A Growing Transgender Population

An Analysis of Medical and Cultural Drivers

Camilla Elizabeth Collington-Hanna

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An analysis of medical and cultural drivers

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Camilla Elizabeth Collington-Hanna

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Abstract

Author's name: Camilla Elizabeth Collington-Hanna

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Supervisor: Ole Jacob Madsen

Today, people who feel a mismatch between subjective gender and bodily sex have come to the fore in public debate. In particular, the transgender population's growth is attributed to increasing rates of clinic-referred female youth who feel distress in relation to their natal sex (gender dysphoria). While "transgender" denotes the experience of a cognitive and bodily gender incongruence, not all suffer distress. Independently of dysphoric distress, transgender people may seek medical interventions align their bodies with felt gender. Causal factors implicated in gender dysphoria and transgender identity are not well understood. Therefore, the present thesis seeks to extract driving factors in the number of young people who experience gender dysphoria, identify as transgender, and seek medical interventions. A range of sources are employed to explore this topic; scientific research, expert opinion and clinical experience, as well as other relevant voices and fora. Three main areas are of interest: (1) the diagnostic depathologising of transgender identities, (2) emergent gender identity theory, and (3) the popularisation of Gender Affirmative treatment. Within these developments, medicine and culture share mutual influence.

Less stringent diagnostic criteria put more young people into contact with the diagnoses of gender dysphoria and gender incongruence. Lowered diagnostic thresholds can inflate the number who receive the diagnoses and youth may encounter vague diagnostic descriptions online. With changes in cultural perceptions of gender and rejection of the gender binary, gender identity increasingly holds authority over biological sex and gender seems to be presented as a psychological project of self-perception. With less focus on bodily reality, young people may employ stereotypical masculine and feminine traits to inform their gender identity. Taken together, medicine and culture has facilitated a novel gender-landscape within which youth need to navigate. These processes can be seen as promoting the Gender Affirmative Model which focuses on confirming gender identity assertions and providing treatment. A possible consequence is bypassing alternative explanations for gender dysphoria, transgender identity, and transition-desire arise. The identified drivers in medical and cultural aspects of transgender topics appear to lead to produce growing rates of transgender identification and intensified focus on medical transitions.

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A Growing Transgender Population

In the past decade, transgender phenomena have become markedly visible in news and media, while being a topic of great debate. Transgender people typically experience a mismatch between their inner sense of gender belonging and physical body. For some, this mismatch can cause psychological distress, known as gender dysphoria, motivating them to seek physical alterations to align their bodies with internal perceptions. Prior to the mid-2000's, clinics across the Western world report seeing one or two patients a year, but now, an unprecedent number of treatment-seeking individuals are observed (see Zucker, 2019). Whereas clinicians and experts are mostly familiar with a transgender trajectory starting in childhood, with persistent cross-sex identification and associated distress continuing into adolescence, a new patient group has emerged. The majority of those presenting in gender clinics today are female adolescents, many of whom appear to have no prior history of gender-related distress (Littman, 2018). How might this novel segment of the transgender population be understood?

The causal factors implicated in the genesis of transgender identities are not well understood, but professionals agree its manifestation is likely caused by the intricate interweaving of psychological, social, and biological factors (Ruble et al., 2006). With respect to contemporary transgender manifestations, explanations often point to greater societal acceptance for those who do not fit with gender norms, wide-spread information about the condition, as well as advancements in transgender treatment (Zucker, 2019). References to new frameworks focused on affirming transgender identities are also noted, in addition to gender clinics popping up across the West with clinicians knowledgeable of the needs of this population. These developments likely allow young people to come out as transgender and seek help in less psychologically taxing ways. Still, are the rising rates of females presenting in clinics sufficiently explained by the above developments?

The perplexing surge of clinic referrals have motivated some to questioned the explanatory ability of the abovementioned factors. Not only is the young female demographic growing; a complete inversion of the male to female sex ratio is observed. The UK's Gender Identity Development Service (GIDS) report significant increases in female adolescents presenting at their clinic (Aitken et al., 2015). Norway and Sweden report marked increases as well (Socialstyrelsen, 2020; Wæhre & Tønset, 2018). A Toronto clinic reports a male majority until 2005, but after 2016, the male to female ratio was 1:2.13 (Aitken et al., 2015). A Finish clinic reports a remarkably skewed ratio of 1:6.83 (Sumia et al., 2017). Given the

historical predominance of males in gender clinics and the relative absence of young females without histories of childhood gender identity issues in the literature until 2012 (Wood et al., 2013; Zucker, Bradley, et al., 2012), I find myself both intrigued and curious as to other drivers possibly explaining the "new generation" of transgender people.

Conflicting research regarding the benefits of transitioning via hormonal therapy and surgical interventions exacerbate this discussion. In terms of benefits and efficacy, data show varied results and is often burdened by a range of limitations; research on adolescent-onset gender dysphoria and associated outcomes is sparser still. Notwithstanding, persistent political and cultural pressure has successfully brought about an impressive number of changes aiming to reduce stigma and adversity facing the transgender population, one of which is increased access to biomedical treatment (Levine, 2021). Culturally, new conceptualisations of gender identity as privileged over biological sex, and as one's true identity generates a conflicting situation for clinicians.

While constituting a highly controversial topic, investigating the mechanisms potentially relevant to the interpretation of gender dysphoric distress, conclusions about having a transgender identity, and subsequent treatment-desire, warrants academic attention. I here question whether the progress made risks limiting insights from critical voices, information about alternative therapies, and promote self-fulfilling treatment approaches intensely focused on affirmation and transition. In light of growing reports of detransitioners, especially after 2016, taking a moment to carefully consider these rapid developments is necessary.

This thesis aims to extract cultural and medical drivers encouraging increasing rates of clinic-referrals, with specific reference to the female population, within three overarching developments: (1) Depathologisation, (2) Gender identity theory, and (3) The Gender Affirmative Model for transgender treatment. I will outline and discuss these processes as self-reinforcing events contributory in facilitating further increasing rates of clinic-referrals, while drawing on the young females' vulnerabilities for erroneous interpretations in the current cultural and clinical context.

With respect to depathologisation, I will depart from two diagnostic systems and outline changes leading to a new conceptualisation of transgender identities as non-pathological, but burdened by societal stigma and societal marginalisation. With positive intentions the various advocacy groups have seemingly settled questions about the GD

condition without support from scientific evidence. The inherent non-pathology or pathology of GD will be discussed, before evaluating depathologisation as a reinforcing mechanism for higher rates of clinic-referred young people through diagnostic inflation, especially in the online material presenting GD is vague ways.

Within the current topic, cultural themes and medicine are inextricably linked in the rapid development that have taken place. Therefore, observing cultural changes in views about gender seem necessary in order to explore how gender identity as a subjective and intrapsychic project has come to be accepted widely. This framework is referenced as a theory because the concept of gender identity remains unverifiable and cannot be measured. Despite this, inner sense of gender enjoys growing acceptance as the appropriate informant for gender, replacing sex in many instances. Of interest is the possible result of encouraging young people to evaluate gender psychologically, removed from physical information. The legal recognition of gender identity in policies and international human rights have impacted newer treatment approaches to be organised around affirmation and treatment to allow authentic gender expression.

The combination of depathologisation and gender identity theory will be explored as facilitating a treatment protocol dedicated to affirming innate and authentic gender identities without unnecessary psychological evaluations before offering access to treatment. Two other approaches to treatment are described in a discussion linked to two main controversies regarding "conversion therapy" and "gatekeeping." These controversies have been significant in further promoting the popularisation of gender affirmative methods focused on treatment. A final discussion contends with the clinical focus on obtaining informed consent to initiate medical treatment and the possible pitfalls of centring informed consent as the requirement.

Taken together, I am motivated to outline main developments in culture and medicine that fuel and promote one single outcome: transgender identification and treatment access. The progress made here is wide-reaching with implications for the transgender population, as well as every gendered person in society. Transgender phenomena are heavily debated and part of a "culture war" which seems to distract and confuse. My motivation rests in the desire to provide an honest and comprehensive account for the developments noted above, with the hope of speaking truthfully about matters possibly putting vulnerable young lives in harm's way.

Method

Initially, a broad and exploratory approach gathered insights from a range of perspectives on causal factors implicated in rising rates of gender dysphoria and transgender identities in a Western context. In search engines and databases, “gender dysphoria,” “gender incongruence,” and “transgender” were among the search words I used, in combination with “prevalence,” “aetiology,” and “epidemiology.” In addition, recently published books on the topic aided my introduction to the field and offered various viewpoints. Together, recent books and relevant scientific articles let to new material of relevance. Through the sources first consulted, it became clear much is unknown about the genesis of transgender identities and gender dysphoria. Even less known about the drivers of contemporary manifestations starting sometime after the onset of puberty; the literature has only recently begun to describe these trajectories. Realising this, in addition to the mutual influence of medicine and culture relating to transgender phenomena, a theoretical thesis seemed promising. While extant research in this field is wanting and new research efforts should be encouraged, it is my impression current debate lacks appropriate sensitivity to pivotal developments scaffolding the transgender population’s presentation today.

As the hypotheses and possible causal factors present in the literature often rely on expert opinion and clinical experience, this thesis does so too. With regard to scientific studies, a challenge presents itself as the most robust data lacks generalisability to contemporary transgender trajectories, while new research quickly becomes outdated as it is contradicted by other findings. When relevant, this thesis attempts to utilise recent and up to date literature. In search for drivers promoting rising rates of young people experiencing gender dysphoria and identify as transgender, studies or perspectives suggesting its genesis in adverse life-experiences or in a context of confusion, do not appear to be favoured. Fear of such findings as ammunition to deny the transgender experience is perhaps understandable, but nonetheless valuable for an elevated understanding for those without nefarious intent. Transgender advocacy groups and LGBT organisations have offered important insights in this regard, while informing other themes as well.

Transgender phenomena’s presence in public debate have made these identities subject to interpretation by many voices from various backgrounds. In addition to scientific studies, expert opinion and clinical experience, I make use of insights from medicine, psychology, philosophy, and biology as well. In order to describe and evaluate the complex themes touched upon in this thesis, each chapter will include a discussion of the relevant topic.

In order to gain insights about the process of depathologising transgender identities, the DSM and ICD serve as points of departure. I account for the changes made since the earliest diagnostic appearance of "transsexualism" in both manuals, and describe how the condition is currently presented. With insights from clinicians and other voices relevant to medicine and psychiatry, I discuss how gender dysphoria may and may not be seen as a mental disorder. Through the s diagnostic inflation framework and concept creep, I evaluate whether the online presentation of this diagnosis can promote increasing clinic-referrals and transgender identification among youth. Insights from detransitioners, clinicians, and research inform this evaluation, in addition to my own exploration of online forums and communities. The vastness of the internet is a challenge and a limited presentation will therefore be offered.

Throughout initial reading, the cultural and theoretical influence on contemporary transgender conceptualisations became evident. After describing current notions of gender identity theory, that is, contemporary beliefs about psychological gender, I explore preceding cultural developments through the feminist movement and queer theory, in addition to human rights documents to elucidate how gender identity became salient. Gender identity theory does not constitute a united front, and some themes are contradictory. Nonetheless, the cultural and ideological developments bear mentioning even if challenging to describe comprehensively. I discuss more profoundly what gender identity really means and evaluate the attempts to account for mind-body conflict in gender dysphoria.

Bearing in mind transgender people have only presented in clinics since the 50's and that new, dissimilar trajectories manifest today, sources describing treatment protocols and adjustments necessary to accommodate rising transition requests informed this chapter. While this chapter centres on the Gender Affirmative Protocol, it became necessary to account for earlier and co-existing approaches to transgender treatment. Thus, those considered experts in the field and their descriptions of treatment approaches are employed here. The inextricable link to cultural shifts relating to gender broadly, and gender identity theory specifically, has engendered two central controversies concerning "conversion therapy" and "gatekeeping," which impact the popularisation gender affirmation and transitions. There are likely other sources able to offer additional insight, but have remained outside the scope of this thesis.

Throughout the process of becoming familiar with this topic, personal concern for the invasive treatments some young people desire to undergo promoted a critical perspective, which has likely come to affect how the sources are reported. While I am anxious about the

reception of this work, I question these methods being practiced in a context of scientific ignorance. Despite my position as an outsider to transgender and LGBTQ+ communities, I remain a young woman empathic to the various challenges facing the younger generation of females. Both positions may influence the collection of material and the way this is reported.

Depathologising Transgender Identities

Some fifty years ago, those presenting in clinics with a desire to transition to a new gender were perceived by some clinicians to have a rare and somewhat new form of psychopathology. The desire and longing to transition were speculated to manifest due to a need for resolving underlying problems that remained unidentified and stemming from some psychological problematic circumstances in childhood. This reasoning was concordant with psychodynamic understanding of development; “every behaviour has antecedents” (Levine, 2018, p. 29). When patients believed they could live happier and more fulfilling lives as the other gender, many were concerned this hope was naïve and their optimism for transitioning unrealistic in terms of bringing about the desired outcome (Meyer, 1982). Today, these clinical perspectives are considered outdated, but at the time, transgender people constituted an unfamiliar phenomenon. Since then, significant developments have occurred, both in medical and clinical perceptions, as well as in the broader culture.

Diagnostic Evolution

Since the introduction of “transsexualism” in the Diagnostic Manual of Mental Disorders (DSM-III; American Psychiatric Association, 1980) and the International Classification of Disease (World Health Organization, 1990), both manuals have undergone significant revisions with respect to gender-related diagnoses. With limited research, reliance on expert opinion, and varying clinical experience, in addition to advocacy concerned with the poor outcomes associated with transgender people, newer editions have had to manage a host of challenges (Beek et al., 2016).

The Diagnostic and Statistical Manual of Mental Disorders (DSM)

In 1980, when DSM-III was published, the diagnosis of transsexualism first appeared and was located in the chapter of Psychosexual Disorders. For children, gender identity disorder was used (APA, 1980). DSM-V collapsed all gender identity-related diagnoses into one category called gender identity disorders, with different criteria sets for adults and adolescents, and children (Bradley et al., 1991). DSM-5 replaced gender identity disorders with gender dysphoria, designated in a chapter of the same name, thereby removing it from its earlier categorisation with paraphilias and sexual dysfunctions. Different sets of criteria for adults, adolescents, and children remained (Zucker et al., 2013). Gender dysphoria (hereafter GD) denotes the distressing experience resulting from a discordance between experienced or expressed gender, and biological sex (APA, 2013). GD was thought to better reflect the core issue of the condition, pointing to the gender identity-related distress that some transgender

individuals feel, rather than pathologizing transgender identities or gender variance (Drescher, 2010).

According to DSM-5, when a marked incongruence between one's experienced or expressed gender and assigned gender is exhibited for at least six months, and at least two of six criteria are met, a diagnosis can be given (APA, 2013). This incongruence can manifest in the following ways: a marked discordance with primary and secondary sex characteristics based on experienced gender; a strong desire to be rid of one's sex characteristics; a strong desire to have the sex characteristics of the other gender; a strong desire for one's sex characteristics to be of the other gender; a strong desire to be the other gender; a strong desire to be treated as the other gender; and an insistent belief that one already has the typical feelings and reactions of the other gender (APA, 2013). When the DSM-5 references the opposite gender, this is followed by a bracketed reference to alternative genders different from birth-sex. Also, in relation to discomfort with sex characteristics, DSM-5 includes for young adolescents the desire to prevent the development of secondary sex characteristics (Cohen-Kettenis & Pfäfflin, 2010).

In the revision process of DSM-III, the lack of data resulted in a reliance on individuals considered experts in the field for delimiting exclusion and inclusion criteria (Zucker & Spitzer, 2005). DSM-IV's work group tasked with refining the diagnostic criteria remained conservative and did not rely on expert opinion for any alterations, but rather the data and studies available (Shaffer et al., 1989). The current DSM-5 relied more on new available data and analyses, as earlier revisions used research almost 50 years old (Beek et al., 2016). Several alterations occurred in DSM-5, largely due to pressure from critics who felt identity was being pathologized, rather than the disorder itself (e.g., Bartlett et al., 2000; Meyer-Bahlburg, 2010).

Whereas earlier DSM versions used dichotomous language when referencing gender identities and gender roles as male or female, DSM-5 view these concepts as spectrums (Zucker et al., 2013). "Sex" was replaced with "gender," and "assigned gender" replaced "biological sex". With regard to diagnostic specifiers, some notable changes occurred. DSM-III included a transsexual subtype designated by sexual orientation. The previously called "homosexual subtype" captured males with female gender identities attracted to others of the same biological sex. Some, including transgender people, however, felt the specifier was offensive and failed to acknowledge gender identity (Beek et al., 2016). In addition, clinicians

were unsure of the appropriate reference point for sexual orientation; gender identity or biological sex (Bradley et al., 1991). Despite critique, DSM-IV retained a sexual orientation-specifier, using different terminology: "attracted towards males, females, both, neither, unspecified." Preserving the specifier was considered necessary as it appeared important for clinical management and research (Bradley et al., 1991, p. 340). DSM-5 removed the specifier as it was not viewed clinically valuable anymore (Cohen-Kettenis & Pfäfflin, 2010).

Another specifier was added in DSM-5 relevant for those who had undergone at least one transition-related intervention, for example cross-sex hormone therapy (Reed et al., 2016). This was used to ensure access to continued health care even if GD had rescinded, indicating the possibility of "losing" the diagnosis (Zucker et al., 2013). A criterion was added in DSM-IV due to concern of false-positives: "the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning" (Spitzer & Wakefield, 1999, p. 1856; Zucker et al., 2013). This "clinical significance" criterion is used in DSM-5, and was added to a range of mental health disorders as well (Beek et al., 2016).

International Classification of Diseases (ICD)

In 1990, the diagnoses transsexualism for adults and adolescents, and gender identity disorder of childhood for children appeared in ICD-10 (Drescher et al., 2016; WHO, 1990). Both diagnoses were listed under the chapter of Mental Disorders and Behavioural Disorder. More than 30 years after ICD-10's approval, ICD-11 was accepted in 2018 and implemented in 2022 by the World Health Organisation (Gaebel et al., 2022). Its more recent publishing means more dramatic changes have occurred, compared to the gradual changes in found in DSM-5 (Reed et al., 2016). Two significant changes appeared in ICD-11: First, gender incongruence has come to replace the abovementioned conditions. Second, the condition is relocated to a new chapter entitled Conditions Relating to Sexual Health (WHO, 2018).

ICD-11 defines gender incongruence as a marked and persistent discordance between the gender felt or experienced and biological sex (WHO, 2018). Gender incongruence of adolescence and adulthood cannot be diagnosed until the onset of puberty and two of a total four essential features must be met, and present for several months (Reed et al., 2016). The criteria of gender incongruence is described as followed: strong dislike or discomfort with primary sex characteristics; a desire to be rid of some or all of one's primary and secondary sex characteristics; a strong desire to have the sex characteristics of the experienced gender;

and the strong desire to be treated as a member of the experienced gender (WHO, 2018) The second criterion, like DSM-5, notes the anticipated development of sex characteristics.

As only two criteria must be met for adolescents and adults, ICD-11 allows for a diagnosis to be placed even when there is no gender dysphoric distress. This edition also places less emphasis on the distressing quality of incongruence (Beek et al., 2016). ICD-11 acknowledges that impairment or distress may not be part of gender incongruence, although it often is. If clinically significant distress is present in relation to important life-areas, ICD-11 notes this is likelier to occur in disapproving social environments or where protective policies are lacking. In such environments, individuals with GI are more vulnerable to psychiatric problems like social isolation, employment loss, victimisation or violence (Drescher et al., 2016). For those, however, who do not experience any impairment or distress, the GI diagnosis will offer access to health services. Furthermore, ICD-11 does not through its diagnostic criteria assume all gender incongruent people desire to physically transition to the opposite gender signalled by similar terminology changes in DSM-5 (Reed et al., 2016).

A New Conceptualisation of Transgender Identities

The recent changes in diagnostic labels and designation describing discordance between bodily sex and felt gender are described in the literature as oriented around two central challenges (Reed et al., 2016). First, transgender people appeared to suffer a double burden as their identities were subject to stigma, as well as burdened by having a mental disorder. Therefore, a diagnostic depathologisation process was thought necessary to remedy both burdens. Secondly, depathologising misaligned gender identities needed to ensure continued access to health care services, as these require a diagnosis to offer treatment tailored to the specific needs of a condition.

DSM-5's contribution to depathologisation of transgender identities is most evident in its focus on the distress deriving from discordance between natal sex and experienced gender; highlighting the distress component as a constitutive part of the condition was thought to better reflect the central problem experienced by some transgender people (Zucker, 2010). While still regarded as a mental disorder, DSM-5's diagnosis does not pathologise identity, per se. This is furthermore evident in the inclusion of a specifier indicating access to treatment may be continued without gender dysphoric distress. In other words, it is possible to "lose" the diagnosis, but remain in treatment.

ICD-11 has pioneered the effort to depathologise transgender identities more thoroughly. While still included as a condition, this is only for the purpose of eliciting health service access and funding by governments (Reed et al., 2016). In a statement regarding the ICD-11, the WHO explain their redefinition of gender identity health mirrors the evidence that transgender identity is not mental illness, and its classification as mental disorder can cause immense stigma (WHO, n. d.). Consequently, the WHO views misalignment between body and felt gender to represent variation in normal human development, which may or may not be accompanied by distress.

Prior to ICD-11, large organisations and health authorities had issued similar stances. Already in 2011, the World Professional Association for Transgender Health (WPATH) declared in their Standards of Care (SoC, 7) there is no inherent psychopathology in transgender individuals (Coleman et al., 2011). In 2012, the American Psychiatric Association (Drescher & Haller, 2012, p. 1) announced in a position statement on discrimination against transgender and gender variant people, that these identities imply no "impairment in judgement, stability, reliability, or general social or vocational capabilities". The statement also notes the disproportionate discrimination endured by those with atypical gender identity and expression due to the lack of protective civil rights policies.

Such a view was motivated by persistent advocacy by member states in the European Union, national- and local organisations. Because the transgender- and gender variant population have been burdened by the stigma attached to mental illness, the excessive rates of discrimination, victimisation, and violence (Testa et al., 2017; Testa et al., 2012) were seen as primarily a result the condition's inclusion in diagnostic manuals (Independent Expert, 2018). In light of societal stigma, the focus afforded to the poor outcomes of transgender people is important. The mental health of transgender people is thought to be significantly impacted by such experiences, producing elevated rates of cooccurring mental health problems like depression and anxiety, in addition to significant suicide risk (Testa et al., 2017).

Comorbidities and Gender Dysphoria

The new perspective of transgender or gender-variant identities as normal developmental diversity has permeated into wider society and is largely accepted (Independent Expert, 2018). This view, however, assumes elevated rates of psychiatric comorbidities are due to societal stigma and negative attitudes toward gender nonconformity. For example, unaccepting and hostile responses from the social environment may become

internalised attitudes about oneself and lead to self-hatred manifesting as internalised transphobia (Coleman et al., 2011; Levine, 2021). Additional mental health problems, like mood disorders, self-harm, and suicidal ideation (de Vries et al., 2011), are therefore assumed alleviated through reduced societal stigma. While the existence of well-functioning transgender people without GD supports this notion (Askevis-Leherpeux et al., 2019), experts and clinicians have as of yet not reached consensus, nor is there an adequate evidential basis to support the inherent non-pathology in GD (Levine, 2021).

When questions about misaligned gender identities' inherent abnormality are voiced, parallels to the harmful psychiatric policies attempting to change non-heterosexual orientations are drawn. Consequently, opposing views risk reifying flawed policies (Levine, 2021). In the lead-up to ICD-11, many transgender people were hopeful that transsexualism would be eliminated like homosexuality when it was depathologised by the APA in 1973 (Drescher, 2010). Sexual- and gender minorities may face social punishment for diverting from heteronormative and non-transgender norms (see Hidalgo et al., 2013). Thus, by drawing on the historical trajectory of increased acceptance toward lesbian, gay, and bisexual people (LGB), a similar outcome is expected for transgender people (Drescher, 2010). The literature frequently describes the adverse outcomes of transgender people by referencing research on the adverse outcomes for LGB people (Coleman et al., 2011; Rafferty, 2018). Considering atypical gender identities to be the same as non-heterosexual orientations has arguably influenced new perspectives on transgender identities, while promoting depathologisation as the remedy. The elision of sexual orientation and gender identity, however, may orient focus away from important questions that remain unanswered about GD.

Currently, there is little agreement among experts and clinicians regarding the high rates of psychiatric disorders present in many transgender people (Levine, 2021). The contested question of whether transgender identities represent normal variation in gender expression or an inherent pathology, divide clinicians and experts (Vrouenraets et al., 2016). Some clinicians question whether the presence of mental illness allow for a view of misaligned gender identities as entirely normal (e.g., Levine, 2018; Cretella, 2016; McHugh, 2017). The available literature cannot adequately explain the developmental trajectory of untreated gender identity discordance, nor the ways in which treatment alters this course. Without understanding the natural history, no one can confidently claim to know whether such identities are inherently limiting, cause disability, or permanent deficit (Levine, 2021). While the term comorbidity is commonly employed, clinicians cannot with certainty claim the

presence of additional issues is entirely separate from, or integral to, GD and the desires of the patient to transition (Levine, 2021).

The additional psychiatric disorders in transgender people guided initial speculations of psychopathology and for decades, gender incongruent people were thought to have abnormal development (Mayer & McHugh, 2016). Clinicians who adhere to this understanding may view the manifestation of transgender identities as an unrealistic, yet a well-intentioned attempt to resolve underlying issues. Support for such a view comes from research indicating a persisting need for psychiatric help after a transition (Bränström & Pachankis, 2020a, 2020b; Dhejne et al., 2016; Simonsen et al., 2016). The literature suggests transgender people are a particularly vulnerable group in need of several protections (Liszewski et al., 2018). Moreover, suicide-risk is also observed to be worryingly high after transitioning (Dhejne et al., 2011) and even in more accepting societies today, the rates do not appear to diminish (Herman et al., 2019). When transgender patients with persistent psychiatric symptoms, accompanied by frequent suicidal ideation seek help, asking how GD represents developmental diversity is warranted (Levine, 2021).

To illustrate the above view, insight from other mental health disorders presenting with a strong desire for bodily alterations can be gained. Three mental disorders appear to share with GD a desire to physically change the body to align an inner sense of identity with external reality. For example, individuals with anorexia nervosa have an intense fear of fatness and believe themselves to be obese (Guarda, 2008). In a clinical setting, this belief is considered erroneous and in conflict with objective reality. A successful remedy to this psychiatric issue would be to correct mistaken beliefs and align subjective perceptions with bodily reality (Cretella, 2016). Arguably, few mental health professionals would suggest a calorie-restrictive diet plan or liposuction.

Similarly, individuals with body dysmorphic disorder (BDD) believes mistakenly they are unattractive. This disorder is often accompanied by great emotional distress and a desire for "corrections" to be made to their physical appearance (Clerkin & Teachman, 2008). Again, a successful treatment outcome would entail nearing alignment between perception and reality, and not a referral for cosmetic surgery (Cretella, 2016). In comparing these conditions to some transgender people's desire to physically transition via hormones and surgeries, a difference in motivation is clear; transgender people seek to become what they

believe they are, while the conditions described above seek to remove themselves from what they fear they are.

Yet another parallel can be drawn between misaligned gender identity and body identity integrity disorder (BIID). BIID entails identification as disabled in some way and the person feels imprisoned in a fully functioning body (First & Fisher, 2012). According transgender doctor, Anne Lawrence, BIID and GD share many parallels (Lawrence, 2006). In people with BIID, belief can result in significant distress causing some to desire surgical amputation, or severing of the spinal cord, to experience psychological concordance with their bodies (First & Fisher, 2012). Conceivably, most surgeons would have ethical qualms providing such procedures as it involves damaging normal ability and healthy tissue (Bayne & Levy, 2005). While some may experience emotional pain-relief from surgical interventions, it does little to address the underlying problem (Cretella, 2016). It is possible the abovementioned conditions suffer psychologically because society is unaccepting of their self-perceived identities and a surgeon's refusal to offer the desired treatment can be taxing. However, it is also possible these conditions generate internal conflict and positions inner identity at odds with bodily facts in a way triggering psychological distress. From the noted similarities, then, it seems feasible to some extent that the intensely felt mismatch between inner sense of gender and bodily reality is capable of generating additional psychiatric issues.

The Role of Psychiatry for Gender Dysphoria

Currently, experts and clinicians find themselves in an interesting situation as the DSM-5 continues to categorise GD as a mental disorder, while ICD-11 has taken a leading role in fully depathologising transgender identities, yet providing medical transitions (Reed et al., 2016). The APA is internationally leading in terms of diagnostic formulations, but the DSM-5 is mostly used in the North American context. The international reach of the WHO is greater and it is reasonable to assume the ICD-11 will impact future removal of GD in the DSM system (Beek et al., 2016). The WHO is the directing health authority within the United Nations and some 70% of the world's psychiatrists primarily use the ICD system (Independent Expert, 2018). The medical and cultural depathologisation of transgender identities appears to have consequences for the role of psychiatry in the assessment and treatment of GD. The mounting perception of misaligned gender identities developmental diversity, both within therapy and culture, the discipline of psychiatry is becoming less concerned with the sources of distress in transgender people (Schulz, 2018). Treatment guidelines have supported psychiatry as the first contact and encourage psychological

assessment (e.g., Coleman et al., 2011). While clinics may prioritise such assessment only when severe mental disorders are suspected (Keo-Meier & Ehrensaft, 2018), establishing why comorbidities and GD occur is becoming less relevant because biomedical treatment is largely considered the only remedy for distress. As such, facilitating access to treatment and building health care providers' knowledge about treatment is prioritised (Ard & Keuroghlian, 2018). With advocates promoting a relocation of GD out of psychiatry and into medicine and endocrinology, a change already implemented in some contexts, treatment protocols dedicated to obtaining informed consent above robust psychological assessment prior to interventions, are facilitated (Arcelus & Bouman, 2015; Schulz, 2018). Such a perspective appears to prioritise the civil rights of transgender people over other considerations (Levine, 2021).

Considering the above view, as well as the view emerging from the depathologisation process broadly, the relevance of psychiatric insights appears uncertain. We might conceive of comorbidities as arising from stigma, or other adverse effects imposed by the social environment; it is arguably severely distressing to face violence for one's gender expression or to be tormented by peers for displaying gender variance (Tankersley et al., 2021). These experiences are likely to cause or worsen mental health conditions. However, with DSM's latest iteration, part of the rationale for retaining GD was to better account for the distress component arising from a mismatch between physical sex and subjective gender identity (Zucker, 2010). For some, GD distress is intense to the point of needing hormonal and surgical interventions; if GD is to be understood in this sense as constituting mental normalcy, other conditions, like the ones described earlier, could be argued for as well.

The older clinical guidelines reflected the core issue of disconnection between subjective self-understanding and bodily reality as itself a matter of concern (Mayer & McHugh, 2016). According to psychiatrist and researcher Paul McHugh (2016), intensely feeling a mind-body discordance can be a mental disorder in two ways: First, the idea that the mind and body can be at odds, is a mistaken belief, and second, this experience can produce a host of negative outcomes. Regardless of societal stigma or other external factors, it remains a transgender person's primary obstacle is their body, perceiving it to be wrong in a dramatic way. Whereas DSM-5 employ the GD diagnosis to encapsulate severe mental distress and to offer access to transition interventions, ICD-11, clearly allows for the possibility of seeking a transition even when GD is absent (Reed et al., 2016). As a result, ICD-11 conveys the discordance between felt gender and sexed body is part of normal human development.

Against this backdrop, a primarily psychological issue is removed from the realm of psychology. As Lori Cretella (2016, p. 51) of the American College of Paediatricians expresses, the discipline of psychology could transform into a "medical interventionist specialty." If a shared objective standard is eroded from psychiatry and clinically necessary concepts of pathology and non-pathology, abnormal and normal are removed, this might sacrifice proper medical and clinical practice, according to Levine (2021). Despite laudable intentions aiming to reduce stigma, departing from these concepts will not provide clinicians with meaningful categories enabling them to offer health services to those who suffer from pathologies or abnormalities (Cretella, 2016). Given the changes in diagnostic nomenclature did not derive from a scientific basis, but through cultural and political changes, we should perhaps be wary of unintended consequences in other areas of medicine and psychiatry broadly.

Normality may be defined as "that which functions according to its design" (King, 1945, p. 494). The brain, for example, is normal when it fulfils its main function of perceiving the physical reality and when thoughts are in accordance with this reality, argues Cretella (2016). Thoughts discordant with physical reality can therefore be considered abnormal, regardless of whether the individual experiences distress from such thinking (Cretella, 2016). For the psychiatric professional, an important task is to help the individual survive the beliefs they hold, but also to help them accept truth, while disentangling the antecedents of their beliefs (McHugh, 2016). Against this backdrop, it seems reasonable to argue the mental scaffolding supporting a transgender identification should at least be evaluated within psychiatry, rather than remain outside the realm of appropriate questioning in a clinical context.

Clinicians have noted the exponential growth observable in some GD pathways, often unfolding and intensifying by receiving feedback from others, which facilitates reinforced beliefs (Sasha Ayad, 2020a; Hakeem, 2018). While Standards of Care (Coleman et al., 2011) prescribe a mental health professional to conduct initial assessment prior to medical interventions, the guidelines emphasise the clinician's role as an advocate for the transgender client and state the ethical responsibility to affirm and support atypical gender identification. This positions the clinician in a conflict of encouraging transgender identification while conducting psychological assessment of eligibility for transition. SoC offers a way around this by recommending mental health concerns "must be reasonably well-controlled" prior to

interventions (Coleman et al., 2011, p. 40). However, as Janssen et al. (2019) note, deciding on what constitutes reasonable control in this regard is entirely subjective.

How clinicians contribute in enforcing mistaken beliefs is awarded little attention in current discussions. Transgender people deserve to be respected and listened to, but it also seems important for a clinician to consult the psychological mechanisms ongoing in the patient prior to intervention-referral as progressing prematurely could cause future harm (Levine, 2021). A range of ethical issues emerge here and clinicians have noted their ethical discomfort with not knowing whether their patients' struggle is a mental disorder or not (Vrouenraets et al., 2015). Other clinicians have resigned due to conscience issues over rapid affirmation and treatment for young people without proper assessment (Bannermann, 2019). How can the clinician know whether psychiatric comorbidity in patients is completely separate from GD and transgender identity, or a fundamental part of their desire for medical interventions?

It appears unavoidable to note the transgender population's significant challenge in regards to additional mental health problems. According to clinicians at the National Treatment Service for Gender Incongruence, two thirds of adolescents suffer from sever comorbidities, including depression, anxiety, self-harm, and trauma (Wæhre & Tønset, 2018, March 23). A 2018-study revealed 50.8% of female to male adolescents reported a previous suicide attempt (Toomey et al., 2018). Similar rates of suicide attempts are found by Williams Institute (Herman et al., 2019). Research also clearly indicates gender identity issues are more frequent in individuals with early adverse life experiences, trauma, sexual abuse, internalised homophobia, and autism (de Vries et al., 2016; Giovanardi et al., 2018; Glidden et al., 2016). Clinical and psychological mapping of transition-desire thus seems highly important.

With regard to adolescent females who experience GD, research observes they are often adamant in their desire to transition and express the immediacy with which interventions must ensue (Churcher Clarke & Spiliadis, 2019; L. Littman, 2018). According to psychologist Kenneth Zucker (2017), who is considered an expert in the field of GD, many young people present in gender clinics within a context of broader identity issues. GD could also manifest as a secondary symptom of another, more primary condition (Zucker et al., 2012). These findings highlight the need for psychiatry to take part in the treatment of transgender people. Addressing the root cause is critical and professionals should make sure they are alleviating the right issue before advising the patients to undergo medical

interventions, many of which are irreversible with future infertility as a result (Coleman et al., 2011). It seems critical to retain a space for well-intentioned questioning in a clinical setting

Notwithstanding, confirmation of gender identity assertions prima facie and transition-facilitation appear to be natural corollaries to the process of depathologisation. As additional psychiatric issues and GD are conceived of as adverse consequences of societal stigma, psychiatry serves less of a function and causal factors for GD remain unlooked for. Consequently, the focus becomes increasingly turned toward medical transitions; some clinicians believe this to the gold standard of transgender treatment and some clinicians feel they are saving lives by facilitating medical treatment (Levine, 2018). As a result, intensified focus on gender affirmation and transition-interventions can be seen as a driver in rates of transgender identification and transitions. In addition, the lowered diagnostic thresholds in both DSM-5 and ICD-11 can illustrate an added effect via diagnostic inflation, facilitated on the internet.

Diagnostic Inflation and Concept Creep

In the lead-up to DSM-5, concern was voiced about several mental health diagnoses becoming less stringently defined, while new disorders were added (Fabiano & Haslam, 2020). According psychiatrist Allen Frances (2014), chairman and leading figure in the revision of DSM-IV, relaxed diagnostic criteria would pathologise normal, non-pathological experiences. This concern was noted relevant in a range of psychiatric disorders, like depression, anxiety, autism, Attention-Deficit/Hyperactivity Disorder (ADHD), and eating disorders, particularly so in relation to young people (Fabiano & Haslam, 2020; Wakefield & First, 2012). Such concern is in keeping with a general impression of young people "shopping for disorders" online, while "quick fix" prescriptions are preferred over time-consuming psychotherapy. The role of pharmaceutical companies' monetary benefit is also of concern (Jones, 2014). Frances' (2014) and others' critique, especially relevant to DSM-5's relaxed criteria for GD in adolescence and adulthood, can be seen through the cultural context of psychological "concept creep" (Haslam, 2016).

Originally, Haslam (2016), hypothesised harm-related concepts have undergone a semantic expansion in in the past decades through social change and cultural shifts. This development was termed "concept creep" and is a framework utilised by prominent thinkers to account for political, cultural, and legal broadening of concepts related to harm (e.g., Lukianoff & Haidt, 2018; Pinker, 2018). Haslam (2016) suggested semantic expansion is

particularly relevant to psychological terms and can occur horizontally and vertically. The latter type of expansion ensues when a concept is less rigidly defined and engulfs less severe notions of a phenomenon. For example, bullying has over time come to include unintentional and unrepeated acts that are less severe. Horizontal expansion entails a concept applied in a new context or adds to its inclusion new phenomena. In this expansion, bullying has been applied to qualitatively new contexts, like cyberbullying (Haslam, 2016).

Along two axes, harm-related concepts can undergo semantic inflation. In the context of GD, this appears relevant both in a clinical setting as clinicians operate with relaxed diagnostic criteria possibly allowing for diagnostic inflation, with the added effect of clinician beliefs about the best treatment, as described earlier. From a cultural perspective, concept creep can enforce this inflationary effect. To illustrate this, social media and user-generated online material relating to transgenderism and GD is helpful. The internet contains vastly more content about transgender topics compared to earlier. Transgender people and gender-questioning teens congregate in online communities, wherein they can share advice, establish friendships, and have social support (Selkie et al., 2020; Trujillo et al., 2017). Yet, many clinicians are concerned with the facilitating effect of the internet on GD interpretations, retroactive meaning-making of past experiences, and social contagion mechanisms producing increased rates of transgender identification with subsequent transition desire (Lisa Littman, 2018; Meyer-Bahlburg et al., 2018; Van Deusen, 2018).

Diluting Diagnostic Criteria Online

The literature on young people's conclusions and realisations about having GD suggests the internet and social media are instrumental to their development (e.g., L. Littman, 2018). Arguably, better access to information and increased visibility of transgender issues has allowed people to understand themselves better and seek the help they need (Bechard et al., 2016). The internet has likely helped those who in the past were un-treated and un-diagnosed. In this way, the internet can be seen as contributory in rising rates of clinic-referrals (Zucker, 2019). At the same time, however, the internet may be understood as a double-edged sword in its contribution to GD among young people (L. Littman, 2018).

With regard to transgender individuals with dissimilar trajectories to those with childhood GD, concern about the role of internet in developing GD has been expressed (Brunskell-Evans, 2019; Van Deusen, 2018). Online transgender communities are typically highly supportive and welcoming. In the context of complex mental health conditions or more

unspecific forms of psychological pain, the internet can play a key role in transgender identity conclusions. When seeking the internet to find what might explain their psychological discomfort, young people can locate forums and websites containing a diluted set of GD diagnostic criteria. On Tumblr, Reddit, or YouTube, youngsters questioning their gender gather to share their experiences and perceptions of being transgender, often describing symptoms of GD as feeling “different from others,” “not fitting in,” or “being uncomfortable in one’s body” (see L. Littman, 2018)

These descriptions are likely easily recognised by young people as they describe relatively common human discomforts. In the troublesome and complex time of adolescence, body discomfort, for example, may resonate deeply (Ayad, 2020a). Diagnostically, GD does entail distressing body discomfort and strong rejection of secondary sex characteristics (APA, 2013). But for the insecure teenager, body-image issues could be mere adolescent discomfort with a developing body. As Levine (2021) argues, there might be an increased difficulty among young people in dealing with naturally occurring life events. Could we view contemporary manifestations of GD as a new way of describing bodily discomfort?

Several clinicians and other voices have observed a relative incapacity to bear and navigate the turbulent waters of adolescence (Churcher Clarke & Spiliadis, 2019). Research does indicate that young girls tend to struggle more with negative body-image compared to male counterparts, especially in association with social media (Aaserud, 2021). Body discomfort and body alienation may stem from other experiences as well, like sexual abuse, mental disorders, personal loss or broken families, according to reports from detransitioned adults (Heyer, 2018). The desire to escape one’s body may have its genesis in a multitude of life stressors and online forums can give the impression of such experiences are indicative of GD. Against this backdrop, adopting a transgender identity could, according to a life-course perspective, be seen as new cultural solutions to familiar intrapsychic distress during psychosexual development (Levine, 2018).

This rationale seems to coincide with a general societal tendency to over-diagnose and view normal traits as psychiatric ones. One Reddit forum dedicated to the topic of gender dysphoria (r/genderdysphoria) shares an article detailing “indirect” GD symptoms. Among these, a sense of “meaninglessness in life” and “lack of purpose”, suggest a GD condition (Jones, 2013). It seems questioning one’s gender in this context is likely to confirm any suspicions; the answer is almost always “yes” (Ayad, 2020a; Littman, 2018b). Anecdotal accounts from

detransitioners emphasise the internet as contributory to interpretations of GD (Shrier, 2020). If young people are solving ordinary developmental angst thought extraordinary means (Levine, 2021), it would seem wise to explore the internet's contribution.

Therapist Sasha Ayad (2020a), who works with gender-questioning youth and their families, observes a tendency in young people to mould their pain to fit with the narratives encountered online. As the young person continues to read, watch, and focus on a transgender interpretation of their distress, the more it will come to make sense and fit with their understanding of the diagnosis, Ayad observes; they become confident that this explains what is going on. Parent reports have revealed that prior to announcing transgender identification, the young people described had spent a prolonged time immersed on the internet, binge-watching transition and trans-related videos (Littman, 2018). In support, clinical experience notes youth arriving in clinics after watching a transgender influencer on YouTube (e.g., Bertie, 2016). Littman's (2018) findings offer additional support as parents frequently reported a rapid progression in their child from unspecific psychological distress to clear and adamant transgender identification.

With this context, a young person stumbling onto information about gender identity and gender incongruence may start a process of considering that they do feel incongruence between who they are and how people see them. According to psychiatrist Hakeen (2018), intense preoccupation with what is perceived to be the core problem and solution can manifest in transgender individuals, resulting in an exponential development with steps serving to reinforce perceptions. For females with GD, high rates of cooccurring autism spectrum disorder (ASD) is reported (de Vries et al., 2010) and a possible link between the GD and autism could be the diagnoses' shared trait of intense and rigid focus on specific activities, for example, cross-sex objects (VanderLaan et al., 2015). Arguably, the online realm can facilitate and maintain perceptions of having a transgender identity and needing treatment.

Young people can both conclude with a transgender identity through appraising their distress as GD online and find non-medical steps to start transitioning. For example, trying a new clothing style, adopting new pronouns, or using a chest binder to masculinise appearance for females ("Your guide", 2017). Initiating this process can relieve perceived GD distress; continued living with psychological discomfort and not fitting in with peers can perhaps seem more straining than commencing with a social transition. Many youths are excited about this revelation and feel a sense of relief from finding "the" solution (Ayad, 2020a). According to

detransitioner reports, peers, social media, and online communities were influential in their transgender identity development and transition-desire (Pique Resilience Project, 2019)

It is furthermore worth noting how online subcultures guide and advice young people, both on how to socially transition, but also on what to say to the mental health professional to gain access to treatment. Littman (2018) found that 22.2% of the transgender young people were exposed to online advice about accessing hormones, and 17.5% were exposed to advice promoting lying to a professional as acceptable. This type of online advice can be seen as similar to “anorexic tricks” in eating disorder communities (Harshbarger et al., 2009). Deceptive behaviours, like hiding the truth about not eating and weight-loss from parents and doctors, are shared between patients and in online forums (Custers, 2015). Communities may also validate eating disorders as an identity, further intensifying deceptive behaviour (Rouleau & von Ranson, 2011). These similarities, in addition to a shared pattern of social contagion within peer groups via co-rumination and excessive reassurance seeking, suggest anorexic developmental pathways could serve as a template for the rising rates of gender clinic referrals in relation to peer- and online influence (L. Littman, 2018; Paxton et al., 1999).

2. Gender Identity Theory & Culture

In tandem with an overarching process of declaring transgender identities to be representatives of human diversity, contemporary conceptualisations of gender have changed significantly in the past decades. Whereas traditional notions of gender grounded in the biological division between male and female has long prevailed, young people are now exploring and questioning gender in a vastly different context. Increasingly, gender is understood as culturally and socially produced and therefore, gender expressions vary across time. Moreover, seemingly ill-fitting and rigid gender categories are replaced with a spectrum-based perspective, wherein gender is characterised by multiplicity and fluidity (Wren, 2014). This chapter will attempt to describe main tenets of a contemporary theory of gender identity, before offering antecedent historical and cultural shifts which have paved the way for current beliefs about gender. A discussion highlighting gender identity theory's driving role in transgender identification and treatment-seeking will follow.

Gender Identity Theory

The concept of gender identity has become common currency in Western culture, as well as within a clinical setting (Keo-Meier & Ehrensaft, 2018). The collection of ideas that make up gender identity theory are many and a widely agreed upon definition is wanting. Still, central ideas can be extracted, the most prevalent of which seems to be that gender identity is a fundamental part of a person's identity and determines who they truly are. According to Yogyakarta Principles (YP; 2006, prin. 3), a publication on human rights in areas of gender identity and sexual orientation, gender identity is "integral to their personality and is one of the most basic aspects of self-determination, dignity and freedom." In a similar vein, transgender bioethicist Simona Giordano argues gender identity is a fundamental element of oneself, "a segment of personal identity" (Giordano, 2012, p. 48).

Others explain gender identity is a core component of who a person truly is (Hoffman-Fox, 2017). The authenticity of gender identity is also emphasised, for instance, influential trans woman and former executive director at the National Centre for Transgender Equality, Mara Keisling, explains transgender people are among the few who are "really approaching things with full integrity and full transparency…We're saying, this is who I really am" (Lopez, 2018). In a children's book entitled *It Feels So Good to be Yourself*, gender identity is innate, fundamental, and an expression of authentic identity (Thorn, 2019).

The LGBT organisation Stonewall offers the following definition of gender identity: "A person's innate sense of their own gender, whether female, male or something else… which may or may not correspond to the sex assigned at birth" (List of LGBTQ+ terms, n. d.). The definition of the word "innate" describes something inborn, existing prior to birth; belonging to the original or essential construction of body and mind (Merriam-Webster, n. d.). Accordingly, when gender identity is discovered, its existence precedes the person's conscious awareness of it. After discovery, a person may outwardly express their gender identity through clothing, hair style, hormones or surgery. In other words, gender identity can manifest through gender expression, which for transgender people often entails biomedical treatment. These external steps are considered evidence of the person's innate gender identity and conveys to the world their authentic identity (Stock, 2022).

Moreover, information about gender identity is often described as something only the holder can know through privileged access to this information (Wren, 2014). Gender is commonly described as being "between your ears" and not "between your legs" (e.g., Olsen, 2014). Thus, gender resides in the mind with the ability to over-ride the biological body as informant for true gender. Evidently, a turn toward gender as separate from biology and depending upon personal and subjective interpretations has occurred. As a result, identification with a gender category is elided with being born belonging to the biological categories of male and female (Stock, 2022). This is not uncontroversial, as is clear from the hotly debated question of whether a transgender woman is the same as a biological woman (Anderson, 2018). For some, distinguishing between two types of women with reference to biology is considered hate-speech and unaccepting of true identity (e.g., Dawson, 2020).

Gender identity theory goes beyond binary categories of male and female, man and woman. When a transgender person identifies with the opposite sex, they maintain a binary identification. Others, for example, non-binary individuals represent a category of gender identities that are neither male nor female (Aaserud, 2021). Some identify as bigender and experience a gender identity made up of both man and woman. Yet others consider themselves genderless, or agender. Omnigender entails possessing all genders (see List of LGBTQ+ terms, n. d.). A set number of gender identities cannot be given and when glossaries are provided, authors often note the inevitable expiry of their descriptions because gender identities are ever-expanding (e.g., Aaserud, 2021). All gender identities are assumed equally valid and should be expressed as the holder wishes, even when this entails medical interventions (Stock, 2022).

A somewhat different contemporary framework for understanding gender identity is through a political lens, wherein the act of departing from normative notions of alignment between body and mind serves the goal of blurring the lines between genders, while destabilising sexuality- and gender-normativity in society (Pluckrose & Lindsay, 2020). As gender is thought to be a social construction with meaning ascribed through cultural context at a certain time, the plethora of new gender identities function as an affront to the binary division of men and women based on sex-categorisation. Political objection to fixed gender categories, with societal organisation centred around them, is seen as subverting dominant narratives which undermine and oppress gender variance (Stock, 2022).

Originally, gender identity was theorised in relation to those who exhibited atypical sexual and gender development, today known as disorders of sexual development and gender dysphoria, respectively (e.g., Money et al., 1957). Gender identity theory today, however, stipulates every person has an innate sense of gender, whether aware of this or not (Anderson, 2018). When referencing "men" and "women," the prefix "cis" is often added to distinguish between transgender people and non-transgender people. That is, to distinguish between "types" of men and women depending on psychological experience of gender (Serano, 2007). From the above, gender identity theory departs dramatically form traditional notions of gender as binary and based on biological sex. Historical shifts can shed light on how contemporary understandings of gender have developed.

Historical Roots of Gender Identity Theory

In 1949, French existentialist Simone de Beauvoir published her influential book *The Second Sex.* In this work, de Beauvoir problematised the differential treatment of men and women in society, while contending a woman is made through exposure to cultural representations of femininity. The cultural role projected onto women and girls was by de Beauvoir seen as determined by the interest of men, and in relation to the man, the woman is peripheral; positioned as "the other." The stereotypes of femininity she objected to were considered limiting and contradictory; women should be domestic and modest, but also sexually available and exciting. Through the famous quote, "one is not born, but rather becomes a woman" (de Beauvoir, 1949, p. 283), de Beauvoir highlights the distinction between being born a female and existing as a woman in society.

According to Stock (2022), this is an early instance of separation between sex and gender. Since the 1960's, a second wave of feminists became increasingly interested in the norms,

expectations, and stereotypes associated with masculinity and femininity. These bundles of norms were referred to as "gender" and thought of as societal constructions, rather than linked to biology. As feminist scholar Ann Oakley (1972, p. 21) argued, "sex" is a biological difference between male and female based on reproductive functions, while "gender" is the social categorisation of masculine and feminine. This perspective further developed and womanhood itself came to be understood within feminism as essentially social; being a woman or girl meant having this social role projected onto you (Stock, 2022).

One of the main critiques from a feminist point of view was the objection to biological arguments for the role of women in society. According to feminist theorist Elizabeth Grosz (1995), essentialism in this regard assumes all women share an essence or true nature that is ahistorical and culturally independent. The view frames the social manifestation of femininity to be a product of female biology, producing certain traits in all women, like psychological traits related to nurturance, non-competitiveness, and empathy. Fixed essentialist biological notions limited the scope of women's possibilities and accepting a "natural" division between the sexes would neutralise the social mechanisms manifesting the oppression of women (Wittig, 1981, p. 104). Philosopher and feminist Judith Butler (1986, p. 35) observed the separation of sex and gender as pivotal in the effort to "debunk the claim that anatomy is destiny."

The feminist movement conceivably altered the conceptualisation of constitutes a woman. This, argues Stock (2022), would later lead to altered perceptions of *who* society could consider a woman. The earlier work of the feminist movement likely did not have transgender accommodation in mind, but they did seek to unchain women from the oppressive limitations of understood only as biological beings (Stock, 2022). Conceivably, current notions of gender identity as privileged over biology springs in part from the social change brought about by the feminist movement.

Postmodernism and Queer Theory

In dealing with the topic of gender identity claims in contemporary society, featuring the overarching epistemologies associated with postmodernism seems inevitable. While a comprehensive exposition is beyond the scope of this thesis, notable postmodern views are pertinent to the formation of gender identity theory today. Broadly, the collection of ideas and arguments in postmodernist thinking can be seen as radical scepticism and rejection of anything in society considered stable, fixed, and orderly. Instead, things are fluid, disorderly,

and uncertain (Pilcher & Whelehan, 2016). In relation to sex and gender, postmodern theorising has problematised the very concept of gender, denied the traditional binary division between two genders, and politically wrestled with the limitations placed on gender opportunity and expression.

According to Kvale (1995), postmodernism is essentially a critique of the modernist assumption that through science, humans can access objective truth. Consequently, postmodernism questions the assumption humans contend with universal reality. Rejecting universal truth has oriented focus away from attempts to represent reality scientifically, towards the linguistic construction of reality informed by individual subjectivity. Furthermore, "truth" is situated within a culture where people with a shared identity marker and societal position culturally construct reality (Kvale, 1995). Cultural relativism in relation to knowledge-production and language means no one constructed reality can be checked by another and all "truths" are equally valid (Pluckrose & Lindsay, 2020).

Linguistic construction and types of knowledge feature as central elements of postmodernism. From this, the inner sense of gender identity is highlighted and viewed as subjective truth. In Western societies, the cultural construction of gender has separated men and women based on biology and unjustly asserted a non-transgender identity as privileged over other gender identities. Rorty (1995) argues binary gender identities are co-defining, but not in reality opposites. The organisation of men and women as separate and fixed categories are defined by what is external to it, therefore, stable categories are by default exclusionary (Wren, 2014). From a political point of view, dichotomous thinking, "maintains inequalities of power" (Squires, 1991, p. 127).

Binary distinctions between entities are considered highly influential in the development and progress of Western societies and modernism (Pilcher & Whelehan, 2016). Outlined by Prokhovnik (2002) and applied to the male-female binary, four processes unfold in dichotomous thinking. First, differences between male and female are constructed as oppositions; each part is defined by not being the other. Second, a hierarchical ordering takes place wherein one part of the pair becomes subordinate to the other. Importantly, the dominant part in a binary had gained this position through its exclusion of the other. In feminism, the subordination of women by men is central, but a postmodern turn has criticised feminisms complicit role in subordinating other groups through maintaining the binary (Lorber, 2006). Third, the dichotomous pair determines the whole; together, male and female

set the parameter for what gender is. Fourth, the subordinate part can only move up or gain in value by becoming more like the dominant part (Prokhovnik, 2002). For feminists, women needed to gain access to material and social goods dominated by men, but this effort is also criticised for neglecting its own utilisation of a discursive framework originally constructed with power-imbalance and hierarchical oppression (Pilcher & Whelehan, 2016). Postmodernism encourages re-examination or deconstruction of assumptions; certain assumptions produce and reproduce fixed categories and attaches meaning to them (Derrida, 1973; Wren, 2014). As a result, gender opportunities are suppressed through a discourse which dominates the available ways to describe and express gender. Dichotomous language "operates to preclude the recognition of plurality and heterogeneity" (Pilcher & Whelehan, 2016, p. 31).

Herein, we may view traditional presentations of men and woman as exclusionary toward those who do not neatly fit in with such presentations. In contemporary culture, those who divert from normal sexual development (intersex) and those who have gender identities at odds with biological sex, are considered oppressed by unequal power dynamics (Pluckrose & Lindsay, 2020). The very idea that there is a norm from which to divert, is criticised (Independent Expert, 2018). Moreover, postmodernism's emphasis on language as constructive refutes the division between men and women based on biological sex because bodies are not ahistorical and pre-discursive; sexed bodies are given meaning only when they are spoken about in a cultural context (Pilcher & Whelehan, 2016). Furthermore, the postmodern rejection of scientific knowledge distrusts the causal relationship between birth-sex and gender identity (Wren, 2014). Therefore, these meanings must be examined extensively, a process which has arguably made subjective gender identity a salient feature in current debate.

Within postmodernism, and in relation to gender, a political turn is taken through queer theory. According to queer theorist Judith Butler (1988), gender can only be expressed as performance, because the idea of gender is socially constructed. The preferred way to "perform" gender is to subvert or "queer" dominant discourses and break down power structures that serve to uphold limiting gender categories. Queer theorists seek to dismantle existing structures perceived to create, maintain, and perpetuate hierarchies and minority-group oppression. In reference to sex and gender categories, the boundaries grouping people together are considered arbitrarily created by unjust systems of power (Pluckrose & Lindsay, 2020, p. 99).

As with postmodernism generally, queer theory remains difficult to understand, perhaps by design; as Annamarie Jagose (1996, p. 3) explains, "its elasticity, is a conscious characteristic." Thus, the central feature of queer theory is its whole purpose: resisting categorisation and distrusting the language used to define those categories (Stock, 2022). Queering is about unmaking any sense of the normal, as a way to liberate people from the expectations of norms (Pluckrose & Lindsay, 2021). The be queer is to be whatever is at odds with the normal, the legitimate, the dominant (Halperin, 1997). The stability and permanence of gender categories are questioned, and gender is presented as fluid across time and culture, but also within the individual. Through this lens, atypical gender identities or queer individuals are applauded and valued for their transgressive function within cultures of cis- and heteronormativity (Wren, 2014).

Gender Identity in a Human Rights Paradigm

While queer theory rejects the validity of stable categories, gender identity has come to be included in a human rights paradigm. The aforementioned Yogyakarta Principles (YP; 2007) is a civil society document authored by a group of experts within law, health, and human rights (Brunskell-Evans, 2019). The YP's 38 principles are not legally binding and have not been implemented into any UN convention or declaration on human rights, although they are regularly cited by the UN (Ettelbrick & Zeran, 2010). The YP constitute the most comprehensive exposition of gender identity within a human rights paradigm and is frequently cited in international legislation, academic papers, bills, resolutions, and other documents (Minkowitz, 2016). Thus, the principles are seen as authoritative to international law (Brunskell-Evans, 2019).

According to principle 3 of the YP (2007, 8), gender identity is defined as "…each person's deeply felt internal and individual experience of gender," independent of bodily sex. Within the YP, transgender rights are seen as politically progressive and intersectional with the rights afforded to other marginalised or oppressed groups (Brunskell-Evans, 2019). The YP (2007, p. 6) stipulate that "all human rights are universal, interdependent, indivisible and interrelated," and "gender identity is integral to every person's dignity and humanity." Thus, gender identity should legally be protected against discrimination on that ground.

Another instance of the human rights aspect of gender identity is the UN Human Rights Commissioner's (HRC) establishment of the Independent Expert in 2016, which is a branch dedicated to issues relating to sexual orientation and gender identity (Independent Expert,

2018). In addition, the UN's Committee on the Elimination of Discrimination against Women (CEDAW) now includes natal males who identify as women alongside women in protection from discrimination based on sex and gender (Minkowitz, 2016). Gender identity is understood as a part of legal personhood and self-defined gender identity is presumed to warrant legal protection (Jeffreys, 2014). Here, gender identity theory's assertions about the separation between bodily sex and subjective gender come to fruition as persons can gain legal protection from gender- and sex-based discrimination through identification with the other sex.

Separating the Mind from the Body

Evidently, major shifts in cultural conceptions of gender have occurred and these stand in stark contrast to long-held notions of gender as linked to biology. Of note is the central assertion that sex and gender are dislocated concepts, with biology resolute in informing one's gender. Additionally, gender is understood as a social construction. These altered perceptions are likely to influence young people's gender-related issues in important ways by making both gender identity and the sexed body salient, but separately and independently so. These main claims about gender identity will feature in the following discussion focused on how scientific and postmodern insight can account the innateness of gender identity and account for the physical reality of inhabited bodies.

Despite accounting for gender identity theory assertions, it remains unclear what gender identity actually is. Commonly, when atypical gender identities are asserted, it should be taken at face value because the transgender person has privileged access to this information. As such, it cannot be questioned or refuted by others, not even in a clinical context (Wren, 2014). The transgender person is the sole authority on these matters and by extension, the sole authority on the body they inhabit and treatment-needs (YP, 2006; Wren, 2014). When there is a desire to alter the body by means of hormones or surgery, self-certainty of gender identity is its own guarantee. Consequently, self-deception in this regard is not possible and no one else can prove the identity to be otherwise (Wren, 2014). But what exactly does it mean to have an inner sense of gender? Moreover, what does this mean in relation to a physical body? Philosophically, we may ask how a female, for instance, can really know what it is like to be a male, as only a male would inhabit that capacity (Nagel, owl).

In an attempt to extract the core meaning of gender identity, a sequence of questions inspired by Robert George (in Anderson, 2018, p. 105) is helpful. Consider, for example, the claim

made by a biological female that they “really are a man” because of a male gender identity. What does this statement mean? Clearly, the person is not claiming their biological sex is male as this would be contrary to scientific truth. Nor is the person saying that their gender is “man” or “masculine.” Even if “gender” in this context is considered wholly a socially constructed role or as mere self-perception, the person is currently not perceived to be a man as no medical interventions have occurred. Moreover, the fact that they are not already perceived to be a man constitutes the reason for undergoing a medical transition. Consequently, treatment is motivated by the wish to be perceived as a man, while the justification for undergoing treatment is that they already are a man. This assertion places gender identity as extant prior to what a transition will achieve, but what does it specifically refer to? Gender identity is often defined as an “inner sense” of gender, but such a definition does not answer what this “inner sense” is sensing. What is “sensed” within the person leading to conclusions about gender identity?

The Postmodern Turn

Answering the above questions is not easy as knowledge about gender identity development is scarce. Yet, clinical experience and the core issue in GD seem to indicate that the body is central to what is being sensed. That is, a person with GD experiences a direct conflict with the body they inhabit and feel a sense of estrangement from bodily reality (Silber, 2019). GIDS psychologist Bernadette Wren (2014, p. 278) describes the difficulty of “privileged access” to gender identity information presenting in combination with a direct bodily experience, as this is a type of sensing of the body through non-identification and non-belonging. Within a postmodern framework, clinicians face a complex situation as the subjectivity of the patient is privileged over exploration of how they sense the body. Body discomfort is at the core of transgender people’s experience, according to Prosser (1998), and the reality of the inhabited body is a “reality” that a postmodern framework fails to do justice (Wren, 2014, 278).

Postmodernism’s rejection of universal and objective truth is in conflict with the assertion of “privileged access” in gender identity theory. When declared in a clinical setting, how one feels on the inside cannot automatically be taken as evidence for the wrongness of the body (Wren, 2014). If it is taken as evidence, what does a GD person’s convincing history of non-identification with their body tell us? As Prosser (2009) argues, a feeling of body integrity is necessary for functioning successfully and body-related perceptions of the self and its continuity informs self-certainty and self-belief. From a postmodern perspective, descriptions

of the bodily self independently of culture cannot be done because the body is not pre-discursive, nor ahistorical (e.g., Stryker, 2008). The requirement of a cultural analysis applied to atypical gender identity development can divert attention away from the body-mind discordance directly deriving from experience of embodiment.

On the other hand, in line with postmodern notions of language as construction and prevailing dominant discourses limiting the ways in which descriptions of oneself can be articulated, GD can be viewed differently. For instance, GD could be seen as an attempt to explain one's inner life via available cultural elements; a version of subjectivity arises and seeks to communicate a story of identity by drawing on one or more of the legitimising discourses in the current culture (Foucault, 1970, 1996). From this, declarations of an atypical gender identity do not represent objective reality, but rather a linguistic attempt to achieve recognition and convince relevant agents in the social environments of internal feelings relating to the body (Wren, 2014). As Rorty (1991) describes, our language are tools, rather than a reflection.

Given the historical prejudice and difficulty transgender people have faced with regard to being believed in their strong convictions of internal gender in contrast with their bodies, it is possible to understand adamant claims of privileged access to the truth of their gender as a re-telling of a story grounded in the wish to have these experiences legitimised and acknowledged. The integrity of gender identity claims could be aimed at convincing others through stories of childhood gender dysphoria moulded to fit with the requirements in a clinical context allowing for access to surgeries. Several authors have noted clients' tendency to conform their stories to achieve the goal of transitioning (Wren, 2014; Littman, 2018; Prosser, 1999). When clinicians are faced with young gender dysphoric patients who present a self-narrative impacted by retrospective adjustments based on the present desire for bodily alterations, Roen (2011a, p. 64) reminds us how "both gender and adolescence are characterised by fluidity, changeability and uncertainty". Well-intentioned questions about gender identity thus seem necessary and valuable.

A Return to Biology

Attempts to legitimise the transgender experience, and eventually gender identity theory, has taken a road counter to postmodernism. Conceivably, the "feminine essence" narrative, originally used by older male transsexuals to ameliorate stigma and increase public acceptance (Jeffreys, 2014), could be seen as an early iteration of gender identity theory. Through claims of having always been female, despite a male body, the "feminine essence"

narrative grounded inner sense of gender in biological terms; they were women, but trapped in male bodies (Soh, 2021, p. 130; Jeffreys, 2014). With similar claims of innateness, "feminine essence" and gender identity theory attempt to cement a tangible reality in individual subjectivity, that by virtue legitimises medical treatment to alter the body.

Within transgender treatment and research, a scientific effort is made to locate gender identity neurobiologically (e.g., Keo-Meier & Ehrensaft, 2018). This endeavour is not only motivated by finding neural correlations between brain structure aspects, but to justify attributing gender identity directly to brain differences, rather than biological sex (Stock, 2022). Some brain-studies have demonstrated weak correlations between cross-gender identification and brain-structure (Mayer & McHugh, 2016; see Ristori et al., 2020). The correlations found do not, however, appear to constitute evidence for a neurobiological basis of gender identity. Non-representative, non-random, and small samples characterise such research, while they fail to show whether brain differences occur between populations or just between individuals (Mayer & McHugh, 2016).

Parts of the feminist movement have expressed worry as brain studies presenting "female brains" or "male brains" seem to backtrack well-known feminist critique of biological essentialism (Stock, 2022). Others criticise the over-zealous conclusions about what such brain studies show through disregarding neuroplasticity, which is the brain's potential for altered microstructure as a consequence of long-time behaviours (Cretella, 2016). There is significant evidence to suggest that experience can change the brain, but there is no evidence that we are born with brain microstructures that are unchangeable (Gu & Kanai, 2014). Some therefore argue that if specific transgender brain differences are discovered, it will most likely result from engaging in transgender behaviour, rather than be the cause of an atypical gender identity (e.g., Cretella, 2016).

Despite gender identity's implausible existence in brain structure, research suggesting hormone exposure in early development as consequential for later behaviour and preferences are taken as evidence (e.g., Bao & Swaab, 2011). According to Dr Polly Carmichael, director at GIDS, hormone exposure in the womb could "have a permanent influence on gender identity and behaviour" (Delvin, 2013). The data Carmichael comments on comes from rare cases of congenital adrenal hyperplasia (CAH) in female children. This condition exposes females to unusually high levels testosterone during prenatal development (Sax, 2002). As children, females with CAH tend to exhibit behaviours and preferences commonly thought of

as more masculine. For example, they tend to prefer toys like weapons or vehicles (Hassett et al., 2008), and to exhibit greater interest in rough-and-tumble play. They also tend to be more aggressive in play and more physically active (Pasterski et al., 2011). However, should such proclivities and the excessive testosterone exposure be understood as producing a male gender identity in natal females?

It is likely females with CAH find themselves more similar to boys. For instance, if boys are their preferred playmates, while offering greater opportunity for an activity-level match, it is not unlikely that they may come to share interests with them. They might perceive of themselves as "tomboys" or identify more with boys (Delvin, 2013). Moreover, testosterone exposure in the womb is linked to later homosexual orientation (see Roselli, 2018), which may accelerate similarity with boys (Stock, 2022). Still, this does not indicate hormone exposure produces an innate gender identity, existing prior to being born.

Thus far, research has not been able to nominate a brain fact wherein gender identity resides (Mayer & McHugh, 2016). Even if a neurobiological basis for misaligned gender identities were to be revealed, this would have no bearing on biological sex. In other words, biology could "prove" a misaligned gender identity exists in the brain somewhere, but this would still not mean a transgender person are the sex they psychologically feel like (Soh, 2020). From the available literature, GD and discordant gender identity strongly suggests a psychological condition, which is today treated via biomedical and surgical means, justified through subjective accounts (Levine, 2021). At the same time, unproven assertions about gender identity flourishes in the culture and is accepted by many clinicians (Anderson, 2018), in addition to being taught in schools and kindergartens (Masvie, 2021).

Prevailing efforts to legitimise transgender identities, whether inspired by postmodernism or science, fail to account reality of the body. Clinicians and other agents of influence in the life of a young gender questioning person should be cautious about the multitude of ways in which the body can come to feel wrong. In a culture where gender is made salient, clinicians should consider how their clients arrive at conclusions relating to gender identity, especially during adolescence. Females tend to wrestle more often with poor self-esteem and distorted body-image in pubertal development (Aaserud, 2021), as noted in the preceding chapter. In addition, common comorbidities in GD patients, like depression, anxiety, or trauma, are recognised as possibly generating body-estrangement (Schlax et al., 2020). Some caution is at least warranted in light of gender identity theory's lack of evidential basis; what are the

possible consequences of giving young people the impression that gender is psychological and innate, when this is closely linked to physical alterations?

Highlighting Gender Stereotypes

Taken together, gender identity from a postmodern and from a scientific lens do adequately contend with the physical reality of sexed bodies or how the body factors in to the inner sensing of gender identity. Nonetheless, cultural perceptions of gender as psychological and subjective have become common currency in Western societies (Stock, 2022). When gender identity is presented as psychological and as separate from bodily reality, what does the inner sense of gender identity sense?

In a range of human rights documents, a clear call for eliminating gender stereotypes is expressed. For example, the YP articulate the necessity of States to "eliminate prejudices and customs based on…stereotyped roles for men and women" (2007, p. 9). According to UN's Independent Expert (2018, p. 8), autonomy and freedom is in direct contradiction to "the idea that a person is born to play a certain role in society." The CEDAW shares a similar theme in that sex-based discrimination facing women is remedied by altering prevailing gender norms grounded in sex-role stereotypes (see Minkowitz, 2016). Against the backdrop of this motivation, it is interesting that the YP (2007, p. 8) state that the internal sense of gender may or may not correspond to natal sex, either in relation to "personal sense of the body" or in relation to other gender-expressions, "including dress, speech and mannerisms."

The YP does offer a definition of gender identity, but does not define gender, nor sex. As Mikowitz (2016) points out, linking gender to correspondence or non-correspondence with sex is the only indication that the authors are not merely speaking of personality traits. Somewhat paradoxically, then, the YP (2007) seem to allude to stereotypical notions of femininity and masculinity expressed through "dress, speech and mannerisms." In contrast to their own goals of eliminating stereotypes by socially deconstructing them, they implicitly support a notion of gender as equivalent to stereotypes (Minkowitz, 2016).

Today, public discourse about gender can be seen characterised by some contradictory assertions. One goal seems to assert that gender stereotypes must be eliminated in order to accommodate those who do not experience alignment between gender identity and sex, or otherwise depart form gender norms. Yet, many transgender people fulfil these stereotypes through their gender external expression. In addition, the treatments associated with GD are masculinising and feminising of outer appearance (Coleman et al., 2011). It is possible that

types of gender nonconformity are conflated in the advocacy for transgender rights and acceptance (Masvie, 2021). One type of gender nonconformity is found in those with a GD condition which for many is distressing to the point of seeking medical interventions to alter their appearance to fit with internal convictions. Another type of gender nonconformity, however, does not entail GD and manifests itself with great variation in both sexes.

Men and women exhibit typically masculine and feminine to varying degrees, but this is not the same as having a strong inner conviction of being transgender. Conflating types of gender nonconformity in the effort to advocate for and accommodate transgender individuals appear to highlight gender-stereotypes as indicative of gender identity. In addition, a tendency to conflate gender identity and gender expression is observable (Stock, 2022). Within this context, young females who see themselves as dissimilar to same-sex peers in terms of interests, preferences, or appearance, may be particularly vulnerable to the application of gender identity theory when stereotypes are highlighted. Research suggests young girls face higher demands form society based on their sex. A governmental report issued by the Norwegian government shows that young girls endure more pressure from expectations in relation to behaviour and physical appearance (NOU, 2019). For young females who display more masculine traits visible to others, could dissimilarity with same-sex peers produce gender identity-related questions?

In relation to sexual orientation, the decreased presence of “butch” lesbians is noted (Stock, 2022; Soh, 2021). According to Soh (2021), the non-binary gender identity is particularly popular among same-sex attracted females and the developmental histories of “butch” lesbians shares similarities with female transgender-identified individuals’ histories (Lee, 2001). A substantial portion of females with GD have homosexual orientations and when they transition, they identify as heterosexual men (Blanchard et al., 1987; Nieder et al., 2011). Norwegian clinician Johnny Aaserud (2021) some adult lesbian women have histories of gender dysphoric feelings, but eventually settled in their bodies.

3. Gender Affirmation & Treatment

As described in the foregoing chapters, significant diagnostic, conceptual, and legal changes have occurred in relation to transgender people, which seems to intensify focus on the body as object for change, while highlighting stereotypes of gender in the absence of an adequate description of how gender identity is perceived by the young individual. Despite this, the general clinical and cultural acceptance of gender identity theory has generated a framework for the treatment of atypical gender identity development which affirms inner sense of gender and views transitioning as a form of gender expression. Today, the gender affirmative model of transgender care (GAM; Keo-Meier & Ehrensaft, 2018; Hidalgo et al., 2013) has gained significant traction. In this chapter, an outline of the clinical views in GAM will be provided, as well as a description of two main controversies pivotal in paving the way for gender affirmation and transitions. A discussion concerned with GAM's role in rising numbers of transgender identification and transitions will conclude the chapter.

The Gender Affirmative Model

The GAM departs from the view that transgender identities are non-pathologicical and each person should be supported by the clinician in the process of living in the desired and most comfortable gender role (Hidalgo et al., 2013). "Gender health" is an important concept and entails a person's opportunity to live in the most comfortable and authentic way, with the ability to express gender free from limitations (Keo-Meier & Ehrensaft, 2018, p. 12). The role of the mental health professional under the purview of GAM is to be a facilitator of gender health and aiding the young person's discovery of an authentic life relating to gender (Keo-Meier & Ehrensaft, 2018). GAM stresses the importance of social support as critical for gender incongruent or gender-variant children and youth (Olson et al., 2016).

GAM is motivated by the older transgender generations' frequently expressed regret for not gaining access to medical transitions earlier in life (Beemyn & Rankin, 2011; Keo-Meier & Ehrensaft, 2018). Additionally, GAM is informed by research indicating low regret rates after transitioning; according to Pfäfflin and Junge (1998), less than 2% of transitioned individuals express regret. Against this backdrop, GAM seeks to affirm and confirm children and youths' inner gender identity, which is believed present in the individual from early on in childhood, for some as early as 18 months old (Golombok & Fivuch, 1994).

According to Keo-Meier and Ehrensaft (2018, p. 6), gender identity is a person's "innermost concept of self as boy or girl or both or neither." GAM understands the concept of gender

identity as biological, psychological, social, and cultural, but maintain gender is decided by a child's cognitions and emotions, not biological sex (Hidalgo et al., 2013). While gender identity is not visible, it is a product of individual perception, self-knowledge, and the words used to reference oneself. "Transgender" is defined as anyone who holds a gender identity other than what has been conveyed to them based on their birth-sex. Thus, GAM accommodates a host of gender identities, both binary and non-binary ones. Irrespective of GD, GAM promotes the affirmation of asserted gender identities, which in part includes altering relational terms (e.g., sister to brother), pronouns (e.g., she to her, or they), and names (Keo-Meier & Ehrensaft, 2018, p. 6).

In line with the depathologisation process, GAM asserts no gender identity or gender expression is pathological (Ehrensaft, 2016), and when comorbidities are present, this is most likely due to negative social reactions to gender nonconformity (Hidalgo et al., 2013). As described by Keo-Meier and Ehrensaft (2018, p. 11), GD in its capitalised form is a DSM-5 diagnosis, but lower-case GD is the feeling that "something is not right" in relation to one's gender. This sense can manifest through body dysphoria, like chest- and genital dysphoria, but also entails distress associated with being gender nonconforming in a "cisgender world." Moreover, GD should be distinguished from other issues, which are best addressed by inspecting psychosocial experiences in the child's social environment and culture (Keo-Meier & Ehrensaft, 2018). Unless there is suspicion of cooccurring psychiatric issues, the young person is not subjected to comprehensive psychological evaluation (Hidalgo et al., 2013).

GAM clinicians advocate for attending to gender variance in children and young people enthusiastically; failing to do so will perpetuate binary gender norms which denies the existence of gender diversity (Baker-Siroty & Hurd, 2020). Informed by a social constructionist framework, cultural sensitivity is necessary in clinical work with atypical gender identities and expressions. Especially as GAM clinicians consider gender to possibly be fluid, exist outside the traditional binary, and can change over time within a person (Keo-Meier & Ehrensaft, 2018). GAM calls for increased knowledge in health care professionals about new ways of seeing gender and sexuality, as well as calling for cultural social constructs of gender and sexuality to be re-evaluated. Children and young people should be free from imposed positions; gender identity and gender expression are considered basic human rights and clinicians should reflect on personal bias from experiences possibly distorting gender vision; such bias risks flawed clinical judgement (Keo-Meier & Ehrensaft, 2018).

A central part of GAM's approach is the distinction between gender expression and gender identity in order to tell apart the children who will need hormonal interventions at the start of puberty. Gender expression is the manner in which a child presents their gender to others, for example, through physical appearance, preferred playmates, and activities (Hidalgo et al., 2013). For GAM clinicians, expressions of gender offer valuable insight to whether a child is exhibiting gender exploration with acceptance of natal sex, or exhibit a persistent gender identity in need of future treatment (Ehrensaft, 2016). The attempt to distinguish children in this way derives from research suggesting the majority of children will not seek medical transitions and be gender dysphoric by the time puberty sets in (Steensma et al., 2011).

Interventions

From the above clinical views about gender identity and right to authentic gender expression, GAM facilitates hormonal interventions for young adolescents in the first stages of puberty (Keo-Meier & Ehrensaft, 2018). What is now dubbed "gender affirmative" treatment entails administration of gonadotrophin-releasing hormone (GnRH) analogues to halt pubertal development of secondary sex characteristics, hormone therapy to promote masculinisation or feminisation of outer appearance, and various surgical interventions to further alter the body as desired by the individual (Coleman et al., 2011; Hembree et al., 2009).

Puberty Blockers

Dutch gender specialists pioneered the use of gonadotrophin-releasing hormone (GnRH) analogues, colloquially known as "puberty blockers" or "blockers" (PBs; Soh, 2021, p. 140). Prior to being used off-label, PBs were used to manage precocious puberty in children (Carel & Léger, 2008). Since the 2000's, this has become a common treatment intervention for young people with GD across European countries, as well as in North America and Australia (Arnoldussen et al., 2020). Based on data from its original purpose, PBs are considered safe and fully reversible (Aaserud, 2021). Two functions justify its use for GD treatment. First, halting natural puberty can offer young adolescents more time to explore gender and for the family to figure out the next steps. Second, PBs prevent masculinisation or feminisation of the body, thereby facilitating a more successful transition by avoiding changes hard to reverse later (Coleman et al., 2011). Despite these advantages, the use of PBs remain controversial, with some regarding its use experimental (Vrouenraets et al., 2015; Giovanardi, 2017).

According to a 2011 study, positive outcomes of well-being were found in a highly selected group of adolescents who reached a strict diagnostic threshold for GD. These participants had histories of GD in childhood and did not have significant psychiatric issues. At age 12, they were offered blockers, before later progressing to cross-sex hormones and surgery (Cohen-Kettenis et al., 2011). Since then, however, the same results have not been replicated and data showing the long-term effects of PBs are lacking (Schagen et al., 2016). While this research is heavily relied on when using PBs to treat GD in young people, the findings are not necessarily generalisable to adolescent-onset GD manifestations in youth with severe psychiatric comorbidities.

Cross-Sex Hormones

For females, cross-sex hormones (CSH) include testosterone which promotes the masculinisation of outer appearance. This treatment is considered partially reversible and has typically been offered to clients aged 16 and over (Coleman et al., 2011; Hambree et al., 2009). After 2-5 years, and dependent upon individual difference, the full effects of testosterone are visible. Testosterone usually produces a deepened voice, clitoral enlargement, facial and body hair growth, as well as decreased body fat compared to muscle mass (Coleman et al., 2011). Once maximum effects are achieved, lowered maintenance doses are necessary with regular monitoring and comprehensive testing of bodily health is necessary (Hambree et al., 2009).

Individual factors impact the safety of testosterone-use and adverse outcomes cannot be predicted. Prior to administration, screening candidates for health risks is important. For example, those with family histories of oestrogen-dependent cancers are at increased risk when taking testosterone (Moore et al., 2003). Other risks include high cholesterol, polycythaemia, sleep apnoea, weight gain, acne and balding, increased risk of blood clots and type 2 diabetes. Testosterone may also destabilise pre-existing psychiatric issues, like bipolar or schizoaffective disorder (Coleman et al., 2011). Current guidelines recommend patients be psychiatrically evaluated and acute comorbidities should be prioritised before initiating CSH. Future fertility and other risks impacting the person’s life should be discussed thoroughly (Coleman et al., 2011; De Sutter, 2009).

Surgical Interventions

Females often desire a mastectomy, euphemistically referred to as “top surgery,” meaning breast-removal (Beek et al., 2015; Wilson et al., 2018, p. 679). Genital surgery is less

common, likely because it is a complex procedure with significant risks. Constructing a neo-penis in female patients through a phalloplasty typically entails taking skin from the forearm and connecting this tissue to the clitoral nerves, which maintains erogenous sensibility. In addition, implantation of erection and testicular prosthesis can be done (Colebunders et al., 2017). Accompanied by phalloplasty is the partial or full removal of the vagina (vaginectomy; Siedhoff et al., 2019). These procedures are often referred to as "bottom surgery" (Siedhoff et al., 2019, p. 155). Other genital surgeries a female may elect to undergo is removing the uterus (hysterectomy) or constructing a neo-scrotum (sctotoplasty; Chang & Ferrando, 2021). Non-genital surgeries may also be done, such as liposuction, lipofilling, pectoral implants, or other aesthetic procedures (Coleman et al., 2011).

Not all transgender people desire complete transition; some are contented with an androgynous appearance and others may experience adequate relief from partial treatment. Beek and colleagues (2015) found partial treatment to be mostly desired for those with non-binary gender identities. While earlier research report few females desire genital surgery (Ergeneli et al., 1999), an increasing number wish to undergo full "sex reassignment surgery" (Beek et al., 2015, p. 2201).

Critique of Other Clinical Approaches

Prior to GAM's popularisation, two clinics Toronto and Amsterdam held leading roles in transgender treatment for decades, and contributed important research and clinical experience with respect to the various needs of gender-questioning young people (de Vries & Cohen-Kettenis, 2012). In Ontario, psychologist Kenneth Zucker and psychiatrist Susan Bradley built their approach on a psychodynamic model to explain a patient's desire to transition to the other gender. Through naturalistic interventions, this approach aimed to help children become comfortable in their bodies and thereby, avoid transitioning (Zucker, Wood, et al., 2012). From the Amsterdam clinic, the Dutch Protocol emerged and is currently informs the treatment approach at Norway's National Treatment Service for Gender Incongruence (NBTS; Aaserud, 2021). This model is sometimes called "watchful waiting" as it carefully monitors psychosexual development in children, with neutral interventions (de Vries & Cohen-Kettenis, 2012; Aaserud, 2021, p. 94).

Both the above approaches refrain from premature gender identity confirmation and transitioning based on two key points revealed by research. First, children display increased flexibility and fluidity in gender identity compared to adolescents and adults (Zucker et al.,

2012). Whereas the Dutch Protocol favours non-interference and neutral observation of children, Zucker and colleagues (2012) used naturalistic interventions and psychotherapy for the family to elucidate what might cause atypical gender identification in the child. Second, the available data suggests some 80% of GD gender will eventually cease to feel dysphoric and therefore, not seek medical interventions after the onset of puberty (Steensma et al., 2011; Steensma et al., 2013). Those who desist usually become lesbian, gay, or bisexual in adulthood (Cohen-Kettenis & Pfäfflin, 2003; Wallien & Cohen-Kettenis, 2008).

Thus far, there is no consensus on how best to treat young people with gender identity issues. With limited scientific knowledge, perspectives differ on how prepubertal children, early adolescents, and youth should be managed (e.g., de Vries & Cohen-Kettenis, 2012; Ehrensaft, 2011; Hidalgo et al., 2013). International guidelines provided by WPATH, articulated in the Standards of Care (SoC, no. 7; Coleman et al., 2011) and the Endocrine Society (Hambree et al., 2009) offer recommendations for transgender treatment. However, these guidelines are not requirements and are found to be based on limited and weak scientific data of poor quality (Byne et al., 2012; Dahlen et al., 2021). Consequently, the treatment of GD varies greatly between clinicians and across clinics, while gender identity theory and the process of depathologising atypical gender identities have had significant impact.

From the process of depathologising atypical gender identities and the common acceptance of gender identity theory, two points of contention with other treatment approaches have paved the way for GAM. These controversies concern criticism of conducting practices akin to "conversion therapy" (see Singal, 2016) and for "gatekeeping" through the adherence to diagnostic and eligibility criteria in order for transgender people to access transition-interventions to express their gender (Ashley, 2019).

"Conversion Therapy"

Zucker and colleagues faced persistent criticism for their treatment approach at the Centre for Addiction and Mental Health in Toronto, Canada (CAMH) (Singal, 2016). CAMH clinicians implemented naturalistic interventions to help aligning the child's gender identity with natal sex, while reducing GD distress (Zucker et al., 2012). The interventions they employed were sensitive to the ample opportunity for children to be confused about their gender, and avoiding medical transitions were considered a successful outcome (Aaserud, 2021). The clinic was also reluctant to participate in the growing popularity of GAM; this

hesitation primarily stemmed from the available data on desistence and the flexible nature of children's gender identity (Steensma et al., 2011).

Parents of children with atypical gender identities and GD were encouraged to promote more nuanced same-sex interactions for their child, for example, by enrolling them in team activities or facilitating friendships with older same-sex peers. Gender consolidation often happens within the context of same-sex peers, which was the rationale behind interventions (Maccoby, 1998; Meyer-Bahlburg, 2002). In addition, the family unit was offered psychotherapy in order to reveal potential underlying mechanisms causing GD in the child, while exploring parents' contributions to GD. The clinicians emphasised the need to evaluate each patient individually within their biopsychosocial context and did not recommend a child socially transition as this could generate persistent GD and cross-sex identification (Aaserud, 2021; Zucker et al., 2012).

Treating problems though to underlie the GD symptoms was done with the hope that the child would feel less distress (Aaserud, 2021). In the event that the child did not desist and their GD experience intensified during puberty, the CAMH clinic facilitated medical transitions. The malleability of gender identity in adolescents and adults appears to be more fixed, especially when GD has been present since childhood (Zucker et al., 2012). When a young person with childhood GD persists in in their cross-sex identification, this approach suggests the use of biomedical interventions as the appropriate way to alleviated GD distress as this will more likely lead to better psychosocial adaption and life-quality (Zucker, Bradley, et al., 2012).

The approach's apparent preference for a non-transgender outcome for children was heavily criticised as "conversion therapy," and persistent activist pressure led to the clinic being forcibly closed in 2015 (Singal, 2016). Despite the clinic's leading role in the field of GD, the interventions used were considered unaccepting of children's authentic gender identities through attempts to change the child's experienced gender. Critics of CAMH felt unaccepting and non-affirming practices were akin to earlier psychiatric efforts to change a person's homosexual orientation. In addition, CAMH clinicians conceptualised GD as a mental disorder, which is in conflict with newer conceptualisations of gender variance and gender identity theory (Coleman et al., 2011).

Arguably, most psychiatric and medical professionals agree conversion therapy is harmful and ineffective (Levine, 2018). From LGBT surveys, most of the reported attempts to conduct such treatment happens in religious communities (Flores et al., 2020). The reification

of this debate likely builds on the assumption that gender identity is the same as sexual orientation, and therefore, deserving of acceptance, affirmation, and freedom to express themselves (Soh, 2020). Suggestive of this elision are the many publications on transgender treatment employing research on the ineffective attempts to change sexual orientation to support its equal ineffectiveness for children with GD. For example, SoC converge on the conclusions that it is harmful and unethical to attempt to change a child's gender identity by citing two studies form the 1960's showing unsuccessful conversion efforts for homosexual people (see Cantor, 2020; Coleman et al., 2011).

In other words, SoC rely on sexual orientation and gender identity constituting the same, or at least very similar, concepts for their claims to be supported. Such a view is likely influenced by the shared history of gender- and sexual minorities as disadvantaged and pathologized groups. An additional rationale might be the shared expression of gender variance; gender nonconformity is common in children who later become LGB adults, but also present in those who become transgender adults (e.g., Green, 1987). From this, some have noted the conflation between sexual orientation and gender identity (e.g., Soh, 2022; Stock, 2022). In light of the earlier mentioned tendency to conflate gender expression and gender identity, it is perhaps not surprising that wanting clarifications in relation to these terms create confusion.

The similarity of sexual orientation and gender identity, however, is not immediately apparent when it serves as an argument for allowing children to socially transition and eventually undergo medical treatments. The ineffectiveness of homosexual conversion therapy is largely grounded in the stability of same-sex attraction and because sexual orientation originates due to factors outside individual control (Stock, 2022; Pluckrose & Lindsay, 2020). The same cannot be said for children with GD, as is clear from the rates of desistance in this population. While Zucker and colleagues' (2012) naturalistic interventions could be seen as an attempt to change gender identity and this effort might be ineffective, there is little else indicating that gender identity is stable and unchangeable in childhood. Sexual orientation and gender identity appear to depart in this regard, thus the similarity between the two concepts does not fulfil the needed extent of similarity to function as an argument for affirmative care interventions for GD children.

The literature also alludes to the assumption that the same ameliorative effect produced by depathologising non-heterosexual orientations, will produce similar outcomes for

transgender people. As understood from the process of depathologising transgender identities, this is thought to reduce stigma toward gender variant individuals, thereby alleviating the additional psychiatric problems in this population (Hidalgo et al., 2013). This development has increased acceptance and affirmation, both culturally and clinically, in relation to transgender people. Thus, the assumption seems to be that if LGB people enjoy better well-being with fewer instances of societal rejection and stigma, but instead are affirmed and accepted, similar outcomes will occur in the transgender population. In other words, affirmation of homosexual identities produces the same results as affirmation of gender identities.

Research does indicate that those with non-heterosexual orientations and transgender identities benefit from social support, accepting environments, and reduced stigma (e.g., Olson et al., 2016), which is likely true for most minority groups. A significant difference arises when acceptance, affirmation, and freedom of gender expression is taken from the cultural realm and applied within a clinical setting. Herein, affirming a sexual orientation does not require that which is necessary for a transgender adolescent or adult. The affirmation of gender identities at odds with natal sex requires modification of the social environment, as well as physical modification in many cases (Coleman et al., 2011). Sexual orientations, on the other hand, come equipped with the tools necessary to live and explore life as gay or bisexual.

Inspired by Sasha Ayad (2020b), we might consider the following practical example of affirmation of sexual orientation and gender identity. For a same-sex attracted or bisexual person, discovery of attraction usually occurs relatively early, prior to puberty. During the teenage years, they may explore romantic and sexual relationships with prospective partners. With such experience, sexual identity becomes better consolidated and they more confidently know to whom they are attracted. Apart from parental support, little else is strictly necessary to affirm and allow the young person to live as gay or bisexual. This is not to minimise the strain of negative attitudes or internal difficulty with non-heterosexual orientations, but assuming the young person is loved and accepted after coming out, little else is required.

Affirming a young person with GD, on the other hand, necessitates significant alterations, both socially and physically. Typically, a new name and pronouns are adopted, and these are required used by parents and the social environment. That is, the social environment has to accommodate to linguistic change, but also adjust their perceptions of the

young person as a different gender. Parents might struggle to view their daughter as a son, because this contrast what they have always known about their child. Often, parents are offered books or other material to understand and learn about transgender identities. These steps are necessary in order to confirm to the young person that they are who they say they are. Moreover, confirmation of gender identity often requires hormone therapy and surgery so the young person can further affirm their psychological perceptions. Unlike sexual orientations, transgender people face a conflict of reality.

In the absence of physical modifications and a willing social environment, the transgender person will not be confirmed as the gender they innately experience, nor will they be perceived by others in a way matching their internal gender identity. External modifications require the psychological compliance of parents, siblings, peers, teachers, and others. In addition, the field of medicine is required to further confirm gender identity via biomedical and surgical tool. With this in mind, sexual orientation and gender identity seem to differ in important ways.

We may also consider the relatively few obstacles in the way of changes in sexual orientations, compared to gender identity change after interventions have occurred. As Ayad (2020b) observes, a teenager may initially be attracted to both sexes, but with dating and relationship experience conclude they are exclusively same-sex attracted or heterosexual. Apart from announcing this to others, the person can continue with life and progress through developmental stages associated with the teenage years. A transgender person, on the other hand, does not have a similarly easy path in the event of regret or gender identity change. If a child has lived in the opposite gender role for a prolonged time, re-identification with natal sex may be difficult (Churcher Clarke & Spiliadis, 2019). If irreversible procedures have been done, life for a female with permanent masculinisation may encounter a new form of GD as her physical characteristics no longer match her gender identity (Ayad, 2020b). Against this background, hesitation to facilitate treatment based on the similarity of sexual orientation and discordant gender identities seems warranted.

Nevertheless, the increasing adherence to GAM with emphasis on gender affirmation and treatment-facilitation to allow for gender expression, seems to remove neutral ground within the clinical context. Claims of conversion therapy may be warranted and the interventions used by clinicians at CAMH could be ineffective, but this does necessarily equate to endorsing the very opposite approach of affirmation with subsequent transitioning.

The relative absence of a neutral space between these camps is observed by several clinicians (e.g., Churcher Clarke & Spiliadis, 2019; Levine, 2021; Wren, 2014). Moreover, the turn toward framing treatment-hesitation or well-meaning questions in the assessment phase as transphobic and unethical (Ashley, 2019; L. Littman, 2018), has reduced the opportunity for the clinician to explore preceding events or other driving factors in GD experience (Bannermann, 2019).

Particularly through the inclusion of gender identity and gender expression as a human right, also in relation to medical treatment as the YP (2007) articulate, moral indictments are levied against cautious clinical practice with criticism of discrimination (Ashley, 2019). The criticism of conducting conversion therapy seems to neglect that little is still known about atypical gender identity development (Levine, 2021), and little is known about the efficacy of transitions in producing a life of well-being (Dhejne et al., 2011). Arguably, clinical caution is not primarily rooted in a desire to discriminate against transgender people, but rather an expression of a genuinely difficult and complex issue to solve. Nor does it seem non-recognition or gender identity discrimination is central to clinical caution. If, for example, a non-binary individual with a broken arm is refused help based on their gender identity, this would be discriminatory. However, the current standard procedures of medical transitions lack the evidential basis necessary to justify its administration, regardless of the recipient's gender identity.

"Gatekeeping"

As noted earlier, the Dutch protocol informs Norway's official treatment practice for gender incongruent people (Aaserud, 2021). This model retains neutral interventions are warranted for children based on the available evidence suggesting the majority of GD children eventually desist and will therefore not seek medical interventions (Steensma et al., 2011). Children's gender identity development is monitored over time as their psychosexual development is considered best helped by keeping options open (Di Ceglie, 2014). When GD does not remit in adolescence, hormone treatments are administered once the young person is considered eligible, which is decided by receiving a GD diagnosis, having a supportive environment, and the relative absence of psychiatric issues impacting diagnosis and treatment (de Vries & Cohen-Kettenis, 2012).

Throughout the assessment phase, a team of psychiatrists conduct a number of sessions with the adolescent, the parents, and the family unit together. The Dutch protocol

seeks to establish open and non-judgemental rapport with patient and parents. Information provided by the parents is considered valuable as they can offer insights about the young person's functioning individually, with family, and peers. Parents are also important for establishing the presence of GD symptoms in childhood, while also providing information about whether GD is possibly due to other issues, for example, confusion about homosexual orientation (Cohen-Kettenis & de Vries, 2012).

If present, psychiatric issues are prioritised when seen as interfering with diagnostic evaluation or treatment. Psychiatric comorbidity is not necessarily indicative of not being eligible, but psychological functioning must be stable and not interfere with determining the presence of GD (Coleman et al., 2011). This model also recognises the need for social support systems given the far-reaching implications of treatment would be difficult to manage without support. The family and patient are informed of alternative treatments and extensive discussions can prevent the young person forming unrealistic expectations of what a transition will achieve. Patient responses to alternative therapies can be diagnostically relevant (de Vries & Cohen-Kettenis, 2012).

Whereas the clinical practice at CAMH was criticised for "conversion therapy", the Dutch Protocol faces criticism for "gatekeeping" treatment by relying of diagnostic criteria and comprehensive medical and psychiatric assessments (Ashley, 2019; Wahl, 2022). A broad critique is that the "gatekeeping" function of clinicians expects a transgender person to prove their identity and GD distress in order to access treatment, with the result that some patients embrace and internalise a distress-narrative in preparation to tell the clinician what is expected and to meet criteria (Schulz, 2018). Consequently, some advocate for the de-medicalisation of transgender treatment with informed consent as the only requirement (Ard & Keuroghlian, 2018). Here, the psychiatric role is removed, while the surgeon serves as a provider for the consumer, effectively based on individual desire.

Adhering to diagnostic criteria and psychological evaluations in the assessment of eligibility for receiving medical interventions can be viewed from the ethical principle of doing no harm (nonmaleficence; Varkey, 2021). A traditional interpretation of this principle is in the context of transgender treatment understood in terms of the possible future harm done to patients who receive unnecessary hormone therapy or surgeries (Cretella, 2016). Today, concerns about future harm is compounded by limited evidence of the benefits and outcomes, in addition to increasingly complex GD manifestations (Zucker, 2019). It is not exactly clear what

constitutes harm in relation to transgender treatment and debate prevails with regard to how the "gates" should be kept.

Nonmaleficence is understood differently, and perhaps more subjectively, by others. For example, in relation to hormonal interventions for adolescents with GD, "doing no harm" is not the same as doing nothing. According to transgender activist Luca Dalen Espseth, denying puberty suppression and cross-sex hormones for young people can cause harm, and is not a neutral option (Wahl, 2022). In support of this view, WPATH's Standards of Care (Coleman et al., 2011) state that withholding PBs and CSH allows puberty to promote development of secondary sex characteristics, which can prolong and worsen GD. In addition, natural puberty can produce changes resulting in physical appearance possibly eliciting stigma and discrimination later on. As such, refusing treatment is considered unethical and may cause future harm (Coleman et al., 2011).

These criticisms seem to fit well with the depathologisation of transgender identities, the assumption that their psychiatric comorbidities are caused by the external environment (Schulz, 2018), and the right to express gender via medically transitioning, if this is desired (Keo-Meier & Ehrensaft, 2018). With acceptance of gender identity as informed through privileged access and a fundamentally important aspect of personal identity (Wren, 2014), gatekeeping treatment is questionable. Indeed, gatekeeping treatment by allowing some, but not all, atypical gender identities access to treatment appears to breach with the human rights perspective, while it pathologises gender variance, in addition to denying some the right to express their gender identity in an authentic way (The Yogyakarta Principles, 2007).

Dr Joanna Olson-Kennedy, a specialist in adolescent medicine, for example, is a supporter of this latter view. To her, nonmaleficence comes from a historically paternalistic position wherein doctors are given the role of deciding what is harmful and not. This, according to Olson-Kennedy, "...in the world of gender, is really problematic" (cited in Cretella, 2016, p. 50). This view is echoed by others who find the clinical context to be characterised by power imbalance between clinician and patient; asymmetric power balances rests on the assumption that the professional knows what is the best treatment for the individual, and thereby holds authority to over-rule patient autonomy and opportunity to take part in treatment decisions (e.g., Aaserud, 2021).

Despite this, new cultural gender identity conceptualisations have no bearing on the established need to implement medical interventions only after sufficient evidence undergirds

its implementation as effective and beneficial to the recipient (Levine, 2018). If this is not the case, then a complete restructuring of evidence-based medical conduct would be necessary, effectively making an expression of desire the decisive criterion for treatment, removed from ethical considerations of the harm or help this offers the individual. Some do advocate for this (Schulz, 2018). Furthermore, it would be naïve to believe that this will not have ramifications for other areas of medicine as well. This rationale seems to blame an inconsiderate medical institutions and Western science for the difficulty found in remedying GD. The reason medication and surgeries have been withheld and continue to be characterised by hesitation is not malevolence or moral fault, but the insufficient evidence extant to tell us clearly that treatment does work, and in fact remedies the struggle associated with GD (Levine, 2018; Anderson, 2018).

Many clinicians agree that a transition can help a GD person live life with more ease, including the clinicians at CAMH (Zucker et al., 2012). The core issue resides in the lack of knowledge about whom will benefit; an issue exacerbated by the complex clinical presentations among young females with severe comorbidities and unclear gender identities (Zucker, 2019). Thus far, the few comprehensive studies available do not allow for optimism in this regard (Bränström & Pachankis, 2020b; Dhejne et al., 2011; Simonsen et al., 2016). Clinicians should be concerned with what happens to their patients when they move through life (Levine, 2021), but as Wren (2014) observed some years ago, clinicians are positioned in a context where Enlightenment knowledge and science are in contrast with postmodern cultural beliefs about gender.

Affirmation and Informed Consent

It appears opinions about transgender phenomena, as well as beliefs and knowledge about scientific data, impact each clinician in their work with gender-questioning and GD young people (Levine, 2021; Cretella, 2016). Through the controversies discussed above, in addition to increasing popularity of gender identity affirmation and treatment-facilitation, informed consent has come to replace comprehensive psychological assessments and exploration of why an atypical gender identity has developed. In this context, there might be opportunity for erroneous affirmation and unnecessary treatment, facilitated by clinicians tasked with the responsibility to obtain informed consent to ensure the patient understands the physical and psychological benefits and risks of treatment, in addition to psychosocial implications (Coleman et al., 2011).

In the controversy and lack of knowledge about how best to treat GD patients who request biomedical interventions, informed consent has become highlighted. While an important clinical principle, informed consent sets the minimal safeguard. Often, informed consent is obtained to prevent the imposition of treatment contrary to the wishes of the patient (Brunskell-Evans, 2019). According to GAM clinicians, and Standards of Care (Coleman et al., 2011), assessing the young person's ability to provide informed consent is necessary, but a range of ethical and practical issues are argued to hamper this process in relation to transgender treatment. For the clinician, patient, and parents, some issues may prevent accurate assessment of informed consent.

For informed consent to be valid, the patient needs to be informed of all necessary information. Arguably, receiving powerful drugs only partially reversible, the clinician should have comprehensive knowledge about the risks and benefits. This knowledge, however, is wanting in research, therefore wanting in the clinician (Malterud, 2020). With regard to PBs, these are only considered safe and reversible in the sense that when treatment is stopped, the body will commence pubertal development. In other words, very little is known about the psychological implications on cognitive and emotional maturation (Giovanardi, 2017). In terms of CSH and surgeries, the relative ability of these treatments to remedy GD are largely unknown (Cretella, 2016). Many young females report initial relief and are enthusiastic about having started treatment, but the long-term effects are uncertain (Churcher Clarke & Spiliadis, 2019). In this way, informed is compromised and could facilitate interventions for the wrong candidates.

Exacerbating this difficulty are some clinicians' beliefs about transitioning as the only remedy for GD, thereby having a sense of saving lives (Levine, 2018). We might suspect the compassionate impulse to help influences the way in which information is provided to parents and adolescent, framed within the context of a transition as necessary regardless of the treatment-seeker's ability to understand. For example, a GIDS-related study, parents were not adequately informed of the significant likelihood of their child progressing to CSH after receiving PBs (Cohen & Barnes, 2019). This bit of information appears important to mention as it will nuance the presentation of PBs as a "pause button" allowing for time to consider next steps (e.g., Coleman et al., 2011). Often, the adolescent and parents are primed by online content prior to seeking hormonal treatment (L. Littman, 2018). Many online information pages omit or misrepresent extant research and fail to convey the risks properly, while using medical jargon (Dunford et al., 2019). Skewed presentations appear relevant for obtaining

informed consent in the clinical setting as transitioning is pre-emptively assumed to be the only remedy.

Such pre-emptive conclusions can lead to a rapid progression from initial assessment to obtaining informed consent. A central element in the assessment phase has been to conduct psychological assessment to evaluate the relative ability in the young person to understand and consent to treatment (de Vries & Cohen-Kettenis, 2012). However, not all clinicians conduct such assessments unless suspecting the presence of a disrupting problem needing to be prioritised (Keo-Meier & Ehrensaft, 2018). Again, the clinicians' beliefs about the role of co-morbidities matters as some see additional psychiatric illnesses as externally imposed upon the patient and not due to the nature of the misaligned gender identity (Levine, 2021). Moreover, SoC's recommendation that psychiatric conditions should be reasonably well managed prior to transition interventions is an entirely subjective assessment (Janssen et al., 2019; Levine, 2021). From the available literature, clinical certainty about the relationships between comorbidities remain uncertain, but the SoC offer a way around this issue nonetheless, and informed consent can be obtained (Coleman et al., 2011).

For the adolescent, a weakened ability to provide valid informed consent is apparent in the ability to understand and comprehend risks and benefits based on the developmental stages they are in. Knowledge about behaviour and maturity in adolescence is important to policies about informed consent. Depending on the situation, authorities like the American Psychiatric Association and American Medical Association have offered different information about knowledge of adolescent cognitive maturity. For example, in a 2005 court case, a 17-year-old convicted of murder escaped the death penalty after both the AMA and APA detailed adolescent brain development as fundamentally set apart from adults. In contrast, APA considered a 14-year-old's decision to have an abortion as unproblematic because decision-making at this age is indistinguishable from that of an adult (see Johnson et al., 2009). The latter example seemingly illustrates better contemporary views on adolescents' ability to consent.

In furtherance, adolescents are found to have weaker impulse-control, feel strong emotions that are more volatile, and have a reduced ability to consider long-term consequences (Romer, 2010; Tonkin, 1987). Often, young gender-questioning people present at clinics with an adamant belief that they truly are transgender, while intensely believing their ills will be alleviated by transitioning (L. Littman, 2018). As one qualitative study shows, transgender

young people express that long-term consequences would not stop them from starting treatment, and possible negative effects are incomparable to the happy life they will come to live (Vrouenraets et al., 2016). With little research offering positive outcomes after treatment, a discrepancy seems to be present in some young people. Their belief that transitioning will bring about a happy life is not shown in research, but they receive this message somehow from external sources (Soh, 2020). Rapid assessment and affirmation are not likely to nuance or lessen this treatment-desire. Rather this approach might facilitate and magnify the young person's beliefs that transitioning is the only way, thereby weakening informed consent.

When both clinician and adolescent share the belief that distress arises from external sources and the only way to solve GD is to alter the physical body, and that this will offer a new life of well-being, what does this convey to the young person? Anderson (2018) argues the validity of informed consent is compromised because the young person is offered the narrative conveying to them that the way they feel will never change, unless a transition is initiated. Alternative therapies possibly able to ameliorate their distress are neglected. Can true informed consent be given when transition steps are presented and understood, both by clinician, patient, and parents, to be the only solution? An added effect of this process is the message that treatment-refusal will lead to increased suicidal risk.

In 2011, Dr Joanna Olson, a lead research in the field, explained in an interview with ABC News how she asks parents if they would "rather have a dead son than a live daughter" in reference to the "astronomical" suicide rates in this population (Patria & Lovett, 2011). Whereas some criticise this narrative for exploiting the deepest of parental fears and weaponizing empathy (Soh, 2021), it appears effective in the process of obtaining informed consent and placing young people on a medical transition pathway. Clinicians should also be cautious of how they are co-authoring a narrative that transitions are the only option, possibly weakening the young person's and parents' ability to consider other options.

Some have questioned whether the reduced focus on assessment and critical questioning, in favour of affirmation, amounts to an abdication of professional responsibility (e.g., Littman, 2018b; Anderson, 2018). Arguably, because non-standard gender identities are considered normal developmental diversity and to be unchangeable (Keo-Meier & Ehrensaft, 2018), clinicians under the auspices of GAM will offer affirmation and acceptance of the asserted gender identity in the treatment-seeking young person; atypical gender identity is not a symptom, but an authentic identity (Ehrensaft, 2011). According to Levine (2021), common

clinical practice when a new symptom occurs is to look at events prior to its manifestation, but newer conceptualisations of gender identity may not allow for such questions, perhaps because it pathologises transgender individuals or risks being labelled as conversion therapy. Consequently, less exploration of GD and its origins may occur, while the clinician takes at face-value the self-diagnosis of the young patient. As Littman (2018b) argues, the young person is not a trained mental health professional and the clinical assessment and treatment plan should not be informed by the patient alone.

In furtherance, the responsibility of the clinician is present regardless of the young person's relative accuracy in self-assessment. Parental insights are typically employed to offer a comprehensive understanding of the young person's development and functioning (de Vries & Cohen-Kettenis, 2012). In today's climate, however, some parents are frustrated when their adolescent is not adequately evaluated for comorbidities, but rather quickly affirmed and offered hormones (Littman, 2018b). Young patients may misrepresent parental reactions to their new gender identity, and it is not unreasonable to suggest some young people frame their parents as unaccepting or transphobic, which does not make parental insights in the clinical setting more likely. Importantly, the young person should be listened to, not dismissed or ignored. Both careful listening and clinical evaluation can be done, even if GAM favours the confirmation of self-assessment. Such an assessment process is likely helped by verification from parental insights about the child's history; is their account at odds with, or similar to, the young person's account? (Littman, 2018b). In the event that parents are prevented from taking part in the assessment and gender identity assertions are taken at face value, clinical facilitation of misguided transitions could occur.

An illustrating example of this effect comes from former GIDS clinicians who found fault with senior management when instructed to refrain from asking about sexual orientation in patients, even if suspected to impact the motivation to transition (Bannermann, 2019). As described earlier, some young females harbour difficulty in relation to sexual orientation and struggle with internalised homophobia from negative social responses or coming out as transgender after intense bullying based on perceived orientation (Wood et al., 2013). Motivation to detransition supports this as some eventually come to understand their difficulties with same-sex attraction generated GD (Littman, 2021). If attempting to elucidate and disentangle the young person's perceptions of sexuality are off-limits in the clinical setting, young people may receive invasive treatments unable to resolve their issues, which would constitute nothing less than a disservice to the patient. The observed disinterest in

adolescent confusion about homosexuality and hasty assessment risks transitioning young homosexuals into young heterosexuals; possibly representing a new form of conversion therapy (Bannermann, 2019).

Churcher Clarke and Spiliadis (2019) argue the critical necessity of keeping a space open for exploration and investigation of young people's gender identity assertions. The inherent in betweenness of adolescence, in combination with the various psychological problems they present with, requires a broader approach than mere affirmation and treatment facilitation. Some detransitioners report they were not assessed comprehensively enough (Littman, 2021). How should this be interpreted in the current context? (Littman, 2021). This becomes more pressing in light of the limited scientific knowledge about the developmental trajectories of adolescents with transgender identities and the low-quality data that treatment is based upon (Cohen-Kettenis & Klink, 2015; Dahlen et al., 2021). Follow-up studies have long been the standard for implementation of methods and the field of medicine has managed cultural criticism and pressure in other contexts. However, this is not the case with transgender medicine (Levine, 2018). In this context, ideological and cultural views about gender and sex have come to hold hands with medicine, but the consequences of this might not reveal themselves until unnecessary damage is done. Perhaps this is what paediatrician and researcher Pål Surén observes as a central issue; fundamentally different ways of viewing the world manifest themselves in transgender debates, and the GD condition's link to medical transitions gives gender nonconformity a dark side (in Masvie, 2021). Hesitance to confront this conflict within the contemporary culture could generate rising numbers of transgender identification and treatment-desire. Indeed, we might ask how the processes covered in this thesis could generate anything but a growing transgender population.

Conclusion

In sum, far-reaching and pivotal developments have taken place with respect to transgender phenomena. The complex and novel clinical presentation constituted by a "new generation" of gender dysphoric female adolescents has placed clinicians and the field of psychiatry in an uncertain position. Through depathologising transgender identities, the conceptualisation of transgender identities has in important ways altered both medical and public perception of atypical gender identities. With good intentions, this process has declared transgender people as representatives of mental health but remain a population burdened by societal stigma and rejection for displaying gender nonconformance. Not all agree on this, however, and there is no certainty that the conflict with reality - the body - for some people can generate psychiatric comorbidities. Nonetheless, what appears to be a primarily psychological condition is treated increasingly outside the realm of psychiatry, and more firmly within medicine. Increased access to biomedical transitions and depathologisation has arguably increased clinic-referrals. Thought diagnostic inflation and dilution, young people encounter a framework for interpretation that can allow for adopting GD as an explanation.

In tandem with depathologisation of transgender identities, a cultural shift has occurred, which cements gender identity as an innate and fundamentally important aspect of personal identity. Information about this identity is gained through privileged access and cannot be refuted by others; the subjective self is the authority and self-deception is not possible. At the same time, gender identity's positioning within a political and human rights paradigm has secured the right to express gender identity through whatever may be desired, even biomedical treatments. While a postmodern framework struggles to account for the GD experience as arising directly from a non-belonginess in the physical body, gender identity theory cannot either locate a brain structure aspect proving how gender identity truly resides in the mind. Notwithstanding, gender identity prevails as a deeply important concept reliant upon, and justified by, its subjectivity. Continued rising rates, especially in young females, is likely to ensue in light of radical subjectivity. After all, these are ideological claims unsupported by an evidential basis.

Whereas other treatment approaches have contributed valuable insights to the needs of transgender people, sensitive to the individuality and complexity in each person's experience, the gender affirmative model has come to triumph through a cultural and medical processes, which appears to significantly risk erroneous affirmations and identifying the wrong candidates for transitioning. The research remains undecided in terms of the benefits and

efficacy of transgender treatment. The critiques of conversion therapy and gatekeeping can be considered to pave the way for intensified focus on gender identity and transitions, with the only criteria for eligibility being informed consent. This criterion is weakened by the many ways in which current discourse polarises perspectives, in particular the fear of suicide. Through depathologisation, gender identity theory in culture and its acceptance in the clinical setting, affirmation and transitions seem to be the natural outcome. Taken together, one might wonder how the processes contended with in this thesis could produce anything but increased transgender identification and treatment-desire.

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