Psychotherapy for Gender Dysphoric Young People: It Is Not About Gender

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Posted Date: 5 August 2025

doi: 10.20944/preprints202508.0272.v1

Keywords: gender dysphoria; children and young people; clinical assessment; psychotherapy; developmental psychology; gender affirming care

Article

Psychotherapy for Gender Dysphoric Young People: It Is Not About Gender

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Abstract

In this paper, I explore the complex question of psychological assessment and therapy for gender dysphoric minors and their families. I begin with a description of the current nosology of gender dysphoria in children and adolescents in the DSM-5-TR. I then discuss the various models of care—gender affirming care, gender exploratory therapy/psychotherapy, and reparative/conversion therapies—before proceeding to a detailed discussion of the elements that comprise a psychological assessment and how this informs therapy. I draw on my own experience of gender dysphoric minors and their families to present a variety of cases that demonstrate the complex psychological dynamics involved in the aetiology of gender dysphoria. I conclude with a cautionary note about the inadequacy and dangers of gender affirming care and the "proper" domain of therapeutic action.

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Nosology is the practice of classification of diseases in the medical sciences, psychiatry, and psychology. To classify behaviours or clinical presentations as dysfunctional requires the making of attributions, defined as automatic causal beliefs about what constitutes normality. History shows that attributions are culturally bound, changing with the times like fashions in music and dress.

One major unresolved controversy is the degree to which dysfunctional behaviours are situationally determined or due to stable, internal qualities of the individual and the degree to which external versus internal attributional biases exist in assessors. Differing attributions along this dimension can have profound effects on diagnosis, management, and treatment (Gold & Gold, 2015). This is the case with gender dysphoric young people, particularly for those classified ROGD (rapid onset gender dysphoria), which is a recently identified sub-group, mostly affecting adolescent girls (Littman, 2018).

Clinical assessment of young people with gender dysphoria (GD) commences with an examination of the criteria for diagnosis in the *Diagnostic and Statistical Manual* Fifth Edition (DSM-5, 2022, Text revision). DSM-5 argues that being transgender or gender nonconforming is not a medical condition to be treated. Conflating transgender with gender nonconforming is a grave conceptual error in this writer's opinion. Their aetiologies, trajectories, and outcomes cannot be assumed to be analogous. There is no clinical taxonomy that pathologizes gender nonconformity. Rather, diagnosis and treatment should be "focus[ed] on dysphoria as the clinical problem, not identity per se" (DSM-5, p. 451). Because the DSM 5 contends that "being transgender" is not a pathological condition, it has accordingly revised the diagnostic criteria (and name) of the previously titled gender identity disorder to GD to "recognize" the clinical distress as the focus of the treatment, not the patient's transgender status per se.[1]

[1] This author has serious concerns with respect to the wording and the implied concepts in that wording used in the DSM 5 to describe GD. It assumes that gender is primary, that sex is "assigned at birth," and that sex is not dimorphic. It further assumes that there are alternative genders that cannot be described but that are neither male nor female. All these propositions are empirically scientifically indefensible, but as a clinician reviewing cases, one is required to ascertain a diagnosis based on DSM 5 criteria. For a summary of some of the issues, see Gornall, J. (2013). DSM-5: a fatal diagnosis? *British Medical Journal*, *346*

 doi:10.20944/preprints202508.0272.v1

Recent studies point to the high prevalence of collateral mental health issues in people identifying as transgender, which may predate or co-date the transgender identification. However, these mental health issues frequently remain ignored and untreated in current models of gender affirming care (GAC).

DSM-5 provides two subcategories for diagnosis—one for children and one for adolescents and adults. Criteria for diagnosing GD in children using reference to gender-typicality is misguided and unsound, characterizing as they do choices of toys, playmates, games, and clothing as the symptomatic signs of GD in very young children. This approach ignores the fact that a child may display an expressed gender that is manifested by social or behavioural traits that are incongruent with the child's biological sex but without identifying as the opposite gender. Even if children did identify as the "opposite" gender to their biological sex, it is likely due to other factors such as not yet having achieved gender constancy, traumatic experiences during the period of early gender development, or difficulties associated with the expectations of prescribed gender roles. Developmental sexual disorder, particularly intersex conditions, can also contribute to GD.

Similarly, the criteria for gender dysphoria in adolescents and adults are self-evidently problematic, relying on vague, poorly specified notions of "marked incongruences," "strong desires," and "strong convictions," and assuming that we are all in agreement about "typical" feelings and reactions of the various genders identified in contemporary society. We must also wonder whether fear of impending puberty justifies the chemical cessation of a developmentally normal biological process.

Models of Care for Young People with Gender Dysphoria

Gender medicine is currently one of the most contested fields of practice in child and adolescent health. The medical profession, via political and social pressure from advocacy groups, has propelled young people into medical and surgical treatments for GD, excluding the possible roles of psychology and psychiatry in the diagnosis and management of this presentation. This continues despite the conclusions of the Cass review (2024), the US Health and Human Services report (HHS, 2025) and numerous systematic reviews pointing to the very low quality of evidence upon which GAC relies (NICE, 2021; SEGM, 2021).

Proponents have to date acknowledged only two forms of treatment for young people—GAC or conversion therapy, the latter being a ragbag into which all approaches other than GAC have been consigned (Ashley, 2023; Jowett, Brady, Goodman, Pillinger, & Bradley, 2020). There is ample evidence that conversion therapy practised primarily on gay men in the last century has not been transferred to the treatment of transgender declaring people, so it is essentially a red herring that has provided a springboard for the passing of conversion therapy ban legislation. Psychotherapy plays little or no role in the gender affirming model, with GAC proponents claiming that any form of psychological therapy is conversion therapy. For example, most children (62%) referred to gender clinics in Canada are prescribed hormones on their first visit (Sinai & Sim, 2024). Notwithstanding, the claimed benefits of GAC and sex reassignment surgeries including reductions in psychological morbidities and reduced suicidality have been shown to be chimeras (Abbruzzese, Levine, & Mason, 2023; Biggs, 2022).

Recently, in some jurisdictions, conversion (gender reparative) therapy has been disaggregated from exploratory/dynamic psychotherapy, also called (gender) exploratory psychotherapy (GET) which explores all aspects of the young person's development, not just gender (Ayad et al., 2022; Kenny, 2024). Psychotherapy has been applied across a wide range of psychological conditions and found to be efficacious in many systematic reviews (Levy, Ehrenthal, Yeomans, & Caligor, 2014; Mufson et al., 2004; Ness et al., 2018; Shedler, 2010; Weisz, Weiss, Alicke, & Klotz, 1987). Its

(7909), 18–20. http://www.jstor.org/stable/23494723. There are no standardised diagnostic tests for GD, which is unlike almost any other field of medicine. [See Pearce, S. (2014). DSM-5 and the rise of the diagnostic checklist. *Journal of Medical Ethics*, *40*(8), 515–516. http://www.jstor.org/stable/43283058].

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applicability to young people with GD is gradually being recognized (D'Angelo, 2023; D'Angelo et al., 2021; Evans, 2023; Lothstein & Levine, 1981).

There is an inadequate number of research studies assessing the efficacy of psychotherapy with GD young people. These are urgently needed. Notwithstanding, the risk to benefit ratio is positive. The WHO (2014) standards for guideline development permit treatments based on low quality evidence in circumstances where the risks are low and alternative treatments are also supported by low quality evidence but have higher risk/benefit ratios. An early study compared the effects of sex reassignment surgery with psychotherapy. The authors concluded that more attention should be paid to psychotherapy, arguing that its most important contributions would be to the subgroup who cannot resolve their gender identity or decide whether to undergo sex reassignment, and for those who need extra support while they are undergoing hormonal treatment (Cohen-Kettenis & Kuiper, 1984).

Evidence supporting psychotherapy for GD, while comprising mainly case reports and small case series at this time, suggest that psychotherapy can reduce GD in some individuals (Ahumada, 2003; Bailey & Zucker, 1995; Bonfatto & Crasnow, 2018; Chiland, 2000; Churcher Clarke & Spiliadis, 2019; Coates, Friedman, & Wolfe, 1991; D'Angelo, 2020; Davenport & Harrison, 1977; Di Ceglie, 2009; Evans & Evans, 2021; Forester & Swiller, 1972; Greenson, 1964; Hakeem, 2012; Kirkpatrick & Freidmann, 1976; Lemma, 2018; Levine & Lothstein, 1981; Loeb & Shane, 1982; Lothstein, 1980; Lothstein & Levine, 1981; Shane & Shane, 1995; Spiliadis, 2019, 2023; Stein, 1995; Zients, 2003; Zucker, 2008; Zucker et al., 2003; Zucker & Wood, 2011; Zucker, Wood, Singh, & Bradley, 2012). Zucker (2001) cites 49 case reports on the treatment of children with GD using psychotherapy or psychoanalysis and concludes that psychotherapy can benefit children with GD (For a fuller review, see Ayad et al., 2022).

A recent approach to the care of GD young people is contained in recommendation 2 of the final Cass review (2024) that states:

Clinicians should apply the assessment framework developed by the Review's Clinical Expert Group, to ensure children/young people referred to NHS gender services receive a holistic assessment of their needs to inform an individualised care plan. This should include screening for neurodevelopmental conditions, including autism spectrum disorder, and a mental health assessment. The framework should be kept under review and evolve to reflect emerging evidence.

These conclusions have been strengthened by the publication of the *US Department of Health and Human Services (HHS)* on 1 May 2025 conducted by independent researchers, concluding that GAC has an unacceptable risk/benefit ratio, violates many of the tenets of the practice of ethical medicine, and that psychotherapy should be the first line of treatment for young people presenting with gender dysphoria.

Psychological Investigations of Gender Dysphoric Youth

There has been a recent shift in the importance assigned to psychotherapy prior to a young person embarking on medicalised gender transition, but many questions remain. What should be included in a psychological assessment? How do practitioners balance respect for patient autonomy and informed consent with the principles of beneficence and non-maleficence (Levine, Abbruzzese, & Mason, 2022)? How do we distinguish safeguarding from gatekeeping? Can we believe the DSM-5-TR and ICD-11 that trans individuals are not "abnormal, diseased, or in need of psychiatric treatment?" Do comorbidities improve with GAC or does psychotherapy relieve GD, obviating the need for profoundly consequential bodily interventions? Does an absence of psychological evaluation and psychological therapy constitute malpractice given our knowledge that most GD minors have compromised mental health, family dysfunction, and social deficits?

Psychotherapy therefore requires a detailed assessment that includes a history of the presenting problem, its current status [e.g., preferred name and pronouns only, fully socially transitioned, taking puberty blockade (PB), taking cross sex hormones (CSH), considering surgery]; early history [e.g., childhood experiences, adverse childhood events (ACE) (physical, emotional, sexual abuse, other

 doi:10.20944/preprints202508.0272.v1

trauma), attachment quality to significant others, perceived marital and parental dyads, siblings], attitude of family to GD declaration; awareness of sexual orientation, social, romantic, and sexual history, symptom review and comorbid conditions, medical history, psychiatric history, current medications, substance use, social and peer history, academics, history of bullying/cyberbullying, exposure to pornography, and special interests/talents (Kenny, 2024).

Most children will grow comfortably into their sex-based designated gender if their developmental trajectory is not derailed by early medicalization. Currently, there is no clear reason for those who do not. We do not yet have sufficient evidence to assign causal roles to biology, cognition, or socialization, including familial dynamics, or trauma. A complex interplay of these factors determines the endpoint of a declaration from the child or young person that they are transgender or non-binary. We do know that attachment trauma or disruption (Cooper et al., 2013; Giovanardi et al., 2018; Kozlowska, Chudleigh, McClure, Maguire, & Ambler, 2021), maladaptive coping strategies, socialization (Basu, Zuo, Lou, Acharya, & Lundgren, 2017), in particular peer relationship difficulties, and internalized homophobia (Aspenlieder, Buchanan, McDougall, & Sippola, 2009; DeLay, Martin, Cook, & Hanish, 2018) and misogyny are all elements of the GD presentation that require careful exploration.

Cass (2022, 2024) noted that GD is multi-determined with no dominant optimal treatment pathway. There remains intense professional disagreement regarding the most appropriate intervention for individual children. However, when in doubt, and given the irreversible consequences of medicalization, surely the preferred option is to do no harm.

I have worked with a great many young people using exploratory, expressive, and supportive psychotherapy, and family therapy to assist young people and their families to reconfigure their understandings and relationships. It is often the case, in my experience, that, while a transgender declaration has brought the family into therapy, it ceases to be the focus after the individual, structural, and systemic factors within the family have been illuminated, analysed, understood, and resolved. I have proposed an assessment protocol for young GD people that requires consideration of a complex network of factors which I discuss in the next section.

Developmental Disorders and the Fluctuating Course of Adolescent Gender Development

Psychological Disorders

The first fork in the diagnostic work up is screening for psychological comorbidities and how these interact with body perceptions and discomforts. It is common for GD youth to have a history of body dysmorphia and/or eating disorders, self-harm, suicidality, suicide attempts, internalizing disorders (e.g., depression, generalized anxiety, social anxiety, separation anxiety, and OCD) and externalizing disorders [oppositional defiant disorder (ODD) and conduct disorder (CD)], which generally indicate problematic parenting, and/or incipient borderline personality disorder (BPD). Substance use/abuse and/or psychosis, although rare, also need to be assessed in this group (Kozlowska, McClure, et al., 2021).

Noting the frequency of the co-occurrence in young GD people of other body perception disturbances, Van Zyl (2024) hypothesized that the overt affective distress targeted at the body signals underlying regret, envy, and aggression that is defensively denied, and therefore cannot be conceptualized or symbolized, thus finding expression in a concrete way, that is, in body dissatisfaction. Once the projection of distress and a seeming solution in bodily correction have been identified, the distress appears to resolve, erroneously confirming the focus of treatment on the body as correct. It is extremely difficult to assist a young person to retreat from such a position, particularly when the medical profession colludes with the "desired reality-defying" goals. Van Zyl identifies several personality characteristics in those presenting with body image disorders, including being temperamentally resistant to change, a propensity to ignore or deny emotional discomfort, rendering the body an easier target for their angry acting out, and impaired capacity for mentalization on a

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background of having experienced (unresolved) developmental challenges or trauma. It is noteworthy that society at large and the medical profession in particular do not collude with the young person in any of the other body image disorders in the way that GD has been. All but GD are perceived as psychological disorders and offered psychotherapy.

Some young people, who are vulnerable as a result of developmental and psychological disorders, a fragile ego that is prone to fragmentation, and magical and/or concrete thinking, and other factors such as attachment ruptures and unresolved grief, when faced with the challenge of their developing sexed bodies at puberty and impending adulthood retreat from these challenges and attempt to halt or derail development. Several psychotherapists (Hakeem, 2012; Kenny, 2024; Sinai & Sim, 2024) have identified anxious or disrupted attachment to the primary caregiver, problems in self-other differentiation, and a harsh superego forged as a result of parental criticism, emotional unavailability, or uncontained anxiety as key factors in the child's subsequent attack on his/her own body.

Case example:

A family of two boys aged six and 12 years lost their mother after a long illness. Father was a war veteran with PTSD and alcoholism and unable to manage his children's grief. The older boy began to mercilessly bully his younger brother, who started to cross-dress, hiding in his mother's wardrobe, and wrapping himself in her clothes. At age 12, he came out as transgender, which represented his attempt to bring his loved, lost mother back to tend to the gaping emotional wound inside. This profound attachment rupture and unresolved grief persisted into adulthood. The younger brother continued to cross dress but with great shame and secrecy. It was not until he underwent psychotherapy to truly grieve for the lost love object, the "only person in the world who cared about me" that he was able to relinquish his cross dressing as he learned to care for, and "parent" himself.

Neurodiversity

Many young people with GD are neurodiverse and these conditions must be assessed and treated. These include ADD/ADHD, autism spectrum disorders (ASD), intellectual disability (ID), specific learning disability (SLD), and academic problems. People with ASD have a higher propensity to develop obsessional foci on seemingly random stimuli of which an obsession with gender is one. Careful listening and exploration will reveal many misunderstandings about how gender transition will improve their wellbeing, including growing a penis, becoming heterosexual if they a same sex attracted, growing taller, being able to bear children after years on testosterone, being able to recover their breasts after double mastectomy, and being happier. Without careful discussion in a safe space, such misconceptions may never be detected or corrected, and the young person may be left with their erroneous beliefs, using them as the basis upon which they make irreversible decisions about their bodies.

Further, young people's gender perceptions change over time and it is dangerous for gender clinics to act on first pronouncements of perceived gender. A significant proportion (~51%) of young people with ASD express anxiety related to gender while not expressing unhappiness with their biological sex (60%) or a desire to change their biological sex (70%) (Adesman, Brunissen, & Kiely, 2020). It is therefore imperative that anxiety about gender not be used as an indicator for medical interventions in ASD adolescent populations.

Cognitive Style/Immaturity

Cognitive immaturity, magical and concrete thinking, cognitive rigidity, cognitive distortions, and lack of understanding or misunderstanding of gender ideology and capacity to critically review it, given the illogical and scientifically unsound basis of the ideology are all cognitive factors that need to be explored in young people presenting with GD. These cognitive errors often extend to confusions between the concept of male/female, which is based on biological sex, and

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masculinity/femininity which is based on gender roles and gender expression. Here are some of examples from my clinical practice.

Case example 1:

A young boy has a special needs younger sister who gets all the attention. Watching his mother tend to his sister one day, he said "Mummy, will you only love me if I am a girl?"

Case example 2:

A pre-adolescent boy (11y) with an older brother (16y) suddenly started wearing makeup and nail polish and demanded his mother buy him female clothing. He declared himself trans. His father was closely attached to his older brother with whom he shared the same interests (racing cars, football, fishing etc) and spent most of his free time. He described his younger son as a "mummy's boy who will probably turn out to be a poofter if he isn't already."

Case example 3

A post-pubertal female (15y) from a Mediterranean family suddenly declared herself transgender. During the assessment, she told me that fathers stopped talking to their daughters after they started their periods. Her father told me during a parental assessment that he did not have much in common with his quirky, bookish daughter and found his relationship with his son much easier and more enjoyable. When asked about showing his daughter physical affection, he replied that fathers had to be very careful about doing that in the era of *#MeToo* and radical feminism which he interpreted to mean that "all men are [potentially viewed as] abusers."

The first child made an error in attending to the wrong dimension as the source of the attention provided to his sister—her gender rather than her disability. The second boy tried to resolve his anguish at his father's disdain by defiantly amplifying the dimension of his development so reviled by his father. The girl in the third example, who had ASD traits, wanted her father's attention and believed she needed to change sex—a cognitively concrete solution—in order to get it because she had observed the father she wanted interacting with her brother in a way that she coveted for herself.

Cognitive immaturity can derail the development of relatively "normal" adolescent girls, who are generally prone to low self-concept, depression, and insecure body perception during the pubertal period, so they are vulnerable to suggestions that they can obtain the "ideal" body through gender transition. Many are also unimpressed with female gender roles and prefer the freedom, individuality, and ascendancy that are characteristics attributed to males. Girls may misguidedly think that they must turn themselves into males to achieve the desired societal status. This group of girls will rarely demand or desire the physical characteristics of males, such as male genitalia or male secondary sexual characteristics; hence they are not gender dysphoric according to DSM 5 but may be mistaken to be so by gender affirming health practitioners because of their statements about wanting to be male.

Cognitive distortions can also arise around the developmentally normal increase in body fat in females during pubertal onset. Comparison between the aesthetic ideals portrayed by the media and the reality of one's actual body shape can become confronting to young girls struggling to accommodate all the significant changes in their bodies at this time. Failure to comply with perceived ideals can result in distorted body image, loss of self-esteem and depression, followed by attempts to narrow the gap between body perception of the real and ideal through disordered eating that may become an eating disorder. It is not surprising that there is a close relationship between GD and eating disorders. The same immature thinking is applied to both the gendered body and the physical body with the result that some adolescent females will develop both conditions in an attempt to return to the ideal of pre-pubertal "androgynous slimness" (Korte & Gille, 2023).

Case example:

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> Elodie was 14 when she suddenly declared to her parents that she was transgender. This came as a shock to her parents who said that she was a really "girly" girl when younger, loving all the accoutrements of femininity. They sought a consultation to assess whether she was genuinely GD. Elodie had a formal diagnosis of ASD level 1 and was somewhat socially awkward. She stated categorically that she was trans and had to do something about it immediately. I asked her what made her so sure that she was trans, and she said, "I hate my breasts. Real girls would not hate their breasts."

Sexual Development and History

Exploration of the child's sexual knowledge, sexual anxiety, and romantic/sexual relationships, and possible sexual abuse experiences all require sensitive yet thorough exploration. Is there an emerging awareness of ego dystonic sexual orientation that could result in internalized homophobia, which often occurs in the presence of external homophobia from cultures, parents and/or friends? Emerging awareness of ego dystonic sexual orientation resulting in internalized homophobia can be challenging for some adolescents. Even in the age of Pride and Mardi Gras, young people awakening to the realization that they are gay can be a confronting and lonely experience (Gray, Sweeney, Randazzo, & Levitt, 2016).

The following features are common in the sexual histories of young GD adolescents: They

a. have been disappointed in their first tentative attempts at romantic relationships.
b. have had no sexual experience except for crushes from a distance, hand holding and kissing.
c. disdain genital sex as "gross" (girls also disdain childbirth).
d. are indifferent to loss of sexual function and fertility.
e. are confused about the nature of "trans" relationships e.g., A self-declared non-binary male (natal sex = male) in a relationship with a transgender declaring natal female (i.e., a trans man) told their parents they were in a gay male relationship. Similarly, two natal females, both transmen but who had not undergone medical or surgical intervention, rejected the suggestion that they were a lesbian couple and stated that they were a gay male couple.

I have noticed in my clinical practice a trend for GD adolescent females to have commenced menstruation early, often while still in primary school. Many of them report intense discomfort with having to cope with their personal hygiene around the menstrual cycle when their friends remain blissfully ignorant of what awaits them. They are often confused by their labile moods, bodily discomfort, and appearance of acne. They resent their menstrual cycle as an imposition with which they feel ill-equipped to cope. Some think it unfair that only girls must suffer such indignities. The promise of later fertility and procreation are of little comfort against these ever-present irritations and impositions of the developing female bodies.

Another relevant factor is early exposure to online pornography, which some girls experience as disturbing, even traumatizing. Certain forms of misogynistic violence including child pornography, which is a form of exploitative child sexual abuse, has probably made a contribution to the increase in GD since 2000 with the rise of the internet and the proliferation and easy access to pornography (Nadrowski, 2024). Premature exposure to misogynistic, violent, or "extreme" sex that conflates pleasure, subjugation, and pain contributes to the development of internalized templates or schemas of sex that normalize outliers of acceptable sexual behaviours, thereby distorting gender roles, creating gender inequality, and making young people vulnerable to online messaging, social media, and online predation. The accompanying fear and vulnerability that young females may experience in such situations leads to the reasoning that they would be less at risk and less fearful if they were male.

Family Constellation and Interpersonal (Intrafamilial) Factors

Studies from the developmental psychology literature about factors that influence gender development in traditional families (McHale, Updegraff, Helms-Erikson, & Crouter, 2001;

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Pierrehumbert et al., 2009; Sumontha, Farr, & Patterson, 2017; Tenenbaum & Leaper, 2002) can illuminate parental gender attitudes and behaviours (Dawson, Pike, & Bird, 2016) in families with a gender variant child (Riley, Sitharthan, Clemson, & Diamond, 2011; Zucker et al., 2012). In GAC, the child is considered as an entity separate from his/her "being-in-the-world" and assumed to have an intrinsic, immutable understanding of his/her gender and this alone forms the basis of treatment. Family conflict/dysfunction, marital and sibling dynamics, in particular, anxious or broken attachments with primary caregivers, overprotective or over-controlling caregivers who create a drive for premature autonomy and independence in their children, child maltreatment (Bandini et al., 2011), marital dysfunction, marital breakdown, and parental wish for an opposite sexed child all figure in the life histories of transgender declaring children (Kaltiala, Heino, Marttunen, & Fröjd, 2023).

GD might be better understood as a relational process rather than an inherent property of the individual (Celenza, 2014). It is essential in any ethical treatment to illuminate the interactional dynamics (Ehrenberg, 2010) in which young children assert that they are transgender rather than unthinkingly affirming their cross-gender assertions and going down a "gender-affirming" i.e., medical and surgical path to treatment instead of casting a wider lens over all the possible factors at play. This can only be achieved by painstaking history taking and a systematic analysis of family and social dynamics that are affecting the child's development.

Childhood maltreatment is frequently found in the medical histories of gender dysphoric individuals, with one study reporting that 25 percent of a sample of 109 adult MtF transgender persons disclosed child maltreatment (Bandini et al., 2011). More serious maltreatment was associated with higher body dissatisfaction. Abuse from a same-sex parent may direct the child to identify with the non-abusing, opposite-sex parent. Insecurely attached preadolescent children experience lower gender contentedness and fewer gender-typical feelings compared with securely attached children (Cooper et al., 2013). Evans (2024) has also observed that young people at risk of GD often have anxious attachments to their primary caregivers who are perceived as intrusive and demanding. Fathers in such families are often distant, absent, or unsupportive, thereby hindering developmentally appropriate separation from mother. The young person deflects onto their own bodies their guilt and aggression towards their mother in pursuit of a liberated, autonomous self.

Case example

> A 13-year-old girl, a highly gifted artist, who, before gender ideology, would have been described as a tomboy with predominantly male interests and male friends declared herself transgender, changed her name and pronouns, cut her hair very short, and wore androgynous clothing. She started to work out to build her muscle mass. In therapy, she was insistent that she was strong and able to look after herself and watch out anyone who tried to bully her. She frequently referred to the weaker and hence more vulnerable status of women in our society, and that she did not intend to be weak or vulnerable. I learned during her therapy that her mother had been sexually assaulted as a child and young adolescent by a male relative and raped in later adolescence by a different perpetrator. This girl's mother had disclosed her history to her daughter as a salutary warning about the dangers of being female in an unsafe, predatory, male-dominated world. Her daughter's solution to keeping herself safe was to become male. Therapeutic work with her mother, who was a successful professional and happily married to her daughter's father, to change her messaging about the vulnerability of women allowed her daughter to gradually relinquish her transgender identity and return to her tomboy status and gender non-conforming interests and activities while acknowledging her female sex.

It is not uncommon to meet families in which one parent had desperately wanted a child of the opposite sex. Unable to resolve her (these parents are more frequently mothers) disappointment, mother begins to treat the child according to the desired sex, which may lead to lifelong gender confusion and other psychological disorders in their children. I have formulated several working hypotheses about the possible aetiologies of GD, one of which is the recurring theme of mothers'

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investment in the gender transition of her child/ren. These mothers share similar characteristics. Some can present in a histrionic way, with wide ranging displays of expressed emotion. They tend to be immediately supportive of their children's transgender declarations and hasten to obtain the necessary medical care in the name of concerned, gender affirming, and accepting parenthood.

Another group of parents, again mostly mothers, tend to have unmet narcissistic needs that are satisfied through the attention and affirmation given by the gender clinics to their transitioning child. They tend to focus on the stress and sacrifice they are making for their child, rather than on the complexity of the child's experience of transition. Like online trolls who vilify detransitioners for never having really been trans, such mothers may make it difficult for a young person to desist, sensing as they do that possible desistance may cause a narcissistic injury to their mothers. Because many young people's transition occurs concurrently in the gender clinics and online, it becomes a very public affair that heightens the risk of public humiliation for mothers with a narcissistic personality organization.

There are often transgenerational mental health issues including alcohol and substance misuse and/or addiction, suicide, clinical depression, bipolar disorder, and schizophrenia in the mothers and in first degree relatives (Zucker et al., 2003). Having a transgender child gains them entry into the "trans family," where previously isolated and lonely mothers are welcomed and feted. One mother told me she had been "embraced" by the trans community, and she felt a sense of "real belonging" for the first time in her life. The trans community becomes collusive of the mother's needs and wishes, not that of her child, who is the instrument whereby she is "embraced" and "nurtured." Consequently, these mothers meet their emotional needs at the expense of the long-term wellbeing of their children. These processes are likely out of conscious awareness. Such mothers will be convinced that they are the protectors and advocates for their children and will not understand until they enter therapy the role that their own mental health issues have played in their child's gender confusion.

Some parents ascribe too much maturity and authority to their children before they are mature enough to cope with such decisions. The gender clinics are also guilty in this regard. Reasons for doing so include libertarian views, "herd" behaviour (i.e., following the dominant *zeitgeist* because so many professional organizations can't all be wrong about gender affirmation), and fear of incurring the anger and defiance of their children. Practitioners of GAC collude with the primitive defences of the young person, "celebrate the arrested self, stifled by maladaptive defences against underlying suffering that seeks resolution" (Van Zyl, 2024), deny and distort reality, discourage reality-testing in the young person's parents through shaming and exclusion from treatment, and encourage cult-like dependence on trans activist groups to ensure lifelong adherence to CSH and gender-based surgeries to support the veracity of their interventions.

In almost all cases of GD, the "symptoms" are the "signals" of underlying psychopathology in the ecology of the child's life—dysfunctional internal schemas/beliefs, parent-child or sibling-child disturbance, peer bullying, neurodiversity etc. The symptoms direct us to underlying mechanisms that are more correctly the focus of treatment. Psychodynamic mechanisms can often be understood as a transfer of unresolved conflict and trauma-related experiences from parent to child. One dynamic frequently encountered in therapy is the reluctance of the child's parents to be reality testers and challengers of the child regarding their true sex. When asked the reason for their reluctance, parents will report that they do not want to give their child the message that they are defective in some way, so they accept the child's cross gender declarations. Some of these parents will disclose, with careful inquiry, that they were made to feel defective as children e.g., not smart enough, sporting enough, attractive enough for their own parents and they do not want to be the cause of their own child feeling the same way. When the child comes into therapy, s/he reports that their parents are supportive and accepting of their wish to transition because they allowed their child to cut their hair, change clothing, and pursue cross gender interests but when the child starts to insist on medicalized transition, conflict arises when the parents baulk and the child feels "betrayed."

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It is somewhat ironic that family connectedness is a protective factor for healthy psychosocial development in children when the trans movement agenda is about disruption of family bonds and disconnection of the young person from his/her family if his/her parents express any hesitation or concern about their child's impulsive decision to embark on life altering interventions that are almost certainly not in their best interests.

Exploration of the impact of sibling relationships (Rust, Golombok, Hines, Johnston, & Golding, 2000) on gender development is another neglected area in the understanding and management of GD children. Sibling dynamics must therefore also be carefully assessed and understood in the diagnostic formulation and treatment plan. Many ROGD girls have brothers who, in their perception, are favoured over themselves. In some cases, father seems more connected with their brothers through shared sporting interests (e.g., father coaches the son's soccer team, takes son camping and fishing etc) than with them. These girls crave father's attention and approbation and when it is not forthcoming, they decide that the only way to gain father's attention is to become/be male. (Note: This is an over-simplification of the complex network of causal factors). Sadly, this strategy usually backfires badly because father is likely to vehemently oppose his daughter's transgender declarations with the result that she becomes further alienated from him. Working with the father-daughter dyad to encourage meaningful engagement can be an important component of therapy.

Sociocultural Factors

School Life Experiences

Attitude towards school, peer rejection, bullying, school refusal or truanting, academic performance, and post school aspirations all need to be evaluated. Interactional dynamics extend to peer relationships that are particularly important during childhood and adolescence. Young GD people are very likely to report a history of peer bullying, including victimization, marginalization, exclusion, and vilification. Different mechanisms of transmission of peer influence have been identified, including peer contagion, deviance training, and co-rumination, which were discussed in Chapter 4.

The Meaning of Non-Binary Identities

It is extraordinary that the concept of the "non-binary identity" has been accepted so uncritically, defined as a GI that could be both male and female on a sliding scale, neither male nor female, or something else entirely, which has never been defined. Self-identifying non-binary persons reported that they began to identify as non-binary following what they described as the "discovery" or "realisation" of the non-binary gender category through involvement in the LGBTQ community, which had increased their knowledge of gender variant identities and re-positioned these as valid expressions of gender (Losty & O'Connor, 2018). This is a clear example of social contagion. A lack of family cohesion differentiated between adolescents reporting trans identification from those reporting non-binary/other gender identification (Kaltiala et al., 2023).

The Systemic Function of ROGD

Defiance of parents, a struggle for autonomy, finding an "in group," being "seen", feeling heroic, denying the development of their sexed bodies, fear of adulthood, and fear of sexual relationships are all factors in ROGD. Although biological and intrapsychic factors are important, we need to investigate the context in which GD arises and the reasons for the exponential increase in cases observed over the past two decades that cannot readily be explained by a phenomenon other than a global social contagion.

Social contagion research has shown that females in early adolescence are the most suggestible group and therefore highly prone to peer and social influences arising from social media. This is the group most frequently presenting to gender clinics with gender concerns, which is a reversal of

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previous patterns of presentation that favoured young boys. Sexual development poses a threat to young people as it signifies approaching adulthood, the demands of which they feel ill equipped to manage. ROGD may be an expression of "trauma" or a panicked response to the reality of puberty that one now has a sexed body.

Case example

A 15-year-old female, who by current Western standards of beauty, was considered attractive by both her male and female peers. She received a great deal on unwanted attention from adolescent boys that made her feel uncomfortable and unsafe. At an end of year school party, one of her classmates plied her with alcohol, which she had not previously consumed, and then had sexual intercourse with her without consent when she was so affected by alcohol, she was unable to resist. Thereafter, she began binding her breasts and dressing in more androgynous clothing to deflect the male gaze. She started to perceive women as powerless and helpless and the phrase of her assaulter ("this is what women are for") constantly reverberated in her mind. She did not disclose the sexual assault to her parents, but inexplicably to them, she suddenly declared herself male and badgered her parents for an appointment with a gender clinic.

The Fluidity of Gender Identifications and Expression

Contrary to gender ideology's precept that gender is a deeply felt innate sense of oneself as male or female, there is ample evidence attesting to the changing nature of how young people perceive their GI, which, is part, created by the madness of the unthinking societal acceptance of gender and sex occurring on a spectrum. A recent study documented the changing identifications of 235 young people (15-24) over a 24-month period and found that changes in self-reported GI were common (n = 181; 77%); 39 (17%) changed gender identities more than twice. More than 50 percent (n = 131; 56%) showed a fluctuating pattern (Ocasio et al., 2024). Here are two case examples, once demonstrating a return to his original state of heterosexual male and the other poignantly expressing profound gender confusion about his current transgender identification.

Case example

A 14-year-old natal boy first came out via letter to his parents as GAY. He soon changed that declaration to BISEXUAL when he experienced a powerful crush on a female classmate. After she rejected him, he came out as TRANS and demanded PB and CSH. In therapy, his demands for transition were strident and incessant. He constantly asked me when I was going to tell his parents that he could go ahead with his transition. He shaved his legs, arms, and body hair, grew his hair long, and started to wear eye makeup and nail polish. He ordered female clothing from the internet and wore it secretly in his room. When his parents confiscated these clothing items, his female friends lent him their clothes to wear. Teachers at his school started calling him by his preferred name and pronouns without parental knowledge or permission. Several months after therapy commenced, while still vehemently protesting his trans-female identity, he wrote a letter to his parents apologising for misleading them. He said he now realised that he was not a trans-female but a DEMIGIRL (denoting partial non-binary, partial female gender identity). He changed this orientation shortly thereafter to DEMIBOY, before again writing to his parents, telling them that he was only joking about the whole thing and that they were the only people who had taken it seriously. (This was very far from objective reality). I advised his parents to give their son the opportunity to exit the gender maze without losing face. The next day he declared himself STRAIGHT and asked his parents to take him for a haircut.

As these case examples demonstrate, a child's trajectory may not be known until later in life and it is imperative that this not be disturbed by iatrogenic interference (Leibowitz & Telingator, 2012). The "shifting identities" of young people expressing gender confusion has been noted in the literature (Ocasio et al., 2024). There are at least four possible outcomes for sexual and GI in gender

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nonconforming children as illustrated below (Figure 8-2). The most likely if they do not board the trans train in early puberty is that they will become gay and lesbian adults. Psychological trauma from the past forms part of one's psychic structure in the present. The expression of these traumas is socio-culturally embedded, that is, social contagion permits particular forms of "acting out" or "symptom pools" of these traumas in different sociohistorical eras. Envy rivalry are an integral part of the human condition and unconscious envy is a factor in trans identification. GD adolescents need assistance to explore their defences and internal psychic conflicts and to manage their psychic pain before irreparably altering their bodies. "The body is used to act out something that cannot be accepted or processed by the mind" (Evans & Evans, 2021, pp. Ch2, 28). Clinicians should not collude with the phantasy that the "embodied" self can be altered or removed.

Conclusion

The care for children and young people with GD should not be aimed at avoiding adult same sex attraction or transsexualism/transgenderism in the manner of WPATH Standards of Care in the past. I am advocating that no social or medical interventions be provided during childhood or adolescence; that counselling/therapy should be focused on reducing the child's distress related to GD, other psychological difficulties within the child and his wider ecology, including the family and school, and on optimizing psychological adjustment and wellbeing. Therapists need to understand the underlying wish (i.e., central core conflict) propelling transition. Examples include:

(i) a grievance against the parents and a struggle for autonomy/individuation
(ii) an idea that one can create an ideal self
(iii) the need to protect against feelings of inadequacy, anxiety, jealousy, and disappointment
(iv) a triumph over feelings of vulnerability
(v) a repudiation of the sexed body and adulthood

It is therefore imperative

(i) to keep the developmental pathway open into adulthood i.e., the young person requires frontal lobe maturation that occurs in the early 20s to fully comprehend the choices GD adolescents must make to medically transition.
(ii) to understand that psychological trauma from the past forms part of psychic structure in the present. The expression of these traumas is socio-culturally embedded (i.e., social contagion permits particular forms of "acting out" of these traumas).
(iii) to assist GD adolescents to explore their defences and internal psychic conflicts and manage their psychic pain before irreparably altering their bodies.
(iv) for clinicians, politicians, teachers, parents, and society not to collude with the young person's fantasy that the "embodied" self can be altered or reinvented.

Authors' contributions: The sole author conceived and wrote the article

Funding: This paper was not funded.

Availability of data and material (data transparency): N/A

Code availability (software application or custom code): N/A

Conflicts of interest/Competing interests: The author declares no conflicts of interest.

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