(3) The affirmation therapy model (model #4)

45. While it is widely agreed that the therapist should not directly challenge a claimed transgender identity in a child, some advocates and practitioners go much further, and promote and recommend that any expression of transgender identity should be immediately accepted as decisive, and thoroughly affirmed by means of consistent use of clothing, toys, pronouns, etc., associated with the transgender identity to which the child expresses an attraction. These advocates treat any question about the causes of the child's transgender identification as inappropriate and assume that observed psychological co-morbidities in the children or their families are unrelated or will get better with transition and need not be addressed by the MHP who is providing supportive guidance concerning the child's gender identity.

46. Some advocates, indeed, assert that unquestioning affirmation of any claim of transgender identity in children is essential, and that the child will otherwise face a high risk of suicide or severe psychological damage. I address claims about suicide and health outcomes in Sections IV and V below.

47. The idea that social transition is the only accepted treatment for prepubertal children is not correct. On the contrary, one respected academic in the field has recently written that "almost all clinics and professional associations in the world" do not use "gender affirmation" for prepubescent children and instead "delay any transitions after the onset of puberty."[19] This approach is widely

[19] J. Cantor (2020), *Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy*, J. OF SEX & MARITAL THERAPY VOL. 46, NO. 4, 307-313.

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practiced because when the intrapsychic, biological, and social developmental processes of puberty are allowed to act unimpaired (but accompanied by supporting therapy), resolution of the gender dysphoria is by far the most common outcome.[20] Natural desistance offers a reasonable likelihood of sparing the individual the life-long physical, mental, and social stresses associated with living in a transgender identity, which I discuss in Section V.

48. It is notable that even the Standards of Care published by WPATH, an organization which in general leans strongly towards affirmation in the case of adults, do not specify affirmation of transgender identity as the indicated therapeutic response for young children. Instead, the WPATH Standards of Care recognize that social transition in early childhood "is a controversial issue, and divergent views are held by health professionals"; state that "[t]he current evidence base is insufficient to predict the long-term outcomes of completing a gender role transition during early childhood"; and acknowledge that "previously described relatively low persistence rates of childhood gender dysphoria" are "relevant" to the wisdom of social transition in childhood.[21]

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[20] D. Singh et al. (2021), *A Follow-Up Study of Boys With Gender Identity Disorder*, FRONTIERS IN PSYCHIATRY Vol. 12:632784 at 12 (available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8039393/.)

[21] WORLD PROF'L ASS'N FOR TRANSGENDER HEALTH (2011), *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People* (7th Version) at 17. I note that I regretfully resigned from the precursor organization of WPATH in 2002 after concluding that many of its positions of enthusiastic and unqualified support of transition for individuals suffering from gender dysphoria were dictated by politics and ideology, rather than by any scientific basis. WPATH is composed of a mix of practitioners and transgender activists with little or no scientific training, and its most recent self-designated "Standards of Care" are not reflective of the practices of a large number of psychiatrists and Ph.D. psychologists who practice in this area. For this reason, WPATH's cautious position with regard to transition of children who suffer from gender dysphoria is all the more notable.

49. In contrast to WPATH's cautious position with respect to children, in 2018 the American Academy of Pediatrics issued a statement asserting that "gender transition" "is safe, effective, and medically necessary treatment for the health and wellbeing of children and adolescents suffering from gender dysphoria."[22] But in a peer-reviewed paper, based on a careful review of the sources cited in the AAP statement, prominent researcher James Cantor concluded that "In its policy statement, AAP told neither the truth nor the whole truth, committing sins both of commission and of omission, asserting claims easily falsified by anyone caring to do any fact-checking at all," and described Rafferty 2018 as "a systematic exclusion and misrepresentation of entire literatures." (Cantor at 312.) Based on my professional expertise and my review of the literature, I agree with Dr. Cantor's evaluation of Rafferty 2018.

50. In fact, the DSM-5 added—for both children and adolescents—a requirement that a sense of incongruence between biological and felt gender must last at least six months as a precondition for a diagnosis of gender dysphoria, precisely because of the risk of "transitory" symptoms and "hasty" diagnosis that might lead to "inappropriate" treatments.[23]

51. I do not know what proportion of practitioners are using which model. However, in my opinion, in the case of young children, prompt and thorough

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[22] J. Rafferty (2018), *Committee on Psychosocial Aspects of Child and Family Health, Committee on Adolescence and Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness*, PEDIATRICS 142(4): 2018-2162.

[23] K. Zucker (2015), *The DSM-5 Diagnostic Criteria for Gender Dysphoria*, in C. Trombetta et al. (eds.), MANAGEMENT OF GENDER DYSPHORIA: A MULTIDISCIPLINARY APPROACH (Springer-Verlag Italia).

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affirmation of a transgender identity disregards the principles of child development and family dynamics and is not supported by science. Rather, the MHP must focus attention on the child's underlying internal and familial issues. Ongoing relationships between the MHP and the parents, and the MHP and the child, are vital to help the parents, child, other family members, and the MHP to understand over time the issues that need to be dealt with over time by each of them.

52. Likewise, since the child's sense of gender develops in interaction with his parents and their own gender roles and relationships, the responsible MHP will almost certainly need to delve into family and marital dynamics.

F. Patients differ widely and must be considered individually.

53. In my opinion, it is not possible to make a single, categorical statement about the proper treatment of children or adolescents presenting with gender dysphoria or other gender-related issues. There is no single pathway of development and outcomes governing transgender identity, nor one that predominates over the large majority of cases. Instead, as individuals grow up and age, depending on their differing psychological, social, familial, and life experiences, their outcomes differ widely.

54. As to causes in children and adolescents, details about the onset of gender dysphoria may be found in an understanding of family relationship dynamics. In particular, the relationship between the parents and each of the parents and the child, and each of the siblings and the child, should be well known by the MHP. Further, a disturbingly large proportion of children and adolescents who seek professional care in connection with gender issues have a wider history of

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psychiatric co-morbidities. (*See supra* n. 12.) A 2017 study from the Boston Children's Hospital Gender Management Service program reported that: "Consistent with the data reported from other sites, this investigation documented that 43.3% of patients presenting for services had significant psychiatric history, with 37.1% having been prescribed psychotropic medications, 20.6% with a history of self-injurious behavior, 9.3% with a prior psychiatric hospitalization, and 9.3% with a history of suicide attempts." (Edwards-Leeper at 375.) It seems likely that an even higher proportion will have had prior undiagnosed psychiatric conditions.

55. In the case of adolescents, as I have noted above, there is evidence that peer social influences through "friend groups" (Littman) or through the internet can increase the incidence of gender dysphoria or claims of transgender identity, so the responsible MHP will want to probe these potential influences to better understand what is truly deeply tied to the psychology of this particular individual, and what may instead be "tried on" by the youth as part of the adolescent process of self-exploration and self-definition.

III. GENDER IDENTITY, GENDER DYSPHORIA, AND THERAPIES FOR GENDER DYSPHORIA IN YOUNGER CHILDREN

A. Natural desistance is by far the most frequent resolution of gender dysphoria in young children absent social transition.

56. A distinctive and critical characteristic of juvenile gender dysphoria is that multiple studies from separate groups and at different times have reported that in the large majority of patients, absent a substantial intervention such as social transition and/or hormone therapy, the dysphoria does *not* persist through puberty. A recent article reviewed all existing follow-up studies that the author

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could identify of children diagnosed with gender dysphoria (11 studies) and reported that "every follow-up study of GD children, without exception, found the same thing: By puberty, the majority of GD children ceased to want to transition." (Cantor at 307.) Another author reviewed the existing studies and reported that in "prepubertal boys with gender discordance . . . the cross gender wishes usually fade over time and do not persist into adulthood, with only 2.2% to 11.9% continuing to experience gender discordance."[24] A third summarized the existing data as showing that "Symptoms of GID at prepubertal ages decrease or disappear in a considerable percentage of children (estimates range from 80-95%)."[25] As cited above, a 2021 extended follow-up of originally evaluated prepubertal boys found a persistence rate of only 12 percent. (Singh 2021.)

57. It is not yet known how to distinguish those children who will desist from that small minority whose trans identity will persist. (Levine, *Ethical Concerns*, at 9.)

58. Desistance within a relatively short period may also be a common outcome for post-pubertal youths who exhibit recently described "rapid onset gender disorder." I observe an increasingly vocal online community of young women who have reclaimed a female identity after claiming a male gender identity at some

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[24] S. Adelson & American Academy of Child & Adolescent Psychiatry (2012), *Practice Parameter on Gay, Lesbian, or Bisexual Sexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents*, J. AM. ACAD. CHILD ADOLESCENT PSYCHIATRY 51(9) 957 at 963 ("*Practice Parameter*").

[25] P. T. Cohen-Kettenis et al. (2008), *The Treatment of Adolescent Transsexuals: Changing Insights*, J. SEXUAL MED. 5(8) 1892 at 1895.

point during their teen years. However, data on outcomes for this age group with and without therapeutic interventions is not yet available to my knowledge.

B. Social transition of young children is a powerful psychotherapeutic intervention that changes outcomes.

59. In contrast, there is now data that suggests that a therapy that encourages social transition before or during puberty dramatically changes outcomes. A prominent group of authors has written that "The gender identity affirmed during puberty appears to predict the gender identity that will persist into adulthood," and "Youth with persistent TNG [transgender, nonbinary, or gender-nonconforming] identity into adulthood . . . are more likely to have experienced social transition, such as using a different name . . . which is stereotypically associated with another gender at some point during childhood."[26] Similarly, a comparison of recent and older studies suggests that when an "affirming" methodology is used with children, a substantial proportion of children who would otherwise have desisted by adolescence—that is, achieved comfort identifying with their sex—instead persist in a transgender identity. (Zucker, *Myth of Persistence*, at 7).[27]

60. Indeed, a review of multiple studies of children treated for gender dysphoria across the last three decades found that early social transition to living as

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[26] C. Guss et al. (2015), *Transgender and gender nonconforming adolescent care: psychosocial and medical considerations*. CURR. OPIN. PEDIATR. 27(4):421 ("*TGN Adolescent Care*").

[27] One study found that social transition by the child was found to be strongly correlated with persistence for natal boys, but not for girls. (Zucker, *Myth of Persistence,* at 5 (citing T. D. Steensma, et al. (2013), *Factors Associated with Desistance & Persistence of Childhood Gender Dysphoria: A Qualitative Follow-up Study*, J. OF THE AM. ACAD. OF CHILD & ADOLESCENT PSYCHIATRY 52, 582.))

the opposite sex severely reduces the likelihood that the child will revert to identifying with the child's natal sex, at least in the case of boys. That is, while, as I review above, studies conducted before the widespread use of social transition for young children reported desistance rates in the range of 80-98%, a more recent study reported that fewer than 20% of boys who engaged in a partial or complete social transition before puberty had desisted when surveyed at age 15 or older. (Zucker, *Myth of Persistence*, at 7; Steensma (2013).)[28] Some vocal practitioners of prompt affirmation and social transition even claim that essentially *no* children who come to their clinics exhibiting gender dysphoria or cross-gender identification desist in that identification and return to a gender identity consistent with their biological sex. As one internationally prominent practitioner stated, "In my own clinical practice . . . of those children who are carefully assessed as transgender and who are allowed to transition to their affirmed gender, we have no documentation of a child who has 'desisted' and asked to return to his or her assigned gender."[29] Given the consensus that no method exists to reliably predict which children suffering from gender dysphoria will desist and which persist, and given the absence of any study demonstrating the validity of any such method, this is a disconcerting statement. Certainly, it reflects a very large change as compared to the desistance rates documented apart from social transition.

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[28] Only 2 (3.6%) of 56 of the male desisters observed by Steensma et al. had made a complete or partial transition prior to puberty, and of the twelve males who made a complete or partial transition prior to puberty, only two had desisted when surveyed at age 15 or older. Steensma (2013) at 584.

[29] D. Ehrensaft (2015), *Listening and Learning from Gender-Nonconforming Children,* THE PSYCHOANALYTIC STUDY OF THE CHILD 68(1) 28 at 34.

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