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Homophobia, conversion therapy, and care models for trans youth: defending the gender-affirmative approach

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ABSTRACT

In recent years, opponents of the gender-affirmative approach to trans youth have argued that it bears homophobic roots and may be tantamount to conversion therapy. This argument is mistaken. In this article, I first argue that there is no evidence that social and/or medical transition is motivated by homophobia. Contrary to the critique's tacit premise, many if not most trans people are LGBQ following transition. Furthermore, despite social progress in the last decade, transphobia remains more common than homophobia. Second, the gender-affirmative approach is fundamentally dissimilar to conversion therapy, unlike clinical approaches that oppose affirmation and seek to prevent transition. The comparison to conversion therapy relies on a superficial understanding of sexual orientation, such that a change of label (e.g. straight, bisexual, gay, lesbian) is equivalent to a change of sexual orientation even without changes to the targets of sexual attraction. By contextualizing conversion therapy in relation to trans youth care, I show that, on the contrary, conversion therapy has long focused on preventing transgender youth from growing up trans.

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Introduction

The scientific consensus is increasingly moving towards the affirmation of youth's gender identities and access to medical transition (Lopez, Marinkovic, Eimicke, Rosenthal, & Olshan, 2017; Rafferty, 2018; Telfer, Tollit, Pace, & Pang, 2018). This approach is often called the gender-affirmative one because it affirms the individual's gender socially and medically. Despite growing consensus, the gender-affirmative approach is not unanimous and some forceful critiques have been levied against it. In recent years, a new critique has emerged from scholars professing feminist and pro-LGB commitments. According to this critique, the gender-affirmative approach is homophobic because it pressures youth who would otherwise be (cisgender and) LGBQ into being (straight and) trans, motivated by internalized and parental homophobia (Bannerman, 2019; Bewley, Griffin,

& Byng, 2019; Littman, 2018; Marchiano, 2017; Soh, 2018). According to this argument, the homophobic underpinnings of gender-affirmative care may even make it tantamount to conversion therapy, a term which refers to efforts to change a person's same-gender sexual orientation (Substance Abuse and Mental Health Services Administration, 2015).

Since these critiques have begun to gain currency in some academic circles and in the media, it appears important to address them directly. As I will explain in this article, the critique is unsound. Affirming youth's expressed gender identities and granting them access to medical transition cannot reasonably be called homophobic.

First, there is no evidence that social and/or medical transition is motivated by homophobia. Despite social progress in the last decade, transphobia remains more common than homophobia. Contrary to the critique's tacit premise, many if not most trans people are LGBTQ following their transition. There is also no evidence that youth are prone to false beliefs about their gender identity.

Second, the gender-affirmative approach is fundamentally dissimilar to conversion therapy, unlike clinical approaches that seek to prevent transition. The comparison to conversion therapy relies on a superficial understanding of sexual orientation, such that a change of label (e.g. straight, bisexual, gay, lesbian) is equivalent to a change of sexual orientation even without changes to the targets of sexual attraction. By contextualizing conversion therapy in relation to trans youth care, I will show that on the contrary, conversion therapy has long focused on preventing transgender youth from growing up trans.

Throughout the paper, I use "trans youth" to refer to all youths who profess a gender identity other than the gender they were assigned at birth, regardless of how they identify in adulthood. Since non-binary people have a gender identity that differs from the gender they were assigned at birth, they are included in the term.

Internalized and parental homophobia

The allegation that affirming gender is homophobic has two components: (1) youth conflate gender non-conformity and/or normal discomfort surrounding pubertal development and unwanted sexual attention with being transgender, and (2) this conflation is motivated by internalized and parental homophobia (Littman, 2018; Marchiano, 2017; Soh, 2018). In this section, I will highlight that the critique relies on empirical misconceptions about the prevalence of transphobia and homophobia, mistakenly assumes that trans youth are straight, and unjustifiably assumes that youth are prone to false beliefs about their gender identity due to social pressures.

Prevalence of transphobia and homophobia

While many trans youth and their parents likely bear homophobic attitudes or beliefs given the systemic and widespread nature of heteronormativity (see e.g. Hatzenbuehler, Dovidio, Nolen-Hoeksema, & Phillips, 2009; Kuyper & Bos, 2016), these beliefs are unlikely to be efficacious in the decision to transition since homophobia must be balanced against transphobic attitudes and belief. For our purposes, I understand homophobia and transphobia broadly as including all attitudes and beliefs that imply a tacit or explicitly preference for being straight over LGBQ and being cisgender over transgender, respectively.

Comparing the prevalence and intensity of homophobia versus transphobia is difficult because there is no standardized measure for comparing them across all aspects (Billard, 2018, p. 6). However, the empirical evidence suggests that parents and broader society see being cisgender and gay as preferable to be transgender and straight. Thus, parental pressure and internalized societal attitudes would tend to favor cisgender and gay outcomes rather than trans and straight ones.

The Human Rights Campaign's survey on LGBTQ youth found that the families of 64% of transgender youth, including non-binary, made them feel bad about their identities compared to 34% of cisgender LGBQ youth (Human Rights Campaign, 2018, p. 8). The statistic does not speak to the intensity of negative familial attitudes, but it is plausible that negative attitudes towards transgender youth would be more intense on average. For instance, it would result if we assume that transphobia and homophobia follow a normal distribution among families with conservative attitudes. In a 2005 study, 58.5% of trans youth reported that their parents reacted negatively or very negatively to their coming out (Grossman, D'Augelli, Howell, & Hubbard, 2005).

The suggestion that parental transphobia is more prevalent and intense than homophobia is born out in clinical observations. Clinicians at the now-defunct Toronto youth clinic observed that while many parents do not have particular qualms with their child growing up to be LGBQ, they would prefer that their child not grow up trans (Zucker, Wood, Singh, & Bradley, 2012, pp. 391–392). Indeed, many clinicians appear to share these beliefs, with one prominent clinician who led a major gender identity clinic claiming (Green, 2017b, p. 82): “I am convinced that it is a helluva lot easier negotiating life as a gay man or lesbian woman than as a transwoman or transman.” One reason for these beliefs is that being transgender often involves bodily changes while being LGBQ without being transgender does not. Another is the perception that stigma impacts transgender people more. Thus, for many parents, growing up gay seems to be the lesser of two evils (Meadow, 2018, p. 66). Anecdotally, trans people who previously came out as LGBQ often report that their parents reacted more negatively

to their coming out as trans than as LGBTQ. These clinical observations stand in stark contrast to the scenarios proposed by those accusing the gender-affirmative approach of homophobia, who see parents as being “more than happy to go along with facilitating their child’s requests to transition to the opposite sex, so that to the outside world, that child will appear heterosexual” (Soh, 2018).

Similar observations can be made with regards to internalized homophobia since transphobia appears more pervasive in society. In a study of cisgender heterosexual attitudes towards LGBTQ people in Canada, 86% reported being very or fairly comfortable interacting with LGBTQ people whereas only 60% had the same answer regarding transgender people (CROP, 2017, p. 20). Whereas 20% of respondents tended to see being LGBTQ as unnatural, 28% tended to see being transgender as natural, and 44% tended to view gender as strictly binary (CROP, 2017, pp. 31–32). These combined factors result in high rates of suicidal ideation and attempt among transgender youth (di Giacomo, Krausz, Colmegna, Aspesi, & Clerici, 2018; Toomey, Syvertsen, & Shramko, 2018). Trans youth suicidality is strongly mediated by parental and social support (Bauer, Scheim, Pyne, Travers, & Hammond, 2015; Durwood, McLaughlin, & Olson, 2017; Olson, Durwood, DeMeules, & McLaughlin, 2016).

Transphobia appears not only more pervasive in society, but also more salient in the daily lives of trans people. For instance, toilet access is a daily occurrence yet in Canada only 43% of people believe that trans children should use the facilities that correspond to their gender identity (CROP, 2017, p. 39) and many trans people avoid public restrooms out of fear (James, Herman, Keisling, Mottet, & Anafi, 2016, p. 228). The potential for negative experiences is heightened by the relative visibility of transness, although youth who transitioned prior to puberty or before entering school, or at a different school than the one they are currently at are less likely to be identified as trans by others.

Beyond access to gendered public spaces, everyday hostility towards transgender people occurs through the distressing phenomena of misgendering (using the wrong pronoun or gendered terms) and deadnaming (using a trans person’s old name) (McLemore, 2015, 2018; Russell, Pollitt, Li, & Grossman, 2018). Something as simple as having a teacher mention you in class poses risks of invalidation, a reality that most trans people are acutely aware of. By comparison, sexual orientation comes up comparatively less often in everyday life. When it does, it is typically mediated by others’ perception of gender non-conformity, a mediating factor that is equally relevant to trans youth. Thus, it seems implausible that being transgender and/or desiring transition is caused by the internalization of homophobia, given the pervasiveness, intensity, and saliency of transphobia.

It is also worth pointing out that isolated interactions and attitudes cannot always be neatly categorized as transphobia or homophobia (Namaste, 2006). Oftentimes, the message sent to children is less “you’re not a boy/girl” or “being gay is wrong” than “stop being such a sissy/tomboy”. Slurs like “fag” are equally applied to gay men and transfeminine individuals and often motivated by perceived gender non-conformity rather than sexual orientation or gender identity *per se*.

Sexual orientation of transgender youth

The suggestion that gay youth are pressured to become trans due to internalized homophobia mistakenly assumes that trans youth are straight. The available evidence suggests that they are predominantly LGBQ, not straight. A Human Rights Campaign survey of over 5,600 trans youth ages 13 to 17 found that 5% of them were straight (Human Rights Campaign, 2018, p. 38). Identification as straight in reported other studies that included youth under 16 years old also form a minority: 11.6% for non-binary youth ($n = 344$), 44.8% for trans girls ($n = 202$), and 19% for trans boys ($n = 175$) ages 11 to 19 (Toomey et al., 2018); 47.2% for trans boys and girls ($n = 180$) and 2.9% for non-binary youth ($n = 70$) ages 14 to 25 (Aparicio-García, Díaz-Ramiro, Rubio-Valdehita, López-Núñez, & García-Nieto, 2018); 7.3% for trans young people ($n = 652$) ages 14 to 25 (Strauss et al., 2017, p. 21); 14% among trans youth ($n = 923$) ages 14 to 25 (Veale et al., 2015). Combining the studies gives us a percentage of 8.7% for straight trans youth, include the survey from the Human Rights Campaign, and 16.8% without. In either case, the percentage of trans youth who are straight is a clear minority. These percentages accord with those observed among trans adults (James et al., 2016; Katz-Wise, Reisner, Hughto, & Keo-Meier, 2016).

The cited studies have various limitations. Of the five studies, three included participants up to 25 years old, well into adulthood. However, both the study with the largest sample (Human Rights Campaign, 2018) and the one with the most representative sampling method (Toomey et al., 2018) had narrower age ranges. Patterns of sexual attraction are also prone to changing over time (Katz-Wise et al., 2016). However, these changes may not correspond to reduced same-gender attraction: despite a majority of trans adults experiencing a change in sexual orientation, only 12.2% of them were straight. In my anecdotal experiences as an active member of trans communities, changes in sexual attraction tend to lie in the direction of bisexual and pansexuality.

Unfortunately, reliable data on younger trans children is unavailable. Assessing sexual orientation at a young age is difficult and might be

ethically questionable. While some longitudinal data from gender identity clinics exist, it fails to adequately distinguish between the broad category of gender non-conforming children and the narrower category of children whose self-reported gender identity differs from their gender assigned at birth, making it unhelpful (Olson, 2016; Temple Newhook, Pyne, et al., 2018; Winters et al., 2018). The intimation of causality based on internalized homophobia is particularly dubious for younger children. Sexual identity typically develops later and is strongly associated with puberty. Younger children are much less likely to experience sexual attraction or be aware of their sexual orientation. Thus, besides the lack of evidence that younger trans children are disproportionately straight, there also lacks evidence internalized homophobia may motivate them.

If internalized homophobia motivates transition, one might wonder why so many trans youths are LGBTQ in their affirmed identities. Many of them appeared straight prior to transition and took on an LGBTQ label through transition. Others were attracted to people of different genders both before and after their transition, such that homophobia is unlikely to have a substantial impact either way. Critics of gender affirmation have so far failed to explain why internalized homophobia would generally encourage transition if only a small minority of trans youth are straight. It's also important to remember that even straight trans people experience homophobic stigma insofar as their relationships are perceived as gay by others (Ashley, 2018a; Blair & Hoskin, 2019). The proposed causal relationship is dubious, even for straight trans youth.

Propensity towards false beliefs

The charge of homophobia levied against the gender-affirmative approach also fails to adequately support the claim that youth are prone to false beliefs about their gender identity. The critiques' focus on youth may reflect the belief that youth are more prone to false beliefs than adults or the view that false belief among adults is not as concerning. According to the critics' argument, youth conflate gender non-conformity and/or normal discomfort surrounding pubertal development and unwanted sexual attention with being transgender. However, the available evidence does not support that thesis.

One of the bases for the argument is speculative: some youth who grow up to be cisgender are distressed or uncomfortable due to changes associated with puberty, notably unwanted sexual attention from men (Bonfatto & Crasnow, 2018; Soh, 2018). For those authors, then, it may stand to reason for youth to seek refuge from these uncomfortable experiences in gender identity. However, this argument is speculative, and it remains to

be established whether some youth genuinely fail to distinguish between discomfort with sexual objectification and gender dysphoria or gender identity. Gender dysphoria may be qualitatively different from other experiences of bodily-related discomfort, as some trans people (including me) seem to suggest, and discomfort towards the body may be insufficient to influence other experiences that are subjectively perceived as indicative of gender identity, such as feelings towards gendered names, pronouns, and gender labels.

Critics sometimes refer to the rate of youth at gender identity clinics who do not grow up to be trans as evidence that gender identity is malleable or vulnerable to mistaken beliefs (Bewley et al., 2019). Bewley and colleagues, for instance, refers to “85% desistance amongst referred transgender children” in their criticism of gender affirmation. However, studies on ‘desistance’—a term condemned for its roots in criminology—have been strongly criticized in the literature (Olson, 2016; Temple Newhook, Pyne, et al., 2018; Temple Newhook, Winters, et al., 2018; Vincent, 2018, p. 121ff; Winters et al., 2018). While the studies contained many methodological and interpretive flaws, the most striking aspect is that they failed to accurately distinguish between youth who expressed identification with a gender other than the one they were assigned at birth and youth who were referred to the clinics for gender non-conformity despite identifying with the gender they were assigned at birth. In other words, they conflated gender nonconformity with being transgender, and as many as 90% of the children in the studies may not have been trans (Olson, 2016). Although studies centering gender identity are limited, evidence suggests that self-reported gender identity is a strong predictor of continued desire to transition (Rae et al., 2019; Steensma, Biemond, de Boer, & Cohen-Kettenis, 2011). A recent study also suggests that trans children are similar to cis children of the same gender and may know their gender just as well (Rae et al., 2019).

It is important to distinguish between the relevance of the stability of children’s gender identities and that of youth’s. Age has an impact on gender self-understanding—gender constancy tends to solidify around 6 years old and puberty is known for its consolidating and intensifying effect on gender dysphoria—and medical interventions are not available for trans youth prior to puberty (Ashley, 2019c). Although some clinicians continue to believe that gender identity is malleable prior to puberty (Turban, de Vries, & Zucker, 2018), there is broad consensus that it is not afterward. The rate of re-transition after puberty is low, at between 0 and 3.8% (Blasdel, Belkind, Harris, & Radix, 2018; Davies, McIntyre, Richards, & Rypma, 2019; de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2011; Dhejne, Öberg, Arver, & Landén, 2014; Wiepjes et al., 2018). Length of

follow-up varies across studies. The de Vries et al. (2018) study which found a 0% re-transition rate had an average of 2.99 year between initial assessment prior to initiating puberty blockers and later hormone replacement therapy. The Davies et al. (2019) study was retrospective among all patients seen between August 2016 and July 2017 at a gender identity clinic and did not indicate average time since initial clinical contact. The Wiepjes et al. (2018) study was a retrospective study of all patients seen at the Amsterdam gender identity clinic between 1972 and 2015. Most of the respondents first visited the clinic earlier than 2010. It is worth noting that the follow-up times were not particularly short.

Among adults, re-transition is most often temporary and does not reflect a change in gender identity, being instead caused by factors such as parental pressure, discrimination, or difficulty finding employment (James et al., 2016, p. 111). Re-transition often does not indicate regret, even when it reflects a change in gender identity (Ashley, 2019c; Blasdel et al., 2018; Turban, Carswell, & Keuroghlian, 2018; Turban & Keuroghlian, 2018).

While false beliefs regarding gender identity may be possible, there is no evidence currently supporting the suggestion that it is common. Speculations about youth seeking refuge in being trans after discomfort with puberty and especially sexual objectification are not born out in the rates at which trans youth and adults re-transition to their original gender role. A study by Lisa Littman has explored the alleged phenomenon of sudden or rapid onset of gender dysphoria in adolescents and young adults, strongly suggesting the presence of false beliefs among these youth. Yet, only 5.5% of the youth reported on by parents ceased to identify as transgender (according to their parents) and only 1.2% had socially transitioned and re-transitioned (Littman, 2018, p. 30). Given the very serious methodological and interpretive flaws of the study (Ashley, 2018b; Ashley & Baril, 2018; Brandelli Costa, 2019; Restar, 2019), these numbers are striking: even in a subset suggested to falsely believe that they are trans, most continued to identify as trans after an average of 15.0 months.

Even if it were the case that trans youth had elevated levels of internalized homophobia relative to transphobia which led them to favor being trans and straight over cis and LGBQ, nothing suggests that it would lead them to deceive themselves as to their gender identity—indeed, why would they deceive themselves as to their gender identity instead of convincing themselves that they are cis and straight, which is undoubtedly the easier life?

Since there is no strong evidence that youth conflate gender non-conformity and/or normal discomfort surrounding pubertal development and unwanted sexual attention with being transgender or that this conflation is

motivated by internalized and parental homophobia, the charge that gender affirmation is homophobic is entirely unfounded. The evidence shows, on the contrary, that transphobia is more prevalent than homophobia among parents and broader society, and that most trans youths are LGBTQ rather than straight. Even if it were not the case, there is no evidence beyond theoretical speculation that trans youth are prone to false beliefs about their gender identity.

Conversion therapy and transgender youth

The charge that gender affirmation of trans youth is homophobic is furthered in the claim that the gender-affirmative approach is tantamount to conversion therapy. In this section, I will explain that changes in labels (e.g. straight, bisexual, gay, lesbian) resulting from gender affirmation are not equivalent to changes in sexual attraction and do not constitute conversion therapy. Then, I will provide a brief history of conversion therapy in relation to trans people, highlighting how it frequently targets trans and LGB youth alike and is much more closely related to clinical approaches that oppose rather than encourage gender affirmation, such as the formerly prominent corrective approach.

Changes in labels aren't changes in orientation

If gender affirmation encourages a change in label from being, say, gay to straight, does it mean that it constitutes conversion therapy? No. Such an argument relies on a superficial understanding of sexual orientation and conversion therapy, which falls apart upon closer consideration. Gender affirmation does not encourage a change in sexual orientation in a relevant sense.

Sexual orientation can be understood in different ways. Among them, personal identity and structures of sexual attraction. If asked what their sexual orientation is, someone might answer: lesbian. Another woman, when asked, might answer: queer. Yet both may be exclusively attracted to women. This would be an example of sexual orientation taking the form of a personal identity, which is expressed through labels. However, we can quickly see the limits of this conception: most people are unlikely to consider that a change in label meaningfully constitutes a change in sexual orientation if the underlying structure of sexual attraction does not change.

Does gender affirmation change the structure of sexual attraction? Trans philosopher Talia Mae Bettcher has developed an account of sexual orientation in which gendered attraction is not solely other-directed but also implies the gendered self as an essential component (Bettcher, 2014). In

other words, sexual orientation is not just about the gender of the people you are attracted to, but also your own. Yet even this conceptualization does not mean that gender affirmation is a change in sexual orientation since gender affirmation merely affirms and nourishes a gender identity that is already there. The trans man who goes from being viewed as a Butch lesbian to affirming himself as a straight man is not changing the structure of his sexual attraction by transitioning, merely aligning its external expression with his internal schema. Just before he transitions, he's *already* a straight man—others just don't know it.

On a fuller account of sexual orientation, gender affirmation does not constitute a change in sexual orientation. Even if it did, however, it may not constitute conversion therapy. While conversion therapy is generally defined as an attempt to change sexual orientation (or gender identity), a decontextualized definition can be misleading. To the extent that meaning is determined by use, we must look at the history of practices labeled conversion therapy to adequately understand whether a given contemporary practice is deserving of the label. Otherwise, we would be at risk of mislabeling some practices 'conversion therapy' even if they do not have the pathologizing, moralistic animus towards marginalized groups of conversion therapy. Since gender affirmation has neither fixed end goals regarding sexual orientation nor views being LGBTQ as negative or pathological, it cannot reasonably be accused of being a form of conversion therapy.

History of conversion therapy and relation to trans youth

Turning to the history of conversion therapy and its relation to trans youth, it should rapidly become clear that gender affirmation is incompatible with the charge of conversion therapy. Instead, it is its opposite of opposing gender affirmation and access to transition that can reasonably be considered a form of conversion therapy. My overview will be articulated around seminal texts on clinical approaches to gender non-conforming youth by Green and Money, Rekers and Lovaas, and Zucker and Bradley.

One of the early influential papers in the history of conversion therapy was written by Richard Green and John Money in *Pediatrics* (Green & Money, 1961). The paper, titled "Effeminacy in Prepubertal Boys", looked at eleven cases of youth assigned male at birth who were referred to the Johns Hopkins clinic for their "excessive and persistent attempts to dress in the clothes of the opposite gender, constant display of gestures and mannerisms of the opposite sex, preference for play and other activities of the opposite sex, or a stated desire to be a member of the opposite sex" (p. 286). After summarizing the eleven cases, they make recommendations for the management of what they call a "gender-role problem", namely

effeminacy of some kind among youth assigned male at birth. Perhaps most telling of the underlying animus of the recommendations is the following quote (p. 289):

Look for insidious and irrational ways in which parents may be unwittingly encouraging girlishness and penalizing their son for developing boyishly. [...] Both [parents] should convey to their son their whole-hearted approval of his present and future masculine behavior and sexuality.

Brought together under the normative umbrella of gender role, Green and Money view the children's effeminacy as a problem to be fixed as it may augur future challenges to normative gender roles in the form of adult "homosexuality and transvestism" (p. 286). No clear distinction is made between gender identity, gender expression, and sexual orientation in the treatment plan, as failing to comport with socially dominant models of any of the three is cast as a problem to be prevented and corrected. Their conception of masculinity includes sexual orientation.

In 1974, George Rekers and O. Ivar Lovaas published their seminal article "Behavioral Treatment of Deviant Sex-Role Behaviors in a Male Child" (Rekers & Lovaas, 1974). The paper had a lasting influence on clinical approaches to gender non-conforming and trans youth. In the very first paragraph, they explain the increase in interest toward the topic of effeminate 'boys' by the "growing evidence that childhood cross-gender manifestations are indicative of later adult sexual abnormalities; e.g., transvestism, transsexualism, or some forms of homosexuality", citing the paper by Green and Money as one of its sources (p. 173).

Rekers and Lovaas were even less nuanced than Green and Money in their approach. Expounding the reasons why gender non-conformity in childhood should be corrected, they state that it is predictive of "severe adjustment problems in adulthood," highlighting that most "adult transsexuals and transvestites and some homosexuals report that their cross-gender behaviors began in early childhood" (p. 174). In a 1977 article, Rekers develops his rationale on this point, arguing that treatment is justified to "prevent transsexualism, transvestism, or homosexuality *per se* as the most probable adulthood diagnostic outcome in the absence of treatment", grouping these outcomes under the label of "future sexual deviance" (Rekers, 1977, pp. 560, 562). The goal of their proposed approach is to avoid these outcomes, and what for this purpose they suggest behavioral therapy, inviting parents to ignore their child's gender non-conforming behaviors and encourage gender-conforming ones. They also instituted a token-based reinforcement system at home. Rekers was later an officer and advisor to the National Association for Research & Therapy of Homosexuality, the foremost organization promoting conversion therapy in the United States and wrote many articles on adult conversion therapy.

The organization, founded by Joseph Nicolosi, Benjamin Kaufman, and Charles Socarides, primarily focused on adulthood.

After Rekers and Lovaas, the next major development in corrective treatments for gender non-conforming youth came in the writing of Kenneth Zucker and Susan Bradley. In 1995, they published the influential book *Gender Identity Disorder and Psychosexual Problems in Children and Adolescents* which very carefully theorized and developed a treatment approach that emphasized discouraging gender non-conformity to avoid adult trans outcomes. In 2012, their seminal article “A Developmental, Biopsychosocial Model for the Treatment of Children with Gender Identity Disorder” concisely described their treatment approach, providing a contemporary update on their 1995 book.

Their proposed approach involves extensive testing and play psychotherapy and directs parents to discourage gender non-conforming behavior, to encourage participation in gender-conforming activities, and to encourage socializing with children of the same gender assigned at birth (Zucker et al., 2012). With regards to the treatment protocol, one substantial departure from the approach proposed by Rekers and Lovaas is their critique of behavioral therapy and reinforcement techniques. Their critique, however, does not lie in the radical or unethical nature of Rekers and Lovaas’ approach to gender non-conforming behavior but rather in its limitations. According to Zucker and Bradley, “[i]t is likely that the procedures used by behavior therapists do not fully alter internal gender schemas, and that as a result the children revert to their cross-gender behavioral preferences in the absence of external cues or incentives” (Zucker & Bradley, 1995, p. 273). As a result, they remove some behavioral interventions (they do not suggest a token system, for instance) and add other interventions intending to alter internal gender schemas. The underlying theory remains the same: marked gender non-conformity in children is disordered and must be corrected (Zucker, 2006, pp. 543–544).

Another departure from Rekers and Lovaas is their view of homosexuality. Unlike Rekers and Lovaas, they do not defend avoiding homosexuality as a legitimate clinical goal. Zucker and Bradley’s views on sexual orientation have evolved over the years and noticeably become more progressive. In their 1995 book, they were partly critical of seeking to discourage adult homosexuality they also demonstrated clear ambivalence towards it (p. 269):

Given that most parents, not surprisingly, prefer that their children not develop a homosexual orientation, the contemporary clinician must carefully think through the ethics of instituting treatment for this reason and the empirical evidence that treatment can have this effect.

In 2012, they explained that “that the goal of treatment is not to prevent the child from developing a future homosexual sexual orientation”, though it may remain the goal of parents (Zucker et al., 2012, p. 390).

It is unclear what is the ethical significance of no longer seeking to avoid later homosexuality if it continues to view childhood gender non-conformity as inherently problematic and adopts interventions similar to those of Rekers and Lovaas. Discouraging children who will grow up to be gay men from being effeminate is arguably a form of homophobia. Indeed, targeting gender non-conformity is one of the primary ways in which homophobia operates. Whether or not the ultimate goal of discouraging homosexuality is present, the proximate approach of discouraging and altering gender non-conformity remains.

The strict separation between preventing LGBTQ outcomes and preventing trans outcomes used to distinguish Rekers and Lovaas’ conversion therapy and approaches that oppose gender affirmation, such as Zucker and Bradley’s corrective approach to children, is illusory. When it comes to youth, conversion therapy has historically targeted gender non-conformity, not gender identity or sexual orientation *per se*. Although Zucker and Bradley’s approach has primarily been theorized in relation to prepubertal children, some recent publications seem to consider extending the approach to older adolescents as well (Zucker, 2019; Zucker, Lawrence, & Kreukels, 2016). The experiences of Erika Muse, related below, also suggest that the corrective approach is also applied to adolescents, despite theoretical claims that gender is not malleable after puberty (Turban, de Vries, et al., 2018).

The similarities between the Rekers and Lovaas approach and the subsequent approach of Zucker and Bradley were highlighted by Jake Pyne, providing important insight into the dangers of discouraging gender affirmation. At the heart of both approaches is an understanding of gender non-conforming children as disordered, casting a specter of shame over their behaviors (and over parents’ tolerance of it) and seeking “redemption, success, and normality for the gender problematic child” (Pyne, 2014b, p. 88).

The relative disinterest in gender identity and sexual orientation compared to gendered behaviors is further revealed in the accounts of adults who were subjected to such correctively-minded interventions in youth. Kirk Andrew Murphy, who appeared as an example of successful treatment in 17 of Rekers’ articles under the name Kraig, reported in late adolescence that Rekers’ interventions had made him feel ashamed. After he took his own life at 38, his family publicly blamed Rekers’ treatments for his death (Pyne, 2014b). Although he grew up to be cisgender and gay, it did not prevent him from being harmed by the approach.

Similar accounts of deep shame and psychological harm can be found among ex-patients of the UCLA clinic where Rekers and Lovaas practiced

and ex-patients of the CAMH clinic where Zucker and Bradley practiced. Some of these patients grew up to be cis and gay, while others grew up to be trans. Among patients who have spoke up publicly on this matter are Karl Bryant, Sé Sullivan, and Erika Muse.

Drs. Karl Bryant and Sé Sullivan, who were patients of the UCLA clinic, have both dedicated their doctoral dissertations to corrective practices and the clinical governance of gender non-conformity (Bryant, 2007; Sullivan, 2017), whereas Erika Muse was instrumental to passing the Ontario law prohibiting conversion therapy.

In her parliamentary testimony, Erika Muse, a trans woman who was a patient at the CAMH clinic for children and youth, called the approach “not therapeutic, but abusive” and said that “scars of his abuse remain. I’ve been suicidal and depressed due to his treatment of me” (Legislative Assembly of Ontario, Standing Committee on Justice Policy, 2015, p. JP-63). In an interview describing her experience in greater detail, she further explained the impact of CAMH’s approach on her, stating: “I feel like he destroyed me as a person. In some fundamental way, it’s hard for me to think of myself in a positive light at all” (Williams, 2017).

As an ex-patient of the UCLA clinic, sociologist Karl Bryant also strongly expressed the negative impact that the practices had on him despite the fact that he grew up to be cisgender and gay, an outcome which Zucker and Bradley’s corrective approach would favor: “The study and the therapy that I received made me feel that I was wrong, that something about me at my core was bad, and instilled in me a sense of shame that stayed with me for a long time afterward” (Schwartzapfel, 2013). The fact that his parents were enlisted in discouraging gender non-conforming behaviors played a significant role in the subsequent trauma: “I was told that the way I felt about that aspect of myself was wrong, was sick, needed to be changed [...]. It was a little different than a kid on the playground threatening to beat you up – you know they’re the enemy. This was my parents, people I trusted” (Kohli, 2012).

The shame, self-esteem issues, anxiety, depression, and suicidality that ex-patients link to the corrective approach is connected to the pathologizing, moralistic animus of conversion therapy, which sees gender non-normative behavior as fundamentally problematic. Even when they are not being made to feel ashamed of their sexual orientation or gender identity *per se*, they are nonetheless highly vulnerable to shame insofar as their gender non-conformity is discouraged and positioned as pathological. Building on attachment theory, Robert Wallace and Hershel Russell have persuasively theorized that corrective approaches foster “proneness to shame, a shame-based identity and vulnerability to depression” (Wallace & Russell, 2013, p. 120). On the contrary, according to them, clinical approaches

should center parental acceptance, since secure attachment is a protective mental health factor. The corrective approach, then, seems tantamount to conversion therapy.

Critics may wish to reply that anecdotal accounts are not adequate evidence of widespread harm. While this is true, no evidence is presented to suggest that the corrective approach and opposing gender affirmation more generally have beneficial outcomes on cis LGBQ or trans youth that may outweigh the grave experiences of harm of ex-patients. The *prima facie* moral objectionability of pathologizing gender non-conformity and occasional grave harm would suffice to rule out a clinical approach if it bore no measurable benefit over alternatives. There is no comparable evidence of psychological harm with the gender-affirmative approach. While medical transition bears risks, it is relatively safe and adverse events do not appear to negatively impact overall psychological wellbeing (Bauer et al., 2015; Center for the Study of Inequality, 2018; Chew, Anderson, Williams, May, & Pang, 2018). Although some youth whose gender is affirmed later re-transition to the gender they were assigned at birth, many are grateful at the opportunity to better explore their gender and regrets appear mediated precisely by the shame dynamics highlighted by Wallace and Russell (Ashley, 2019a, 2019c; Blasdel et al., 2018; Turban, Carswell, et al., 2018; Turban & Keuroghlian, 2018).

A short parenthesis is imperative. It is important to note that not all reputed risks are medically concerning. For instance, lower bone mineral density is often mentioned as a concern with puberty blockers. Yet, the bone mineral density of youth on puberty blockers is comparable to that of younger youth, whose bone density is not a major health concern—having the bone mineral density of an average 15-year-old at 18 years old is not necessarily concerning. While adverse cardiovascular events associated with estrogens are more concerning, the studies have been criticized for failing to control for important factors impacting cardiovascular health such as serious psychological distress (Goldstein, Streed, Resiman, Mukherjee, & Radix, 2019). A full discussion of the benefits and risks of transition-related interventions is beyond the scope of this paper.

Medical transition doesn't seem harmful. On the contrary, access to transition is a well-established protective factor for trans youth. Youth whose identities are affirmed and who have access to desired transition-related interventions have a significantly better quality of life (Bauer et al., 2015; Durwood et al., 2017; Hill, Menvielle, Sica, & Johnson, 2010; McLemore, 2018; Olson et al., 2016; Russell et al., 2018). As a result, the gender-affirmative approach is rapidly solidifying as the consensus approach, while corrective approaches are severely criticized for being harmful to trans and cis LGBQ youth alike (Ashley, 2019b; Bryant, 2006; Lev, 2019; Pyne, 2014a,

2014b; Sullivan, 2017; Temple Newhook, Pyne, et al., 2018; Tosh, 2011). In the words of Dr. Simon Pickstone-Taylor, the corrective approach “is something disturbingly close to reparative therapy for homosexuals” (Pickstone-Taylor, 2003).

Some controversy remains as to whether it is appropriate to attribute the label of conversion therapy to contemporary corrective approaches. Some authors have highlighted differences in the evidence base regarding the malleability of gender identity versus sexual orientation and the harm of ‘correction’ (Byne, 2016; Dreger, 2015; Drescher & Pula, 2014; Green, 2017a). The literature on conversion therapy targeting adult sexual orientation is much more extensive. However, it should not be overstated. Reviewing the evidence of sexual orientation malleability and harm in conversion therapy, the APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation concluded that (American Psychological Association, 2009, p. 42):

Although the recent studies do not provide valid causal evidence of the efficacy of [LGBQ conversion therapy] or of its harm, some recent studies document that there are people who perceive that they have been harmed through [LGBQ conversion therapy].

While some authors may suggest that we have evidence that sexual orientation cannot be changed and no corresponding evidence for gender identity, it would be more accurate to assert that the possibility of changing either through external efforts is unproven. Naturalistic evolution and fluidity cannot be used as evidence of the success of corrective practices.

Fewer studies exist regarding LGBQ children and youth, with the majority of the literature being composed of studies on gender non-conforming youth by Green, Money, Rekers, Lovaas, Zucker, and Bradley (American Psychological Association, 2009, pp. 72–73). Proof that corrective approaches are harmful may be difficult to establish, since research may not meet clinical equipoise given its widespread condemnation. Methodological difficulties also arise since negative psychological outcomes may only reveal themselves later in life, and parents are unlikely to accept participating in a comparative study of different approaches. Since the relative scarcity of evidence has not prevented persistent opposition to LGBQ conversion therapy, I would argue that the differences in evidence bases do not justify rejecting the label of conversion therapy for corrective approaches to trans and gender non-conforming youth.

Regardless of whether the corrective approach and opposing gender affirmation are tantamount to conversion therapy or related-but-distinct unethical approaches, it should be clear that affirming youth’s expressed gender identity and granting them access to desired transition-related interventions falls far from the pathologizing, moralistic animus that underpins

conversion therapy. By accepting youth at their word, the gender-affirmative approach communicates that there is nothing wrong with being yourself, whoever you may be.

Conclusion

The suggestion that gender affirmation and access to transition-related care are homophobic and tantamount to conversion therapy are groundless. There is no evidence that youth are conflating gender non-conformity and/or normal discomfort surrounding pubertal development and unwanted sexual attention with being transgender. Nor is there evidence that they are motivated to transition by homophobia, given the higher prevalence and saliency of transphobia and the fact that only a minority of trans youth appears to be straight. The charge that gender affirmation and transition are tantamount to conversion therapy also fails because it relies on a superficial understanding of sexual orientation and an ahistorical, decontextualized framing of conversion therapy. As I have shown, the validating animus of the gender-affirmative approach is inconsistent with the history of conversion therapy, which foregrounds pathologizing views of gender non-conformity, targeting trans and cis LGBQ youth alike. Opposing, rather than encouraging, gender affirmation appears more consistent with the charge of conversion therapy and homophobia, placed against this historical and factual background.

Without a comprehensive understanding of the world that trans youth navigate and of the history of clinical approaches to LGBTQ youth, deceptive accusations against trans youth care may seem plausible. With increasing polarization over trans youth care in the media, it is crucial for those who work with trans youth and their families to familiarize themselves with these accusations and work out how to best respond to them.

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Notes on contributor

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References

- American Psychological Association. (2009). Report of the American Psychological Association Task force on appropriate therapeutic responses to sexual orientation. Retrieved from <https://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf>
- Aparicio-García, M., Díaz-Ramiro, E., Rubio-Valdehita, S., López-Núñez, M., & García-Nieto, I. (2018). Health and well-being of cisgender, transgender and non-binary young people. *International Journal of Environmental Research and Public Health*, 15(10), 2133. doi:10.3390/ijerph15102133
- Ashley, F. (2018a). Don't be so hateful: The insufficiency of anti-discrimination and hate crime laws in improving trans well-being. *University of Toronto Law Journal*, 68(1), 1–36. doi:10.3138/utlj.2017-0057
- Ashley, F. (2018b, December 3). *There is no evidence that rapid-onset gender dysphoria exists*. Retrieved from PsychCentral website: <https://psychcentral.com/lib/thereis-no-evidence-that-rapid-onset-gender-dysphoria-exists/>
- Ashley, F. (2019a). Gender (de)transitioning before puberty? A response to Steensma and Cohen-Kettenis (2011). *Archives of Sexual Behavior*, 48(3), 679–680. doi:10.1007/s10508-018-1328-y
- Ashley, F. (2019b). *Outlawing trans reparative therapy* (LL.M. Thesis, forthcoming). Montreal: McGill University Faculty of Law.
- Ashley, F. (2019c). Thinking an ethics of gender exploration: Against delaying transition for transgender and gender creative youth. *Clinical Child Psychology and Psychiatry*, 24(2), 223–236. doi:10.1177/1359104519836462
- Ashley, F., & Baril, A. (2018, March 22). *Why 'rapid-onset gender dysphoria' is bad science*. *The Conversation*. Retrieved from <https://theconversation.com/why-rapid-onset-gender-dysphoria-is-badscience-92742>
- Bannerman, L. (2019, April 8). It feels like conversion therapy for gay children, say clinicians. *The Times*. Retrieved from <https://www.thetimes.co.uk/article/it-feels-like-conversion-therapy-for-gay-children-say-clinicians-pvsckdvq2>
- Bauer, G. R., Scheim, A. I., Pyne, J., Travers, R., & Hammond, R. (2015). Intervenable factors associated with suicide risk in transgender persons: A respondent driven sampling study in Ontario, Canada. *BMC Public Health*, 15(1). doi:10.1186/s12889-015-1867-2
- Bettcher, T. M. (2014). When selves have sex: What the phenomenology of trans sexuality can teach about sexual orientation. *Journal of Homosexuality*, 61(5), 605–620. doi:10.1080/00918369.2014.865472
- Bewley, S., Griffin, L., & Byng, R. (2019, February 11). Safeguarding adolescents from premature, permanent medicalisation. Retrieved from BMJ Rapid Responses website: <https://www.bmj.com/content/364/bmj.l245/rr-1>
- Billard, T. J. (2018). Attitudes toward transgender men and women: Development and validation of a new measure. *Frontiers in Psychology*, 9, 387. doi:10.3389/fpsyg.2018.00387
- Blair, K. L., & Hoskin, R. A. (2019). Transgender exclusion from the world of dating: Patterns of acceptance and rejection of hypothetical trans dating partners as a function of sexual and gender identity. *Journal of Social and Personal Relationships*, 36(7), 2074–2095. doi:10.1177/0265407518779139

- Blasdel, G., Belkind, U., Harris, A., & Radix, A. (2018, November). *Description and outcomes of a hormone therapy informed consent model for minors*. Poster Presented at the 25th WPATH Symposium, Buenos Aires, Argentina.
- Bonfatto, M., & Crasnow, E. (2018). Gender/ed identities: An overview of our current work as child psychotherapists in the Gender Identity Development Service. *Journal of Child Psychotherapy*, 44(1), 29–46. doi:10.1080/0075417X.2018.1443150
- Brandelli Costa, A. (2019). Formal comment on: Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. *Plos One*, 14(3), e0212578. doi:10.1371/journal.pone.0212578
- Bryant, K. (2006). Making gender identity disorder of childhood: Historical lessons for contemporary debates. *Sexuality Research and Social Policy*, 3(3), 23–39. doi:10.1525/srsp.2006.3.3.23
- Bryant, K. (2007). *The politics of pathology and the making of gender identity disorder* (Doctoral Dissertation). University of California, Santa Barbara, Santa Barbara.
- Byne, W. (2016). Regulations restrict practice of conversion therapy. *LGBT Health*, 3(2), 97–99. doi:10.1089/lgbt.2016.0015
- Center for the Study of Inequality. (2018). What does the scholarly research say about the effect of gender transition on transgender well-being? Retrieved from “What We Know” Project at Cornell University website: <https://whatweknow.inequality.cornell.edu/topics/lgbt-equality/%20what-does-the-scholarly-research-say-about-the-well-being-of-trans-gender-people%20/>
- Chew, D., Anderson, J., Williams, K., May, T., & Pang, K. (2018). Hormonal treatment in young people with gender dysphoria: A systematic review. *Pediatrics*, 141(4), e20173742. doi:10.1542/peds.2017-3742
- CROP. (2017). *Perceptions, interactions and comfort level of the heterosexual cisgender population with sexual minorities: LGBT+ Realities Survey*. Retrieved from Foundation Jasmin Roy website: <https://fondationjasminroy.com/en/initiative/lgbt-realities-survey/>
- Davies, S., McIntyre, S., Richards, C., & Rypma, C. (2019). *Rate of detransition and regret in an NHS Gender Identity Clinic*. Third Biennial Conference of the European Professional Association for Transgender Health, Rome, Italy.
- de Vries, A. L. C., Steensma, T. D., Doreleijers, T. A. H., & Cohen-Kettenis, P. T. (2011). Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study. *The Journal of Sexual Medicine*, 8(8), 2276–2283. doi:10.1111/j.1743-6109.2010.01943.x
- Dhejne, C., Öberg, K., Arver, S., & Landén, M. (2014). An analysis of all applications for sex reassignment surgery in Sweden, 1960–2010: Prevalence, incidence, and regrets. *Archives of Sexual Behavior*, 43(8), 1535–1545. doi:10.1007/s10508-014-0300-8
- di Giacomo, E., Krausz, M., Colmegna, F., Aspesi, F., & Clerici, M. (2018). Estimating the risk of attempted suicide among sexual minority youths: A systematic review and meta-analysis. *JAMA Pediatrics*, 172(12), 1145. doi:10.1001/jamapediatrics.2018.2731
- Dreger, A. (2015, June 4). The big problem with outlawing gender conversion therapies. *Wired*. Retrieved from <https://www.wired.com/2015/06/big-problem-outlawing-gender-conversion-therapies/>
- Drescher, J., & Pula, J. (2014). Ethical issues raised by the treatment of gender-variant pre-pubescent children. *Hastings Center Report*, 44(s4), S17–S22. doi:10.1002/hast.365
- Durwood, L., McLaughlin, K. A., & Olson, K. R. (2017). Mental health and self-worth in socially transitioned transgender youth. *Journal of the American Academy of Child & Adolescent Psychiatry*, 56(2), 116–123.e2. doi:10.1016/j.jaac.2016.10.016

- Goldstein, Z., Streed, C., Resiman, T., Mukherjee, M., & Radix, A. (2019). Cross-sex hormones and acute cardiovascular events in transgender persons. *Annals of Internal Medicine*, 170(2), 142. doi:10.7326/L18-0563
- Green, R., & Money, J. (1961). Effeminacy in prepubertal boys. Summary of eleven cases and recommendations for case management. *Pediatrics*, 27, 286–291.
- Green, R. (2017a). Banning therapy to change sexual orientation or gender identity in patients under 18. *Journal of the American Academy of Psychiatry Law*, 45(1), 7–11.
- Green, R. (2017b). To transition or not to transition? That is the question. *Current Sexual Health Reports*, 9(2), 79–83. doi:10.1007/s11930-017-0106-5
- Grossman, A. H., D’Augelli, A. R., Howell, T. J., & Hubbard, S. (2005). Parents’ Reactions to Transgender Youth’ Gender Nonconforming Expression and Identity. *Journal of Gay & Lesbian Social Services*, 18(1), 3–16. doi:10.1300/J041v18n01_02
- Hatzenbuehler, M. L., Dovidio, J. F., Nolen-Hoeksema, S., & Phillips, C. E. (2009). An implicit measure of anti-gay attitudes: Prospective associations with emotion regulation strategies and psychological distress. *Journal of Experimental Social Psychology*, 45(6), 1316–1320. doi:10.1016/j.jesp.2009.08.005
- Hill, D. B., Menvielle, E., Sica, K. M., & Johnson, A. (2010). An affirmative intervention for families with gender variant children: Parental ratings of child mental health and gender. *Journal of Sex & Marital Therapy*, 36(1), 6–23. doi:10.1080/00926230903375560
- Human Rights Campaign. (2018). *Gender-expansive youth report*. Washington, D.C.: Human Rights Campaign.
- James, S. E., Herman, J. L., Keisling, M., Mottet, L., & Anafi, M. (2016). *The report of the 2015 U.S. transgender survey*. Washington, DC: National Center for Transgender Equality.
- Katz-Wise, S. L., Reisner, S. L., Hughto, J. W., & Keo-Meier, C. L. (2016). Differences in sexual orientation diversity and sexual fluidity in attractions among gender minority adults in Massachusetts. *The Journal of Sex Research*, 53(1), 74–84. doi:10.1080/00224499.2014.1003028
- Kohli, S. (2012, November 15). Gender behavior therapy and gay conversion: UCLA’s past, California’s future. *Daily Bruin*. Retrieved from <http://dailybruin.com/features/conversion-therapy/>
- Kuyper, L., & Bos, H. (2016). Mostly heterosexual and lesbian/gay young adults: Differences in mental health and substance use and the role of minority stress. *The Journal of Sex Research*, 53(7), 731–741. doi:10.1080/00224499.2015.1071310
- Legislative Assembly of Ontario, Standing Committee on Justice Policy. (2015). Affirming Sexual Orientation and Gender Identity Act, 2015. 41–1 (3 June).
- Lev, A. I. (2019). Approaches to the treatment of gender nonconforming children and transgender youth. In A. I. Lev & A. R. Gottlieb (Eds.), *Families in transition: Parenting gender diverse children, adolescents, and young adults*. New York: Harrington Park Press.
- Littman, L. (2018). Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. *PLoS One*, 13(8), e0202330. doi:10.1371/journal.pone.0202330
- Lopez, X., Marinkovic, M., Eimicke, T., Rosenthal, S. M., & Olshan, J. S. (2017). Statement on gender-affirmative approach to care from the pediatric endocrine society special interest group on transgender health. *Current Opinion in Pediatrics*, 29(4), 475–480. doi:10.1097/MOP.0000000000000516
- Marchiano, L. (2017). Outbreak: On transgender teens and psychic epidemics. *Psychological Perspectives*, 60(3), 345–366. doi:10.1080/00332925.2017.1350804

- McLemore, K. A. (2015). Experiences with misgendering: Identity misclassification of transgender spectrum individuals. *Self and Identity, 14*(1), 51–74. doi:10.1080/15298868.2014.950691
- McLemore, K. A. (2018). A minority stress perspective on transgender individuals' experiences with misgendering. *Stigma and Health, 3*(1), 53–64. doi:10.1037/sah0000070
- Meadow, T. (2018). *Trans kids: Being gendered in the twenty-first century*. Oakland, CA: University of California Press.
- Namaste, V. K. (2006). Genderbashing: Sexuality, gender, and the regulation of public space. In S. Stryker & S. Whittle (Eds.), *The transgender studies reader* (pp. 584–600). New York: Routledge.
- Olson, K. R. (2016). Prepubescent transgender children: What we do and do not know. *Journal of the American Academy of Child & Adolescent Psychiatry, 55*(3), 155–156.e3. doi:10.1016/j.jaac.2015.11.015
- Olson, K. R., Durwood, L., DeMeules, M., & McLaughlin, K. A. (2016). Mental health of transgender children who are supported in their identities. *Pediatrics, 137*(3), e20153223. doi:10.1542/peds.2015-3223
- Pickstone-Taylor, S. D. (2003). Children with gender nonconformity. *Journal of the American Academy of Child & Adolescent Psychiatry, 42*(3), 266. doi:10.1097/00004583-200303000-00005
- Pyne, J. (2014a). Gender independent kids: A paradigm shift in approaches to gender non-conforming children. *The Canadian Journal of Human Sexuality, 23*(1), 1–8. doi:10.3138/cjhs.23.1.CO1
- Pyne, J. (2014b). The governance of gender non-conforming children: A dangerous enclosure. *Annual Review of Critical Psychology, 11*, 79–96.
- Rae, J. R., Gülgöz, S., Durwood, L., DeMeules, M., Lowe, R., Lindquist, G., & Olson, K. R. (2019). Predicting early-childhood gender transitions. *Psychological Science, 30*(5), 669–681. doi:10.1177/0956797619830649
- Rafferty, J. (2018). Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents. *Pediatrics, 142*(4), e20182162. doi:10.1542/peds.2018-2162
- Rekers, G. A. (1977). Atypical gender development and psychosocial adjustment. *Journal of Applied Behavior Analysis, 10*(3), 559–571. doi:10.1901/jaba.1977.10-559
- Rekers, G. A., & Lovaas, O. I. (1974). Behavioral treatment of deviant sex-role behaviors in a male child. *Journal of Applied Behavior Analysis, 7*(2), 173–190. doi:10.1901/jaba.1974.7-173
- Restar, A. J. (2019). Methodological critique of Littman's (2018) parental-respondents accounts of "rapid-onset gender dysphoria. *Archives of Sexual Behavior*. <https://doi.org/10.1007/s10508-019-1453-2>
- Russell, S. T., Pollitt, A. M., Li, G., & Grossman, A. H. (2018). Chosen name use is linked to reduced depressive symptoms, suicidal ideation, and suicidal behavior among transgender youth. *Journal of Adolescent Health, 63*(4), 503–505. doi:10.1016/j.jadohealth.2018.02.003
- Schwartzapfel, B. (2013, March 14). Born this way? *The American Prospect*. Retrieved from <http://prospect.org/article/born-way>
- Soh, D. (2018, October 23). The unspoken homophobia propelling the transgender movement in children. *Quillette*. Retrieved from <https://quillette.com/2018/10/23/the-unspoken-homophobia-propelling-the-transgender-movement-in-children/>
- Steensma, T. D., Biemond, R., de Boer, F., & Cohen-Kettenis, P. T. (2011). Desisting and persisting gender dysphoria after childhood: A qualitative follow-up study. *Clinical Child Psychology and Psychiatry, 16*(4), 499–516. doi:10.1177/1359104510378303

- Strauss, P., Cook, A., Winter, S., Watson, V., Wright Toussaint, D., & Lin, A. (2017). *Trans Pathways: The mental health experiences and care pathways of trans young people. Summary of results*. Perth: Telethon Kids Institute.
- Substance Abuse and Mental Health Services Administration. (2015). *Ending conversion therapy: Supporting and affirming LGBTQ youth*. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Sullivan, S. (2017). *Conversion therapy ground zero: Interrogating the production of gender as a pathology in the United States* (Doctoral Dissertation). California Institute of Integral Studies, San Francisco.
- Telfer, M. M., Tollit, M. A., Pace, C. C., & Pang, K. C. (2018). *Australian standards of care and treatment guidelines for trans and gender diverse children and adolescents: Version 1.1*. Melbourne: The Royal Children's Hospital.
- Temple Newhook, J., Pyne, J., Winters, K., Feder, S., Holmes, C., Tosh, J., ... Pickett, S. (2018). A critical commentary on follow-up studies and "desistance" theories about transgender and gender-nonconforming children. *International Journal of Transgenderism*, 19(2), 212–224. doi:10.1080/15532739.2018.1456390
- Temple Newhook, J., Winters, K., Pyne, J., Jamieson, A., Holmes, C., Feder, S., ... Sinnott, M.-L. (2018). Teach your parents and providers well: Call for refocus on the health of trans and gender-diverse children. *Canadian Family Physician*, 64(5), 332–335.
- Toomey, R. B., Syvertsen, A. K., & Shramko, M. (2018). Transgender adolescent suicide behavior. *Pediatrics*, 142(4), e20174218. doi:10.1542/peds.2017-4218
- Tosh, J. (2011). Zuck Off! A commentary on the protest against Ken Zucker and his 'treatment' of Childhood Gender Identity Disorder. *Psychology of Women Section Review*, 13(1), 10–16.
- Turban, J. L., Carswell, J., & Keuroghlian, A. S. (2018). Understanding pediatric patients who discontinue gender-affirming hormonal interventions. *JAMA Pediatrics*, 172(10), 903. doi:10.1001/jamapediatrics.2018.1817
- Turban, J. L., de Vries, A. L. C., & Zucker, K. J. (2018). Gender dysphoria and gender incongruence. In A. Martin, M. H. Bloch, & F. R. Volkmar (Eds.), *Lewis' child and adolescent psychiatry* (5th ed., pp. 632–643). Philadelphia: Wolters Kluwer.
- Turban, J. L., & Keuroghlian, A. S. (2018). Dynamic gender presentations: Understanding transition and "de-transition" among transgender youth. *Journal of the American Academy of Child & Adolescent Psychiatry*, 57(7), 451–453. doi:10.1016/j.jaac.2018.03.016
- Veale, J., Saewyc, E., Frohard-Dourlent, H., Dobson, S., & Clark, B., & the Canadian Trans Youth Health Survey Research Group. (2015). *Being safe, being me: Results of the Canadian Trans Youth Health Survey*. Vancouver, BC: Stigma and Resilience among Vulnerable Youth Centre, School of Nursing, University of British Columbia.
- Vincent, B. (2018). *Transgender health: A practitioner's guide to binary and non-binary trans patient care*. London: Jessica Kingsley Publishers.
- Wallace, R., & Russell, H. (2013). Attachment and shame in gender-nonconforming children and their families: Toward a theoretical framework for evaluating clinical interventions. *International Journal of Transgenderism*, 14(3), 113–126. doi:10.1080/15532739.2013.824845
- Wiepjes, C. M., Nota, N. M., de Blok, C. J. M., Klaver, M., de Vries, A. L. C., Wensing-Kruger, S. A., ... den Heijer, M. (2018). The Amsterdam cohort of gender dysphoria study (1972–2015): Trends in prevalence, treatment, and regrets. *The Journal of Sexual Medicine*, 15(4), 582–590. doi:10.1016/j.jsxm.2018.01.016
- Williams, C. (2017, February 2). #DiscoSexology Part V: An interview with Zucker's patient. *TransAdvocate*. Retrieved from https://www.transadvocate.com/part-v-interview-with-zuckers-patient-the-rise-and-fall-of-discosexology-dr-zucker-camh-conversion-therapy_n_19727.htm

- Winters, K., Temple Newhook, J., Pyne, J., Feder, S., Jamieson, A., Holmes, C., ... Tosh, J. (2018). Learning to listen to trans and gender diverse children: A Response to Zucker (2018) and Steensma and Cohen-Kettenis (2018). *International Journal of Transgenderism*, 19(2), 246–250. doi:[10.1080/15532739.2018.1471767](https://doi.org/10.1080/15532739.2018.1471767)
- Zucker, K. J. (2006). Commentary on Langer and Martin's (2004) "How dresses can make you mentally ill: Examining gender identity disorder in children. *Child and Adolescent Social Work Journal*, 23(5-6), 533–555. doi:[10.1007/s10560-006-0074-5](https://doi.org/10.1007/s10560-006-0074-5)
- Zucker, K. J. (2019). Adolescents with gender dysphoria: Reflections on some contemporary clinical and research issues. *Archives of Sexual Behavior*. <https://doi.org/10.1007/s10508-019-01518-8>
- Zucker, K. J., & Bradley, S. J. (1995). *Gender identity disorder and psychosexual problems in children and adolescents*. New York: Guilford Press.
- Zucker, K. J., Lawrence, A. A., & Kreukels, B. P. C. (2016). Gender dysphoria in adults. *Annual Review of Clinical Psychology*, 12(1), 217–247. doi:[10.1146/annurev-clinpsy-021815-093034](https://doi.org/10.1146/annurev-clinpsy-021815-093034)
- Zucker, K. J., Wood, H., Singh, D., & Bradley, S. J. (2012). A developmental, biopsychosocial model for the treatment of children with gender identity disorder. *Journal of Homosexuality*, 59(3), 369–397. doi:[10.1080/00918369.2012.653309](https://doi.org/10.1080/00918369.2012.653309)