

EXHIBIT 134

https://www.sfexaminer.com/archives/opinion-the-health-establishment-is-failing-young-adults-who-question-their-gender/article_52832479-1ddd-596b-b64b-6c7b60addbdf.html

Opinion: The health establishment is failing young adults who question their gender

By Wire Service
Mar 21, 2022



Due to the informed consent model of medical treatment, a person age 18 or older can obtain gender affirming hormones...

By Erica Anderson

Special to The Examiner

In a recent consultation, divorced parents recounted that their 18-year-old son questioned his gender during senior year in high school, moved on to a university and, during the fall term as a freshman, presented as female at the student health center and was started on gender affirming hormones.

The student lacked health insurance through the university or from his parents, and so his care was transferred to the local Planned Parenthood clinic. At neither place did this 18 year old receive an evaluation by a mental health provider. In both places and during the first visits, the prescription for hormones was based upon Privacy - Terms

“informed consent” model.

The advance in acceptance for sexual and gender minorities is something for which I have advocated and applauded for years. But I have been witnessing worrisome developments in gender care. Issues with young adults are among my concerns. And I am not alone; a March 2022 journal article by Case Western Reserve University Professor Stephen B. Levine questions the limits and dangers of the informed consent model for trans-identified young adults.

For some time, pediatric specialty clinics at major university medical centers have recognized the needs of the 18- to 25-year-old population. These centers have often continued to care for young adult patients in pediatric clinics or built pathways to adult specialty clinics. The fact that specialty clinics care for patients into their twenties confirms what most understand: Turning 18 does not mean one attains adult competency — particularly for life-altering medical decisions like gender transition.

Yet across hundreds of college campuses and Planned Parenthood clinics, an 18 year old can present for hormones and, at the first visit, obtain a prescription and begin a full medical gender transition. Sometimes this happens with no mental health screening or evaluation beyond the opinion that they are competent to consent by a medical provider.

Every week, I hear from the parents of such young people who report their child has announced a change in gender identity and intends to go on hormones or already has done so. In too many of these cases, there has been no dialogue between parent and child and no input from mental health professionals and gender specialists who can help guide the young adult.

In most cases, the staff at university health or counseling centers are conscientious and well meaning. But because of the Family Educational Rights and Privacy Act, employees of colleges and universities are prohibited from releasing information about students to their parents and communication with them is illegal unless the student requests it. Many counselors do not want to interfere in these family dynamics, because their peers have coached them that a student’s identity is their identity, their body is their body and their choices are their choices.

Yet the costs of such practices can be considerable and potentially disastrous, as in cases — and there are many — when parents learn about their child’s medical gender transition following a psychiatric hospitalization. In such cases, the young person decides to transition but is ill-equipped to handle both the transition and the adjustment to college, which can be challenging for young adults with preexisting or co-occurring mental health issues.

A gender transition represents among the most difficult psychological changes a person can experience. Planning and the support is critical. In my case, I planned to have two gender affirming surgeries within six months of each other. Fortunately, my advisors helped me understand that this was overly ambitious and I

changed it. Unchecked by these trusted advisors, I could have subjected myself to additional stress and potential problems from other aspects of my transition. Pacing and planning aspects of a gender transition are critical to its success.

The consequences of such miscalculation are harsh. If a young person crashes and burns, as I have seen in some cases, it can take years to recover and relaunch. In past decades, parents of college-bound young adults worried if their child was prepared to deal with drug or alcohol experimentation. Now, an increasing number of parents are being confronted with their children's decision to transition genders and take hormones. Experimentation in this area can be every bit as destabilizing as recreational drugs or alcohol abuse.

It is widely known that the executive function of the brain — specifically in terms of planning and anticipation of consequences — is not fully mature until approximately age 25. That is why so many parents, and often progressive parents who strongly support LGBTQIA+ rights, express concern when their child announces they are trans and have started hormones without undergoing gender exploratory psychotherapy.

As mentioned, the student health centers and Planned Parenthoods operate under the informed consent model, which casts aside mental health screening requirements. Yet parents frequently tell me aghast that their young adult withheld from the medical provider a history of mental health challenges, including in some cases self harm or suicidal thoughts. Other college-age students gloss over details of their mental health history, dismissing further inquiry or accusing providers of “gatekeeping,” which in gender affirming circles is akin to being called out for racism by a person of color.

What to do? Previously in the Examiner and Washington Post, I cautioned that absent an individualized comprehensive evaluation prior to initiating gender affirming medicine, a gender transition may be premature or, worse, inappropriate. The exception are youth whose persistent gender variance at a young age compels a full transition prior to puberty.

Gender dysphoria presenting abruptly in late adolescence/young adulthood may not be a simple or straightforward recognition of gender identity. It is also sometimes complicated by other factors, such as depression, anxiety, autism spectrum disorder, social inadequacy, competency fears, delayed impact of trauma and/or misplaced adolescent rebellion against parents and family. I also believe that the pandemic, social isolation and, in too many cases, excess consumption of social media with its bizarre and prescriptive dynamics are unhealthy for gender questioning young adults.

The more strident and ideological voices in the trans community argue that no one should be subjected to gatekeeping or any requirements for psychological evaluation or treatment. But many older transgender persons, and professors of psychiatry and medicine such as Stephen Levine, extol the benefits of such exploration. I put myself in the care of a skilled gender psychologist prior to transition, though I myself am a psychologist with decades of experience. Few of us can be objective about ourselves. The stakes are high.

Erica E. Anderson, Ph.D. is the former president of the United States Professional Association for Transgender Health, former board member of WPATH and is writing a book on the evolution of the science, practice and culture of transgender healthcare; she is based in Berkeley.

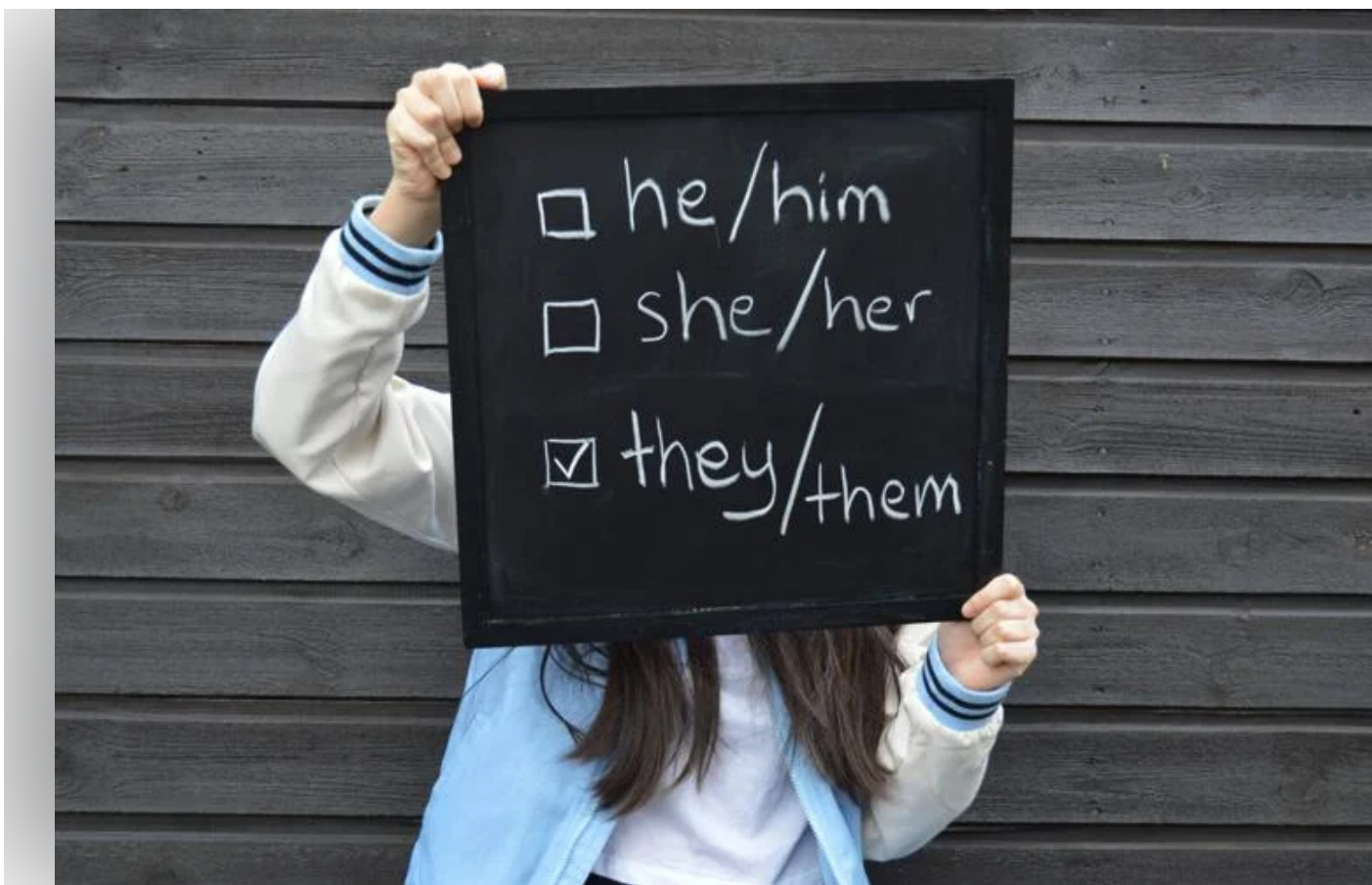
EXHIBIT 135

https://www.sfexaminer.com/archives/opinion-when-it-comes-to-trans-youth-we-re-in-danger-of-losing-our-way/article_833f674f-3d88-5edf-900c-7142ef691f1a.html

Opinion: When it comes to trans youth, we're in danger of losing our way

By Wire Service

Jan 3, 2022



By Erica Anderson

Special to The Examiner

Through a grant from the San Francisco Department of Public Health, UCSF's Child and Adolescent Gender Center has for the past five years provided training and consultation on transgender kids to all youth-serving agencies and professionals in The City, including its public schools. The vision has been to make San Francisco a model in caring for its gender creative youth.

I was part of that effort, and for years worked at UCSF's Gender Center as one of its two psychologists. I provided consultation, taught in the professional schools and wrote about the work. It is well documented that LGBTQ youth are subject to minority stress and higher rates of almost every potential psychological and social problem.

As a trans woman and therapist to trans and gender creative people, I've worked hard to advance acceptance of trans identities, including those of trans youth. But increasingly I'm worried that in our zeal to identify and protect these special children and adolescents, we may have strayed from some core principles and we are in danger of losing our way.

In this extraordinary time during a global pandemic, we have all been subject to extra stress to stay vigilant and avoid COVID and all its variants. Young people have pivoted to remote learning and stayed at home for in many cases more than an entire academic year, depriving them of ordinary social experiences. As a result, most adolescents have also depended upon social media and the internet to an extent never before seen.

We are learning some worrisome things about this massive, unplanned social experiment. Even the tech giants have conceded in their own research that there is a new kind of addiction/attraction to certain content and a kind of contagion among select groups, especially adolescent girls. Increased rates of depression and suicide, declines in dating and sexual activity, more reported loneliness and feelings of being left out, lower rates of involvement in extracurricular activities and surprisingly less sleep all characterize the current generation of adolescents. These trends seem to be accelerating in the era of the smartphone.

There is little question that reliance on screens and devices has isolated adolescents who may be most vulnerable and susceptible to peer and other influences, intensifying their usage of and reliance on whatever messages and images they see. I am concerned that our computer-mediated, always online environment is creating isolated echo chambers that can work on adolescents in an insidious way. And I believe that it's been worse during COVID.

For example, some content on YouTube and TikTok includes "influencers," who themselves are barely out of puberty. They dispense advice to other young people, specifically encouraging them to explore their gender identity freely.

On the one hand, I'm glad our society has evolved toward greater acceptance of all LGBTQ identities. On the other hand, some of the messaging has landed on vulnerable youth searching not just for keys to their own identity but solutions to other psychological and emotional problems, including serious psychiatric problems.

Here is where things may have gone wrong.

Some influencers are literally encouraging the idea that one's psychological distress may be because a young person is trans and is suffering from gender dysphoria. The remedy, they say, is to come out as trans or non-binary, which the influencers advise will alleviate their suffering. Welcomed into the company of other trans

and gender creative persons, such young people may have found acceptance — though virtual acceptance, since much of this rapport is online.

They also may be coached on how to navigate and/or control these issues with their parents, who they are told may not “get it.” Among the advice from these influencers is to make a quick social and gender transition, which may include a new chosen name and pronoun and access to gender-affirming hormones. Many of these influencers are literally dispensing medical advice.

Increasingly, I am contacted by parents whose child has come out to them as trans in recent weeks. Searching for help, they find me because they want to be affirming. But they report that the newly asserted gender identity occurred during the pandemic, and they cannot recall any significant suggestion of gender creativity by their child prior to recent events, though many parents report previous psychological problems with their child.

For example, I received a recent inquiry from a San Francisco father whose 14 year old came out as trans in late October after a year of therapy for anxiety and depression. “We were pretty surprised by the news, as we’d had no indication that he had thoughts in this area,” the father communicated.

Supportive, open-minded and conscientious parents like these have been contacting me at an accelerating rate in the past year. They also report that their initial contact with therapists leads to affirmation of their child’s asserted trans identity and referral to gender clinics. The numbers of new cases at such clinics have exploded. (A recent Gallup poll found that 1 in 6 members of Gen Z identify as lesbian, gay, bisexual, transgender or queer.)

In some cases, well-meaning psychological and medical providers are allowing themselves to be “triangulated,” pitting a child’s wishes against parents who are reluctant to see their child quickly put on hormone blockers and/or cross-sex hormones. Minors need parental consent for gender-affirming medicines that can pause natal puberty and/or introduce physical changes concordant with the affirmed transgender identity. And minors, especially those between the ages of 12 and 17, often prefer not to heed the advice of their parents.

So instead of forging an alliance between child and parent to evaluate what is needed and drive consensus as the basis for gender affirmation, providers may challenge parents and fuel adolescent rebellion. Of course, virtually all young people need their parents and will for years. Some families experience a rupture from which it may be difficult to recover. In my experience, the vast majority of parents want to support their child whom they love. But they are overwhelmed with shock, grief and legitimate concern for their child’s well-being.

In the hundreds of cases I have seen over the past half decade at UCSF and in my private practice, these types of cases are growing. Often by the time I get involved, there has been set up a pitched battle between a youth whose interest is to hurdle toward life-changing decisions with enduring consequences and parents who are bereft and torn between the acceptance and affirmation they want to give their child and their terror about consenting to medical interventions they fear are not right for their child at this time or at all. Ominously, such parents are worried that the child will later regret such decisions and blame parents for allowing it.

With some colleagues, I have been speaking and writing about these concerns. Unfortunately, we find the research on trans youth has not kept up with what is happening. The pandemic has turbo-charged these dynamic trends. Some deny the reality of peer influence upon identity formation. Others decry the methodological approach necessary and consistent with best practices, namely the World Professional Association for Transgender Health Standards of Care and the Endocrine Society and APA guidelines — which encourage an individualized, comprehensive biopsychosocial evaluation prior to initiation of gender-affirming medications and, of course, surgeries.

Research confirming the benefits of gender-affirming psychological and medical care has been done at university-based gender clinics like UCSF in the U.S. and Europe. The gender creative youth served by these clinics, which offer a careful methodical approach with the support of parents and professionals, go on to do well. In the case of a recently disclosed gender identity, the established clinics and best practices have encouraged gender exploratory therapy. This can be a matter of a few weeks to a year or more.

In my over 40 years as a psychologist, I've seen psychotherapeutic phenomena come and go. Eating disorders, multiple personality disorders and repressed memory syndrome have in retrospect spread through subgroups of adolescents and the professionals who have treated them. This spread is like wildfire through vulnerable underbrush, clearly borne in an environment of contagion.

Why is this phenomenon distinctly different from previous ones? How is it possible that gender identity formation constitutes the only area of development in adolescence that is immune from peer influence? Having gone to extraordinary lengths to make San Francisco the best city in the world for trans acceptance and affirmation, let's not be derailed by zealous disregard for what we see happening in our own back, front and virtual yard.

The COVID pandemic doesn't appear to be going away anytime soon, nor are online dynamics detrimental to young people. So let's make sure that every young person questioning their gender gets what they need, not just what they want.

Erica E. Anderson, Ph.D. is the former president of the United States Professional Association for Transgender Health, former board member of WPATH and is writing a book on the evolution of the science, practice and culture dealing with transgender healthcare; she is based in Berkeley.

EXHIBIT 136

The mental health establishment is failing trans kids

Gender-exploratory therapy is a key step. Why aren't therapists providing it?

By Laura Edwards-Leeper and Erica Anderson

November 24, 2021 at 5:54 p.m. EST



CORRECTION

A previous version of this essay said that a quarter of study subjects who reversed their gender transitions did not report this change to their doctors. In fact, three-quarters did not share the information.

At 13, Patricia told her parents she was a transgender boy. She had never experienced any gender dysphoria — distress at a disconnect between gender identity and the sex assigned at birth — she said. But a year earlier, she'd been sexually assaulted by an older girl. Soon after this trauma, she met another older girl who used they/them pronouns and introduced her to drugs, violent pornography and the notion of dissociation from her body. Her lingering psychic wounds, coinciding with a raft of new and unsettling ideas, plunged her into depression and anxiety. Patricia's parents took her to a therapist so she could talk through her shifting identity and acute mood swings.

The job of a mental health provider here should have been clear: Perform an assessment, ask how long she'd experienced dysphoria and investigate how mental health issues and any other changes in her life might be contributing to it. Instead, on first meeting, the therapist simply affirmed her new identity, a step that can lead to hormonal and eventually surgical treatments. Was Patricia ready for these next steps — or, her parents wondered, was this a normal bout of teenage confusion stemming from a recent trauma? The therapist instructed them to “support” their child's trans self-diagnosis and to socially transition her. If they didn't, Patricia might end her own life: 41 percent of unsupported children commit suicide, they were told. Would Patricia's parents rather have a dead child or a trans one?

They sought another therapist, one who was more curious and less certain, one who listened closely. After a year of exploring who she was, Patricia no longer felt she was a boy. She decided to stop binding her breasts and wearing boys' clothes.

We are both psychologists who have dedicated our careers to serving transgender patients with ethical, evidence-

based treatment. But we see a surge of gender dysphoria cases like Patricia's — cases that are handled poorly. One of us was the founding psychologist in 2007 of the first pediatric gender clinic in the United States; the other is a transgender woman. We've held recent leadership positions in the World Professional Association for Transgender Health (WPATH), which writes the standards of care for transgender people worldwide. Together, across decades of doing this work, we've helped hundreds of people transition their genders. This is an era of ugly moral panic about bathrooms, woke indoctrination and identity politics in general. In response, we enthusiastically support the appropriate gender-affirming medical care for trans youth, and we are disgusted by the legislation trying to ban it.

But the number of adolescents requesting medical care is skyrocketing: Now 1.8 percent of people under 18 identify as transgender, double the figure from five years earlier, according to the Trevor Project. A flood of referrals to mental health providers and gender medical clinics, combined with a political climate that sees the treatment of each individual patient as a litmus test of social tolerance, is spurring many providers into sloppy, dangerous care. Often from a place of genuine concern, they are hastily dispensing medicine or recommending medical doctors prescribe it — without following the strict guidelines that govern this treatment. Canada, too, is following our lead: A study of 10 pediatric gender clinics there found that half do not require psychological assessment before initiating puberty blockers or hormones.

The standards of care recommend mental health support and comprehensive assessment for all dysphoric youth before starting medical interventions. The process, done conscientiously, can take a few months (when a young person's gender has been persistent and there are no simultaneous mental health issues) or up to several years in complicated cases. But few are trained to do it properly, and some clinicians don't even believe in it, contending without evidence that treating dysphoria medically will resolve other mental health issues. Providers and their behavior haven't been closely studied, but we find evidence every single day, from our peers across the country and concerned parents who reach out, that the field has moved from a more nuanced, individualized and developmentally appropriate assessment process to one where every problem looks like a medical one that can be solved quickly with medication or, ultimately, surgery. As a result, we may be harming some of the young people we strive to support — people who may not be prepared for the gender transitions they are being rushed into.

American opinions about transgender youth have shifted dramatically in the past 15 years. The pendulum has swung from a vile fear and skepticism around ever treating adolescents medically to what must be described, in some quarters, as an overcorrection. Now the treatment pushed by activists, recommended by some providers and taught in many training workshops is to affirm without question. "We don't actually have data on whether psychological assessments lower regret rates," Johanna Olson-Kennedy, a pediatrician at Children's Hospital in Los Angeles who is skeptical of therapy requirements and gives hormones to children as young as 12 (despite a lack of science supporting this practice, as well), told the Atlantic. "I don't send someone to a therapist when I'm going to start them on insulin." This perspective writes off questions about behavioral and mental health, seeing them as a delaying tactic or a dodge, a way of depriving desperate people of the urgent care they clearly need.

But comprehensive assessment and gender-exploratory therapy is the most critical part of the transition process. It helps a young person peel back the layers of their developing adolescent identity and examine the factors that contribute to their dysphoria. In this stage, patients reflect on the duration of the dysphoria they feel; the continuum of gender; the intersection with sexual orientation; what medical interventions might realistically entail; social media, Internet and peer influences; how other factors (e.g., autism, trauma, eating disorders/body image concerns, self-esteem, depression, anxiety) may help drive dysphoria, rather than assuming that they are always a result of dysphoria; family dynamics and social/peer relationships; and school/academic challenges. The

messages that teens get from TikTok and other sources may not be very productive for understanding this constellation of issues.

There are several reasons the process can move too quickly and hurtle toward medical treatment. For one, the stigma around mental health in general, along with the trauma caused to transgender adults by the health-care field in the past (yes, including conversion therapy), has made our peers extremely skeptical of becoming “gatekeepers” — experts who deny the needed help because they supposedly know best. Slowing down the process and encouraging deeper, thoughtful exploration is considered, many tell us, unnecessary and unaffirming. Providers may also be afraid of being cast as transphobic bigots by their local colleagues and referral sources if they engage in gender exploring therapy with patients, as some have equated this with conversion therapy. We’ve personally experienced this backlash at professional conferences.

All this means only that the purpose of assessment is improperly understood. The approach WPATH recommends is collaborative and aims to provide a developmentally appropriate process that involves the parents and takes the complexities of adolescence into consideration. (The constituency of agitated parents who feel excluded is also growing rapidly. These are not conservative evangelicals who don’t believe trans people exist or deserve treatment. They’re usually progressive, educated, loving people who all say, *If our kid is really trans, we’ll fully support them. We just want to be as sure as possible, and we can’t find a provider who will actually engage in gender exploring therapy. Instead, doctors and psychologists and social workers are ready to start hormones after one short visit.*)

Another reason that teens can receive substandard mental health care is that gender clinics are disastrously overwhelmed. Most have a single social worker who completes a brief “intake,” relying instead on other mental health clinicians in the community to assess patients and offer their conclusions. Frequently, those community clinicians, just like the parents, assume that a more comprehensive assessment will occur in the gender specialty clinic. But in our experience, and based on what our colleagues share, this is rarely the case. Most clinics appear to assume that a referral means a mental health provider in the community has diagnosed gender dysphoria and thereby given the green light for medical intervention.

When working in gender clinics, we’ve also both received letters from therapists who had “assessed” patients they were referring to us. An astonishing number of these were nothing but a paragraph that stated the youth identified as trans, had dysphoria and wanted hormones, so that course was recommended. There are nearly 200,000 members of the American Psychological Association and the American Psychiatric Association. Add to that the clinical social workers, marriage counselors and family therapists. The overwhelming majority of those well-intentioned professionals receive limited or no training in the assessment of gender-diverse youth. (We receive requests frequently from people eager for more comprehensive, nuanced trainings, which we both deliver.) In simple terms, the demand for competent care has outstripped the supply of competent providers.

In professional circles, we hear from pediatric endocrinologists and others who prescribe hormones for trans youth. Many openly discuss how they use the adult informed-consent model of care with their teen patients, which almost always means no mental health involvement and sometimes no parent input, either. “If you are trans, I believe you,” says A.J. Eckert, the medical director of Anchor Health Initiative in Connecticut. Eckert is wary of psychologists who follow the guidelines by completing a comprehensive assessment before recommending medical intervention for youths. “Gender-affirming medicine,” Eckert holds, means that “you are best equipped to make decisions about your own body,” full stop. These providers do not always realize they’ve confessed to ignoring the standards of care. (Contacted by The Post for comment on this essay, Eckert said that “no medical or surgical interventions are provided to anyone who has not started puberty” but added that, as Anchor Health sees it, “Therapy is not a requirement in this approach because being trans is not a pathology.”)

Some providers may move quickly because they believe that an adolescent's clarity around their gender identity is no different than that of transgender adults, whose care is now typically based on simple informed consent. Some assume that a person with gender dysphoria who declares they are transgender is transgender and needs medical interventions immediately. Yet we know this is not always true. In a recent study of 100 detransitioners, for instance, 38 percent reported that they believed their original dysphoria had been caused by “something specific, such as trauma, abuse, or a mental health condition.” Fifty-five percent said they “did not receive an adequate evaluation from a doctor or mental health professional before starting transition.”

A handful of studies supposedly showing the suicide risk of gender minority youth who are not supported are also not entirely conclusive. The term “support,” for instance, is defined differently across studies, and it is never defined as “starting medical interventions.” Supporting trans youth may include using the correct name/pronouns or allowing the young person to present in a way that aligns with their affirmed gender (e.g., clothing, hairstyle). These studies also show correlations between teen-transition hurdles and suicidality, but not causal relationships. Suicide is a horrifying outcome for too many gender-diverse youth, but its specter should not be used to push forward unrelated medical treatment without professional care or attention for each patient.

Longer-term longitudinal studies are needed to better understand the role of medical interventions on lifetime psychological health, particularly with the newer subset of adolescents presenting with no childhood dysphoria and significant mental health concerns. Research is needed to help determine whether quick medical treatment or a more cautious approach is best in these cases. Based on our experience with patients, we suspect that there will be variability based on age, when gender identity questions first emerged and other factors — which is why an individualized approach with careful assessment is so critical.

Trans youth, more than most patients in the health-care system, require an interdisciplinary approach: Their doctors rely on mental health colleagues for direction, and it is crucial that those therapists take the reins. Without proper assessment, many youths are being rushed toward the medical model, and we don't know if they will be liberated or restrained by it. National figures do not yet exist, but the rising number of detransitioners that clinicians report seeing (they are forming support groups online) indicates that this approach can backfire. This is not the most common outcome of a transition process, but it is hardly unheard of, either. These are typically youth who experienced gender dysphoria and other complex mental health issues, rushed to medicalize their bodies and regretted it later. Only a quarter of them told their doctors they had reversed their transitions, making this population especially hard to track.

Many trans activists want to silence detransitioners or deny their existence, because those cases do add fuel to the conservative agenda that is pushing to deny medical treatment to all transgender young people. (Those conservative views are unacceptable, and medically unsound.) Instead, we should be learning from them and returning to the empirically supported careful assessment model recommended by WPATH. And none of this means that we shouldn't be listening to the views of gender-diverse teens; it only means that we should listen in the fullest and most probing way possible.

The pressure by activist medical and mental health providers, along with some national LGBT organizations to silence the voices of detransitioners and sabotage the discussion around what is occurring in the field is unconscionable. Not only is it harmful to detransitioned young people — to be made to feel as if their lived experiences are not valid, the very idea that the gender-transition treatment is meant to remedy — but it will undoubtedly raise questions regarding the objectivity of our field and our commitment to help trans people. The fact that some people detransition does not mean that transgender people should not receive the services they need.

The energy currently spent fighting this political battle would be much better directed toward improving care for all gender-diverse young people. They deserve nothing less.

EXHIBIT 137

THE FREE PRESS

EXTRA!

*Read our ongoing
coverage of the war in
Israel*

Monday, October 30, 2023

5:12 PM

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Dr. Riittakerttu Kaltiala in New York City on October 12, 2023. (Photos by Daniel Paik for The Free Press)

‘Gender-Affirming Care Is Dangerous. I Know Because I Helped Pioneer It.’

My country, and others, found there is no solid evidence supporting the medical transitioning of young people. Why aren’t American clinicians paying attention?

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Riittakerttu Kaltiala
October 30, 2023



Dr. Riittakerttu Kaltiala, 58, is a Finnish-born and trained adolescent psychiatrist, the chief psychiatrist in the department of adolescent psychiatry at Finland’s Tampere University Hospital. She treats patients, teaches medical students, and conducts research in her field—publishing more than 230 scientific articles.

In 2011, Dr. Kaltiala was assigned a new responsibility. She was to oversee the establishment of a gender identity service for minors, making her among the first physicians in the world to head a clinic devoted to the treatment of gender-distressed young people. Since then, she has personally participated in the assessments of more than 500 such adolescents.

Earlier this year, The Free Press ran a [whistleblower account](#) by Jamie Reed, a former case manager at [The Washington University Transgender Center](#) at St. Louis Children’s Hospital. She recounted her growing alarm at the effects of treatments that sought to transition minors to the opposite sex, and her escalating conviction that patients were being harmed by their treatment.

Although a recent New York Times [investigation](#) largely corroborated Reed’s account, many activists and members of the media continue to dismiss Reed’s claims because she is not a physician.

Dr. Kaltiala is. And her concerns are likely to get more attention in the U.S. now that a young woman who medically transitioned as a teenager has just [sued](#) the doctors who supervised her treatment, along with the American Academy of Pediatrics. According to the suit, the AAP, in advocating for youth transition, has [made](#) “outright fraudulent statements” about evidence for “the radical new treatment model, and the known dangers and potential side effects of the medical interventions it advocates.”

Here, Dr. Kaltiala tells her own story, describing her increasing worries about the treatment she approved for vulnerable patients, and her decision to speak out.

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Early in my medical studies, I knew I wanted to be a psychiatrist. I decided to specialize in treating adolescents because I was fascinated by the process of young people actively exploring who they are and seeking their role in the world. My patients' adult lives are still ahead of them, so it can make a huge difference to someone's future to help a young person who is on a destructive track to find a more favorable course. And there are great rewards in doing individual therapeutic work.

Over the past dozen or so years there has been a dramatic development in my field. A new protocol was announced that called for the social and medical gender transition of children and teenagers who experienced gender dysphoria—that is, a discordance between one's biological sex and an internal feeling of being a different gender.

This condition has been described for decades, and the 1950s is seen as the beginning of the [modern era](#) of transgender medicine. During the twentieth century, and into the twenty-first, small numbers of mostly adult men with lifelong gender distress have been treated with estrogen and surgery to help them live as women. Then in recent years came new research on whether medical transition—primarily hormonal—could be done successfully on minors.

One motivation of the medical professionals overseeing these treatments was to prevent young people from facing the difficulties adult men had experienced in trying to convincingly appear as women. The most prominent advocates of youth transition were a group of Dutch clinicians. They published a [breakthrough paper](#) in 2011 establishing that if young people with gender dysphoria were able to avoid their natural puberty by blocking it with pharmaceuticals, followed by receiving opposite-sex hormones, they could start living their transgender lives earlier and more credibly.

It became known as the “Dutch protocol.” The patient population the Dutch doctors described was a small number of young people—almost all male—who, from their earliest years, insisted they were girls. The carefully selected patients, apart from their gender distress, were mentally healthy

and high-functioning. The Dutch clinicians reported that following early intervention, these young people thrived as members of the opposite sex. The protocol was quickly adopted internationally as the gold standard treatment in this new field of pediatric gender medicine.

Concurrently, there arose an activist movement that declared gender transition was not just a medical procedure, but a human right. This movement became increasingly high profile, and the activists' agenda dominated the media coverage of this field. Advocates for transition also understood the power of the emerging technology of social media. In response to all this, in Finland the Ministry of Social Affairs and Health wanted to create a national pediatric gender program. The task was given to the two hospitals that already housed gender identity services for adults. In 2011, my department was tasked with opening this new service, and I as the chief psychiatrist became the head of it.

Even so, I had some serious questions about all this. We were being told to intervene in healthy, functioning bodies simply on the basis of a young person's shifting feelings about gender. Adolescence is a complex period in which young people are consolidating their personalities, exploring sexual feelings, and becoming independent of their parents. Identity achievement is the outcome of successful adolescent development, not its starting point.

At our hospital, we had a big round of discussions with bioethicists. I expressed my concern that gender transition would interrupt and disrupt this crucial psychological and physical developmental stage. Finally, we obtained a statement from a national board on health ethics cautiously suggesting we undertake this new intervention.

We are a country of 5.5 million with a nationalized healthcare system, and because we required a second opinion to change identity documents and proceed to gender surgery, I have personally met and evaluated the majority of young patients at both clinics considering transition: to date, more than 500 young people. Approval for transition was not automatic. In early years, our psychiatric department agreed to transition for about half

of those referred. In recent years, this has dropped to about twenty percent.

As the service got underway starting in 2011, there were many surprises. Not only did the patients come, they came in droves. Around the Western world the numbers of gender-dysphoric children were skyrocketing.

But the ones who came were nothing like what was described by the Dutch. We expected a small number of boys who had persistently declared they were girls. Instead, 90 percent of our patients were girls, mainly 15 to 17 years old, and instead of being high-functioning, the vast majority presented with severe psychiatric conditions.

Some came from families with multiple psychosocial problems. Most of them had challenging early childhoods marked by developmental difficulties, such as extreme temper tantrums and social isolation. Many had academic troubles. It was common for them to have been bullied—but generally not regarding their gender presentation. In adolescence they were lonely and withdrawn. Some were no longer in school, instead spending all their time alone in their room. They had depression and anxiety, some had eating disorders, many engaged in self-harm, a few had experienced psychotic episodes. Many—*many*—were on the autism spectrum.

Remarkably, few had expressed any gender dysphoria until their sudden announcement of it in adolescence. Now they were coming to us because their parents, usually just mothers, had been told by someone in an LGBT organization that gender identity was their child's real problem, or the child had seen something online about the benefits of transition.

Even during the first few years of the clinic, gender medicine was becoming rapidly politicized. Few were raising questions about what the activists—who included medical professionals—were saying. And they were saying remarkable things. They asserted that not only would the feelings of gender distress immediately disappear if young people start to medically transition, but also that *all* their mental health problems would

be alleviated by these interventions. Of course, there is no mechanism by which high doses of hormones resolve autism or any other underlying mental health condition.

Because what the Dutch had described differed so dramatically from what I was seeing in our clinic, I thought maybe there was something unusual about our patient population. So I started talking about our observations with a network of professionals in Europe. I found out that everybody was dealing with a similar caseload of girls with multiple psychiatric problems. Colleagues from different countries were confused by this, too. Many said it was a relief to hear their experience was not unique.



“Medicine, unfortunately, is not immune to dangerous groupthink that results in patient harm,” Dr. Kaltiala writes.

But no one was saying anything publicly. There was a feeling of pressure to provide what was supposed to be a wonderful new treatment. I felt in myself, and saw in others, a crisis of confidence. People stopped trusting their own observations about what was happening. We were having doubts about our education, clinical experience, and ability to read and produce scientific evidence.

Soon after our hospital began offering hormonal interventions for these patients, we began to see that the miracle we had been promised was not happening. What we were seeing was just the opposite.

The young people we were treating were not thriving. Instead, their lives were deteriorating. We thought, *what is this?* Because there wasn't a hint in studies that this could happen. Sometimes the young people insisted their lives had improved and they were happier. But as a medical doctor, I could see that they were doing worse. They were withdrawing from all social activities. They were not making friends. They were not going to school. We continued to network with colleagues in different countries who said they were seeing the same things.

I became so concerned that I embarked on a study with my Finnish colleagues to describe our patients. We methodically went through the records of those who had been treated at the clinic its first two years, and we characterized how troubled they were—one of them was mute—and how much they differed from the Dutch patients. For example, more than a quarter of our patients were on the autism spectrum. [Our study](#) was published in 2015, and I believe it was the first journal publication from a gender clinician raising serious questions about this new treatment.

I knew others were making the same observations at their clinics, and I hoped my paper would spark discussion about their concerns—that's how medicine corrects itself. But our field, instead of acknowledging the problems we described, became more committed to expanding these treatments.

In the U.S., your first [pediatric gender clinic](#) opened in Boston in 2007. Fifteen years later there were more than [100 such clinics](#). As the U.S. protocols developed, fewer limitations were put on transition. A [Reuters investigation](#) found that some U.S. clinics approved hormone treatments at a minor's first visit. The U.S. pioneered a new treatment standard, called "gender-affirming care," which urged clinicians simply to accept a child's assertion of a trans identity, and to stop being "[gatekeepers](#)" who raised concerns about transition.

Around 2015, in addition to the very psychiatrically ill patients, a new set of patients started arriving at our clinic. We began to see groups of teenage girls, also usually from 15 to 17 years of age from the same small towns, or even the same schools, telling the same life stories and the same anecdotes about their childhoods, including their sudden realization that they were transgender—despite no prior history of dysphoria. We realized they were networking and exchanging information about how to talk to us. And so, we got our first experience of [social contagion-linked](#) gender dysphoria. This, too, was happening in pediatric gender clinics around the world, and again health providers were failing to speak up.

I understood this silence. Anyone, including [physicians](#), [researchers](#), [academics](#), and [writers](#), who raised concerns about the growing power of gender activists, and about the effects of medically transitioning young people, were subjected to organized campaigns of vilification and threats to their careers.

In 2016, because of several years of growing concern about the harms of transition on vulnerable young patients, Finland's two pediatric gender services changed their protocols. Now, if young people had other, more urgent problems than gender dysphoria that needed to be addressed, we promptly referred those patients for more appropriate treatment, such as psychiatric counseling, rather than continuing their gender identity assessment.

There was a lot of pressure against this approach from activists, politicians, and the media. The Finnish press published stories of young

people dissatisfied with our decision, portraying them as victims of gender clinics that were forcing them to put their lives on hold. A Finnish medical journal ran a piece that took the perspective of dissatisfied activists titled, “Why do trans adolescents not get their blockers?”

But I was trained that medical treatment has to be based on medical evidence, and that medicine has to constantly correct itself. When you are a physician who sees something is not working, it is your duty to organize, research, inform your colleagues, inform a big audience, and stop doing that treatment.

Finland’s national healthcare system gives us the ability to investigate current medical practices and set new guidelines. In 2015 I personally asked a national body, called the Council for Choices in Health Care ([COHERE](#)), to create national guidelines for treatment of gender dysphoria in minors. In 2018 I renewed this request with colleagues, and it was accepted. COHERE commissioned a [systematic evidence review](#) to assess the reliability of the current medical literature on youth transition.



Around this same time, eight years into the opening of the pediatric gender clinic, some previous patients started coming back to tell us they now regretted their transition. Some—called “detransitioners”—wished to return to their birth sex. These were another kind of patient who wasn’t supposed to exist. The authors of the Dutch protocol asserted that rates of regret were miniscule.

But the foundation on which the Dutch protocol was based is crumbling. Researchers [have shown](#) that their data had some serious problems, and that in their follow-up, they failed to include many of the very people who may have regretted transition or changed their minds. One of the patients had died due to complications from genital transition surgery.

There is an oft-repeated statistic in the world of pediatric gender medicine that only one percent or less of young people who transition subsequently detransition. The studies asserting this, too, rest on biased questions,

inadequate samples, and short timelines. I believe regret is far more widespread. For example, one [new study](#) shows that nearly 30 percent of patients in the sample ceased filling their hormone prescription within four years.

Usually, it takes several years for the full impact of transition to settle in. This is when young people who have entered adulthood confront what it means to possibly be sterile, to have damaged sexual function, to have great difficulty in finding romantic partners.

It is devastating to speak to patients who say they were naive and misguided about what transition would mean for them, and who now feel it was a terrible mistake. Mainly these patients tell me they were so convinced they needed to transition that they concealed information or lied in the assessment process.

I continued to research the issue and in 2018, with colleagues, I published [another paper](#), one that investigated the origin of the surging numbers of gender-dysphoric young people. But we didn't find answers as to why this was happening, or what to do about it. We noted in our study a point that is generally ignored by gender activists. That is, for the overwhelming majority of gender dysphoric children—around 80 percent—their dysphoria resolves itself if they are left to go through natural puberty. Often these children come to realize they are gay.

In June of 2020 a major event happened in my field. Finland's national medical body, COHERE, [released](#) its findings and recommendations regarding youth gender transition. It concluded that the studies touting the success of the "gender-affirming" model were biased and unreliable—systematically so in some cases.

The authors wrote: "In light of available evidence, gender reassignment of minors is an experimental practice." The report stated that young patients seeking gender transition should be instructed about "the reality of a lifelong commitment to medical therapy, the permanence of the effects, and the possible physical and mental adverse effects of the treatments."

The report warned that young people, whose brains were still maturing, lacked the ability to properly “assess the consequences” of making decisions they would have to live with for the “rest of their lives.”

COHERE also recognized the dangers of giving hormone treatments to young people with serious mental illness. The authors concluded that for all these reasons, gender transition should be postponed “until adulthood.”

It had taken quite a while, but I felt vindicated.

Fortunately, Finland is not alone. After similar reviews, the [UK](#) and [Sweden](#) have come to similar conclusions. And many other countries with national healthcare systems are re-evaluating their “gender-affirming” stance.

I felt an increasing obligation to patients, to medicine, and to the truth, to [speak outside](#) of Finland against the widespread transitioning of gender-distressed minors. I have been particularly concerned about American medical societies, who as a group continue to assert that children know their “authentic” selves, and a child who declares a transgender identity should [be affirmed](#) and started on treatment. (In recent years, the “trans” identity has evolved to include more young people who say they are “nonbinary”—that is, they feel they don’t belong to either sex—and other gender variations.)

Medical organizations are supposed to transcend politics in favor of upholding standards that protect patients. However, in the U.S. these groups—including the [American Academy of Pediatrics](#)—have been actively hostile to the message my colleagues and I are urging.

I attempted to address the rising international concerns about pediatric gender transition at this year’s annual conference of the American Academy of Child and Adolescent Psychiatry. But the two proposed panels were [rejected](#) by the academy. This is highly disturbing. Science does not progress through silencing. Doctors who refuse to consider evidence presented by critics are putting patient safety at risk.

I am also disturbed by how gender clinicians routinely warn American parents that there is an enormously elevated risk of suicide if they stand in the way of their child's transition. Any young person's death is a tragedy, but careful research shows that suicide is very rare. It is dishonest and extremely unethical to pressure parents into approving gender medicalization by exaggerating the risk of suicide.

This year the Endocrine Society of the U.S. reiterated its endorsement of hormonal gender transition for young people. The president of the society wrote in a letter to *The Wall Street Journal* that such care was "lifesaving" and "reduces the risk of suicide." I was a co-author of a letter in response, signed by 20 clinicians from nine countries, refuting his assertion. We wrote that, "Every systematic review of evidence to date, including one published in the *Journal of the Endocrine Society*, has found the evidence for mental health benefits of hormonal interventions for minors to be of low or very low certainty."

Medicine, unfortunately, is not immune to dangerous groupthink that results in patient harm. What is happening to dysphoric children reminds me of the recovered memory craze of the 1980s and '90s. During that period, many troubled women came to believe false memories, often suggested to them by their therapists, of nonexistent sexual abuse by their fathers or other family members. This abuse, the therapists said, explained everything that was wrong with the lives of their patients. Families were torn apart, and some people were prosecuted based on made-up assertions. It ended when therapists, journalists, and lawyers investigated and exposed what was happening.

We need to learn from such scandals. Because, like recovered memory, gender transition has gotten out of hand. When medical professionals start saying they have one answer that applies everywhere, or that they have a cure for all of life's pains, that should be a warning to us all that something has gone very wrong.



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EXHIBIT 138

Have the psychiatric needs of people seeking gender reassignment changed as their numbers increase? A register study in Finland

Research Article

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Corresponding author:

Riittakerttu Kaltiala;

Email: riittakerttu.kaltiala@tuni.fi

Riittakerttu Kaltiala^{1,2,3} , Timo Holttinen²  and Katinka Tuisku⁴

¹Faculty of Medicine and Health Technology, Tampere University, Tampere, Finland; ²Department of Adolescent Psychiatry, Tampere University Hospital, Tampere, Finland; ³Vanha Vaasa Hospital, Vaasa, Finland and ⁴Department of Psychiatry, Helsinki University Hospital, Helsinki, Finland

Abstract

Background. The number of people seeking gender reassignment (GR) has increased everywhere and these increases particularly concern adolescents and emerging adults with female sex. It is not known whether the psychiatric needs of this population have changed alongside the demographic changes.

Methods. A register-based follow-up study of individuals who contacted the nationally centralized gender identity services (GIS) in Finland in 1996–2019 (gender dysphoria [GD] group, $n = 3665$), and 8:1 age and sex-matched population controls ($n = 29,292$). The year of contacting the GIS was categorized to 5-year intervals (index periods). Psychiatric needs were assessed by specialist-level psychiatric treatment contacts in the Finnish Care Register for Hospital Care in 1994–2019.

Results. The GD group had received many times more specialist-level psychiatric treatment both before and after contacting specialized GIS than had their matched controls. A marked increase over time in psychiatric needs was observed. Among the GD group, relative risk for psychiatric needs after contacting GIS increased from 3.3 among those with the first appointment in GIS during 1996–2000 to 4.6 when the first appointment in GIS was in 2016–2019. When index period and psychiatric treatment before contacting GIS were accounted for, GR patients who had and who had not proceeded to medical GR had an equal risk compared to controls of needing subsequent psychiatric treatment.

Conclusion. Contacting specialized GIS is on the increase and occurs at ever younger ages and with more psychiatric needs. Manifold psychiatric needs persist regardless of medical GR.

Introduction

Gender dysphoria (GD) in DSM-5 [1] refers to distress and impairment arising from incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics. In ICD-10 the corresponding term is Transsexualism [2], and in ICD-11 Gender Incongruence [3]. Hormonal and surgical interventions aiming at aligning the bodily characteristics with the experienced gender are considered the treatment of choice to alleviate distress among people with sex-discordant gender identity [4]. Transgender is an umbrella term referring to all gender identities incongruent with one's natal sex [4, 5]. Not all those identifying as transgender necessarily suffer from dysphoria or seek treatment.

The number of people seeking gender reassignment (GR) or identifying as transgender has increased throughout the Western world, these increases particularly concerning adolescents and emerging adults with female sex [6–9]. The reasons for these increases are not known; increasing awareness, reduced stigma, better service availability, and increased treatment options, but also media and social media influences and seeking belongingness have been suggested to be behind them [4, 10–13].

Transgender people in the population, in general health care settings, and specialized gender identity services (GIS) commonly present with psychological distress and mental disorders [14–18] which are often understood as secondary to stress concerning the sexed bodily characteristics or minority stress [15, 19]. However, studies notably on the youngest patients seeking GR have also reported numerous risk factors common to child and adolescent psychiatric morbidity at large, and severe mental disorders with onset preceding the onset of GD [20–23]. Among minors referred to GIS, as many as two-thirds present with diagnosable mental disorders, particularly depressive and anxiety disorders and autism spectrum conditions [17, 18]. Of adults seeking GR, about 30–40% present with current and 60–80% with lifetime diagnosable mental disorders, mainly depressive and anxiety but also substance use and personality disorders [14, 15, 24]. Most of the studies among both minors and adults have been single-center studies with small samples and without control groups. They can shed no light on possible changes in psychiatric

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comorbidities among people with different treatment trajectories or across times when contacts to GIS have vastly increased.

Research exploring mental health prognoses among people presenting with clinical GD and the impact of GR interventions on mental health and psychosocial functioning is rare. It is based mainly on short-term, low-quality studies, the findings being inconclusive among both adults and minors [14, 25–30]. Two studies stand out as being more informative on outcomes regarding long-term psychiatric needs: a register-based follow-up study (for an average of 10.4 years) of all 324 individuals who underwent medical GR in the period 1973–2003 in Sweden and 10:1 matched population controls [31], and a register-based study of 3754 minors with GD and their 6660 siblings from the USA [32], covering a follow-up of a mean of 8.5 years. In the former, the transgender patients had over fourfold crude risk for psychiatric morbidity during follow-up, and almost threefold when psychiatric morbidity prior to GR was accounted for [31]. In the latter study, transgender adolescents had over fivefold more psychiatric disorders than their siblings. The need for psychiatric care did not diminish after the GR interventions [32].

Thus, comprehensive, large-scale, and long-term follow-up studies on psychiatric morbidity among patients who seek medical GR are rare. Further, possible changes in these needs alongside vast increases in numbers seeking GR are so far not known. If increasing numbers of patients seeking GR relate to increased openness and treatment availability, with diminishing stigma and prejudice, mental health issues might have been expected to have likewise diminished over time in this population. A Dutch study found little change in patients admitted to child and adolescent GIS over time [33], but we are not aware of such studies among adults. Therefore, we set out to explore possible changes in the psychiatric needs of individuals seeking GR in Finland between 1996 and 2019, a period during which these contacts increased considerably. More specifically, we asked:

1. Did individuals seeking GR differ from matched population controls regarding contacts to specialist-level psychiatric treatment and disorders treated?
2. Did changes occur over time in the proportion of those having had specialist-level psychiatric treatment contacts before their first contact with GIS, and in the proportion of those needing specialist-level psychiatric care after contacting the GIS?
3. Did individuals seeking GR in Finland differ from matched population controls regarding needs for psychiatric treatment after contacting GIS, and were there differences in subsequent psychiatric needs between those who did and those who did NOT proceed to medical GR?

Materials and methods

Setting

Gender identity assessments potentially leading to medical GR interventions are by (code of) law [34] nationally centralized in Finland to two of the five university hospitals. Services for legal adults have been available since the early 1990s [35], and became available to minors in 2011 [20]. A doctor's referral is required. The current national guidelines require that the necessary psychiatric assessment and treatment needs be in place before gender identity assessments can be considered [36–38], however, during the period studied there was no such threshold.

Design

A register-based follow-up study was carried out using information routinely collected for inclusion in the nationally representative population and health care registers in Finland. Comprehensive and reliable national registers make it possible to study large patient groups and to collate information collected in different registers on an individual level using the unique personal identity code assigned to each permanent resident of Finland. Register data can be obtained for research purposes by application to the Finnish Social and Health Data Permit Authority Findata and to Statistics Finland. Data extraction, linkages, and pseudonymization are carried out by these authorities, and researchers can use the data through a special secure connection. Analyses producing overly precise information potentially enabling a person being identified must be amended to ensure the anonymity of persons included. The present study duly obtained ethical approval from the ethics committee of Tampere University Hospital (R20040R) and the relevant permissions from Findata (THL/5188/14.02.00/2020) and Statistics Finland (TK/1016/07.03.00/2020). In issuing the national guidelines for the treatment of GD for transsexual and nonbinary adults and for minors presenting with gender distress, COHERE Finland, operating under the Ministry of Social Affairs and Health, prompted comprehensive follow-up research on GR [36–38]. In accordance with Articles 6 e and 9 i and j of the Regulation (EU) 2016/679 of the European Parliament and of the Council [39], the individual informed consent of each registrar was not required.

Data extraction

Subjects referred to GIS were identified from the hospital databases of Tampere and Helsinki University Hospitals. The first appointment in the diagnostic team in either of the two GIS was recorded as the index date. The unique personal identity numbers of the subjects thus identified, with index date and age at the index date, were securely transferred to the Finnish Social and Health Data Permit Authority Findata, where the lists were merged. In those cases when subjects had attended the gender identity units of both hospitals, the earlier index date was taken to be the index date. In total 3,665 individuals were identified as having contacted the nationally centralized gender identity units between 1996 and 2019 (=GD group).

From the Population Register, eight controls matched for age and place of residence at birth were identified for each GD group member, four males and four females. Occasionally there may not have been enough subjects to extract a group of eight controls for all cases. The final sample included 29,292 controls. The cases and the controls were followed up in registers until 9 June 2022, or until their latest specialist-level psychiatric contact was registered, whichever earlier. Mean (SD) follow-up time was 6.9(0.02) years, median 5.7 years, maximum 26.4 years.

The Population Register does not grant researchers access to information on change of registered sex in identity documents. Only registered sex at the time of data extraction is included in the data. On the extraction date, 9 June 2022, 56.1% of the GD group were legally females, and of the controls 50%.

The Care Register for Health Care (CRHC) [40] was used for information on contacts to specialist-level psychiatric services for the GD group and the controls from 1994 to 2022 (excluding contacts due to gender identity assessments). The register, in operation since 1994, records all outpatient and inpatient contacts to specialist-level health services in Finland. Dates of admission and

discharge, service provider, the patient's age at admission and diagnoses (primary and two additional) for all contacts in specialist level psychiatric services according to ICD-9 (1994–1995) and ICD-10 (1996–) were extracted and ICD-9 converted to ICD10 using WHO conversion tables [41]. The CRHC was further used to provide information on GR surgeries that were included vaginoplasty/falloplasty and mastectomy.

The register of the Social Insurance Institution of Finland (KELA) including information on prescription medications purchased and information on their reimbursement by the national social insurance [42] was used to obtain information on hormonal GR (masculinizing/feminizing hormones) in the GD group. Persons duly diagnosed with F64.0 (since 2020 also F64.8) in the nationally centralized gender identity units are entitled to a special reimbursement (code121) for their hormonal treatment when it has continued for more than a year. Patients with specified endocrine disorders are also entitled to this reimbursement.

Measures

Sex as registered in the Population Register will be referred to below as sex or registered sex. For the controls, this invariably coincided with their biological sex.

The GD group subjects' index date and their age at index date were assigned to all their eight personal controls.

Psychiatric treatment history other than contact to GIS was described using the following variables: any history of specialist-level psychiatric treatment (yes/no), any history of psychiatric inpatient treatment (yes/no), specialist-level psychiatric treatment (any and inpatient) before the index date (yes/no), specialist-level psychiatric treatment (any and inpatient) after the index date (yes/no).

The diagnoses recorded in specialist-level psychiatric care were used in the analyses categorized to the main diagnostic groups F00–09, F10–19, F20–29, and so forth. When necessary, in order to further anonymize the data, main categories F00–09, F10–19, and F70–79 were combined in the analyses. A diagnosis in a psychiatric main category was recorded as present if it appeared in the register as the primary or as the first or second additional diagnosis.

Medical GR interventions used in the analyses were hormonal GR (indicated by purchases of masculinizing/feminizing hormones under special reimbursement code 121) and/or mastectomy and/or vaginoplasty/falloplasty.

In order to study change over time, index dates were classified to 5-year index periods (last period 4 years) as follows: 1996–2000, 2001–2005, 2006–2010, 2011–2015, and 2016–2019.

Year of birth (continuous) was used as a covariate.

Statistical analyses

The data were described using distributions of the categorical variables and mean(sd); median(IQR) statistics of continuous variables. Categorical variables were compared between the GD group and the controls with cross-tabulations and chi-square test/Fisher's exact test where appropriate (Table 1). Mantel-Haenzel test was used to explore linear associations. Continuous variables were compared using *t*-test and ANOVA. Cox regression accounting for the differences in follow-up times was used to predict specialist-level psychiatric treatment after the index date. Having the latest specialist-level psychiatric contact later than the index date was used as the dependent variable. Independent variables entered were first group membership (controls vs. GD patients who had not proceeded to medical GR [GD_GR–] vs. GD patients who had proceeded to medical GR [GD_GR+]), controlling for sex and year of birth. Next, index period was added, followed by the history of specialist-level psychiatric treatment before the index date. Hazard ratios (HR) with 95% confidence intervals (95% CI) are presented. Due to the large data size, the cutoff for statistical significance was set at $p < 0.001$.

Results

Numbers and demographics

Mean (SD) age at first appointment with GIS was 24.28 (9.3) years, median(IQR) 21 (9). Across index periods, the numbers of people first seen in GIS increased, their age grew younger and the proportion of those currently female increased (Table 2). Of patients seen

Table 1. Sex distribution, indicators of specialist-level psychiatric treatment and GR interventions among people seeking GR in the period 1996–2019 and their age and birth sex-matched controls

	GD group $n = 3665$	Controls $n = 29292$	p
Proportion females	56.1	50.0	
Any history of specialist-level psychiatric treatment	71.5	24.2	<0.001
History of psychiatric inpatient treatment	21.8	6.0	<0.001
Specialist-level psychiatric treatment before the index date	33.0	13.7	<0.001
Specialist-level psychiatric treatment after the index date	60.6	14.5	<0.001
Inpatient treatment before the index date	11.7	3.6	<0.001
Inpatient treatment after the index date	10.7	2.7	<0.001
Number (mean [SD]; median) of psychiatric treatment contacts	238.0 (9.7); 152	144.4 (6.4); 59	<0.001
Masculinizing/feminizing hormones with special reimbursement	37.1	0.1 ^a	<0.001
Mastectomy	15.9	0.2 ^a	<0.001
Vaginoplasty/ falloplasty	10.9	–	<0.001
Either hormonal or surgical GR interventions	38.4%	(0.1) ^a	<0.001

^aControls may have had hormonal treatments with special reimbursement for endocrine disorders and mastectomy due to medical reasons.

Table 2. Age (mean [SD]) and current sex (%) distribution of people who contacted GIS during the different index periods

	All cases	Legal adults at index date ^a	Proportion females at the time of data extraction ^b
1996–2000 (n = 72)	33.9 (9.9)	34.4 (9.6)	41.7
2001–2005 (n = 81)	32.8 (10.9)	33.1 (10.6)	48.1
2006–2010 (n = 407)	27.8 (10.5)	28.1 (10.5)	48.1
2011–2015 (n = 1115)	24.3 (9.5)	26.0 (9.6)	45.7
2016–2019 (n = 1990)	22.9 (8.1)	24.9 (8.1)	64.4

^aBecause GIS were only officially opened to minors in 2011, development of age distribution is also presented for legal adults only across time.

^bLinear by linear association, $p < 0.001$.

in GIS, 38.2% had obtained medical GR during the study period, most commonly masculinizing/feminizing hormones (Table 1).

The GD group had more commonly needed specialist-level psychiatric treatment in general and before and after the index date than the controls and contact had on average been more intensive in the GD group (Table 1).

A linear increase across index periods was seen among both the GD group and the controls in any psychiatric treatment history and history of psychiatric treatment before the index date (Table 3). Among the GD group, a linear increase was seen in psychiatric treatment after the index date calculated over the first four index periods and the relative risk (RR) compared to that of the controls increased across periods (Table 3). Although the follow-up time was shorter in subjects referred to GIS during the later index periods, the mean number of overall psychiatric contacts and inpatient periods did not change across index periods (data not shown).

Psychiatric diagnoses

The most common diagnosis in the first psychiatric contact was that of severe mood disorders (F30–39) in both groups, with a

higher prevalence in the GD group (Table 4). The second most common diagnosis in both groups fell into the category of anxiety disorders (F40–48), with no difference between groups, and the third most common into the category of disorders with onset in childhood (F90–99). All other diagnoses were rare. The same diagnostic groups predominated in the most recent recorded psychiatric treatment contacts. (Table 4).

Due to the small numbers presenting with any other diagnostic groups than severe mood disorders and anxiety disorders, analysis of possible changes over time in diagnostic distributions was explored dichotomizing index dates to 1996–2010 versus 2011–2019. The prevalence of the most common diagnostic groups (F30–39 and F40–48) remained stable over time in both groups. Disorders with onset in childhood (F90–99) increased in prevalence from 1996–2010 to 2011–2019 in both groups (GD group at first visit 4.8% in the earlier vs. 10.3% in the later period; controls 7.3% vs. 11.8%, respectively; GD group at the most recent visit 9.3% in the earlier vs. 14.3% in the later period, controls 7.0% vs. 14.9%, respectively; $p < 0.001$ in all comparisons). Developmental disorders (F80–89) were more commonly recorded at the most recent psychiatric contact in the later period in both the GD group (5.1% vs. 9.1%, $p = 0.005$) and the controls (1.8% vs. 4.3%, $p < 0.001$).

Psychiatric needs and medical GR

Of those GD patients who had received GR interventions, 15.3% had psychiatric treatment contact prior to the index date, and of those who had not proceeded to medical GR, 47.0% ($p < 0.001$). Of those who had received medical GR interventions, 52.9% had had some psychiatric treatment contact subsequent to contacting GIS, and of those who had not proceeded to medical GR, 66.7% ($p < 0.001$). Among those with no psychiatric contact before the index date, subsequent need for psychiatric treatment was less common but nevertheless considerable among those receiving medical GR (49.7% vs. 56.9%, $p < 0.001$), whereas among those already needing psychiatric treatment before the index date,

Table 3. Proportion (%), n/N) of patients contacting GIS during the different index periods and their age-matched controls with psychiatric treatment history and relative risk (RR) for the patients

	1996–2000	2001–2005	2006–2010	2011–2015	2016–2019	p (Mantel-Haenzel test for linear association)
History of specialist-level psychiatric contact						
Cases	59.7 (43/72)	61.7 (50/81)	64.6 (363/407)	71.7 (800/1115)	73.7 (1466/1990)	<0.001
Controls	16.8 (97/576)	17.8 (115/647)	22.8 (742/3254)	24.5 (2184/8911)	24.8 (3952/15904)	<0.001
RR cases versus controls	3.6	3.5	2.8	2.9	3.0	
Specialist-level psychiatric contact before the index date						
Cases	8.3 (6/72)	12.3 (10/81)	18.7 (76/407)	28.2 (314/1115)	40.3 (802/1990)	<0.001
Controls	1.2 (7/576)	5.4 (35/647)	10.6 (346/3254)	12.8 (1140/8911)	15.6 (2480/15904)	<0.001
RR cases versus controls	6.9	2.3	1.8	2.2	2.6	
Specialist-level psychiatric contact after index date						
Cases	54.2 (39/72)	56.8 (46/81)	58.0 (236/407)	63.7 (708/1115)	59.9 (1193/1990)	<0.001 /0.77 ^a
Controls	16.3 (94/576)	15.3 (99/647)	16.7 (545/3254)	16.1 (1438/8911)	13.1 (2085/15904)	0.1/0.02 ^a
RR cases versus controls	3.3	3.7	3.5	4.2	4.6	

^aAcross four first periods.

Table 4. Psychiatric diagnoses (primary or first or second additional diagnosis) recorded at the first and the last specialist-level psychiatric contact among the GD group and the controls with a history of such contact

	First psychiatric contact			Latest psychiatric contact		
	GD group <i>n</i> = 2622	Controls	<i>p</i>	GD group <i>n</i> = 2622	Controls <i>n</i> = 7090	<i>p</i>
F00–09, F10–19, F79–79	39 (1.5%)	255 (3.6%)	<0.001	67 (2.6%)	391 (5.5%)	<0.001
F20–29	50 (1.9%)	194 (2.7%)	0.01	111 (4.2%)	361 (5.1%)	0.04
F30–39	881 (33.6%)	1828 (25.8%)	<0.001	1139 (43.4%)	2368 (33.4%)	<0.001
F40–49	575 (21.9%)	1638 (23.1%)	0.1	796 (30.4%)	2303 (32.5%)	0.02
F50–59	48 (1.8%)	329 (4.6%)	<0.001	71 (2.7%)	337 (4.8%)	<0.001
F60–69	81 (3.1%)	94 (1.3%)	<0.001	241 (9.2%)	290 (4.1%)	<0.001
F80–89	91 (3.5%)	136 (1.9%)	<0.001	224 (8.5%)	281 (4.0%)	<0.001
F90–99	250 (9.5%)	791 (11.2%)	0.01	356 (13.6%)	979 (13.8%)	0.4

Note: The first contact may have been registered with only a z-code and all subjects may have 1–3 diagnoses, thus the sums of the columns are not 100%.

difference by medical GR status did not reach statistical significance (70.9% in GR+ vs. 77.8% in GR–, $p = 0.01$).

Multivariate models

Both those GD patients who had proceeded to medical GR and those who had not were more likely to need psychiatric treatment after the index date than were the controls (Table 5). Later need for psychiatric treatment contact increased markedly in later cohorts. Psychiatric treatment before the index date was a predictor of psychiatric treatment after the index contact. When both index period and psychiatric treatment before the index date were added into the model, GD_GR– and GD_GR+ groups had an equal risk for later psychiatric treatment. In addition, psychiatric treatment after the index date was predicted by female sex and later year of birth (Table 5).

Discussion

From the 1990s toward the present time, with vast increases in numbers contacting specialized GIS, the needs for psychiatric treatment among those seeking GR have increased absolutely and in relation to age and sex-matched population. The novel contributions of the present study arise from the comprehensive register data comprising a large group of unselected patients contacting specialized GIS and matched population controls as well as from the long time period covered. Earlier studies have seldom compared the psychiatric needs of GD patients with those of the general population or studied changes over time.

Over the study period, the proportion of those in contact with specialist-level psychiatric services also increased among the controls. RR in GD patients first decreased reaching its lowest before 2010, but thereafter the RR in the GD group it increased. Over time,

Table 5. Risk (Hazard Ratios [HR], 95% confidence intervals [CI]) of need for specialist-level psychiatric treatment after index date according to group membership, registered sex at data extraction, year of birth, index period, history of specialist-level psychiatric care before contacting GIS and medical GR interventions

	Model 1. Group membership, sex, and year of birth	Model 2. Group membership, sex, year of birth, and index period	Model 3. Group membership, sex, year of birth, and history of psychiatric care before the index date	Model 4. Group membership, sex, year of birth, index period, and history of psychiatric care before the index date
Group				
Controls	Ref.	Ref.	Ref.	Ref.
GD_GR–	6.4 (6.0–6.9)	6.0 (5.6–6.3)	4.1 (3.9–4.4)	3.9 (3.6–4.2)
GD_GR+	3.6 (3.4–3.9)	4.0 (3.7–4.3)	3.5 (3.3–3.8)	3.8 (3.6–4.1)
Registered sex female	1.5 (1.4–1.5)	1.4 (1.4–1.5)	1.4 (1.3–1.5)	1.4 (1.3–1.4)
Year of birth (continuous)	1.07 (1.07–1.07)	1.03 (1.03–1.04)	1.07 (1.07–1.07)	1.03 (1.03–1.04)
Index period	–		–	
1996–2000		Ref.		Ref.
2001–2005		1.6 (1.2–2.1)		1.5 (1.2–2.0)
2006–2010		3.9 (2.3–3.9)		2.6 (2.0–3.4)
2011–2015		7.5 (5.6–9.9)		6.4 (4.8–8.5)
2016–2019		25.0 (19.7–33.5)		21.0 (15.7–28.2)
Specialist-level psychiatric treatment before the index date			3.3 (3.1–3.4)	3.1 (2.9–3.2)

Note: ORs statistically significant at level $p < 0.001$ are highlighted in bold.

the number of patients contacting specialized GIS increased, and they presented at younger ages. These demographic changes corroborate findings from reviews and meta-analyses on the topic [6, 8, 9]. As far as we know, the increase over time in psychiatric morbidity among those seeking GR has not previously been presented.

The most common psychiatric disorders among the GD group were severe mood disorders and anxiety disorders. This is in line with earlier research both among adults and minors [14, 17, 18]. These disorders were also most common among the controls. No statistically significant changes were seen in the proportions of these disorders over time. The increase over time in disorders with onset in childhood obviously reflects the younger index age in later cohorts. Developmental disorders (F80–89 comprising autism spectrum conditions) were more common among the GD group, which corroborates the earlier literature [43]. The increases over time in these diagnoses may reflect both actual changes in the populations studied and also increased awareness of autism.

Multivariate models taking into account differences in follow-up times between index periods showed that psychiatric needs subsequent to contacting GIS were predicted by later index period, prior psychiatric needs, and later year of birth. The need for psychiatric treatment prior to contacting GIS also explained the difference first observed in subsequent psychiatric needs between those GD patients who proceeded to medical GR and those who did not. In the final model, GD patients, regardless of GR status, continued to experience greater psychiatric treatment needs subsequent to contacting GIS than did the controls. The most readily comparable earlier study [31], likewise reported increased psychiatric morbidity after medical GR. The risk they reported was slightly less than that presented here, but then their study focused only on patients who had undergone complete medical GR while our sample included all those who contacted the GIS. The subjects in their study were older at baseline, and their sample was treated well before the contemporary increases in contacts to GIS.

Proceeding to medical GR interventions was not independent of psychiatric treatment needs prior to contacting GIS. Those who proceeded to medical GR presented less commonly with needs for specialist-level psychiatric treatment before contacting GIS and after the index date. However, of those who underwent medical GR, slightly over half had a subsequent psychiatric treatment contact, and the proportion requiring specialist-level psychiatric treatment actually increased more among those who underwent medical GR. These observations are in line with the findings reported by Hisle-Gorman *et al.* [32] from a register-based follow-up study where the psychiatric needs of transgender and gender-nonconforming minors were much more common than among their siblings and did not decrease after medical GD. Their findings and ours do not suggest that medical GR interventions resolve psychiatric morbidity among people experiencing gender distress.

The increase in all the younger people contacting GIS and in psychiatric needs among them have taken place simultaneously with the emergence of the widely recognized crisis in mental health among adolescents and young adults throughout the Western world [44, 45], largely associated with the increasing use of social media [44–46]. Social influences that reduce stigma and barriers to care for people suffering from incongruence between their sexed body and lived gender experience likely improve mental health in this group and social media may offer invaluable support and belongingness that buffers against minority stress. However, social media influences may also result in adolescent

and emerging adult females – who present particularly frequently with identity confusion [47] – seeking for a solution to their distress through GR [11] and overshadow the need for psychiatric treatment.

Methodological considerations

A strength of the present study is the large, nationally representative register-based sample with a sizeable group of matched population controls. Reporting to these registers is compulsory for service providers. This research focused on specialist-level psychiatric treatment contacts that reflect severe psychiatric needs. Access to specialist-level treatment requires a referral that is evaluated and accepted by the specialist-level service, and mild to moderate mental disorders are treated in primary care. Gender identity assessments that may result in proceeding to medical GR are nationally centralized to two of the five university hospitals in Finland, providing an opportunity to reliably sample the GD group seeking access to GR interventions. The long inclusion period made it possible to analyze changes over time, constituting the novel contribution of this study.

Limitations of the study include that the psychiatric diagnoses registered in CRHC may not always be based on structured diagnostic interviews. However, clinical psychiatric diagnoses among specialist-level psychiatric services have been shown to be very reliable in Finland [48]. The study does not include transgender identifying persons who have not contacted the GIS and hence cannot provide information on their psychiatric needs and changes therein. Survey studies are more suitable for exploring experiences in population not contacting health services.

This study focused on changes in psychiatric profiles among people who had contacted the GIS in order to seek medical GR. Confirming a diagnosis of Transsexualism, Gender Incongruence or GD and medical GR are possible outcomes of the assessment in the specialized GIS, but some patients will need other kinds of interventions more urgently or may nevertheless choose not to pursue medical GR. Mental health treatment may also be recommended, but specialist-level psychiatric treatment, the target of the present study, nevertheless indicates severe psychiatric disorders regardless of pathway to this level of care.

Special reimbursement for hormonal treatments due to transsexualism/GD is only granted after a year's continuous use of hormonal treatments. Thus, patients who initiated hormonal treatments but soon discontinued will have been excluded from the group obtaining medical GR, meaning that the numbers of those initiating medical GR may have been underestimated. On the other hand, initiated but soon terminated hormone treatments likely have less impact on mental health and functioning than continued treatment.

Conclusion

The number of people contacting specialized GIS has increased vastly since the 1990s until today, and their mean age has become steadily younger. Along with this, their needs for psychiatric treatment have increased. Both before and after contacting GIS, they present with many more common psychiatric needs than do their matched population controls, even when medical GR interventions are carried out. Among people seeking GR psychiatric needs have to be carefully assessed and addressed, also when medical GR interventions are provided. This vastly increased pursuit of GR with increases in psychiatric comorbidities warrants cautious

assessment of the timeliness of medical GR and of other treatment needs that may be more urgent.

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Competing interest. None declared.

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EXHIBIT 139

The Battle Over Gender Therapy

More teenagers than ever are seeking transitions, but the medical community that treats them is deeply divided about why — and what to do to help them.



By Emily Bazelon

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Scott Leibowitz is a pioneer in the field of transgender health care. He has directed or worked at three gender clinics on the East Coast and the Midwest, where he provides gender-affirming care, the approach the medical community has largely adopted for embracing children and teenagers who come out as transgender. He also helps shape policy on L.G.B.T. issues for the American Academy of Child and Adolescent Psychiatry. As a child and adolescent psychiatrist who is gay, he found it felt natural to work under the L.G.B.T. “umbrella,” as he put it, aware of the overlap as well as the differences between gay and trans identity.

It was for all these reasons that Leibowitz was selected, in 2017, to be a leader of a working group of seven clinicians and researchers drafting a chapter on adolescents for a new version of guidelines called the Standards of Care to be issued by the World Professional Association for Transgender Health (WPATH). The guidelines are meant to set a gold standard for the field of transgender health care, and this would be the first update since 2012. What Leibowitz and his co-authors didn’t foresee, when they began, was that their work would be engulfed by two intersecting forces: a significant rise in the number of teenagers openly identifying as transgender and seeking gender care, and a right-wing backlash in the United States against allowing them to medically transition, including state-by-state efforts to ban it.

During the last decade, the field of transgender care for youth has greatly shifted. A decade ago, there were a handful of pediatric gender clinics in the United States and a dozen or so more in other countries. The few doctors and therapists who worked in them knew one another, and the big debate was whether kids in preschool or elementary school should be allowed to live fully as the gender they identified as when they strongly and consistently asserted their wishes.

Now there are more than 60 comprehensive gender clinics in the United States, along with countless therapists and doctors in private practice who are also seeing young patients with gender-identity issues. The number of young people who identify as transgender nationally is about 300,000, according to a new report by the Williams Institute, a research center at U.C.L.A.’s law school, which is much higher than previous estimates. In countries that collect national data, like the Netherlands and Britain, the number of 13-to-17-year-olds seeking treatment for gender-identity issues has also increased, from dozens to hundreds or thousands a year.

Just as striking, the types of cases have changed. Many of the current group of teenagers haven’t told their families, from a young age, that they feel they are a different gender, though they often say they internalized such feelings for years. The average age when a young person first comes to a clinic tends to be around 14 or 15, according to some clinicians I talked to. Cases of teenagers coming out as trans aren’t new. But their prevalence is. In addition, the current caseload is around two-thirds youths who were “assigned female at birth,” in the current parlance of the field, and identify as trans boys — or as nonbinary, in a smaller but growing number of cases. In the past, by contrast, most patients at gender clinics were trans girls who were “assigned male at birth.”

As they worked on a draft of the adolescent chapter of the Standards of Care, the big debate among clinicians was how they should respond to the thousands of teenagers who are arriving at their doors. Some are asking about medication that suppresses puberty or about hormone-replacement treatments. Leibowitz and his co-authors thought that the timing of the rise in trans-identified teenagers, as well as research from Britain and Australia, suggested that the increased visibility of trans people in entertainment and the media had played a major — and positive — role in reducing stigma and helping many kids express themselves in ways they would have previously kept buried. At the same time, the authors acknowledged that they weren’t sure that visibility was the *only* factor at play.

As they wrote in their December draft chapter, part of the rise in trans identification among teenagers could be a result of what they called “social influence,” absorbed online or peer to peer. The draft mentioned the very small group of people who detransition (stop identifying as transgender), saying that some of them “have described how social influence was relevant in their experience of their gender during adolescence.” In adolescence, peers and culture often affect how kids see themselves and who they want to be. Their sense of self can consolidate, or they can try on a way of being that doesn’t prove right in the long run as the brain further develops the capacity for thinking long-term. To make matters more complicated, as a group, the young people coming to gender clinics have high rates of autism, depression, anxiety and eating or attention-deficit disorders. Many of them are also transgender, but these other issues can complicate determining a clear course of treatment.

Without stating them outright, the draft raises tricky questions: Could some of the teenagers coming out as trans today be different from the adults who transitioned in previous generations? For them the benefits are well established and the rate of regret is very low. How many young people, especially those struggling with serious mental-health issues, might be trying to shed aspects of themselves they dislike?

Leibowitz and his colleagues knew these were delicate issues. They were deeply troubled when right-wing politicians grasped the unsettled nature of these matters — which barely registered for most Americans 10 years ago — and turned them into political dynamite. In 2019, right-wing groups, the Heritage Foundation and Family Policy Alliance, which fought for many years against same-sex marriage, held a meeting on “Protecting Children From Sexualization” that covered “controversial medical treatments to treat gender dysphoria,” which is defined as a form of distress and is also a psychiatric diagnosis. Model legislation followed. Organizations like Family Policy Alliance helped state legislators draft a ban on gender-related medical treatment for anyone under age 18. Arkansas passed the first such ban in April 2021, and over the next months, similar bills were introduced in 18 other Republican-led state legislatures.

WPATH is a 3,300-member international organization, mostly made up of health care professionals. It came into existence in 1979, the year it issued its first Standards of Care. These standards influence the positions taken by major medical groups, including the American Academy of Pediatrics and the American Psychological Association, and the coverage offered by health insurers and national health services around the world. Trans and nonbinary practitioners are helping to write and oversee the new guidelines, called the SOC8 because it’s the eighth edition.

Over the eight months I reported on this story, I talked to more than 60 clinicians, researchers, activists and historians, as well as more than two dozen young people and about the same number of parents. WPATH gave me exclusive access to the final SOC8 (which is divided into 18 chapters, most of which address treatment for transgender adults) and lifted some of the confidentiality agreements the authors signed. Now the final version of the new Standards of Care is scheduled to come out this summer — in the midst of a raging political battle.

When I started talking to Leibowitz last December, he was watching the political attacks unfold with growing alarm. In his own state, Ohio, there was a bill afoot to ban the care he himself provides to trans young people and sees as essential to their well-being. His group’s job for the SOC8 was to be “as rigorous and scientific as possible,” he said, about how to translate the evidence about gender care into clinical practice. But they were acutely aware that any unknowns that the working group acknowledged — any uncertainties in the research — could be read as undermining the field’s credibility and feed the right-wing effort to outlaw gender-related care.



Scott Leibowitz, a child and adolescent psychiatrist, helped lead the working group writing a chapter on adolescents for the Standards of Care, a set of guidelines from the World Professional Association for Transgender Health (WPATH).
Maddie McGarvey for The New York Times

The group was stocked with experts, including Leibowitz’s co-leader for the adolescent chapter, the Dutch child psychiatrist Annelou de Vries, who for 19 years has worked at what was the first transgender pediatric clinic in the world, and the clinical psychologist Ren Massey, who is a former president of the Georgia Psychological Association and is transgender. When WPATH released the draft of the SOC8 for public comment, Leibowitz and his co-authors braced for the inevitable conservative attack. For teenagers who have parental consent, the draft adolescent chapter lowered to 14 (from 16 in the previous guidelines) the recommended minimum age for hormone treatments, which can permanently alter, in a matter of months, voice depth and facial and body hair growth and, later, other features like breast development. It set a minimum recommended age of 15, for breast removal or augmentation, also called top surgery. (The previous standards didn’t set a minimum age.)

Opponents of gender-related care did, indeed, denounce all of this. But Leibowitz and his co-authors also faced fury from providers and activists within the transgender world. This response hit them harder, as criticism from your colleagues and allies often does. It arose from two of the conditions the draft chapter established in order for young people to start taking puberty suppressants and hormones. First, the draft said, preteens and teenagers should provide evidence of “several years” of persistently identifying as, or behaving typically like, another gender, to distinguish kids with a long history from those whose stated identification is recent. And second, they should undergo a comprehensive diagnostic assessment, for the purpose of understanding the psychological and social context of their gender identity and how it might intersect with other mental-health conditions.

Assessments for children and adolescents have long been integral to the Standards of Care. But this time, the guard rails were anathema to some members of a community that has often been failed by health care providers. “The adolescent chapter is the worst,” Colt St. Amand, a family-medicine physician at the Mayo Clinic and a clinical psychologist, posted on the Facebook page of International Transgender Health, which has thousands of members and functions as a bulletin board for the field. (St. Amand is on the working group for another chapter in the SOC8 on hormone treatments.) In a publicly streamed discussion on YouTube on Dec. 5, activists and experts criticized the adolescent chapter, with the emotion born of decades of discrimination and barriers to care. “This statement sucks,” Kelley Winters, a moderator of International Transgender Health who is an interdisciplinary scholar and community advocate in the field, said of the assessment. “This is talking about singling out trans kids, and specifically with a mental-health provider, not medical staff, to interrogate, to go down this comprehensive inquisition of their gender.” The requirement for evidence of several years of gender incongruity before medical treatment is “harmful and destructive and abusive and unethical and immoral,” said Antonia D’orsay, another moderator of the group who is a sociologist and psychologist. In January, in a public comment to WPATH, International Transgender Health blasted the adolescent chapter for “harmful assertion of psychogatekeeping” that “undermines patient autonomy.”

And just like that, after four years of painstaking work, Leibowitz, de Vries and the rest of their group were being called out as traitors by peers and the community they sought to care for. “We understood the enormity of the need for these standards from the beginning,” Leibowitz told me. “I’m not sure we recognized the enormity of the controversy. It’s a result of the fact that our world, the world of gender care, has exploded.”

In the 1950s and ’60s, a small cadre of doctors in Europe and the United States started to talk about how to evaluate adults who wanted to medically transition. Harry Benjamin, the endocrinologist for whom WPATH was originally named, embraced the idea that the people he agreed to treat (mostly trans women) were “born in the wrong body.” Fearing lawsuits from dissatisfied patients, the doctors were quick to exclude patients for reasons of mental stability. And, arbitrarily, they only included those who they believed would go on to pass as the gender they identified with, as Beans Velocci, a historian at the University of Pennsylvania, wrote in an article last year in *TSQ: Transgender Studies Quarterly*. Some doctors made trans adults promise to live as heterosexuals after they transitioned.

The small group of clinicians who wrote the first Standards of Care were all cisgender. After WPATH was created in 1979, transgender advocates increasingly gained influence in the organization, but many transgender people viewed subsequent versions of the standards as imposing paternalistic and demeaning barriers to treatment. For some genital surgery, the standards required adults to live for a year as the gender they identified with and to provide referrals from two mental-health professionals. The SOC8 is the first version to dispense with these requirements, adopting a model of “shared decision-making” between adult patient and surgeon.

The leap toward medical transition for young people occurred in the Netherlands in the 1980s. Peggy Cohen-Kettenis, a Dutch clinical psychologist specializing in children, began receiving referrals of teenagers who were experiencing gender dysphoria (then called gender identity disorder). But therapy wasn’t the primary answer, Cohen-Kettenis, who is retired, told me over the phone this spring. “We can sit and talk forever, but they really needed medical treatment.” As their bodies developed in ways they didn’t want, “they only did worse because of that.” She decided to help a few of her patients start hormone treatments at 16 rather than waiting until 18, the practice in the Netherlands and elsewhere at the time. She monitored them weekly, then monthly. “To my surprise, the first couple were doing much better than when they first came,” she said. “That encouraged me to continue.”

Cohen-Kettenis helped establish a treatment protocol that proved revolutionary. Patient Zero, known as F.G., was referred around 1987 to Henriette A. Delemarre-van de Waal, a pediatric endocrinologist who went on to found the gender clinic in Amsterdam with Cohen-Kettenis. At 13, F.G. was in despair about going through female puberty, and Delemarre-van de Waal put him on puberty suppressants, with Cohen-Kettenis later monitoring him. The medication would pause development of secondary sex characteristics, sparing F.G. the experience of feeling that his body was betraying him, buying time and making it easier for him to go through male puberty later, if he then decided to take testosterone. Transgender adults, whom Cohen-Kettenis also treated, sometimes said they wished they could have transitioned earlier in life, when they might have attained the masculine or feminine ideal they envisioned. “Of course, I wanted that,” F.G. said of puberty suppressants, in an interview in “The Dutch Approach,” a 2020 book about the Amsterdam clinic by the historian Alex Bakker. “Later I realized that I had been the first, the guinea pig. But I didn’t care.”

Over the next decade, Cohen-Kettenis and Delemarre-van de Waal designed an assessment for young people who seemed like candidates for medical treatment. In questionnaires and sessions with families, Cohen-Kettenis explored the reasons for a young person’s gender dysphoria, considering whether it might be better addressed by therapy or medication or both. The policy was to delay treatment for those with issues like attention-deficit and eating disorders or who lacked stable, supportive families, in order to eliminate factors that might interfere with the treatment. “We did a lot of other work before letting them start, which created a lot of frustration for them,” Cohen-Kettenis said. “Maybe we were too selective in the early stages.” In retrospect, she says, she thinks young people who might have benefited were excluded.

The stringent screenings seemed critical, however, given the opposition they faced. Other doctors, in the Netherlands and outside it, publicly accused them of recklessness. At a low moment, at a medical conference in the late 1990s, she said, they were likened to Nazis experimenting on children.

Cohen-Kettenis stressed that she and her growing team at the Amsterdam clinic were not channeling children toward a particular outcome. The Dutch advised what they called “watchful waiting.” Throughout his childhood, with his parents’ support, F.G. lived as a boy, with short hair and a gender-neutral nickname. But Cohen-Kettenis counseled parents to “keep the door open, as much as possible, for children to be able to change back.” Among the adolescents who came to the clinic beginning at the age of puberty, 41 percent went on puberty suppressants, and more than 70 percent received hormone treatments and went on to surgery.

The Amsterdam clinic attracted international interest. Norman Spack, an endocrinologist at Boston Children’s Hospital who began treating transgender adults in the 1980s, and Laura Edwards-Leeper, then a child psychologist there, visited Amsterdam in 2007 for a gathering of clinicians from countries including Canada, Britain, Norway and Belgium. Spack and Edwards-Leeper went back to Boston, where they and another doctor were opening the first dedicated gender clinic for kids in the United States that provided medical treatment based on the fundamentals of the Dutch approach — a comprehensive assessment before patients could begin puberty suppressants or hormone treatments and close consultation between a clinic’s mental-health professionals and medical doctors.

Scott Leibowitz joined the Boston clinic as a psychiatrist in training a year later. In the early days, families traveled long distances for appointments. The waiting list grew. Edwards-Leeper and Spack eventually shortened the period a child had to be in therapy before the clinic did its own assessment, from a year to between three and six months. “If a child was on the cusp of puberty, and anxious about how their body was about to change, we tried to squeeze them in faster, which I still think is really important,” Edwards-Leeper says.



Tori (a nickname), who is 13 and lives outside Atlanta: “With gender, it has been more and more, wanting more things to happen. And luckily I have parents who are willing to let me describe myself and be whoever I want.” Anne Vetter for The New York Times

In 2011, de Vries and her colleagues published the first of two landmark studies about medical interventions in adolescence. Among the first 70 patients who received puberty suppressants at the Amsterdam clinic after their initial assessment at the mean age of about 13½, the researchers found “a significant decrease in behavioral and emotional problems over time.” A second study published in the journal *Pediatrics* in 2014, of about 55 of those who went from puberty suppressants to hormone treatments at the mean age of about 16½, showed that five years after starting hormone treatments and at least one year after surgery, they had the same or better levels of well-being as a control group of cisgender adults their age. None of the 55 regretted their treatment. (The 15 of the original 70 who were not included in the follow-up study did not take part mainly because of the timing of their surgery.)

For the first time, a long-term, peer-reviewed study showed positive outcomes after medical treatment in adolescent patients who’d gone through Cohen-Kettenis and Delemarre-van de Waal’s protocol. They had all been through a version of the type of assessment the December draft of the SOC8 adolescent chapter would recommend years later. They had experienced gender dysphoria since childhood (according to their families), lived in supportive environments and had no interfering mental-health conditions. As is often the case in medicine, the question for those drafting the SOC8 would be how to apply the findings of a particular cohort to the growing numbers of teenagers lining up at clinics in a host of countries.

In the United States and Canada, meanwhile, two dueling approaches to therapy for young children, before they reached puberty, were vying for supremacy. At what is now called the Child and Adolescent Gender Center at the University of California, San Francisco, Diane Ehrensaft, a developmental and clinical psychologist, was counseling families to take what she and others called a “gender affirming” approach, which included a social transition: adopting a new name and pronouns for a child who expressed such a preference, along with letting kids dress and play as they pleased.

For years, Ehrensaft’s intellectual foil was Ken Zucker, a psychologist and prominent researcher who directed a gender clinic in Toronto. Between 1975 and 2009, Zucker’s research showed that most young children who came to his clinic stopped identifying as another gender as they got older. Many of them would go on to come out as gay or lesbian or bisexual, suggesting previous discomfort with their sexuality, or lack of acceptance, for them or their families. Based on this research, in some cases Zucker advised parents to box up the dolls or princess dresses, so a child who was being raised as a boy (a majority then) wouldn’t have those things to play with.

In 2012, the last version of WPATH’s Standards of Care, with Cohen-Kettenis and Zucker among the authors, cited his work 15 times and called social transition in early childhood “controversial.” The American Psychological Association said in 2015 guidelines that there was no consensus about a best practice for children before puberty, describing both accepting children’s “expressed gender identity” (citing de Vries and Cohen-Kettenis, Ehrensaft, Edwards-Leeper and Spack, among others) and, alternatively, encouraging them to “align with their assigned gender roles” (citing Zucker, among others).

At the end of 2015, the Canadian medical center that ran Zucker’s clinic in Toronto shut it down because of complaints from activists about his method. (Zucker sued the center for defamation and later received an apology and a settlement of \$450,000.) In February 2017, protesters interrupted and picketed a panel featuring Zucker at the inaugural conference of USPATH (the U.S. affiliate of WPATH) in Los Angeles. That evening, at a meeting with the conference leaders, a group of advocates led by transgender women of color read aloud a statement in which they said the “entire institution of WPATH” was “violently exclusionary” because it “remains grounded in ‘cis-normativity and trans exclusion.’” The group asked for cancellation of Zucker’s appearance on a second upcoming panel. Jamison Green, a trans rights activist and former president of WPATH, said the board agreed to the demand. “We are very, very sorry,” he said.

After that controversy, other providers were on notice that Zucker’s methods were no longer acceptable. His approach was likened to conversion therapy, which treats being gay or trans as a mental illness to be cured, and which many states and localities have made illegal.

The Amsterdam clinic shifted, too. Some Dutch families socially transitioned kids on their own, which de Vries and her colleagues accepted; they began counseling other families about social transition too. Though the Amsterdam researchers’ previous results, like Zucker’s, showed that most kids who came to the clinic in elementary school later realigned with the genders of their birth, and often came out as gay, lesbian or bisexual, de Vries and her colleagues now see those findings as a product of their time, when the children whom parents brought to the clinic included many boys with an interest in wearing feminine clothing and playing with dolls that didn’t turn out to be gender dysphoria. Today many Dutch parents are more accepting of this behavior, and the Amsterdam clinicians think that as a result, most of the children who come to the clinic are asserting a strong and persistent gender preference. It’s more likely that such children will stay the course of being transgender, research shows. One long-term study, published in 2021, of 148 kids in the United States who socially transitioned with their families’ support between the ages of 8 and 14, found that five years later their psychological well-being was on par with their siblings and a control group of cisgender peers.

There is a separate chapter in the SOC8 that focuses on young children and that recommends that health care professionals and parents support social transition when it originates with the child while also recognizing that for some kids, gender is fluid. An outstanding question, asked by gay commentators like the author Andrew Sullivan, is whether some kids who socially transition today, and remain trans, would have grown up to be gay or lesbian in previous generations. “I know there are worries that effeminate males can be assumed

to be female or masculine girls can be assumed to be male,” says Amy Tishelman, the lead author of the SOC8 chapter on children and a child psychologist who is the former director of clinical research at the gender clinic at Boston Children’s Hospital. “That’s not what we’re advocating. Support for trans people should not be a way of limiting what a girl or a boy or a woman or a man or a person can be.”



Marci Bowers, a gynecologic and reconstructive surgeon, is slated to be the next president of WPATH.
Ryan Young for The New York Times

A few months before the release of the December draft of the SOC8, WPATH had a preview of the firestorm to come. In October 2021, the journalist Abigail Shrier published a post called “Top Trans Doctors Blow the Whistle on ‘Sloppy’ Care” on the Substack of Bari Weiss, a former opinion editor and writer for The New York Times.” The word “sloppy” was a quote from Erica Anderson, a clinical psychologist who was a past president of USPATH and who worked at the U.C.S.F. gender center for years before leaving in October (for unrelated reasons). She told Shrier she expected more regret among young people because some providers were rushing them toward medication without sufficient mental-health evaluations.

Shrier also quoted Marci Bowers, a gynecologic and reconstructive surgeon who is slated to be the next president of WPATH, who voiced a separate concern about blocking puberty too early. Though there is no published data on this question, over hundreds of surgeries, Bowers has found that trans girls who don’t go through male puberty may find it difficult to have an orgasm after they have genital surgery as adults. They also could have less penile tissue with which to create a vagina, which can lead to more complications from surgery, according to Bowers. These concerns apply in a small percentage of cases in the United States, as most teenagers come to gender clinics at 14 or older, after puberty. But for the younger kids, Bowers advocated delaying puberty suppressants to a later stage of development.

Anderson and Bowers are transgender women, which brought more attention to their critique and to their decision to talk to Shrier, who is the author of a 2020 book, “Irreversible Damage: The Transgender Craze Seducing Our Daughters,” which many trans people and their allies abhor. Many trans health providers were furious. “I was like, Whoa, what is this? And then I texted Erica,” says Maddie Deutsch, the president of USPATH and a professor at U.C.S.F. as well as the medical director of the Gender Affirming Health Program there, who is also transgender. “We were all broadsided.” She worries about the political fallout. “States like Texas and Florida are looking to these articles to fan the flames.”

About a week after Shrier’s post appeared, USPATH and WPATH issued a statement opposing “the use of the lay press” for scientific debate about gender-related medical treatment. Anderson disagreed with the directive. “Some of our colleagues would have us shut up,” she told me in the fall. “No. It’s not OK to ignore the problems.” In late November, she and the child psychologist Laura Edwards-Leeper published an opinion essay in The Washington Post. They said they were “disgusted” by the proposed state bans on gender-related medical treatment for minors, but they warned that some providers in the United States were “hastily dispensing medicine” and skipping comprehensive assessments.

‘Young people are quite capable of understanding themselves, but not all of them will.’

The following week, news broke in Texas that the only gender clinic for adolescents that provides hormone therapy in the Dallas region, Genecis, was being disbanded, a result of political pressure from Gov. Greg Abbott. “We have wolves at the door,” says Ehrensaft, who worked with Anderson at U.C.S.F. and is an author on the SOC8 chapter on children with Edwards-Leeper. “Conversations among us get aired as controversy and confusion. You end up eating your own instead of making the wolves go away.” Others were scathing about placing blame. “Every time a law passes blocking trans youth from getting care, I hope it’s called an Edwards-Leeper law,” Andrew Cronyn, a pediatrician and a former adviser on policy about L.G.B.T. health for the American Academy of Pediatrics, wrote on a professional email list with more than 500 recipients. “And I hope that every time one of the youth who is blocked from affirmative care dies, she gets sent a copy of the obituary.” He subsequently apologized and the post was removed at his request.

When I spoke to Bowers in December, she distanced herself from Anderson and Edwards-Leeper. “The most important thing is access to care,” she said. “And that is a much bigger problem than the issue of how the medical community and transition is failing people.” But she remained intent on drawing attention to her concerns about the early suppression of puberty. “Sexual satisfaction is a huge thing,” she said. “You’ve got to talk about it.”

Partly in response to Bowers’s concerns, the December draft of the SOC8 adolescent chapter suggested that health care providers discuss “future unknowns related to sexual health” when families consider puberty suppressants. The Amsterdam clinic often waits to prescribe suppressants until later in puberty.

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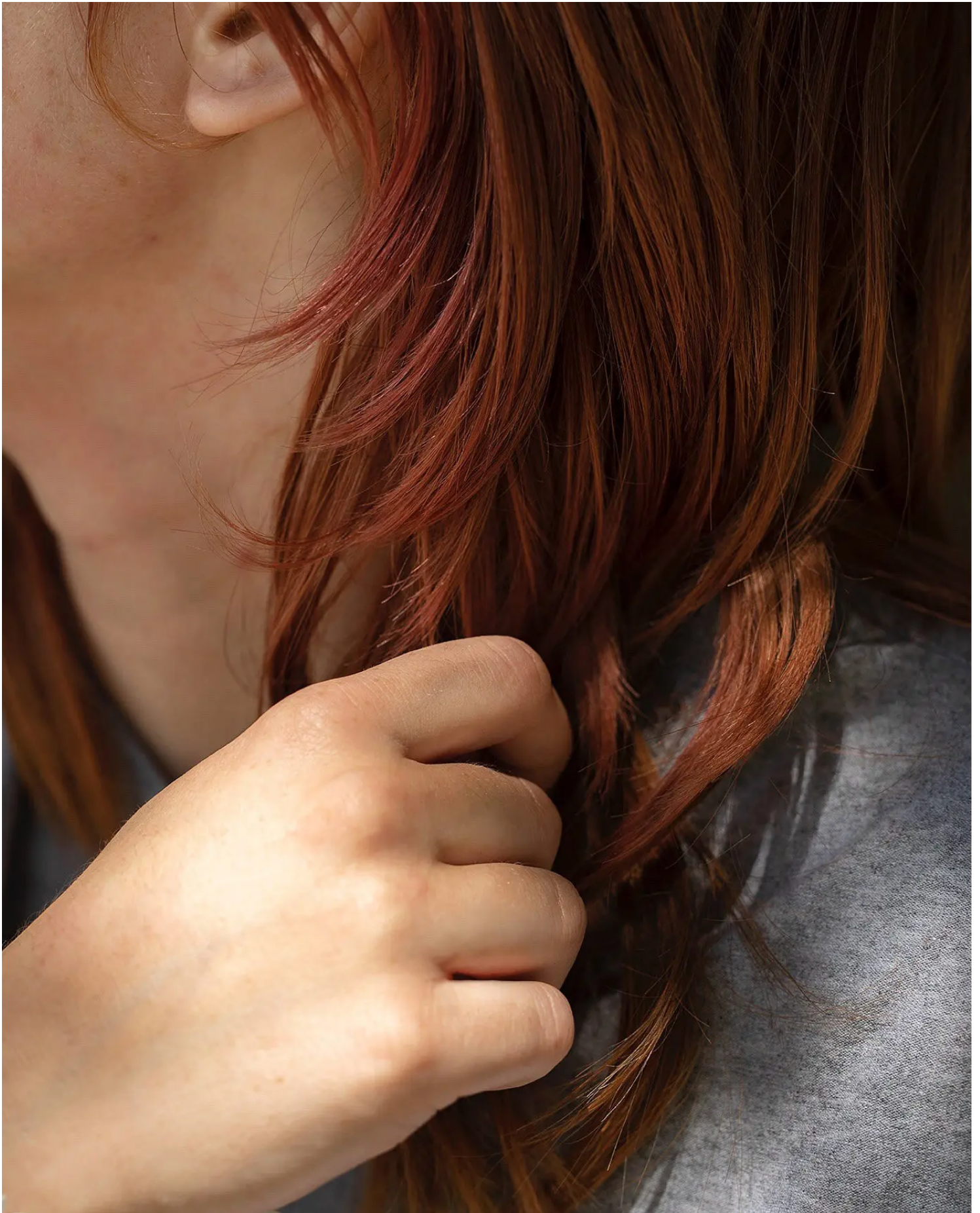
In the United States, waiting would be a major shift for the relatively small group of younger kids at gender clinics. For them, families weigh the relief the medications can provide against the health implications. Taking puberty suppressants (or hormones) for gender affirmation is “off-label,” meaning this specific use of the medications is not approved by the Food and Drug Administration. Off-label prescriptions are common and don’t imply anything improper, but there may be less research about the drug’s effects. If young people continue on to hormone treatments, puberty suppressants “probably” compromise fertility, especially for trans girls, Stephen M. Rosenthal, a pediatric endocrinologist at the gender center at U.C.S.F. who is on the group for the SOC8 chapter on hormone treatments, explained in a review last year for Nature Reviews Endocrinology. The medication can also prevent bone density from increasing as it typically would, and while levels returned to normal in trans boys who went on to hormone therapy, they remained low in trans girls who did the same, according to a 2020 study from the Amsterdam clinic. Little is known about the impact on brain development. “The relative paucity of outcomes data raises notable concerns,” Rosenthal wrote in his review. But he has no hesitation about prescribing puberty suppressants to kids who are deemed ready for them at his clinic. “The observed benefits greatly outweigh the potential adverse effects,” he said.

As winter approached, criticism of Anderson and Edwards-Leeper by their peers mounted as right-wing attacks on medical care for minors grew louder. In early November, the board of USPATH privately censured Anderson, who served as a board member. In December, the board imposed a 30-day moratorium on speaking to the press for all board members. That month, Anderson resigned.

In February, Governor Abbott ordered child-abuse investigations of parents and providers in Texas who give gender-related medical treatments to kids, generating national headlines and causing fear and anguish for families. In March, Arizona became the second state to ban gender medical care for minors. (The law, which applies to surgery, not medications, is scheduled to go into effect in 2023.)

The next month, four doctoral students in psychology asked to drop Edwards-Leeper from their dissertation committees at Pacific University, where she is an emeritus professor. And yet in the same week, she presented on the SOC8 adolescent chapter at the annual pediatric conference of the American Psychology Association, where the moderator of one of her panels praised her for her bravery in voicing her concerns about her field. The roller coaster of reaction, at the same time kids were losing access to care altogether in red states, shook Edwards-Leeper and her co-authors of the SOC8 chapters on adolescents and children. They didn’t want to be blamed for the right-wing backlash — neither by activists nor their own peers.

Watching the waves of conflict break, Leibowitz worried. He respected Bowers, Anderson and Edwards-Leeper for raising difficult issues but could see their views being mischaracterized to justify banning gender-related care. For people who don’t know much about the issues, “banning the care probably sounds more enticing than the idea that kids are dictating what treatment they should get,” he says. “Our guidelines are the voice from the middle.”



Kat (a nickname), who is 18 and lives in the Midwest: "When I was younger, I tried to wear girls' clothes, but it hurt. I still can't quite explain why. But I don't focus on gender that much now. It's just one aspect of myself." Anne Vetter for The New York Times

One morning over the phone, Leibowitz explained to me the elements of the mental-health assessments he saw as essential. His starting point, when a child presents as transgender, is obtaining a complete diagnostic profile. This means understanding the relationship between gender dysphoria and any other conditions (like depression or an eating disorder) or another factor that might be causing discomfort (like trauma or feeling confined by gender stereotypes) before coming up with a treatment plan. “It’s about understanding how the issues that might make someone experience gender dysphoria are connected,” he said.

As Leibowitz and his co-authors discussed revisions over video calls and email, colleagues who were critical of the draft chapter were also working together. Colt St. Amand, the psychologist and physician who disparaged the adolescent chapter on the Facebook page of International Transgender Health, brought together a collective of 16 mental-health professionals who are either transgender (as he is) or nonbinary, or have a close family member who is, to talk about how the assessment guidelines in the adolescent chapter fit with their lived experience and professional knowledge.

St. Amand thinks the purpose of an assessment is not to determine the basis of a kid’s gender identity. “That just reeks of some old kind of conversion-therapy-type things,” he told me over the phone in April. “I think what we’ve seen historically in trans care is an overfocus on assessing identity.” He continued: “People are who they say they are, and they may develop and change, and all are normal and OK. So I am less concerned with certainty around identity, and more concerned with hearing the person’s embodiment goals. Do you want to have a deep voice? Do you want to have breasts? You know, what do you want for your body?”

The draft of the adolescent chapter suggests that “extended assessments” may be useful for young people who are autistic or have some characteristics of autism without a full diagnosis. “One of the key accommodations for autistic youth is providing more time and structure to support the young person’s self-advocacy and communication capacity,” said John Strang, the specialist on the intersection of autism and gender identity on the SOC8 adolescent and child chapters and a neuropsychologist at Children’s National Hospital in Washington, D.C. But St. Amand calls a standard of extended assessments a “gross generalization” and “discriminatory.”

The priority for the collective St. Amand organized, which is working on a series of articles and training materials, is to ensure that transgender and nonbinary youth get the care they need rather than to shield teenagers from taking medication with effects they might later decide they didn’t want. St. Amand’s focus is on a young person’s response after beginning puberty suppression or hormone therapy. “If that is the right thing for them, then the response over time will tell me,” he says. “Once we start those interventions, we are checking in with the patient to see how they’re doing.” If the drugs don’t suit them, in his view, they can simply stop.



Colt St. Amand, a family-medicine physician at the Mayo Clinic and a clinical psychologist, is in the working group for a chapter on hormone treatments in WPATH’s new Standards of Care.
Ben Innes for The New York Times

Other providers, however, see an ethical dilemma stemming from the principle of justice — which promotes access to care for trans youth — and the principle of doing no harm. “I wouldn’t recommend just initiating testosterone straight away,” says Nathaniel Sharon, a child psychiatrist in New Mexico who has helped shape mental-health policy that affects transgender young people for the American Academy of Child & Adolescent Psychiatry. “Their voice gets permanently low. They’re hairy. Their clitoris is enlarged. And what do you do now? I just find that inappropriate and unsafe.”

The differences among gender-affirming providers over assessments and medical intervention don’t break down along cisgender-transgender lines. Some transgender practitioners, like Sharon and Ren Massey, a psychologist on the SOC8 adolescent chapter, support the chapter’s approach to assessments. “We need to understand that the reality is that adolescents go through a lot of developmental changes and have a lot of internal and external influences on their development,” Massey says. And some transgender activists also support a cautious approach. “It is life changing,” Jamison Green, the former president of WPATH, says of transitioning. “It is all encompassing. If it’s right for you, then it’s really important. It’s very easy to get interested in a new idea, get excited and not think it through all the way. Young people are quite capable of understanding themselves, but not all of them will. That’s why I think prudence is useful.”

Leibowitz had a related concern. For young people who have yearned for puberty suppressants or hormone treatments, reversing course can be difficult, he says. “Some people, once they make the decision, they’re not going to go against it, because they feel internal pressure to continue. They might be susceptible to feeling ashamed.”

Research is just beginning about why young people halt medical treatment and what it means for them. Some continue to identify as trans or nonbinary, like Nova West, a 27-year-old filmmaker I spoke to, who was happy with top surgery and the way testosterone lowered their voice and helped them build muscle — and then stopped the treatment because they didn't want to go bald (which sometimes happens) and felt they'd reached their "optimal gender expression."

Others decide they want to fully detransition and return to their cis identities. Grace Lidinsky-Smith, who is 28, has written about her regret over taking testosterone and having her breasts removed in her early 20s. She told me that she wished she'd had the kind of comprehensive assessment the last Standards of Care endorsed for adults. "That would have been really good for me," she said.

St. Amand and the collective argue that as no study has directly compared different types of assessment, there's no evidence that the Amsterdam clinic's approach is better. They point to research from clinics in the United States, which shows small-to-moderate improvements in depression and anxiety and large improvements in body-related dysphoria for young patients six months or a year after beginning medication. One of those studies is by the clinical child psychologist Laura Kuper, based on a sample of young patients, some of who went through a streamlined assessment process that Kuper helped design at the Genecis program in Dallas. "In medicine in general, if you find a new treatment and it seems overwhelmingly helpful, you start to roll it out before you have a 10-year follow up," says Kuper, who helped start the collective with St. Amand and is one of the authors of a SOC8 chapter on nonbinary individuals. "You continually reflect on new research and clinical findings as you go."

It's not yet known how well improvement in the short term predicts how teenagers today will feel as older adults about the changes they made to their bodies. In their draft chapter, Leibowitz, de Vries, Massey and their co-authors note that to date, only the Amsterdam clinic, with its comprehensive assessments, has results showing strong psychological benefits later in life for people who medically transitioned in their teens. Today, the Amsterdam clinic usually requires at least six monthly sessions (following a longer period on a waiting list) to begin medical treatment. "We've always said, Do it in a careful way," de Vries says.

Most of the young people today who come to clinics for treatment are affluent and white, live in progressive metropolitan areas and have health insurance. For them, gender-related care has become more accessible since 2016, when the Obama administration included gender identity in a rule against denying health care benefits on the basis of sex. If a provider deems the care medically necessary, it's possible to get insurance coverage for puberty suppressants, which can be injected or implanted under the skin, and hormone treatments, which can be taken orally, injected or applied as a gel or a patch. Each can cost thousands of dollars a year.

But in other parts of the country, there is often no gender clinic and sometimes no therapist or doctor to help transgender kids — who often still face bullying and harassment — navigate the process of coming out. "I have a patient in rural Mississippi who tried to find mental-health support, but it was traumatic," says Izzy Lowell, a family-practice doctor and the founder of QueerMed, which treats patients mostly via telemedicine (without in-person visits) in about a dozen states covering the Southeast. In effect, states like Arkansas are banning care where it is already rare.

'I say to parents, "I have no idea if your child is trans or not — they need an open field to explore."'

Finding care can also be harder for low-income or religious families and families of color. Lizette Trujillo, a mother in Arizona, told me that when she realized her son was trans several years ago, she found a parent support group on Facebook where her family was one of only two that were Hispanic. When she became the group's facilitator, she worked to get the word out in her community. But some parents are reluctant to join because of their religious backgrounds, and the wave of bills to ban gender-related medical treatment is generally increasing families' fears. "It's terrifying," Trujillo said. "It was the first time my son was actually afraid. 'Could this happen here? Will you make sure I'm safe?' He's 14."

Among those who had access to care, many parents and kids told me they were deeply grateful for a relatively smooth path to medical transition. Tori (a nickname) told her parents she didn't want a boy's body at the beginning of seventh grade. Her pediatrician in Atlanta referred her to QueerMed, Lowell's practice. "We asked all our questions," says Tori's father, who belongs to the local chapter of TransParent USA, a national support group. "What if she changes her mind? What can you and can't you come back from? There was no question on the table they didn't have a research-based answer for. You see your kid light up at the answers, and you say, 'OK, this is the right thing to do.'" Tori says she just wishes her transition could go faster.

Other parents, however, were bewildered by a landscape in which there are no labels for distinguishing one type of therapeutic care from another. In recent years, the Endocrine Society, the American Psychological Association, the American Psychiatric Association and the American Academy of Pediatrics have endorsed gender-affirming care as the only acceptable approach. But the major medical groups tended to speak in broadly supportive terms without specifying how providers should actually do it.

It's not clear how common comprehensive assessments are among gender-affirming providers in the United States. "The American Psychiatric Association doesn't really have an official position on the best way to treat the kids," says Jack Drescher, a clinical professor of psychiatry at Columbia University who helped write the group's position statements.

One mother in New England told me about talking to a therapist when her 6-year-old, Charlie (a nickname), became tearful about using the girls' bathroom and urgently asked for a buzz cut. Without meeting Charlie, the therapist told the mother during a single session that her child was a trans boy. Feeling overwhelmed, the mother took Charlie to another therapist, Julie Mencher. "I say to parents, 'I have no idea if your child is trans or not,'" Mencher told me. "They need an open field to explore." Charlie, who is now 12, told me that he figured out over the next year or so that he was sure of his male identity. His parents could see it solidifying and supported his wish to go on puberty suppressants. "The first therapist was right," his mother says. "But we needed a process we could trust."



Charlie (a nickname), who is 12 and lives in New England. Here's something I really remember: My older brother introducing me as "Hey, this is my brother" for the first time. I was so happy. We were at camp. I think I was around 7." Anne Vetter for The New York Times

I also talked to parents who were surprised when their teenagers came out as trans. Some wanted to be both supportive and cautious. Four years ago, when she was 12, Catherine (her middle name) left a note under her mother's pillow saying she was a trans boy. She followed a script from YouTube videos she'd watched of other teenagers coming out. Catherine's mother says she looked for a therapist who "would be open to whatever came," and found Jennifer Butzen, a licensed counselor in the Atlanta area. Butzen estimates that about two-thirds of her young clients with gender-identity issues eventually choose to go on hormones, while the other one-third either are nonbinary, nonconforming or trans but decide not to have medical interventions or are cisgender.

Butzen told me about the influence of the types of YouTube videos Catherine watched. She calls them "butterfly videos" because of their curated, beautiful portrayal of self-transformation. For some kids, the videos are a valuable resource — a bridge to the self they desire that they can't easily find in real life. But others, Butzen finds, are on a less coherent search for belonging. "Being trans comes with goals — this is what to do," Butzen says. "It comes with a support network and a cause to fight for." Online, where the stakes start relatively low, teenagers in progressive communities can trade in a cisgender, heterosexual, white identity — the epitome of privilege and oppression — to join a community with a clear claim to being marginalized and deserving of protection.

When Catherine started seeing Butzen, the pair talked about sexuality as well as gender identity and did exercises, using a whiteboard, about male and female stereotypes, which Butzen wants her clients to know they can challenge whatever their gender. Butzen also explained the physical and social changes that come with medical transition. "Everything became more real, and it got a little scary," Catherine says. "But I was in this forward movement, like, 'I have to do this.'"

But one day on the way to her appointment with Butzen, Catherine started crying and told her mother she'd been lying to herself. In retrospect, she thinks the YouTube videos gave her a way to relieve discomfort she felt about being attracted to girls, which wasn't accepted at her Catholic school. Later, Catherine came out as bisexual. If her parents had said no to the idea that she was trans, she says, "I would have revolted against them." But when they gave her room to explore, "I internalized what I wanted to do."

Other teenagers talked about the way misogyny affected their thinking. One 18-year-old, Kat (a nickname), started using a boy's name and pronouns four years ago and asked to take puberty suppressants, as a friend was doing in her Midwestern college town. Her mother said no to medication. She worried about the health effects and the role of peer influence; she also told me she wanted to make sure her child understood there was no right or wrong way to be a girl. "I didn't get it as well as other people did, what being a girl even meant," Kat told me, looking back. "And my mental health wasn't great. I was cutting around that time." At about 17, she went back to her girl's name and pronouns. "I still have weird, internalized misogyny in my brain I'm trying to get over," she says. "I don't even get where it's coming from."

In other families, a teenager's decision to come out was a source of prolonged conflict. F., now 18 and living in Maryland, started identifying as a trans boy and binding his breasts in seventh grade. His mother told me that when she found out, she told F. she didn't believe anyone was born in the wrong body. Later, she went to a protest at a gender clinic in Washington, D.C., which upset F. His group of friends, which included other trans and queer kids, became "a really big part in me being able to be myself," he says. These days, F., who has not medically transitioned, identifies as nonbinary. "I'm kind of coming to terms with my body," he says. "Who's to say my body is female? I'm not a girl and it's my body. Don't put your labels on me."

To parents who doubt the authenticity of a child's assertion or oppose medical treatments their kids strongly want, the smooth road to gender care looks like a dangerously slippery slope. Such parents have increasingly found each other online, in Facebook groups and on websites. Last fall, an international group called Genspect started holding web-based seminars that are critical of social and medical transition and, a spokeswoman said, gained thousands of members.

Some Genspect parents told me the rise in trans-identified teenagers was the result of a "gender cult" — a mass craze. (In February, an anonymous parent on a Substack newsletter affiliated with Genspect wrote a post called "It's Strategy People!" about how the group gets its perspective into the media by making sure not to talk about their kids as "mentally ill" or "deluded.") Other parents said they were not conservative and generally supported L.G.B.T. rights but not medical transition for their own children or usually for anyone under the age of 18. Several parents argued that though 18 is the legal age to vote, buy a gun and consent to medical treatment, in this single area of medicine — gender-related treatment — the age of consent should be 25, when brain development is largely complete. (At 18, these parents are aware, teenagers can go to Planned Parenthood, one of the largest providers of gender-affirming hormones in the country, and receive hormones after a roughly half-hour consultation and giving consent.)

Several Genspect parents told me their teenagers came out as trans after struggling for years with serious mental-health issues. One mother in Northern California said her child had previously been hospitalized for a suicide attempt and started identifying as trans while spending many hours online. The mother said yes to puberty suppressants at the recommendation of a local gender clinic, but her child became more volatile, she said. Around 15, her child wanted to progress to hormone treatment, which the gender clinic supported, according to emails I reviewed. When the mother refused, she became the object of her child's fury. "What if I'm wrong?" she asked. "Knowing my kid sees me as the barrier to happiness — that's the worst part. I feel like a monster."



Laura Kuper, a clinical child psychologist, is one of the authors of a chapter in the Standards of Care on nonbinary individuals.
Misty Keasler for The New York Times

As the United States battled over whether gender-related care should be banned or made more accessible, a few European countries that had some liberal practices concerning young people seeking medication imposed new limits recently. In February, the national health board in Sweden limited access to puberty suppressants and hormones before the age of 18 to “exceptional cases” and in research settings. The shift followed a Swedish public-television documentary that claimed doctors tried to hide spinal damage in a young patient whose bone density wasn’t adequately monitored. Finland has similarly restricted access. One month after Sweden’s decision, the National Academy of Medicine in France called for “great medical caution” regarding treatment for young people, citing health risks (including for bone density and fertility) and noting the unexplained rise in trans-identified teenagers.

In March, I visited the Amsterdam clinic to talk to de Vries about its trailblazing program and what she made of the responses of other European countries. We talked in her office, near a waiting room with a foosball table and artsy photos of an androgynous masked dancer. As a child, de Vries told me she resisted stereotypical gender roles. “Why were the boys asked to help the teacher carry heavy loads and the girls had to bring coffee and tea?” she said. “You could make me quite angry by asking me as a kid to do those things, as a girl!”

Working in her clinic now, de Vries is concerned about the waiting list, which she called “devastating.” Young people often wait two years or more for an appointment in the Netherlands. One of them, a theater student named Yaël who is now 22, told me that the delay felt endless. “My friends started growing beards, and people were looking at me like they were the guys and I was a girl or their little brother,” he said. “It was just very frustrating and depressing.” He remembered the day he started hormones at 16. “Someone came to the door to deliver a package, and when I signed for it, he said, ‘Have a good day, ma’am.’ For the first time, it didn’t bother me. I thought, I know in a couple of months you won’t say that.” He added, “I can’t imagine a life without being able to transition.”

De Vries said she was disappointed by the developments in Scandinavia and France. But she thought the retreat in those countries signaled a different kind of conservatism, about how to practice medicine in light of scientific uncertainty, from the bans in the red American states, fueled by anti-trans vitriol. The shift from European health authorities also suggested that scientists and physicians who don’t have the clinical experience of seeing young people receive gender treatments felt more constrained by the limitations of the research.

England’s National Health Service, too, asked for an independent review of the country’s gender-identity services (following a whistleblower’s report in 2018 that the nation’s only pediatric clinic was fast-tracking young people into medical treatment and a lawsuit by a former patient — who later detransitioned — over the care she received there). Hilary Cass, a prominent pediatrician, is leading that effort. In a preliminary report in February that doesn’t make a final recommendation, she said the “lack of available high-level evidence” about puberty suppressants and hormone therapy for young people was “too inconclusive to form the basis of a policy position” on whether to continue the treatments. She also described a “mismatch” between the ethical responsibilities of clinicians to meet certain standards before a treatment and the distress some young people feel about a detailed assessment because they want “rapid access to physical interventions.” Like the SOC8 adolescent chapter, Cass suggested that the Dutch approach to assessment is the one best supported by the research.

New findings continue to support that approach. In April, de Vries presented data at a pediatric conference, still unpublished, about more than 80 patients from the clinic’s early cohort who were now between the ages of 25 and 50. (The response rate was about 50 percent.) According to the answers they provided, the trans men were doing just as well, in terms of mental health, as the general population. The trans women were slightly below the norm. No one in the group had reversed their hormonal treatments or surgeries. There is no published research on the physical effects in middle or old age of having transitioned in adolescence; the Amsterdam clinic is now collecting data on this question.

'In our society right now, something is either all good or all bad. Either there should be a vending machine for gender hormones or people who prescribe them to kids should be put in jail.'

In a video chat this spring, I talked to F.G., the first patient to take puberty suppressants for gender affirmation 35 years ago, when he was 13. He's a veterinarian, and when we spoke, he wore a yellow track jacket and had a short brush cut and a patch of beard under his lip. He told me that when he was a child, he wanted simply to *be* a boy. But of course that was impossible. Taking medication to stop puberty, he said, saved his life. He waited until he was 18 for hormone treatment. It would be unusual now to have such a prolonged stint on puberty suppressants. F.G. says he never wanted to have children, though he's not sure if that's because he didn't know if he could. For years, he stayed away from romantic and sexual relationships, but that changed in his 30s, and these days he has a serious girlfriend.

F.G. has watched the rise in numbers of transgender young people with a mix of joy and trepidation. He thinks kids who want the medical treatment he received should go through a significant assessment process. "It makes me sound a bit of a hypocrite, because I needed that to be who I am," he said. And yet the time on the suppressants, to test the strength of his own desires, was essential to his peace of mind. "I really, really thought about it," he said, "and I've never been so sure of anything in my whole entire life."

In March, the Biden administration's Department of Health and Human Services put out a statement unequivocally supporting gender care for minors, "when medically appropriate and necessary," as a matter of federal civil rights law. But the backlash was gaining momentum. The bill to ban trans medical treatment that Leibowitz had been worrying about was moving through the Ohio House; in April, Alabama passed a similar bill. On Fox News, Tucker Carlson called treatment for young people "chemical castration." And the Florida Department of Health issued guidelines that opposed social or medical transition for kids of any age. Conservatives usually champion parental authority, but in families with trans kids, they were lining up to take it away.

Judges blocked the statewide bans, but in some cases, preteens and teenagers were losing access to a course of medication they'd already begun because pharmacies refused to fill prescriptions and doctors or hospitals preemptively stopped treatment, fearing liability or political opposition. In Texas, Ximena Lopez, a pediatric endocrinologist who worked at Genecis, the Dallas program that was forced to disband in November, sued to continue to see patients, and Leibowitz prepared to testify in support of her case. (Lopez has continued to see her previous patients and is temporarily accepting new ones under a one-year injunction.)

Leibowitz was frustrated by a political dilemma. To defend against the bans, some gender-affirming providers were oversimplifying aspects of the treatments. They said minors never or almost never had surgery at all, even though top surgery is important to some trans teenagers to relieve their dysphoria and is rising. (In the Kaiser Permanente health care system in Northern California, the incidence rose from a handful of operations in 2013 to nearly 50 in 2019, according to a study published in *Annals of Plastic Surgery* in May. Only two of the 200-plus teenagers in the study said they regretted the surgery at least one year later.)

To make the urgent case that medical interventions are necessary, some providers started emphasizing the risk of suicide among trans kids. The rate of suicide attempts among them in the previous year is terribly high — nearly 35 percent in a 2017 survey of high school students by the Centers for Disease Control and Prevention compared with single digits for the cisgender population. A 2020 study of trans patients of all ages, over more than four decades, at the Amsterdam clinic, found that deaths by suicide, which are fortunately rare, though still higher than for the general Dutch population, seem to "occur during every stage of transitioning."

In the overheated political moment, however, parents were getting the terrifying message that if they didn't quickly agree to puberty suppressants or hormone treatments, their children would be at severe risk. Many parents told me they'd heard the mantra: "It's better to have a live son than a dead daughter."

In individual cases, teenagers often say that being able to medically transition is lifesaving. Jack Turban, a fellow in psychiatry at Stanford Medical School, has become a major voice in the media and on Twitter among gender-affirming providers including on the question of medications and suicide risk. He leads a research team that worked with data from a 2015 survey of transgender adults in the United States. The survey asked respondents if they remembered taking puberty suppressants or hormone treatments before age 18. Using those adult recollections, Turban's team published articles in 2020 and 2022 finding an association between taking puberty suppressants and hormone treatments and having lower odds of suicidal thoughts in adulthood. But the studies didn't find the same link between taking the medications in adolescence and actually planning or attempting suicide. (Through a Stanford spokeswoman, Turban said he didn't have time to talk to me.)

Another 2022 study based on a different survey, by researchers from the Trevor Project (which provides crisis support to L.G.B.T.Q. young people), did show a 40 percent lower incidence in recent depression and in past-year suicide attempts for transgender and nonbinary 13-to-17-year-olds who said they had hormone treatments. There was no such finding for 18-to-24-year-olds.

The survey-based studies received prominent media coverage. But this research doesn't prove that young people who get puberty suppressants or hormones are at lower risk *because* of the medications, points out Christine Yu Moutier, a psychiatrist and the chief medical officer for the American Foundation for Suicide Prevention. The adults who remembered getting the treatments as teenagers could have had other advantages — “socioeconomic factors, having health insurance, having supportive families” — that better accounted for why their rates of suicidal thoughts or attempts were lower, Moutier says. And they could have received the medications they wanted in part because their mental health was evaluated as stable beforehand.

One of the clearest and most consistent findings about L.G.B.T. young people is that support from their families is essential for protecting them from a host of poor outcomes, from depression and suicide attempts to homelessness. The Family Acceptance Project, a research and intervention program for families of L.G.B.T. children, tells parents that refusing to use a child's chosen names and pronouns is a form of rejection. But the project stops short of saying that parents who delay or refuse to consent to medication, despite their children's wishes, are rejecting them or putting them at risk.

In the heat of a battle like the one raging over gender-related medical care for minors, insisting on precision about scientific evidence can seem nitpicky. But Leibowitz thinks gaining the trust of families necessitates acknowledging complexity. “It's irresponsible to reinforce very scary statistics to families in an attempt to gain consent for treatment,” Leibowitz says. “This strategy doesn't build the type of love and acceptance that a child needs, which is truly at the heart of preventing suicidal behavior.”

Maddie Deutsch, the president of USPATH, worries that the loud voices on all sides are the extreme ones. “In our society right now, something is either all good or all bad,” she says. “Either there should be a vending machine for gender hormones or people who prescribe them to kids should be put in jail.”

At a hearing called by the Ohio Assembly in May, supporters testified in favor of a ban on gender-related medical treatment, called the “Save Adolescents From Experimentation Act,” while opponents rallied outside the hearing-room window. One conservative activist singled out Leibowitz for attack, based on statements he has made about gender-affirming care and supporting transgender young people and their families. It felt surreal to him to hear his remarks turned into fodder for testimony about how parents were being “coerced” into agreeing to medical intervention. It was a reminder, if he needed one, that for all the care and moderation he tried to take, he would always be perceived as dangerous by the right.

The 62-page final version of the adolescent chapter, which WPATH sent me the first week of June, is scheduled to be released this summer. It will include a key change in the top-line recommendations of the SOC8, in response to advocates like International Transgender Health. In place of the December draft's recommendation of evidence of *several* years of gender incongruence before a preteen or teenager begins any medical intervention, the final chapter set a vaguer timeline: gender incongruence that is “marked and sustained over time.” Below their recommendations, Leibowitz, de Vries and their committee did note that several years of experience is important for teenagers who want hormones and surgery but said that for puberty suppressants, several years was “not always practical or necessary.” In the end, the chapter sided with the trans advocates who didn't want kids to have to wait through potentially painful years of physical development.

Leibowitz, de Vries and their co-authors held their ground on assessments. The final version of their chapter said that because of the limited long-term research, treatment without a comprehensive diagnostic assessment “has no empirical support and therefore carries the risk that the decision to start gender-affirming medical interventions may not be in the long-term best interest of the young person at that time.”

“Sometimes I feel that the field is so polarized that I worry whether the guidelines will be followed — how much authority will they have?” de Vries said of the upcoming publication of the chapter. “But I think a sensible reader will read a very nuanced, thoughtful approach that will help those who really need it.”

In the run-up to the release of the final SOC8, Leibowitz couldn't imagine a more nerve-racking moment to make the guidelines public. In early June, the administration of Gov. Ron DeSantis of Florida asked the state's health department essentially to ban gender-related medical care for minors — and in addition, to lay the groundwork to take that care away from trans *adults* with a report that justified ending Medicaid coverage for them.

Leibowitz said he hoped the SOC8 would improve the quality of care. He knew it wouldn't settle the larger debates about how well teenagers know themselves and how parents and professionals should respond to them. “It's convenient to say there's not enough evidence if you *don't* believe in the treatment — and that there's enough evidence, if you *do* believe,” Leibowitz said. The clinical experience he had, seeing kids every day, was uppermost. “Evidence matters, yes, but common sense matters, too.”

Emily Bazelon is a staff writer for the magazine and the Truman Capote fellow for creative writing and law at Yale Law School. Her 2019 book, “Charged,” won the Los Angeles Times Book Prize in the current-interest category. **Anne Vetter** is a photographer and writer in California and Massachusetts. Their work is focused on the fluidity of identity, as well as Jewishness, whiteness and wealth.