of a confining box of rigid femininity and jumping into a box of rigid masculinity.

Alina: As soon as I started puberty, and developed breasts, I tried to hide them, I didn't like them. Mum bought me tight fitting clothes. I thought, maybe I don't feel pretty, asked my friends to do my makeup, but it didn't help.

Therapist: Puberty must have felt scary—growing breasts, having periods, changing body shape all reminding you that you are approaching adulthood.

Alina: I feel really desperate for a binder. Wearing a binder is better than wearing five sports bras because I can't breathe. I have asthma. I swam in the carnival but

lost consciousness in the water and had to be dragged from the pool and taken to hospital. I was vomiting, I couldn't feel my legs. They made me take all the sports bras off. I was kept in hospital until my parents came. Dad said, "You could have drowned." I felt embarrassed, and Mum and Dad wouldn't talk to me for a couple of days. Binders are safer but Mum and Dad confiscated mine. I have always been uncomfortable with my breasts, uncomfortable with my body, it feels wrong, I feel trapped.

Hypothesis: Hatred of the sexed body and fear of adulthood.

Over the ensuing weeks, Alina became more strident and argumentative with her parents, raging one minute, sullen and withdrawn the next. I struggled to find a balance between nurturing the helpless, rageful infant and supporting healthy development through adolescence by recognizing her skills and abilities, which were in evidence outside the home, including her participation in a drama group, playing the guitar and songwriting, and being an elite swimmer.

Alina's body became the battleground for control between her and her parents. Alina harbored the unconscious belief that transition would remove psychic pain and confusion and allow her to control her body and her body's development. She thus transferred her psychic conflict into her body, which then became the locus of her omnipotent wish to wrest control of her from her parents.

Hypothesis: Alina has not internalized a "good enough" mother who could help her contain her rage, anxiety, and jealousy.

Alina became fixated on her rage and disappointment that her parents would not return the binder that she had saved to buy. She asked for it repeatedly and they eventually told her that it had been destroyed.

Alina: Dad said that I was never going to get another binder and I felt guilty and ashamed for wanting one. They say that my friends are forcing me into this.

Is the "binder" a 'container' for her developmental (sexual) anxieties as well as an 'obliterator' of them?

Alina: (Pause) Why won't you talk to my parents and convince them to get me a binder?

Therapist: You are hoping that I will be your ally in this dispute, but this is a matter for you to work through with your parents. Perhaps, we can try to understand what all this means?

Alina: (head down, stops talking) *Silence...*

Therapist: You are angry and disappointed with me for not agreeing to talk with your parents.

Alina: I am frustrated with everyone who tries to help me, but they can't because of my parents. We are trapped.

Therapist: Perhaps you feel some of these issues belong to your parents, and that makes it harder to be clear which are yours? You feel I am trapped in this with you.

I told Alina that her gender dysphoria may be only the tip of the iceberg in terms of her unhappiness and that there may be a host of unresolved and difficult emotions underlying it.

Therapist: Perhaps you and I can work on those feelings. This is a place where neither of us are caught in a trap, where you can feel safe to explore your social world, not just the transgender part of it.

Alina: (*silent for some time*) Our house before we moved here was old and miserable, and always messy. I had a bunk bed in a small room. Noah's room was much bigger than mine. Mum and Dad preferred Noah; he always got better things.

Therapist: Men and boys are privileged over women and girls in your family.

The specifics of the sibling rivalry have just been announced!

Alina: Dad says I have Mum's BPD—so he has given up on me. I have always felt jealous of Noah because he was always favored.

Therapist: Did Dad say you had BPD?

I was shocked that a father would say this to his daughter and therefore focused on the BPD instead of the sibling rivalry which was the more significant issue.

Alina: No, (*Alina retracts the statement immediately*) but he used to escape with Noah and leave me to cope with Mum. I always just tried to make Mum happier and look

after Dad. So, my feelings are put aside.

Therapist: Do you feel that dynamic still exists?

Alina: I have given up trying to deal with Mum's emotions.

Therapist: What are your feelings towards your dad for favoring Noah?

Alina: I am disappointed, but it is business as usual.

Therapist: You are wondering whether it is better to be a boy who can attract your father's attention.

For several sessions, the nature of the family relationships was discussed. Alina described a very dysfunctional marriage. Alina said that her parents have slept in different beds for as long as she can remember. The theme of sibling rivalry for her father's attention was also prominent.

I asked Alina if she wanted me to share her thoughts about favoritism with her dad. She didn't hesitate, indicating that she was motivated to improve family relationships but has felt defeated attempting to do so on her own.

Here was a subject about which I could speak with her parents to demonstrate to Alina that I was not as trapped and hopeless as she feared. This was a way to restore my "potency" in her eyes and to strengthen the therapeutic alliance.

I had a meeting with her father and discussed this with him. He was surprised that Alina had this perception but agreed to talk with her about it. It proved a very successful encounter. They both reported that the relationship had deepened as a result of it. Father wrote to me the following:

Father: When Alina and I had the conversation about her feeling abandoned by me, she described the times when I went somewhere with Noah and left her with "that monster." She spoke up for that younger self and gave me a real telling-off. "It's not fair! I was only 5 or 6, I can't take care of her, she's supposed to take care of me! You threw me to the wolves to save yourself! You betrayed me." I was shocked and cried; I told her I was sorry, and I reassured her that I loved her and was just trying to be a good dad to both kids. She believed me because we both knew it was true and she forgave me. It was absolutely wonderful.

Father later reported that Alina's behavior towards Noah had softened since their talk.

In a subsequent session, Alina reported that she was trying to recruit Noah onto her side of the transgender divide. After several attempts to prevail upon her brother to call her Nat, Noah sent her this text message:

Noah: I am very scared to tell you that changing your name is not a good idea. I hate the name Nat. Also, it will be very confusing to have two Master NJs in one family. When we get on a plane, they won't know which seat is mine.

Therapist: Noah is worried that you will turn yourself into him and then you could not be differentiated. I wonder whether you are trying to turn yourself into him so that you can have what he has—parental love and attention and approval?

A week later, Alina shaved her head.

Therapist: I notice that you have shaved your head. What message did you want to send by doing that?

Alina: (head down) *Unresponsive...* Don't know.

Therapist: I wonder if you are making a bald statement about yourself, drawing peoples' eyes and attention to you so that you don't feel invisible and unheard and to express your rage and sadness.

Alina: Being a boy is tearing my family apart.

Alina started sobbing and said that she couldn't even remember to brush her teeth. She had had a recent trip to the dentist who told her that she had a big build-up of plaque on her teeth and that she should brush her teeth regularly.

Therapist: Your head is so full of distress and pain and confusion, there is no space left for remembering to brush your teeth.

Hypothesis: *'not brushing teeth' represents neglect of basic care. Alina is letting me know that the real issues to be struggled with in this therapy will be 'pre-Oedipal.' At issue are her feelings of not being seen as a person—her parents not featuring in her early life, nor during lockdown, and to have disappeared/been displaced with the arrival of the younger sibling—are traumatic. Her parents are made to feel this, too.*

Developments and Outcomes

This account represents the first six months of therapy with Alina and her family. It demonstrates how the intrapsychic life of this young person, and the complex web of family relationships and interactions may impact on a young person's transgender strivings.

The influence of peers and the school environment in directing Alina's gender questioning is also very much in evidence. It provided a useful vehicle into which Alina poured all her confusion and distress, making her solitary struggle with her mental health a collective issue regarding her body, for which she had allies.

Automatic affirmation of Alina would, of course, have missed this complexity and compounded it further, diverting attention from the underlying intrapsychic issues. Declaring herself transgender highlighted the intense sibling rivalry ("I am jealous of my brother; it is better to be a boy"), and the perceived loss of her father when her brother was born ("You prefer your son to your daughter; I will become your son."). It also represented a de-identification with her emotionally volatile mother from whom father had distanced himself.

I hope that working through these issues will result in a resolution of Alina's gender dysphoria and demands to transition. There are already indicators that this is so. Alina talks much less about her transgender strivings in therapy and more about her distress around the family dynamics. She is less angry and petulant at home, has restored her relationship with her father, is more positively interactive with her brother, and is less combative with her mother.

Case Study: Emma

Case studies represent a composite of several patients. Identifying details have been fictionalized.

Case Background: Emma is a 13-year-old, high-functioning, gifted girl, currently identifying as a trans boy. Emma is very interested in social justice issues and was previously a compliant child with an enmeshed/over-involved mother. She has an older brother with a chronic medical condition.

Age, onset and symptom development/time course

Emma is a 13-year-old female who has identified as a transboy for 6 months. Parents, Jason and Debora, report a typical childhood and that she did not present with any concerns about gender before adolescence. They note that she has always been fairly anxious and has struggled socially at times. Emma remembers having been very gender non-conforming in childhood and emphasizes having played with some boys in school and choosing a male avatar in a video game.

At age 11, Emma began puberty before all of her friends, which she claimed made her feel self-conscious. At age 12, she had a falling out with her main friend group that resulted in additional distress. At this point, Emma found new friends by joining her school's GSA (Gender and Sexuality Alliance). Six weeks later, she came out as bisexual, then non-binary a few weeks later, then a month after that, she came out as trans at school. She did not reveal this to her parents. Debora discovered, by reading Emma's text messages, that her daughter was being addressed as "Elliott" by her peers.

Emma complains of gender dysphoria and states that she is uncomfortable in her female body, though parents note that on a recent family vacation she enthusiastically chose a two-piece bathing suit for the beach. She has been requesting testosterone and has stated that she wants to get top surgery in the future.

Appearance/Personality/Presentation

Emma presents as bright and confident but easily becomes defensive when challenged. She wears her blue hair in a trendy, short boy's style and dresses in oversized sweaters. She uses a wide variety of

LGBT inclusive language and is preoccupied with issues of identity. For example, before exploring gender identity, she fixated for a time on mental health diagnoses that she felt apply to her.

Who is she out to?

Emma's new identity is supported by the teachers at school and her peers in the GSA club. She is out to her parents, ever since Debora discovered her texts, told Jason, and confronted Emma. Extended family has not been informed about her identification.

Family / Parental dynamic (mother runs a design consulting business from home and father is a software developer)

Debora reports that she and Emma have always been very close and she is now worried about damaging the bond by responding “incorrectly” to her daughter's trans identity. Debora appears anxious and distressed and oscillates between capitulating to the daughter's demands and responding in a highly controlling manner. Debora indicates she recently sought psychiatric help for her own spike in anxious and depressive symptoms.

Jason is passive and less involved and is often critical of Debora for being overly anxious.

It is clear that Emma has disproportionate power in the family dynamic. Despite functioning well in school and peer relationships, Emma has warned her parents that if they don't support her identity, she will be at risk of suicide.

Older brother with a medical illness that requires significant time and emotional investment from the family.

Social Relationships

Since coming out as trans, Emma has enjoyed increased social success as a student leader at the GSA. Her new friends consult her with their own identity questions, and she sees herself as an activist. She has recently begun dating another FtM student and they describe themselves as a gay male couple, though she reports they are too dysphoric to engage in intimate physical contact.

Presenting Difficulties

There's been a deterioration in the family relationships with significant increased tension between

Emma and Debora and between the parental couple. Emma's withholding of her new identity from Debora has shifted the relational dynamic from one of compliance to contention and secrecy. Because the parents have not offered clarity around Emma's demands for medical transition, Emma continues to push boundaries and escalate her expressions of distress.

Academic

Emma is academically gifted and has always done well. Though her grades are still maintained at this point, Debora has expressed worry that Emma's preoccupation with identity will result in a commensurate decrease in motivation for schoolwork.

Medical

Emma does not present with any medical issues at this time. She feels distress about her period and cites this as a primary reason she would like to take testosterone. She has been requesting puberty blockers and has stated that she wants to get top surgery in the future.

Case Write-up

Introduction

The emergence of Emma's struggle with gender identity is presumed to have developed within a certain social, cultural, and familial context. Working with adolescents who are in the midst of a developmental process informs the expectations of a flexible, and sometimes unexpected, unfolding of identity. Therefore, I used an eclectic approach which draws from family systems, attachment, developmental, psychodynamic, and client-centered modalities.

The therapeutic work revolved around family dynamics, Emma's other interpersonal relationships, and her sense of self as an individual. At times, it can be challenging to determine when the work should remain exclusively on the gender struggle and when to broaden the focus to wider contexts. Additionally, when should a validating and empathic approach be used, and when should the therapist challenge the client? To help make these decisions, our individual work was guided by the following principles:

- * Relate to client as a whole person with many facets of identity and self-hood which are

constantly evolving

- * Nurture well-rounded behavioral repertoires and psychological flexibility to facilitate the client having more choices and options
- * Attempt to identify underlying needs which are expressing themselves through the gender conflict and strengthen the client's ability to meet those needs
- * Engage collaboratively while remaining curious about dynamics which may be out of the client's current perception, e.g., help to complexify client's understanding of life challenges
- * Foster curiosity and self-awareness to give client tools for future independent problem solving

Working with parents

In meetings with both parents, it became apparent that Debora felt overwhelmingly responsible for guiding her daughter through the experience of questioning her gender. One of our initial goals was to unburden her by allowing her to focus on parenting and let the therapist work with Emma on her gender exploration. Additionally, Debora was asked to refrain from continuously offering directives and suggestions about what should be discussed in therapy. The parents were connected with a support group to offer Debora a more appropriate channel for her hurts and frustration.

Jason described feeling similarly overwhelmed by the entire situation, but he felt nervous that the conflict between Debora and Emma would lead to permanent damage. His strategy, then, had been to stay out of it, for fear of fueling the flames of discord at home. It also became clear that Jason took on the role of a somewhat-indulgent parent, as he attempted to compensate for the intensity of emotion between Emma and her mother. He let Emma stay up past her bedtime, gave her extra time on her iPad, and would occasionally implore Emma, “don’t tell Mom.”

We reflected that Jason had ‘earned some points’ with Emma but, also, inadvertently undermined Debora’s authority. We worked to get both parents on the same page regarding expectations for Emma’s behavior. By slightly redistributing the roles of indulgent parent and rule enforcer, we shifted the dynamic in a more appropriate and balanced direction. Jason will continue sharing enjoyable one-on-one moments with Emma through their favorite TV shows and by signing them up for a local “Dads & Kids Robotics” class. Additionally, though, he would begin enforcing internet

time limits, bedtime routines, and other agreed-upon daily structure. Since academics and report cards often caused anxiety for Emma, Jason would use the leverage he had built with his indulgent parenting style to take over the quarterly report card checks.

Debora, on the other hand, was coached on how to set and uphold expectations with Emma around the use of names/pronouns and binders. Debora began to offer more clarity on the expectations around medical intervention but avoided power struggles and lengthy diatribes about such topics. She was also encouraged to avoid negotiating, debating, or groveling with her daughter. By using a loving, confident, authoritative stance and carefully following through on the expectations set, Debora developed a less chaotic way to hold her parental authority and reduce conflict with Emma.

To rebuild the bond with her daughter, Debora was asked to engage Emma in more low-pressure enjoyable activities that don't involve any "gender talk." Based on this suggestion, Debora began by picking Emma up from school every day, rather than having her ride the bus, and allowing Emma to put on her favorite music. They would talk about artists, songs, concerts, and these car rides became a daily highlight for both Debora and Emma.

Individual time for each parent to spend with Emma, in the absence of her brother, also became an important priority so that any attachment Emma might be attempting to meet through her trans identification could be met in other ways. On the other hand, Emma's developmentally appropriate need to separate from Mom was met by shifting Debora's stance—from one of control to one of positive connection—and asking Deborah to encourage more independence in Emma. Her relationship with her brother remained distant and strained, but they began to engage with each other more playfully as Emma's mood improved in her later teen years.

In addition to these practical steps, working with the parents allowed us to anticipate and accept a slow process of growth. Adolescence can be a very turbulent time which requires great resolve and patience on the part of parents. Cooperation, consistency, and better-delineated parenting roles assist in making the long process more tolerable for all family members.

Working with Parents - Summary

- * Rebalancing roles of disciplinarian/indulgent parent

- * Helping parents establish structure and clear expectations with child
- * Encouraging distant parent to engage more deeply, through both quality time with child and additional discipline-related responsibilities
- * Shifting the relationship with anxious/enmeshed parent and child from conflicted fixation on gender to a space with more ease through joyful and positive relationship-building activities
- * Assist parents in viewing gender exploration as a long process, rather than attempting to force rapid resolution

Working with Emma

Introductions and Naming Convention

Establishing non-inflammatory protocols around name/pronouns.

Since Emma's last name is Moore, I asked if I could follow my practice tradition and use an informal nickname. I asked if I could call her by the first letter of her last name "M." She said this was fine for her but found it a bit annoying because it "kinda sounds like Emma." As an alternative, I offered to call her "E" and she said that was better because her new name is "Elliott."

Since Emma began therapy at the age of 13, she was a long way from the legal age to medically transition. Due to the grand assertions Emma was making about which medical procedures she wanted, Debora initially pushed me to "educate Emma" about medical risks. I, however, felt it was unhelpful to start with this material for a few reasons. Firstly, at the age of 13, Emma was likely incapable of fully comprehending the social, medical, physical, and sexual ramifications of 'sex change' procedures. Secondly, she was in a highly defended position around the fantasy of transition. Attempting to discuss these fiercely held assertions of her independence could lead to a power struggle and conflict during the nascent stages of therapy.

Instead, we began by finding common ground and agreement on the importance and complexity that gender was currently playing in E's life and family relationships. I clarified roles and dynamics between E, myself, and her parents and what our work around gender might look like.

1st Session Dialogue, Age 13

Therapist: Thanks for helping us figure out how we'll be addressing each other. So, E, I've heard from your parents about their perspective and concerns around your gender exploration, but I'd like to hear your version of the story too.

E: Well, I'm trans and my parents don't really accept me. Last year, I was feeling really messed up and having some mental health issues. When I started to learn about LGBT stuff, I realized there was a lot I didn't know and, honestly, discovering that I'm trans has been the most important discovery of my life. I didn't tell my parents right away, because I wanted to try things out first and be sure. I was planning to come out to them right before my mom looked in my phone, so it's frustrating that they don't trust me now. Obviously, this has all been really hard and I'm kinda surprised about their reaction because my parents are supportive of other trans people, just not me.

Therapist: Wow, E, that sounds really difficult. I can see that you questioning your gender has probably had a huge impact on you and your parents. So, my role is to be YOUR therapist, not your parents' therapist. That means I'll do my best to understand your experience here, and also treat you like a whole person—you're not just a big walking gender identity right?

E: *(laughs)* Right.

Therapist: We are going to talk a lot about who Elliott is, and who Emma is, and try to understand how these two characters operate in your life, with friends, school, parents, all of that. Make sense?

E: Yeah, that makes sense, but I'm much more confident as Elliott!

Therapist: I look forward to hearing all about that as we get to know each other.

In therapy, there will be other times when my job will be to help you think about things a bit differently or offer you another perspective. Counseling can be challenging for that reason. But we can always talk through how you're feeling during our sessions and pace ourselves together.

Also, I will be checking in with your parents every few months. This gives me an opportunity to do a few things: I'll get to hear from them and get their perspective, I can give them some parenting and communication strategies when needed, and I can provide some general updates on what you and I are discussing. For

example, themes I might share with them include things like “we’re discussing social relationships,” or “E and I have been working on body image.” Do you feel comfortable with that kind of check in between me and your parents?

E: Yes, that’s fine. Because they think I’m completely closed minded, but I’m really not. I am just not ok with them trying to talk me out of being trans. I’m glad you will be helping my parents understand what I’m going through here.

Within the first months of therapy, I aimed to assess what role gender is playing in E’s life and what problems it may be attempting to solve. Ever since “becoming Elliott” at school, E found a new sense of authority and position of influence, especially within the GSA. When we discussed the differences between her social behavior as Emma and Elliott, she described that Emma had only been successful in the realm of adults. Being bright and academically ambitious, Emma was an “annoying dork who all the kids hated.” As Elliott, E would often adopt a jovial but ridiculing tone when recounting memories from the “Emma years,” as she came to call them.

Dialogue, Age 14

Therapist: Do you have any particularly embarrassing memories from before age 12 when you started questioning your gender?

E: How much time do we have? *(laughs)*

I was always just generally annoying. I always answered the teachers’ questions, got called on when other kids didn’t know the answers to stuff. I had a huge ego. I’m still smart and stuff, but much less annoying these days. I’ve learned to stop driving people nuts around me and I’ve figured out which friends actually appreciate my weirdness.

E: *(gets quiet for a moment)*

Therapist: Is there something particular on your mind that you remembered?

E: When I was 11, I was really good friends with Ashley and Jessica and a few other kids in that group. One day, Jessica was messaging with this older guy, and we all thought we needed to do an intervention. Ashley is Jessica’s best friend, but Ashley didn’t want to say anything or hurt her feelings, so she asked me to talk to Jessica instead. When I tried to, Jessica took screenshots of my messages and posted them

online saying that I was “starting drama.” I was seriously just worried about her, but everyone made fun of me for being the “annoying Mom” and Jessica even blocked me. Ashley DM’ed me to tell me she thought it was messed up, but, after that, they all just started distancing themselves from me.

Therapist: That sounds like a really tough situation. What do you make of this now that you’re a bit older?

E: What they did was not cool, they could have talked to me about it. But also, I shouldn’t have stuck my nose in her business. Now, I’ve learned to give advice only when asked! Look, I don’t agree with talking to random older dudes online, but if I were Jessica I would have been annoyed by me, too.

Therapist: If you can think back, and really try to put yourself in the same place as you were when you messaged Jessica, can you remember what was motivating you then?

E: Well, I was kinda worried about her. I mean, she didn’t know this guy, and I heard she was sending him lots of selfies and stuff. I just felt like it could go bad. I guess I was looking out for her.

Therapist: It sounds like you were coming from a really good place. But you’re pretty hard on your younger self. Others were pretty hard on you, too.

E: Yeah, I guess so. It was really bad to sit alone for lunch after all that happened. I ended up going to my teacher’s classroom and eating with them because I didn’t want to be in the cafeteria. I don’t really like to think about that year.

Throughout our work together, E and I worked on processing the painful experiences that seemed to directly precede her split into the Elliott persona. We also worked to bridge the gap between her split off feelings and split off sense of identity. Creating better continuity between Emma’s younger self and the current persona she’s curated helped soften the resistance she held towards integrating her past experiences into her sense of self in the present.

In addition to building more compassion and empathy for her younger self, our work also explored the value and lessons she’d learned through the Elliott presentation. Elliott was a sought-after expert within the LGB group and spoke with confidence about matters that interested other group members. What does Elliott have to teach Emma? How can E incorporate good qualities that serve

her, independent of masculine presentation, gender identity, or the gender-perceptions of others?

Dialogue, Age 14

Therapist: In the GSA it sounds like you've really found a way to shine. What are you like as a leader in that club?

E: I love helping people and learning about gender. I was really uneducated about gender when I was younger so I'm still learning, but I like that people can come to the club and ask questions or come to support others. I actually get to be myself there, so that feels really great.

Therapist: What do you mean by that? It seems like you might be talking about something beyond just name/pronouns? Am I right about that?

E: Yeah, now I actually get to be more outgoing, talkative, confident. When I was younger, everyone thought of me as this perfect "good kid" who was always the teacher's pet. But now, I'm much more open with my friends. We joke around about stuff and my sense of humor is way more "inappropriate" than what my parents probably think.

Therapist: Aha, so would your parents disapprove of how you joke around in the meetings?

E: Oh ya! My mom doesn't allow me to curse at home.

Therapist: Are there other ways you have to self-monitor when you're with your mom or dad? Are there things you're not allowed to do that you want to do?

E: Yeah, I've been wanting to go back to summer camp, but my mom basically won't let me go anywhere because of the gender thing. It was so fun when I used to go, and all my old summer friends are still attending every year. I thought I'd be going back but after I came out, she said no because she doesn't want them "pretending I'm a boy."

Therapist: Was there a conversation about it?

E: No, I don't want to bother asking again because she's just going to say no.

Therapist: So, let me run this by you, and you tell me what you think, ok?

E: Sure.

Therapist: So, at school, at the GSA, you're this confident, leader kind of kid who answers questions and says what you really think. But, at home, when you really want something you kinda back down after one "no" from your mom?

E: Yeah, it feels like she never listens to me. Whenever we try to talk about stuff she gets stressed out and upset. Then I just get really quiet.

Therapist: It seems like there are some really good qualities that you have at the GSA that you could probably use at home. Even though gender is an issue between you and your Mom, it still sounds like having a bit more confidence and being able to speak assertively about what you'd like to discuss would be helpful. Do you think that's something we can work on together in therapy?

E: Yeah, I think that would be good for me. I don't know if Mom will listen to me though.

Therapist: You may not successfully change your mom's mind about camp, but at least being honest about your opinion is a good start. In general, it's important to be able to speak up for yourself and also listen to others in a discussion. I think that would probably make you feel much more confident if you could communicate that way.

E: Yeah, that's definitely something I want to work on.

Reality testing E's beliefs about transition played a minor yet impactful role in therapy. In the following exchange E's idealistic beliefs about medical intervention and transition were challenged and revealed an intense fantasy about the simplicity and ease of sex reassignment.

Dialogue, Age 15

E: I had a really bad day yesterday. Some kids in math class misgendered me. I heard them talking about me and they used she/her pronouns.

Therapist: Hmm. So that bothered you for the rest of the day?

E: I was annoyed and angry until the end of the day. At the GSA club meeting I got

to vent about it and everyone there validated me, so I felt better.

Therapist: What happened in the club meeting to help you feel ok?

E: Well, everyone there uses my pronouns, first of all. I mean, it's basic respect. But also, I started thinking about transitioning and how this stuff won't happen anymore once I pass.

Therapist: So, you imagine that transition will make some of this go away?

E: Yeah, I mean, I don't want to be trans, I just want to be a guy. And when I transition everyone will see me as a guy, finally.

Therapist: I can understand why that would be a very powerful fantasy—to be able to leave your old self behind. But I think it's important to understand what medicine can and can't do.

E: Well, I've done a lot of research; I know about the unwanted side effects like acne and baldness. But I'm fine with that, as long as I am a guy.

Therapist: I understand how badly you want that right now. But I would be dishonest if I didn't tell you the truth about transition. It can't turn you into a literal male person. Transition can only change some things about your body, but it won't make you male.

E: *(Gets quiet, stiffens up and looks upset. Long silence.)* This is the same kind of bullshit my mom tells me.

After this moment in therapy, I tried to engage E, but she remained withdrawn for the remainder of the session. In the next meeting, we discussed the feelings of apprehension we both had about coming to session today. We processed the impact the last conversation had on our therapeutic relationship. E explained that she felt disbelieved and that's how she felt trying to talk to Mom about gender. I thanked her for being vulnerable and honest and acknowledged the projection about her mom. I explained that I do believe E's feelings are real and important and never meant to express otherwise. Yet, I gently pressed that confronting the reality of what's physically possible is an important part of the work we are there to do together—for her sake, not for me, and not for her mother.

We also discussed the context in which gender had become most salient by examining her peer and familial relationships. It became clear that E's presentation of the transgender identity was most important among peers. E described feeling like her "true self" at school but also admitted that "Elliott" required a great deal of curation and exaggeration. At the GSA, her identity as a trans boy was unquestioned, but with other students in academic classes, she felt the need to enhance her caricature of masculinity to be "seen as valid." Increases in anxiety seemed to spike for E on Sunday evenings in anticipation of "presenting male" at school.

The contradiction between her reports of being happier as "Elliott" and the reality of her observable anxiety about this, became very apparent around March 2020 when the COVID pandemic caused the school to move to an online learning format. In the first weeks of this transition, E's anxiety levels significantly reduced. She described that keeping her video off during class zoom calls was "just a lot easier" and using the text messaging function meant she didn't have to "feel dysphoric" about her voice.

With the family relegated to working and learning from home, an opportunity was created for spending more time together. Cooking meals as a family, going for walks outdoors, and increasing each parent's individual quality time with E contributed to their improved relationships, as did the changes implemented in Debora and Jason's parenting strategies. With summer camp now canceled this year, Debora had time to consider allowing E to attend summer camp the following year as a means of providing healthy opportunities to separate and gain independence.

At this stage, after therapeutic rapport had been firmly established and with clear expectations long-set by parents, E was able to "settle into" the rules around medical intervention. Knowing where the limits were reduced her feelings of urgency for transition and to "convince" her parents that this wasn't just a phase. With that pressure alleviated, E was able to develop a more genuine curiosity about gender-related issues, identity, and even about her parents' rules.

Dialogue, Age 16

Therapist: I know you and your parents have gone through lots of ups and downs on the gender issue. At this point, they've shared with you that medical intervention is not on the table and some of their reasons why. Could you tell me if there's anything about your parent's perspective that you agree on? And what feels hard to be on the same page about?

E: I get that my parents are worried about the health risks and what if I change my mind. I've seen some detransitioners, or whatever, and I get it—that sucks. To be honest, I know when I first came out, I was really obsessed with transition. I'm not really focused on that now, so I guess in that way we're on the same page. But, I just hate that they don't believe me, because I do feel trans. They think that if they affirm my gender, it will make it harder to change my mind if I don't feel trans later. I just don't agree, because I am going to do what's best for me even if that means I'll have to detransition one day.

Therapist: I see. So, you're talking about how things may or may not change over time, in the long run.

E: Right.

Therapist: Well, even though it's only been a few years, have you noticed any shifts in your experience around gender? Like, for example, has there been an evolution? I remember you told me, at first, you were “trying too hard” to be extra masculine and now you're just being yourself more. Am I remembering that correctly?

E: Oh yeah, definitely. I was always looking up stuff about passing and how to look more male. Now, I've just gotten more comfortable with being trans in my own way, not so much copying what other trans guys do. I used to not allow myself to like certain things because I thought they were too feminine, but that's stupid—I was young! I'm probably kind of non-binary to be honest, but labels are just not as important to me now as they used to be.

Another theme that emerged in therapy was E's fantasy of being cared for after “top surgery.” This became an important exploration as we discussed her relationship with her brother and her experience of his medical problems. During E's first menstrual period, her brother was having a particularly difficult time. Her parents, trusting that she'd always been such a smart and responsible kid, assumed she would be fine through puberty. Debora felt awkward about having a sex talk with her daughter. She gave E a book about periods and puberty and occasionally asked her how she was feeling and if she wanted to talk about “anything.” E, however, was embarrassed and avoided any discussion of her menstrual cycle. At the same time, her brother was hospitalized regularly and Debora was visibly panicked about his illness. E became somewhat parentified as she reassured Debora and offered her emotional support. During Debora's moments of despair, Jason would occasionally ask E to go look after her mother and often thanked E for being so reliable.

In remembering these moments, E was asked in therapy to put the “responsible” part of her aside and process other feelings that weren’t well tended to at the time. This is when a fantasy of being taken care of began to form in E. She felt a mixture of longing for nurturance and guilt for being so selfish, knowing that her ill brother was truly suffering. She’d discovered YouTube videos in which transgender teens come out to their parents. In interviews with mothers and transgender sons, a desire to ‘support’ and stand by their children was a running theme. In one video, that E had watched many times, a mother had filmed the caretaking process of helping her child after top surgery—she helped look after the drains and change bandages. She reported that taking care of her “son” brought them closer together. Her parents had struggled to meet their daughter’s needs during a chaotic and scary time within the family. Additionally, E’s inability to recognize, legitimate, and articulate her desire for closeness might have contributed to her subconsciously seeking nurturance in other ways.

Working with Emma, Summary:

- * Remaining adaptable with the arc of an adolescent identity
- * Establishing rapport and avoiding tension around gender in initial stages
- * Understanding the client’s perspective with relation to family conflict
- * Exploring client’s evolving sense of identity and bringing awareness to this fluidity
- * Listening for client’s perception of contradiction or paradox in current worldview
- * Helping client articulate internal conflicts arising from personal, social, and relational experiences related to identity
- * Encouraging assertiveness and giving voice to client’s unspoken desires and concerns
- * Bringing awareness to the unmet needs the client may be attempting to meet through identity
- * Assisting the client in reality-testing certain rigid or maladaptive beliefs about self and others
- * Validating client’s experience of family conflict and encouraging perspective-taking and reflection

Developments and Outcomes

Over the 4 years of work together, the intensity and frequency of E's demands around transition lessened and softened. She was encouraged to pursue interesting and challenging life experiences, and she developed and matured over time. This reduction in E's fixation was also aided by the improvement in the family dynamic. Clear expectations were established in her early teen years, and Debora and Jason developed a better distribution of parenting roles. When her parents were able to properly attend to both her attachment and individuation needs, their relationships greatly improved. Psychological explorations in individual therapy helped E to recognize and attend to her core emotional needs and to practice some critical thinking around gender. At this stage in therapy, E seems to have steered towards a more androgynous/feminine presentation and her fixation with labels has decreased significantly. She started using the nickname "Ell," short for Elliott, with friends and as her screen name for school. She applied to university using her birth name and requested Ell as her preferred name. She selected "prefer not to say" for gender, explaining to her therapist that she's still figuring it out, but it's not the most important thing about her.

Case Study: Stephen/Amy

Case studies represent a composite of several patients. Identifying details have been fictionalized.

Case Background: Stephen is a 20-year-old “techy autistic” male who returned from freshman year as a “trans woman.” He doesn’t currently present as a woman and is waiting for medical transition to reveal his womanhood.

Age, onset, and symptom development/time course

Stephen, a 20-year-old male who has identified as a transwoman for 6 months, is a gamer, an introvert, and fully absorbed in his online life. His parents report that Stephen shows some autistic traits and has an anxious disposition.

Last year, Stephen found life very difficult when he left home to attend 3rd level college 100 miles from home. The college course didn’t suit him, and he didn’t make any friends at college, and he arrived home three months later feeling very distressed and isolated. During his schooldays, Stephen had relied upon a small group of boys who were also absorbed in online gaming. These old school friends were thriving in their new lives at college and Stephen felt disengaged and envious of them. Stephen immersed himself in online gaming during the winter break.

Stephen was reluctant to return to college but he eventually did; however, he began to miss his lectures, preferring to remain on his computer online in his room. He came back home at springtime and told his parents that he was really a woman, that he needed to medically transition as soon as possible, and that he wouldn’t return to college until he had transitioned.

Appearance/Personality/Presentation

Stephen presents as shy and awkward; he is uncommunicative and avoids eye contact. Stephen wears baggy, nondescript male clothes and doesn’t show any signs of stereotypically feminine presentation.

Stephen is intensely private about his desire to transition and has only told his parents. He resists any offers from his parents to dress in a feminine manner or to buy any feminine clothes as he believes

this would be “inauthentic.” Stephen instead prefers to wait until he can medically transition and “do it properly.”

Where is the young person “out”?

Stephen is not “out” anywhere in real life, but he identifies as a woman online. He has a feminine name and a feminine picture for his social media profiles, and has a feminine avatar for his video gaming. Stephen says he doesn’t dress as a woman, despite being encouraged to by his parents.

Compulsive behavior

Stephen is distressed about his body hair and spends a lot of time in the bathroom removing his body hair. Stephen appears to be phobic about his body hair and is very conscious of his leg and arm hair which he spends hours shaving, plucking, and examining assiduously every single day.

Family /Parental dynamic (mother is a teacher and father is an engineer)

Stephen is very connected with his mother, Alison, and depends on her to communicate his more complicated feelings. Alison has an anxious disposition and is prone to catastrophic thoughts. Emotions are fraught between Stephen and Alison, at the moment, and every communication appears to be at fever pitch.

Tom, Stephen’s dad, is very different to Alison and is disengaged. Tom is passive, he doesn’t believe that Stephen will transition and relies upon Alison to “make the boy see sense.”

Both parents appear intimidated at Stephen’s professed intelligence and believe that his intelligence is at the root of all the issues—they believe Stephen is “too clever for this world.”

Stephen’s little sister, Ciara, appears to be functioning well, without any major concerns, and little of the family’s energies are centered upon Ciara.

Social Relationships

Stephen has made no effort to come out as trans and instead prefers to stay at home in his room. He reports that he has a rich and varied online life and that this is perfectly adequate. He is politically active on social media and enjoys engaging in complicated online discussions with the LGBTQ+ community. He also often has arguments with “TERFs and transphobes.”

Stephen reports that he is a lesbian although he has never had a girlfriend and he has never had physical intimacy with anyone. He watches anime porn and shows signs of porn-induced fetish.

Presenting Difficulties

Communication with the family is very low. Stephen prefers to remain in his room or in the bathroom. He eats late at night when everyone has gone to bed, however his parents insist that he presents at dinner time every evening.

Stephen has recently become highly politicized on Reddit and other online forums and is prone to making what his parents consider to be outrageous statements at the dinner table. This causes rows and combative arguments between Stephen and his dad.

Until recently, Stephen has always had a good, albeit enmeshed, relationship with his mother, but it has recently become tense and antagonistic.

There is very little positive communication between Stephen and his father or his sister. Stephen's sister, for example, has been told by her parents that Stephen wishes to transition, but there has never been any discussion between Stephen and his sister about this.

Stephen has reported suicidal ideation and has stated that he will die by suicide if he doesn't transition.

Academic

Stephen has dropped out of college and says he will resume when he has medically transitioned. He believes that transitioning will provide him with a personal transformation and that he will be able to live a different life once he has transitioned.

Stephen has always been academically gifted; however, Stephen did not like his college courses and his grades suffered when he went to university. He has not contacted the college about this; instead, his mother has endeavored to retain some links with the college.

Stephen's mother and father had great hopes for Stephen's academic career and are intensely disappointed by this turn of events. Most of the family conversation is centered upon how Stephen should return to college, whereas Stephen brings the subject back to LGBTQ+ issues.

Medical

Stephen's mother wishes to have Stephen assessed for autism; however, Stephen is resistant as he believes that this is pointless.

Stephen takes anti-anxiety medication, and he reports this calms his mind somewhat.

Stephen will not discuss his issues with his body hair as he believes it is directly related to his gender dysphoria. He has not been diagnosed with gender dysphoria and is keen to obtain this diagnosis; but his parents do not support this, leaving the family at an impasse.

Case Write-up

Working with parents

- * Building awareness of family dynamics
- * Rebalancing parental roles
- * Establishing boundaries
- * Identifying expectations

Although Stephen is an adult, he intends to live in the family home for the foreseeable future. The parent-child dynamic is such that Stephen welcomed his parents' participation in the therapeutic process. We agreed to have family meetings every six weeks.

Alison's intense involvement in Stephen's life became apparent and the question of appropriate boundaries became the subject of protracted discussion. Alison was supplied with information about a support group that she could attend to help her process the changes that were happening to the family dynamic.

Tom raised his lack of engagement with Stephen's issues and how Tom felt alienated by the very concept of medical transition, a subject that he had heretofore never engaged with. Although Tom was aware that Alison had studied vast amounts of information about gender-related distress, Tom did not feel able to become knowledgeable in this field. Tom's information was patchy and sometimes incorrect, mostly garnered from passing comments that Alison had made. Alison

expressed frustration that she felt she was shouldering the emotional burden, while Tom described how he felt overwhelmed by the prospect of Stephen's future.

It emerged that both parents felt fear and foreboding about Stephen's future. They perceived Stephen as "extremely immature," "innocent," and "incapable." They didn't believe that Stephen would be capable of leading life as a fully-functioning adult and had both long harbored the hope that Stephen would marry a person who would "look after him."

The concept of "learned helplessness" was raised along with the benefits of establishing and communicating appropriate expectations within family dynamics. Stephen's late night gaming was raised as a source of contention within the household, and the parents expressed their frustration at Stephen's unhealthy lifestyle.

A program of psychoeducation was carried out so that the parents became knowledgeable about the need to establish appropriate rules within the household. The parents were supplied with certain material to discuss together so that the disparity of knowledge between the two could be reduced. The concept of identity formation was discussed within the psychoeducation element of the family meetings, and this provided Tom and Alison with a deeper understanding of Stephen's challenges in terms of adolescent development and sexual maturation.

Discussion about the value of healthy online behavior, and circadian rhythms that support connection within the household, enabled Stephen, Tom, and Alison to establish agreed-upon boundaries and appropriate expectations. Following some discussion, Stephen agreed to contribute more to the family home, to carry out the weekly shopping, and to accept the need for certain rules regarding late-night gaming and late-night eating.

Alison came to realize that she was overly involved in Stephen's life and needed to reintegrate into her own life. Alison continued to attend the online support group, started a course of personal counseling, and re-established some old friendships.

Tom became aware that his lack of involvement was a source of distress for both Stephen and Alison and attempted to become more engaged in the issues. The issue of Ciara, Stephen's sister, was raised and, following some analysis of the communication gaps within the family, Tom decided to bring Stephen and Ciara camping again. This was an old family tradition that had fallen away

in recent years, and it took some encouragement from the parents to convince Stephen and Ciara to go camping; however, this became a pleasant sporadic diversion for the family.

Working with Stephen

Establishing the therapeutic relationship

From our first introductory meeting, I attempted to establish a therapeutic alliance, as initial meetings are often supremely important for the therapeutic process. Stephen was visibly nervous when he arrived into my office, and I strove to put him at ease so that he would feel the benefit of a safe therapeutic space.

1st session dialogue, Age 20:

Therapist: Thanks for coming in. I've had some emails from your parents, but I'd rather you filled me in on everything you wish me to know—about your gender exploration and about everything else that is going on too.

Stephen: The main issue that my parents have is that they can't accept my real self. They don't want to accept that I'm a girl. To be honest, it's not me that has a problem but them. They've always been very kind to me before this but they just don't understand the trans thing.

Therapist: I hear you, this must be very difficult for you, and I'd like to take this opportunity to emphasize that I'm your therapist and my professional focus is on you, not your parents. All I know about you is that you are 20 years old, that you attend UCD, and that you came out as a transwoman six months ago. Could you tell me a little about your life before you came out as a transwoman?

Stephen: Sure. Well, I've always been a quiet person. I'm a gamer and spend most of my time online. I've a sister, Ciara, who's younger than me. I'm studying electronic engineering at college, but I dropped out so as to give some time to my transition, and I plan to re-engage when I'm fully transitioned.

Therapist: Fair enough. Have you met many transwomen in real life?

Stephen: I've met hundreds online, and I feel like I really belong in this community; but, no, I haven't met a transwoman in real life. I don't think that matters though.

Therapist: How was the college experience for you?

Stephen: It hasn't gone very well. First of all, I enrolled in Computer Science but I didn't like it, and so I changed to Electronic Engineering, but I'm not mad about this, either. I think when I'm transitioned I'll make an appointment and consider my options.

Therapist: If it's ok with you, we will explore a lot about who you plan to be when you transition, and who you are now, and what is the difference, what is the gap, between the two. Let me check in with you, how does that feel for you?

Stephen: Fine with me.

Therapist: It's my job to consider the whole person, all the influencing factors, the inner motivations, the conscious and the unconscious, and to support you as we explore your inner psyche. Sometimes I will go wrong and sometimes I'll get it right, and I'm keen that you feel comfortable enough to challenge me when you disagree. On the other hand, counseling can be challenging in itself, and so you might sometimes find that you're exhausted by this process. We can go as slow as you wish, we don't have to hurry this process along; what matters most is that you fully explore your deepest reaches before you take the step to medically transition.

Stephen: I can't wait to transition. It'll be the best moment of my life.

Therapist: Why?

Stephen: Because I'll be the person I was truly meant to be; I'll be free to be myself.

Therapist: Could you elaborate on that a bit? Make it more personal so I can fully understand you?

Stephen: I suppose it means that when I'm truly myself—when I'm a woman—I'll feel much better in myself. I won't feel this perennial discomfort. I'll be happy.

Therapist: A central part of the ethos of counseling is to keep my eyes open to everything that is going on between us, to remain open minded enough to acquire a deeper understanding of you, and to try to identify the patterns of behavior in your life. Could you help me acquire a better understanding of what sort of freedom you will have when you transition?

Stephen: Sure, I can. I'll be free to wear dresses and make-up and to just walk

around as a woman. I think I'll be much more comfortable in my own skin then.

Therapist: That's really interesting. I look forward to hearing all about that as we get to know each other. By the way, I'm aware that you live with your parents and they are against your transition, and they are also paying the bills for therapy. This is a common scenario for me, and so it doesn't raise much difficulty for me, but I would like to be as transparent as possible so that you can ask any questions or raise objections along the way. Your parents have requested that I check in with them every so often. How does that impact you?

Stephen: I'm very close to my parents—well, I'm especially close to my mother and that's fine with me. I'd like you to make them see sense.

Therapist: Well, it'll be more along the lines of explaining to your parents that “we're exploring Stephen's identity,” or “we are pondering the impact of college,” or even “we're discussing Stephen's social life.” I don't aim to be a go-between in your relationship with your parents—I'm more focused on forming a therapeutic alliance with you, and this will be my primary focus. Is that OK?

Stephen: Yes, that's perfect with me.

The initial stage of therapy with Stephen was focused on establishing a positive therapeutic relationship. I sought to understand what medical transition represented for Stephen and any inner conflicts that could be driving this wish to become another person. Stephen was keen to begin medical transition as soon as possible; it was my role, however, not to allow the eagerness to medically transition have an undue influence on the therapeutic process. Over time, it turned out that Stephen's wish to transition was influenced by an intense self-loathing and alienation from himself. Stephen had been engaging in compulsive behavior for some years, and the latest manifestation of this was spending many hours every day removing his body hair. He seemed to be under significant emotional distress yet unable to verbalize this distress. Stephen also seemed very isolated and lonely, and we started to work upon renewing old friendships and even starting new friendships. This was a slow and reflective process.

Obstacles to progress

Since Stephen was over 18, he was free to begin hormone therapy whenever he wished. Stephen is an obedient and compliant young person and was keen to obtain his parents' blessing to

begin medical transition. The sense of urgency from Alison and Tom to prevent Stephen from transitioning was palpable and needed some acknowledgment within our meetings so that we could maintain a congruent and authentic relationship. Before I met Stephen, it had been already agreed upon between Stephen and his parents that he would wait until therapy was “over” before he started to medically transition. This put an inappropriate tension upon the therapy, and it could have influenced Stephen to seek a premature ending to the therapeutic process. I suggested that perhaps we would liberate ourselves from this arbitrary rule and, instead, free Stephen to transition whenever he wished. Stephen’s parents were unhappy with this, and I needed to maintain strong boundaries in this context. On the other hand, a direct result of this was that Stephen and I established a firmer therapeutic bond, as he trusted that I had his best interests at heart.

Stephen often communicated grandiose stories about his future life that generally presumed great success, yet he was finding it difficult to return to university and chose to take another year off. This was a long and difficult year for Stephen, as he felt lost and alone. His anti-anxiety medication was increased, and the therapeutic process went through some peaks and troughs during this time. As the months went by, we spent some time analyzing Stephen’s intelligence and his academic prowess. Stephen was noted to be very clever at an early age, and he enjoyed being known as a “brainiac.” Even though he was bullied throughout his school years, Stephen remained proud that his school peers regarded him as a genius, and he had constructed his self-identity around this.

Dialogue, Age 21

Therapist: Could you tell me about your schooldays?

Stephen: I didn’t enjoy school. No one liked me; and it was embarrassing for me when I was a kid, because everyone called me gay.

Therapist: I wonder why the boys decided that you were gay. It’s amazing the crazy ideas a mob can latch on to sometimes.

Stephen: Yes, I know. I suppose I was quite a bit different. I was into computers when they were into football. And my parents weren’t part of things like the way other families are. We’re considered a bit of a weird family. They used to call us “the Farrelly Freaks.”

Therapist: That sounds really cruel and distressing. Could you tell me a bit about

that?

Stephen: I was bullied from the age of about 8 until I left school at 18. They all hated me. They used to write messages for me online and then pile-on when I answered. They created memes of me and my mother having sex. They called me a pervert. They all hated me.

Therapist: Woah. This must have had a huge impact on you. This sounds like a cruel and sustained campaign. Did you have any support?

Stephen: (*reflective*) I kept it a secret from everyone. It would have only upset my mother and whatever they could have done would have made it worse. It was horrible at the time, but I'm over it now.

Stephen showed flat affect when he related some harrowing experiences. He seemed disconnected from his inner self and often presented as almost unreachable. We worked together, to slowly create some self-awareness and self-compassion in Stephen's sensibilities. We also explored Stephen's complicated relationship with his mother, and it emerged that he wished to individuate from his parents but didn't quite feel able. Stephen's hostility towards his parents emerged when we further explored the bullying he experienced. He believed that his parents created the reputation of "being weird," and they didn't understand how difficult it was to go to school with the wrong school bag, the wrong haircut, and the wrong lunch box. He was angry that they didn't realize how terrible the bullying was for him, and he was angry that they didn't protect him. Through some family meetings, Stephen recounted the bullying he had suffered, and the grief and anger of his parents about the bullying was palpable. It turned out that Stephen's mother had also been bullied when she was a child, and they connected about this. This was a pivotal point in the therapeutic process, and after these discussions, Stephen became more protective of his mother, more empathetic toward his family, and more helpful and cooperative within the household.

Stephen recalled how when he first attended university, he experienced the burden of early promise, and he felt derailed when he couldn't keep up with his course work or found the texts impenetrable. When Stephen changed his course from Computer Science to Electronic Engineering he felt somewhat of a failure but was ready to put it all behind him and buckle down. However, he had missed the first term of his Electronic Engineering course, and he felt destabilized by his lack of competency, as he struggled to keep up with the work. Stephen had a long-held pattern of

internalizing his problems, so he didn't think to communicate his academic challenges to his loving and supportive parents. Stephen had already had a dysfunctional habit of an expansive online life that consisted of gaming, social media, and anime porn; so when he felt distressed, uncertain, and confused, he automatically turned to his online world. Stephen described how he stopped attending college and instead turned to the laptop in his bedroom at his student lodgings. In this context however, Stephen was experiencing a crisis of identity and, having lost his identity as a "brainiac," he was susceptible to a fantasy of rebirth.

We addressed Stephen's compulsive behavior about his body hair, and, together, we explored other periods in Stephen's life that demonstrated obsessive and compulsive behavior. We delved into Stephen's online gaming lifestyle, and it emerged that he was also obsessive about his gaming. As he agreed that excessive gaming and excessive focus on his body hair was creating further distress, we endeavored to seek outside pursuits, and Stephen agreed to go camping with his father from time to time. He also agreed to help with the weekly shopping and go for a walk with his mother from time to time. These were small changes, and yet, they were important as Stephen's life had become increasingly narrow.

As we continued to work together, we delved further into Stephen's complex sexuality. His connection with sex was devoid of humanity or emotionality, and, instead, he described a dehumanized, atomized approach to sex that centered on cartoon figures and anime porn. I raised the concept of autogynephilia but Stephen showed little interest in exploring this subject. Indeed, Stephen appeared very uncomfortable, almost squeamish, about his sexuality and preferred to keep this aspect of his life private.

Dialogue, Age 21:

Therapist: Could you tell me your earliest sexual memory?

Stephen: I remember trying on my mother's clothes when I was younger. I remember the boys in my class sent me porn on my phone when I was about 11.

Therapist: Do you mind if I ask where you go mentally when you masturbate?

Stephen: Well, I quite like anime porn so, I suppose, that's my favorite.

Therapist: Are you taking the time to explore your sexual orientation?

Stephen: I think I'm a lesbian. I'm not fully sure yet. When I transition I'm sure it will become clearer.

As we moved through the therapeutic process, we began to address the impoverished relationships in Stephen's life and how he was struggling to connect with others. We explored the merits of seeking a diagnosis of ASD, and we also gave a great deal of focus on the links between anxiety and autism. Stephen believed he was "on the spectrum" but did not see value in obtaining a diagnosis. Nonetheless, Stephen was very interested in the links between ASD and anxiety and from these conversations decided to make an appointment with his GP. Stephen was already taking an anti-anxiety medication, and his doctor decided to further increase the dosage and also seek an ASD evaluation for Stephen. This was a pivotal moment for Stephen as the increased dosage seemed to energize Stephen and, ultimately, lead him to taking the first steps with medical transitioning. Soon afterwards he attended a gender clinic and was prescribed cross-sex hormones. Stephen seemed initially pleased with this; however, he also reported "crying often," and "feeling very emotional and highly distressed."

Naming Conventions

The issue of names can become an obstacle to therapy and so it is the role of the therapist to manage this process with flexibility, compassion, and understanding.

At this point in the therapeutic process, Stephen requested that I use the name "Amy" and female pronouns within the family meetings. This led to extensive discussion about the tradition of parents' naming their children. We discussed the concepts of human rights and how with rights comes responsibilities. We explored Stephen's right to use another name, and we discussed Alison and Tom's right to use the name they had chosen for him as a baby. I communicated that I would be open to using Amy. I also pointed out that he was my client so I would follow his direction and use whatever pronouns he wished. I also stated that the emotions surrounding names were very heightened within the family unit and so, if at all possible, I wouldn't be adding to this intensity and would endeavor to use language that deescalated any tension during family meetings. Further, I suggested that mistakes might be made and requested an allowance that this is a complex process

that required compassion and understanding from everyone. This was a challenging issue for the family, however; thankfully, their bond was robust and relationships remained loving and engaged.

New identity, same life

Amy³ started cross-sex hormones at this point in the process and started to use the name Amy and she/her pronouns. She began to present in a more stereotypically feminine manner and spoke with a different voice. We discussed the implications of these differences—although on the surface they seemed to be because she was a woman, on further examination, it turned out that it was because she reveled in femininity. She loved silk clothes and flamboyant colors. She loved the feeling of silk on her skin, and she loved the creativity involved in wearing women's clothes.

Although Amy was initially euphoric, the many complex challenges she faced remained close to the surface. Amy seemed to become morose as the months passed by despite claiming that she was happier. There emerged a contradiction between Amy's declared happiness and her reports of crying and reports of increased suicidal ideation; so we needed to further explore Amy's psyche. It turned out that Amy was disappointed in the medical transitioning process. Even though she was transitioning, and even though she now had breasts, she still remained the same person. She wasn't the social butterfly that she hoped to be; she didn't have hordes of people seeking her company, and, perhaps more importantly, she still felt like the same person inside. As we continued to meet, Amy became more reflective and almost angry about the terrible experiences she had suffered when she was a lonely young boy.

Key moments in the therapeutic process

Once Amy started to medically transition, the tone of the therapy changed. Initially euphoric, she ultimately became more reflective and philosophical about what it is to be a woman. Amy became more candid about her sexuality and more interested to learn about autogynephilia. I had raised this issue earlier in the therapeutic process but Amy had not been interested in it then. Amy began to integrate her apparent autogynephilia into her persona and gained a deeper understanding of herself in the process.

The results of the ASD evaluation showed that Amy was on the spectrum and certain supports were put in place to help Amy return to university. We spent a considerable amount of time reflecting

3 Stephen is called Amy from this point in the process

on the impact of ASD, the links with anxiety and obsessive compulsive behavior, and, also, the connection between ASD and trans identification. Amy initially believed that her being on the spectrum meant that she was more likely to be “really trans;” however, on further reflection and with some psychoeducation about ASD, Amy came to realize that her autism led her to literal thinking and to certain gender non-conforming behavior that could easily be associated with trans. When she eventually made the decision to return to university, Amy’s general mood improved. She decided to stop therapy when she started back in university and showed an eagerness to develop other aspects of her life. We left the door open for Amy to return to therapy should she ever feel the need.

Dialogue, Age 22

Therapist: We have been through a lot over the last few years and you believe it is time to end our process together. I wonder what obstacles do you foresee in the future?

Amy: I think I need to be careful about gaming and spending too much time online. However, I’m satisfied that we have done enough. I’ve a lot more going on now and so I haven’t time to be analyzing myself all the time. Since I started back in college, I’m so busy. I kind of wonder was that the problem all along—did I have too much time on my own, in my bedroom? I’m happier now that I’m a woman though.

Developments and Outcomes

Working with Amy was an enlightening process as the many layers of medical transition were examined. The initial euphoria of transition gave way to a multilayered disappointment with the complications related to the process. Amy’s life didn’t transform when she transitioned—and she needed increased therapeutic support as a result. Nonetheless, reflective therapeutic support provided Amy with ample time and space to more fully integrate the complexities of her personality that had hitherto been fragmented.

The added tension of devastated parents who wished to stop Amy making the decision to medically transition was difficult to navigate and required boundaries of steel throughout the process. In addition, the enmeshment between Amy and her mother, and Amy’s unconscious hostility towards her parents led to further challenges. The parents’ noble and natural desire to protect Amy from the difficulties of the world as she was “too innocent” also created more problems than they resolved. The parents’ decision to seek therapeutic support enabled

them to come to terms with Amy's medical transition and family relations are significantly improved.

Amy is now currently expanding her sense of herself and seems to have come to a place of self-acceptance. She has moved out of the family home and is currently attending college and enjoying her course—which is in filmmaking. Amy has improved her social life and now has some friendships. Certain medical changes have taken place and she is comfortable living as a transwoman.

As Carl Jung tells us, *“But the right way to wholeness is made up, unfortunately, of fateful detours and wrong turnings. It is the longissima via [longest path], not straight but snakelike, a path that unites the opposites in the manner of the guiding caduceus, a path whose labyrinthine twists and turns are not lacking in terrors.”*

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