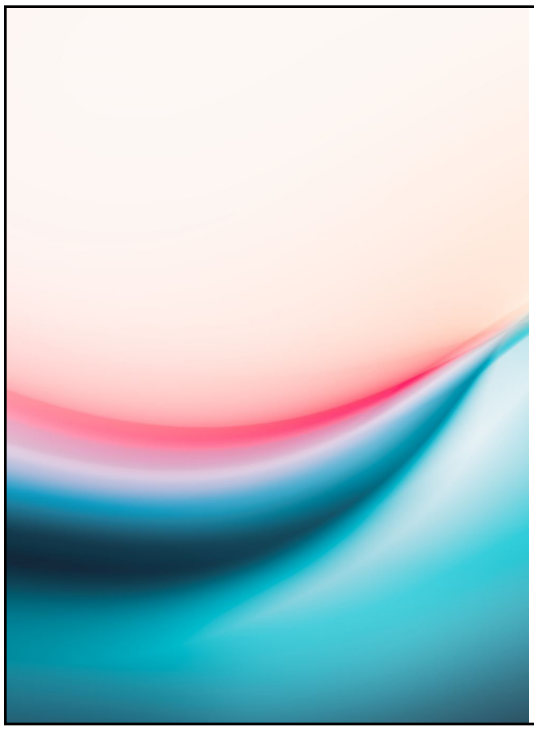

Bias Disguised as Science: Debunking the Myths around Gender and Best Practice Affirming Care

Amelia Brewer, LPC

1

Objectives

- Pinpoint the current myths around gender identity and affirming care
- Explore the peer reviewed evidence that debunks these myths
- Discuss how these are used in media and law to fuel disinformation
- Learn ways to distinguish science from anti-trans bias masked as science and incorporate this into professional work.

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2

Terminology

- **Gender Identity-**refers to a person's internalized sense of being male, female, both or neither (experiential--not visible to others)
- **Gender Expression-how** a person externally present themselves in terms of society's ideals of "masculine and feminine" -includes clothing, hairstyles, mannerisms, social interactions and roles (visible to others)
- **Gender Dysphoria/Incongruence-** Incongruence between the sex assigned at birth and gender identity
- **Gender expansive/nonconforming-**An umbrella term to describe individuals who expand notions of gender expression and identity beyond perceived or expected societal gender norms.
- **AMAB/AFAB-**Acronyms for Assigned Male at Birth/Assigned Female at Birth

Pflag, 2022, Ashley, 2021

3

Why is This Important?

- Harm to the TNBGNC Community
  - Media fuels clients' and family's anxiety with false information
  - Creates polarized views to keep society at odds on this issue
  - Gives rise to anti-trans policy across the globe

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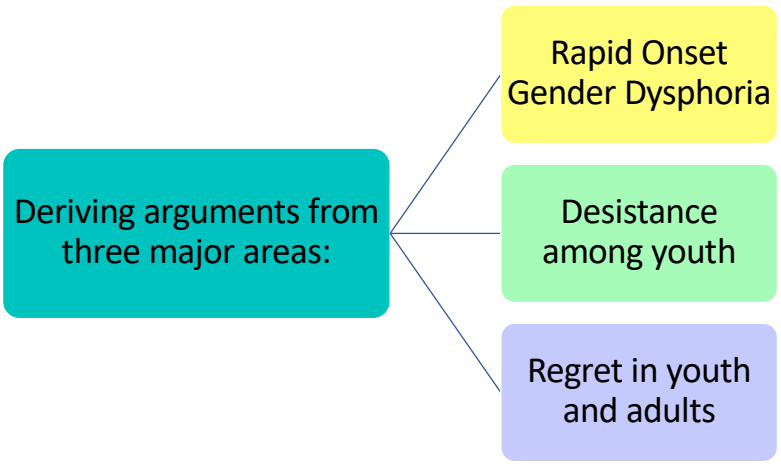
4

Addressing the Myths



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5

Rapid Onset Gender Dysphoria (ROGD)

- Study: Rapid-onset gender dysphoria in adolescents and young adults: A study of parental reports-Littman 2016
- Claim: ROGD is as a subtype of gender dysphoria brought about by social contagion
- Key Features:
  - Dysphoria presents in adolescents when criteria was not met in childhood
  - "Sudden presentation" during or after puberty begins
  - Developing Hypotheses:
    - H1:Develops from social/peer contagion and
    - H2 ROGD is a "maladaptive coping mechanism"

Littman, 2016

6

Rapid Onset Gender Dysphoria (ROGD)

- Participants were 256 parents
- Recruitment via 3 websites "where parents and professionals had been observed to describe rapid onset gender dysphoria" (4thwavenow,transgender trend, and youthtranscriticalprofessionals)
- Survey was online format; 90 questions (Likert, MC, and Open)
  - Questions focused on:
    - DSM-5 Criteria
    - Friend group and social media exposure
    - Behaviors, outcomes & interactions
    - Coping mechanisms

Littman, 2016

7

ROGD Debunked

- Methodological Flaws
  - Sample Bias:
    - Only parent report-assumes child only came out to parent immediately
    - Recruited through parent blogs known for openly anti-trans bias
  - Demand Characteristics:
    - Title: "Rapid-onset gender dysphoria: New study recruiting parents"
    - Participants know what they are testing for-alters behavior
  - Descriptive design-weakest of all designs

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8

ROGD Debunked

- Methodological Flaws
  - Flawed assumptions (claims):
  - Late onset gender dysphoria is suspicious or atypical
    - Onset in adolescence is recognized as appropriate in DSM-5 and WPATH and decades of research
    - Parents were the only source of "diagnosis", persistence and desistence
    - AYA's would not have met diagnostic criteria for gender dysphoria during their childhood
  - Coping style or parent/child relationship predicts reality of TGD?

Ashley, 2020, Williams, ret. 2023

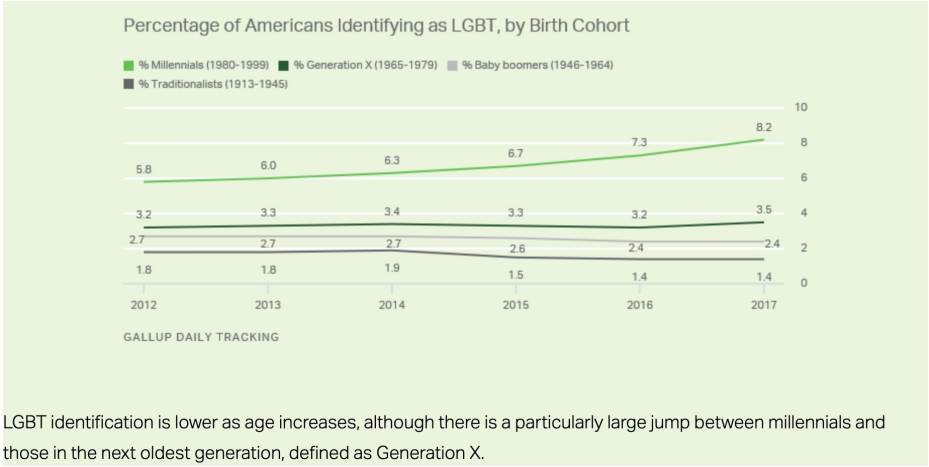
9

ROGD Debunked

- Flawed assumptions con't. (claims):
  - This rapid onset is particularly high in those assigned female at birth
  - Uses stat to say we may be able to follow a similar template for ROGD in comparison to anorexia in AYA's which is also primarily female
    - Failed to report that LGBT self identity has doubled overall between Gen X and Millennial cohorts (misleading)
    - False dichotomy- All identities are higher

Ashley, 2020, Williams, ret. 2023

10



LGBT identification is lower as age increases, although there is a particularly large jump between millennials and those in the next oldest generation, defined as Generation X.

Gallup, 2017

11

TABLE 2 Numbers and Percentages of Transgender and Cisgender Adolescents by YRBS Year and Sex Assigned at Birth

YRBS Year	2017	2019
All adolescents, *n* (%)		
Transgender	2161 (2.4)	1640 (1.6)
Cisgender	89 776 (97.6)	103 797 (98.4)
AMAB adolescents, *n* (%)		
Transgender	1285 (2.8)	866 (1.7)
Cisgender	43 848 (97.2)	50 618 (98.3)
AFAB adolescents, *n* (%)		
Transgender	876 (1.9)	774 (1.4)
Cisgender	45 928 (98.1)	53 179 (98.6)
Sex assigned at birth ratio, transgender AMAB:transgender AFAB	1.5:1	1.2:1

"The sex assigned at birth ratio of TGD adolescents in the United States does not appear to favor AFAB adolescents and should not be used to argue against the provision of gender-affirming medical care for TGD adolescents."

Turban et al., 2022

12

ROGD Debunked

- PLOS One publishers pulled article and Littman submitted corrections
- “Because this is a study of parent reports, there is some information about the AYAs that the parents would not have access to and the answers might reflect parent perspectives.”
- “Limitations of parental report include information that parents may not be aware of and parental biases.”

Littman, 2018

13

ROGD Debunked

- “The damaging effects of these unfounded hypotheses in further stigmatizing transgender and gender diverse youth cannot be understated…We hope that clinicians, policymakers, journalists, and anyone else who contributes to health policy will review these findings.”-Turban 2022
- "The term 'Rapid Onset Gender Dysphoria (ROGD)' is not a medical entity recognized by any major professional association, nor is it listed as a subtype or classification in the Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD).”-WPATH

14

Desistance Myth

- Study-Desisting and Persisting Gender Dysphoria After Childhood: A Qualitative Follow-up Study-Steensma et al., 2011
  - Claim: More than 80% of children reporting gender dysphoria will "desist."
    - Desistance is defined as gender dysphoria remittance
- Key Features:
- Objective-"Obtain a better understanding of the developmental trajectories of persistence and desistence of childhood gender dysphoria and the psychosexual outcome of gender dysphoric children. "
- Desistance occurs between ages of 10-13 years old
- Occurs as a function of 1) the social environment, 2) anticipation of or actual puberty, and 3) emerging romantic/sexual feelings and sexual partner choice

Steensma et al., 2011

15

Desistance Myth

- Method:
  - Participants: N= 25 adolescents
    - Referred to the Gender Identity Clinic at Amsterdam VUmc
  - Age range 14-18 "previously diagnosed with GID"
  - Data collection was via semi-structured biographical interview
    - Questions focused on gender identity, gender role and sexual orientation
  - Reported an 84% desistance rate
  - Suggest not validating GID with social transition because it won't last

Steensma et al., 2011

16

Desistance Myth Debunked

- Methodological Flaws
- Reported N=25, but ran stats on N=53 (included 24 who dropped)
- Those who dropped the study (43.5%) were **assumed** to have desisted
  - *"As the Amsterdam Gender Identity Clinic for children and adolescents is the only one in the country, we assumed that their gender dysphoric feelings had desisted, and that they no longer had a desire for sex reassignment."-Steensma et al., 2011*
- Did not include information on family support or external variables for desistance

Steensma et al., 2011

17

But There's More…

- Steensma et al., 2013 Factors Associated With Desistence and Persistence of Childhood Gender Dysphoria: A Quantitative Follow-Up Study
- Reported: 47 persisted (37%), 80 desisted (63%)
  - 80 dropped (52 followed up/ 28 misclassified as desisting)
  - All 127 included in figures
- Treated gender dysphoria and gender non-conformity as synonymous
  - Interviewed children who did not meet GD criteria (non-conforming)

Steensma et al., 2013, Brooks 2018

18

Follow Up 2018

"Because of the purpose and the design of this study we did not report prevalence numbers in the sample under study. Furthermore, the sample in the 2013 study did not include children in the younger age spectrum of the referred population to the Amsterdam clinic. Reporting prevalence of persistence and/or desistence in this sample would therefore not be reliable. …both studies cannot be used "to support the 80% 'desistance' estimation."

"Until there is more knowledge about this mechanism, and because the clinical management of children with GD in general should not be aimed to block gender-variant behaviors, the proposed approach regarding social transitioning in the Standards of Care of the World Professional Association for Transgender Health (WPATH) seems to be best fitting."--Steensma & Cohen-Kettenis 2018

19

Desistance Myth Debunked

- "The methodology of those studies is very flawed, because they didn't study gender identity…You can't do that in scientific studies. You have to have your subjects in front of you and know who they are. You can't just assume somebody is in a category because you don't see them anymore." - Diane Ehrensaft, 2018
- "The tethering of childhood gender diversity to the framework of "desistance" or "persistence" has stifled advancements in our understanding of children's gender in all its complexity. These follow-up studies fall short in helping us understand what children need."-Temple-Newhook et al., 2018

20

Debunking Detransition/Regret Myth

- Mass media message is that there is a high level of regret among those who seek gender affirming surgeries.
- Calls into question the appropriateness of Gender Affirming Care
- Difficult to quantify due to lack of reporting
- Disinformation around ages for surgeries and differences in what constitutes regret

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21

Debunking Detransition/Regret Myth

- Study: Regret after Gender-affirmation Surgery: A Systematic Review and Meta-analysis of Prevalence- Bustos et al., 2021
- Aim: "to evaluate the prevalence of regret in transgender individuals who underwent GAS and evaluate associated factors of regret."
- Method: Random-effects meta-analysis, meta-regression, and subgroup and sensitivity analyses
  - 27 studies included / 7928 transgender patients
  - Hypothesized "prevalence of regret is less than the last estimation (Pfafflin in 1993), due to improvements in standard of care, patient selection, surgical techniques, and gender confirmation care."

Bustos et al., 2021

22

Debunking Detransition/Regret Myth

- Results:
  - The overall prevalence of regret after GAS = 1%
    - Out of 7928 patients, 77 reported regret
  - Prevalence of regret among patients
    - Transmasculine= <1% (IC <1%–<1%)
    - Transfeminine= 1% (CI <1%–2%)
- Conclusion-"Based on this review, there is an extremely low prevalence of regret in transgender patients after gender affirming surgery."

Bustos et al., 2021

23

A Closer Look at Regret

- #1-Psychosocial Circumstances
  - Response from family/social presenting in identified gender
  - Predictive factors: lack of support from the patient's family and the patient belonging to the non-core group of trans individuals
- #2-Poor Surgical Outcomes
  - Low quality surgery or aesthetic outcomes (didn't match ideal)
  - Predictive factor: Physical results (function, sensation, appearance)
  - No correlation with age, education or gender assignment at birth

Bustos et al., 2021

24

Table 6. Causes of Regret

Studies	Reasons of Regrets
Blanchard et al, 1989	• 1 patient was dissatisfied with life as a woman and considered returning to the masculine role • 1 patient reported that surgery failed to produce the coherence of mind and the body he wanted • 1 patient would not opt for a new surgery as it had not accomplished what she wanted • 1 patient dressed as a man but didn't felt as feminine nor masculine
Bouman, 1988	Work and social acceptance
De Cuypere et al, 2006	• Transmasculine = Physiologic period before GAS (delusional disorder-erotomaniac type), scored very low in credibility • Transfemenine = Emotionally troubled by a break-up with his girlfriend
Imbimbo et al, 2009	NS
Jiang et al, 2018	Didn't want to wait genital electrolysis prior vaginoplasty
Kuiper et al, 1998	• 4 patients mentioned they were not transsexual • 1 patient after surgery she realized she did not want to live as a woman. 1 never wished for the surgery (forced by the partner) • 2 patients lost the partner and had social problems • 1 patient had no doubts (double role requested by the partner)
Lawrence, 2003	• 8 patients felt disappointed with physical or functional outcomes of surgery (lost clitoris sensation) • 2 participants reported reversion to living as a man after GAS. There were family and social problems
Olson-Kennedy et al, 2018	NS
Pfafflin, 1993	NS
Van de Grift et al, 2018	• Transmasculine = Body does not meet the feminine ideal • Transfemenine = Recurrent abdominal pains, dependence on exogenous hormones
Wiepjes et al, 2018	• 5 patients had social regret (still as their former role/"ignored by surroundings" or "the loss of relatives is a large sacrifice") • 7 patients had true regret (though that the surgery was the solution) • 2 patients felt non-binary
Zavlin et al, 2018	NS
Judge et al, 2014	NS
Weyers et al, 2009	NS
Poudrier et al, 2019	Aesthetic outcomes
Laden et al, 1998	NS

NS, not specified.

Bustos et al., 2021

25

Regret Comparisons

- Breast Reconstruction in cis women-47% (Sheehan et al., 2008)
- Vascular surgeries -14.2% (Anderson et al., 2021)
- Prostate surgeries-13-20% (Wallis et al., 2022, Schroeck et al, 2008)
- Knee Replacement-10-14% (Choi & Ra, 2016, Cassidy et al., 2023)
- Hip Replacement-4% (Cassidy et al., 2023)

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26

What's the Harm?

- Damage to families-fueling fear
- De-legitimizes trans experiences
- Runs counter to the body of studies of GI
- Mischaracterization harms the integrity of science and law
- Language used to justify reparative therapy
- Used as part of the rhetoric in anti-trans policy
  - Missouri AG used this narrative as reasoning for side stepping the state legislature to ban gender affirming medical care for youth

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27

What's the Harm?

- The affirmative model is presented as a way to move away from the question of, "How should children's gender identities develop over time?" toward a more useful question: "How should children best be supported as their gender identity develops? Temple-Newhook et al., 2018 (APA)

- The approach is also influenced by a group of early studies with validity concerns, methodologic flaws, and limited follow-up on children who identified as TGD and, by adolescence, did not seek further treatment ("desisters"). More robust and current research suggests that, rather than focusing on who a child will become, valuing them for who they are, even at a young age, fosters secure attachment and resilience, not only for the child but also for the whole family." AAP 2018

28

Current Studies

- Existing evidence suggests that gender-affirming medical care results in favorable mental health outcomes:-
  - Lower odds of past-year suicidal ideation and past year severe psychological distress
  - Access to gender-affirming hormones during adolescence was associated with a lower odds of these same adverse mental health outcomes when compared to not accessing gender-affirming hormones until adulthood. (Turban et al., 2022)
- Lower odds of depression and suicidality among young people who had started gender-affirming medical care, when compared to those who did not. (Torodoff et al., 2022)
- 82.5% reported at least one external driving factor for desistance: pressure from family and societal stigma (Turban et al., 2021)
- Statistically significant improvements in body dissatisfaction, depressive symptoms, and anxiety symptoms.(Kuper et al., 2020)
- Transgender adolescents in the study who received gender-affirming hormones had statistically significant improvements in several mental health measures, including anxiety and depression. (De Lara et al., 2020)

Compiled by Turban 2022

29

How Do We Identify Pseudoscience?

- Research Design Matters!
  - Who funded the research? (Ulterior motives?)
  - What type of research design? Did their conclusions match the design?
  - Are their methodologies sound?
  - Are the hypotheses testable?
  - Burden of Proof-did they provide adequate evidence to support claim?
- Is it science or "bigotry masquerading as science?" (-Laura Jacobs)
  - Appears as science to spread misinformation

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30

Examples of Science Bias

- "Childhood-onset gender dysphoria has been shown to have a high rate of natural resolution, with 61-98% of children reidentifying with their biological sex during puberty"- Texas AG: Paxton

- Quoted SEGM- "Society for Evidence Based Gender Medicine"
  - Known for spreading misinformation
  - Not recognized as a scientific organization
  - Anti-trans Bias
  - Similar group: ACP-American College of Pediatrics (also not recognized)

Alstott et al.,2022; Boulware.et al., 2022

31

Helping Families

- Affirming Therapy is Family Therapy
  - Address caregivers(s) attitudes, knowledge and worries
    - Learn and explore their view on gender/orientation
    - Reduce distress/anxiety with reflection and psychoeducation
    - Help family navigate issues related to disclosure, extended family, school, community, social, etc.

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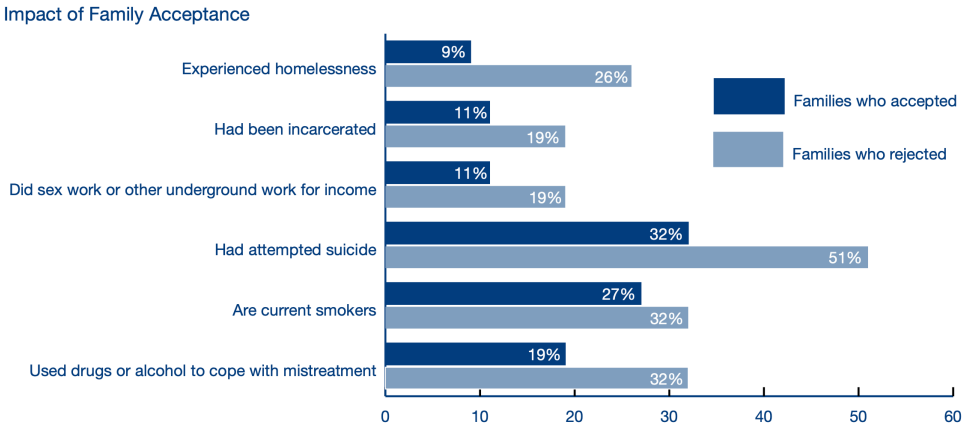
32

Family Support



National Center For Trans Equality 2020

33

Resources

- American Academy of Pediatrics (AAP)
- American Academy of Child and Adolescent Psychiatry
- Endocrine Society
- American Medical Association,
- American Psychological Association
- American Psychiatric Association
- World Professional Organization for Transgender Health

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34

Contact Information

I provide gender affirming therapy to all ages, as well as offer supervision to LPC candidates and consultation to other providers, schools, organizations and other community leaders.

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35

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36

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37