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# Supporting autonomy in young people with gender dysphoria: psychotherapy is not conversion therapy

Roberto D'Angelo

The Institute of Contemporary Psychoanalysis, Los Angeles, California 90064, USA

**Correspondence to**
Dr Roberto D'Angelo, The Institute of Contemporary Psychoanalysis, Los Angeles, CA 90064, USA;
roberto@robertodangelo.com

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## ABSTRACT

Opinion is divided about the certainty of the evidence base for gender-affirming medical interventions in youth. Proponents claim that these treatments are well supported, while critics claim the poor-quality evidence base warrants extreme caution. Psychotherapy is one of the only available alternatives to the gender-affirming approach. Discussion of the treatment of gender dysphoria in young people is generally framed in terms of two binary approaches: affirmation or conversion. Psychotherapy/exploratory therapy offers a treatment option that lies outside this binary, although it is mistakenly conflated with conversion therapies. Psychotherapy does not impose restrictive gender stereotypes, as is sometimes claimed, but critically examines them. It empowers young people to develop creative solutions to their difficulties and promotes agency and autonomy. Importantly, an exploratory psychotherapeutic process can help to clarify whether gender dysphoria is a carrier for other psychological or social problems that may not be immediately apparent. Psychotherapy can therefore make a significant contribution to the optimal, ethical care of gender-dysphoric young people by ensuring that patients make appropriate, informed decisions about medical interventions which carry risks of harm and have a contested evidence base.

The treatment of gender dysphoria in children and adolescents is one of the most polarising and contested issues facing psychiatry today. The Royal Australian and New Zealand College of Psychiatrists (RANZCP) articulates the central controversy in Position Statement 103, namely that 'evidence and professional opinion is divided as to whether an affirmative approach should be taken in relation to treatment of transgender children or whether other approaches are more appropriate'.[1] The recent Cass Review[2] and subsequent National Health Service (NHS) Interim Service Specification[3] highlight the uncertainty about whether gender-affirming medical interventions or psychosocial and mental health interventions (including exploratory psychotherapy) are most helpful and safe for young people experiencing gender dysphoria. The divergent views on how best to respond to young people with gender distress present clinical and ethical challenges for clinicians working in this area.

## THE EVIDENCE FOR GENDER-AFFIRMING INTERVENTIONS: OPINION IS DIVIDED

The gender-affirming approach, which involves various combinations of social transition (changes to appearance, names, pronouns, official documents, etc), endocrine treatment (puberty blockade and cross-sex hormones) and surgical interventions, has increasingly become the dominant treatment paradigm.[4 5] However, professional opinion is indeed divided regarding gender-affirming medical and surgical treatments for youth.[6 7] On the one hand, they have been widely supported by many professional medical organisations, particularly in the USA.[8–10] Proponents argue that gender-affirming interventions for youth are well established and safe treatments that have been shown to improve mental health outcomes and may even be life-saving.[11 12] They point to numerous studies reporting improvements in depression, anxiety and suicidal ideation in young people receiving medical interventions (see Coleman *et al*[5] for an overview of publications supporting gender-affirming interventions).

In contrast, European health authorities have conducted systematic reviews of studies examining the effectiveness and risks of medical interventions and have found that the evidence, including those studies reporting positive outcomes, was of very low quality and at high risk of bias, rendering any conclusions uncertain.[13–16] A rating of very low quality indicates that the true effect of the study intervention is likely to be substantially different from what the studies report.[17 18] Notably, the Swedish Health Authority concluded that the risks of hormonal interventions for youth do not outweigh the benefits at the population level.[15] Systematic reviews in Finland and the UK have led to significant revisions of official guidance on gender-affirming medical interventions, restricting their availability and limiting them to research settings.[3 19] Notably, the strong endorsement of gender-affirming medical interventions for youth by US medical bodies is not based on systematic reviews of their benefits.

Furthermore, critical analyses have cast doubt on whether the outcome data actually support claims that medical and surgical interventions result in substantial psychological benefits or reduced suicidality.[20 21] Some researchers have found that youth who had psychiatric problems before transition are no better off after transition and continue to struggle with these problems.[22] Notably, apart from a single case report,[23] no long-term studies have evaluated the physical and mental health outcomes of adolescents who have undergone gender-affirming interventions beyond very early adulthood. While influential organisations warn that delaying gender-affirming medical treatments is harmful to young people,[5 9] there is no longitudinal evidence to support this claim. The only prospective study comparing a treated and untreated group of gender-dysphoric adolescents found no difference

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in psychosocial functioning between those receiving puberty blockers and psychosocial support, and a comparison group receiving only psychosocial support.[24] Another study found that the majority of adolescents who were denied gender reassignment chose not to pursue gender transition as adults.[25] Studies which raise question about the benefits of gender-affirming interventions, however, are also of poor quality, as are all studies included in the National Institute for Health and Care Excellence reviews.[13 14]

Puberty blockers, once thought to be fully reversible, are now known to have significant impacts on bone density[26–28] and, when followed by cross-sex hormones, are likely to cause infertility.[29] There are also questions about whether they affect brain development.[2 14] In particular, while puberty blockers are often understood to provide a 'pause',[23] allowing the young person time to explore their gender and consider future treatment, virtually all children who start puberty blockade progress to cross-sex hormones.[30–33] Cross-sex hormones cause irreversible cosmetic changes such as deepening of the voice, breast growth and balding. Long-term hormone therapy has long been known to increase the risk of cardiovascular disease, stroke and cancer, leading to a black box warning for these drugs in the USA.[34 35] Gender-affirming surgeries are irreversible and entail significant risks, including loss of sexual function, infertility, fistula, urinary incontinence or stenosis, numbness or chronic pain,[36 37] and even death.[38]

The polarised appraisals of the outcome literature regarding the efficacy and safety of medical interventions are at the heart of the dilemma articulated by the RANZCP. Healthcare practices and policies in relation to youth with gender distress vary widely, depending on how clinicians and policymakers evaluate the research. In the USA and Australia, many states are working towards easier access to medical intervention, with some introducing models of care for adolescents over the age of 16 years that no longer require any evaluation or even parental support.[39] At the same time, an increasing number of states are introducing legislative bans on gender-affirming medical interventions for minors.[40] In Europe, a growing number of countries, including the UK, Finland and Sweden, have sharply curtailed medical interventions for trans-identifying youth and now recommend psychosocial interventions as first line.[3 15 41 42] Given the absence of long-term follow-up studies and the low quality of the evidence base, it is impossible to know which approach is most likely to achieve long-term resolution of gender dysphoria, improved functioning and better mental health outcomes while minimising the risk of iatrogenic harm.

## PSYCHOTHERAPY: THE EVIDENCE

One of the only available alternative approaches to the highly medicalised affirmative model of care for gender dysphoria in youth is psychotherapy. However, the evidence supporting psychotherapy for gender dysphoria is even more limited than that for medical treatments, consisting primarily of case reports and small case series (eg, 43–50). Nevertheless, despite the limited evidence for their efficacy for gender dysphoria, individual and family psychological interventions, including psychodynamic, cognitive–behavioural and systemic approaches, are generally considered safe and are the established foundations of child and adolescent mental healthcare.[51 52] They have been helpfully applied to diverse forms of psychological distress, including conditions associated with distress about the body and identity problems, suggesting their applicability and likely helpfulness for patients experiencing gender distress. Importantly, a substantial evidence base supports the efficacy of psychodynamic psychotherapy for a wide range of conditions,[53–58] including those affecting children and adolescents.[59] Furthermore, researchers highlight that psychotherapy can be considered 'transdiagnostic' rather than diagnosis specific, making it applicable to a range of emotional disorders.[54] Importantly, while numerous potential harms of gender-affirming interventions have been established, there is no evidence that appropriate, non-pathologising psychotherapy causes harm to trans-identified youth.

Consideration of psychotherapy as a first-line treatment for gender dysphoria consistently raises concerns about the potential harms of delaying medical intervention and allowing a young person to go through an unwanted puberty.[60 61] As with most other research in this area, the evidence to support this concern is of low quality. For example, a cross-sectional study found an association between puberty blockade and reduced suicidality, but the study, which was based on a convenience sample, could not determine the direction of causality.[62] And in a sample of teens with gender dysphoria, those who presented at an older age had poorer mental health than those who presented at a younger age.[63] While this may suggest that early medical treatment is beneficial, as the study authors claim, this study also could not prove causality. An equally likely hypothesis is that these studies indicate that young people with later-onset gender dysphoria have more mental health problems, a phenomenon reported by researchers across the western world.[64 65] Dutch researchers have warned that the recent unprecedented increase in adolescent-onset gender dysphoria represents a change in the presentation of this condition. These researchers have raised questions about whether the positive outcomes they observed in the early-onset group will apply to young people with adolescent-onset gender dysphoria, who now make up the vast majority of child and adolescent referrals.[66]

This presents clinicians with an ethical dilemma in which they have no reliable data with which to weigh up the potential impact of delaying medical interventions, with the risks of these treatments, and the potential benefits or risks of providing psychotherapy instead of medical intervention. There is a notable absence of research literature comparing psychological interventions with gender-affirming interventions for young people with gender dysphoria. One small study comparing adolescents treated with puberty blockade with those receiving psychotherapy alone found that there was no significant difference between the two groups at the study endpoint.[24] There is an urgent need for robust research to assess the benefits and any possible risks of psychotherapy in this patient group, as well as reliable research to investigate the impact of delaying medical intervention.

## THE CONFLATION OF PSYCHOTHERAPY WITH CONVERSION THERAPY

Gender dysphoria in both adults and minors encompasses a range of experiences involving distress about and preoccupation with one's natal sex, particularly the sexed body, and with the gender roles associated with that sex. Individuals commonly report distress over a *sense of incongruence* between their experienced gender and their natal sex. The focus on incongruence as the central problem has shaped public and clinical discourses, leading to an assumption that there are only two possible approaches to treatment, each of which attempts to address the experience of incongruence in different ways. The first is the gender-affirming approach, which provides social, medical and surgical interventions to alter the body/appearance so that

it is experienced as more aligned with the individual's experienced gender.[5 67] The second approach to incongruence seeks to change the subjective experience of gender by aligning the mind with the body. It aims to help the person to accept their sexed body as it is and to live as the gender they were assigned at birth. Some claim that this approach is a form of 'conversion therapy'.[68–70]

The term 'conversion therapy' was originally coined to describe interventions designed to make same-sex attracted people heterosexual, using psychological, behavioural, aversive or faith-based approaches. These interventions are now considered to be both ineffective and harmful.[71] In the UK, gay conversion therapy consisted mainly of aversion therapy.[72] There are no data to determine how common the other forms of conversion therapy were. It is important to note that trans-sexuals, as they were known at the time, were never routinely offered aversion therapy—instead, the clinical response involved determining whether the patient was suitable for medical gender reassignment.[72] Conversion therapy is now illegal in several states in Australia,[73] the USA,[61] and an increasing number of countries worldwide have bans in place or are working to introduce them, including the UK. Statements and bans on conversion therapy usually problematically merge gender identity with sexual orientation, which is misleading as these are very different constructs.[72 74] Further, the appropriateness of grouping aversive and other conversion techniques applied to gay adults in the past with exploratory therapy for gender-distressed youth today is highly questionable.[72 74]

In the mid-20th century, many psychoanalytic practitioners, in both the USA and the UK, believed that homosexual behaviour was pathological, arguing that it was a perversion or developmental fixation, or that it was driven by phobic avoidance or neurotic conflict.[75 76] Gay men and lesbians were excluded from training in American Psychoanalytic Association institutions until 1991[75] and from British analytical training programmes until the early 2000s.[76] Influential psychoanalytic writings from the 1960s to the 1980s recommended that analysts should take a directive stance in working with patients and actively discourage homosexual behaviour.[77] It is not clear for how long or to what extent this 'directive-suggestive' approach was representative of the way most analysts actually practised at the time,[77 78] but most psychoanalytic writing about homosexuality in the 20th century was unequivocally pathologising.[75 76 79] The psychoanalytic view that homosexuality should be treated was not based on science but was a collusion with the widespread xenophobia and conservatism of the time.[79] Psychoanalysis ignored the emerging science being produced by sexologists such as Kinsey, which demonstrated that homosexuality was not pathological.[75] Thankfully, psychoanalytic theory and practice have changed dramatically since then, and most contemporary psychotherapists and psychoanalysts would agree that attempts to direct or coerce change in an individual's sexual orientation or gender identity have no place in healthcare. However, the unfortunate legacy of this era is that psychotherapy and psychoanalysis are now viewed with suspicion when applied to sexuality and gender-diverse individuals.

Against this background, psychotherapy has become increasingly controversial as an appropriate approach to gender dysphoria in young people. Critics of psychotherapeutic work with gender dysphoria argue that it aims for a 'cisgender' outcome, particularly when it explores whether gender distress is secondary to other issues.[80–82] This assertion is based on a mistaken assumption about the purpose of psychotherapy and is evidence of the continuing effects of psychoanalysis' troubled history with regard to homosexuality. The conflation of psychotherapy with conversion therapy is arguably also a consequence of the pervasive binary[83] within which affirmation or conversion have become the only available ways of conceptualising responses to trans-identified youth. This conflation is evident in a statement from the Australian Professional Association for Transgender Health (AusPATH): 'The AusPATH Board do not support 'exploratory therapy' which is often used as a euphemism for conversion therapy'.[84] It is also promoted by in publications written by advocates of medical transition, claiming that gender-exploratory psychotherapy and conversion therapy share many conceptual similarities.[82 85]

In the rapidly evolving and heated political climate surrounding healthcare for trans youth, clinicians may assume that anything other than the gender-affirming approach, particularly psychotherapy, is 'conversion therapy'.[86 87] This is also fuelled by conversion therapy laws, which are often unclear as to whether exploring rather than immediately affirming constitutes conversion therapy.[86 88 89] Some conversion therapy bans are so broad that they potentially put clinicians at risk of prosecution for providing exploratory psychotherapy.[86] In response to this conflation, the British Psychoanalytic Council has expressed concern that exploratory therapies may be outlawed by conversion therapy bans.[90] This has far-reaching implications for psychiatric practice, as exploratory therapy is synonymous with psychodynamic psychotherapy,[91] a treatment modality endorsed by the Royal College of Psychiatrists[92] and the RANZCP.[57]

To suggest that psychotherapy is a form of conversion therapy betrays a fundamental misunderstanding of psychotherapy. Psychotherapy *resides outside the affirmation-conversion binary* and aims to address the *distress* of gender-dysphoric youth *rather than to correct a sense of misalignment*. Psychotherapy does not attempt to force change or impose any predetermined notion of 'cure' or preferred gender or sexual orientation on the patient. A core ethical principle of psychotherapy is that therapists must respect patient autonomy and self-determination[93] and refrain from any attempt to influence the patient. A priori assumptions, either that trans identification is *always a healthy development* or that trans identification is *always pathological,* violate this foundational principle. A genuine psychotherapeutic process starts from a position of not knowing and seeks to open things up. Anything else is a misuse of psychotherapy. Mitchell, one of the most prominent voices in late 20th-century American psychoanalysis, made this clear four decades ago when he warned that a 'directive-suggestive' approach to homosexuality contravenes 'several fundamental principles of sound psychoanalytic practice'.[77] The same is true of therapeutic work with gender dysphoria.

## PSYCHOTHERAPY SUPPORTS AUTONOMY

The gender-affirming approach holds that patient autonomy is best protected when we allow the young person to take the lead in making decisions about treatment and transition.[4] Psychotherapy is also a patient-led process that privileges autonomy. However, psychotherapists believe that the best way to support autonomy is to help patients to know themselves, including how their current experience has been shaped by past and present relational and contextual factors, some of which may be beyond their awareness. Psychotherapy is a collaborative process of curiosity and exploration that helps individuals locate and illuminate the origins of their distress so that durable, meaningful solutions can be generated. Psychotherapists working at depth with trans youth often find that gender issues are nested within complicated

psychosocial, family and/or developmental issues or that trans identification is a proxy or carrier for other difficulties.[45 94–99] Experienced psychotherapists know that the traumatic or developmental origins of emotional distress often only become apparent after many, many months of careful exploratory work. Dealing with these issues sometimes dramatically alters self-experience in a broad range of ways, including the experience of gender dysphoria.[43–50] This cannot occur without a detailed inquiry that questions and explores the patient's presenting difficulties and convictions. Unquestioning affirmation is in itself a form of influence that forecloses a thoroughgoing exploration and potentially compromises autonomy.

But here is the rub: is this not a repetition of that problematic era in our history when homosexuality was thought to be a manifestation of psychopathology, developmental arrest or unconscious conflict? This would be the case if the intention was to impose a preferred, normative outcome on the patient, as some 20th-century psychoanalysts did with gay and lesbian patients. To be clear: *using psychotherapy to impose a moral bias against gender diversity or gender non-conformity is a perversion of the psychotherapeutic process*. However, there is a significant difference between homosexuality and trans identification. Transgender identification sometimes involves invasive, irreversible body alterations with uncertain long-term benefits and known risks,[15 16 30 81 82] so the stakes are much higher than for young people exploring their sexual orientation. A person whose sexual orientation changes at some point in the future is in a very different position to a person whose gender identity changes after undergoing irreversible gender-affirming treatments, which they may regret and feel damaged by. The growing number of online testimonials from detransitioners[i] illustrates the potential adverse outcomes that can occur. While detransition and regret were previously thought to be vanishingly rare, emerging evidence suggests that it may be a much more common outcome.[100–102] Recent publications indicate that up to 30% of people who start hormone therapy as minors will discontinue within a few years.[103–106] By this time, they will already have undergone irreversible physical changes. Although not all patients who detransition or discontinue treatment will experience regret, it is likely that many will. Most clinicians would agree that such adverse outcomes should be avoided and this is where psychotherapy can make a crucial contribution.

Psychotherapy empowers gender-distressed youth to make truly informed choices about their lives. By helping patients gain greater clarity about the sources of their distress, which are often more complex than initially thought, they will then be in the best position to determine whether gender-affirming interventions will bring the benefits they hope for, whether they may do more harm than good or whether the solution lies elsewhere. Psychotherapy can make a crucial contribution to this process by helping patients to consider whether trans identification will be liberating and growth promoting or whether it is a carrier for other previously unaddressed or even unacknowledged difficulties. Recent publications suggest that most detransitioners feel they did not receive adequate exploration, with most subsequently realising that their gender dysphoria was not simply a matter of identity or gender diversity as they initially thought.[107] Many came to understand that their gender distress was secondary to other issues, such as mental health conditions, trauma, internalised homophobia or internalised misogyny.[108]

## WHEN GENDER DYSPHORIA IS A MANIFESTATION OF OTHER ISSUES

A 2021 report on conversion therapy commissioned by the UK government specifically identifies talking therapies as a common form of conversion therapy.[109] The report claims that mental health professionals who treat minority gender identities as symptoms of mental illness may be practising conversion therapy. On the other hand, the NHS has recently emphasised that gender dysphoria *may in fact be secondary to other difficulties*. The recent Interim Service Specification states that gender incongruence may be related to mental health problems, neurodevelopmental issues, or family and psychosocial complexities in ways that 'may not be readily apparent and will require careful exploration'.[3] These conflicting positions reflect the central debate in the field, which lies at the heart of uncertainty about whether gender-affirming treatments or psychological interventions are most appropriate. Opinion is divided as to whether clinicians should explore whether a patient's trans identification is a manifestation of other difficulties or whether they should accept trans identities at face value as a normal variation of human gender. However, even Diane Ehrensaft, an influential gender clinician and vocal proponent for the 'normal variation' perspective and the gender affirming approach[67] acknowledges that psychotherapists 'have the tools to decipher whether a child's gender expansive articulations could possibly be a solution to or a symptom of another life problem or underlying psychiatric issue'.[110]

If we accept that some people will be helped by transition and some will not, then the most important ethical responsibility for clinicians is to explore whether gender dysphoria is a manifestation of another problem. As the NHS has noted, these problems are not always easy to identify, suggesting that inadequate exploration increases the risk that they may be missed, leading to misdiagnosis. As a result, patients may not receive appropriate and necessary interventions that comprehensively address their difficulties, leaving their core issues unaddressed and untreated.[107] Furthermore, failure to explore exposes these patients to interventions that will ultimately be unhelpful and carry a significant risk of iatrogenic harm. Indeed, the psychotherapeutic 'deep dive' into the child's or young person's experience recommended by Ehrensaft is arguably essential to ensure safe, informed and effective care for gender-distressed youth. The reality is that many, if not most, young people are not offered the opportunity to engage in self-reflection with the support of a qualified clinician in order to understand themselves more deeply before undergoing medical gender transition. Assessments for medical interventions are often brief, taking place over only a handful of sessions, and are often based on the belief that the young person's self-identified gender should be affirmed.[87 111 112] The USA is increasingly moving towards a model of care for people over 18 years that no longer requires any psychological assessment prior to initiating treatment. This approach is also recommended for adolescents,[113] and clinics that operate according to this model offer to prescribe hormones on the first or second visit for young people aged 16 years and over.[39]

This trend is arguably a consequence of a perspective that views trans identity not just as a normal variation but as an intrinsic, even constitutional aspect of human experience. If we accept this reification of gender identity, detailed psychological

[i]'Detransition' refers to stopping or reversing a transition and can involve social and legal changes, discontinuation of endocrine medications, surgical intervention to reverse the effects of transition or varying combinations of the above.[100]

exploration is misguided and unnecessary. Contemporary theorists present a more fluid view of gender identity development, arguing that it is an emergent phenomenon that arises at the intersection of multiple interacting systems.[96] Gender is 'softly assembled', evolving in a non-linear fashion, and shaped by the current context and the individual's relational and developmental history.[114] This model of gender, based on complexity theory, asserts that small shifts in component subsystems can lead to large, unexpected and unpredictable changes. This applies to psychotherapy, which can result in significant shifts in self-experience that cannot be predicted at the outset. In addition to elucidating the idiosyncratic shaping of each person's gendered experience, psychotherapeutic exploration can also be a catalyst for further growth, evolution and change. How we respond to gender-distressed youth is therefore profoundly shaped by whether gender is conceptualised as a reified property of the individual or as 'softly assembled'. This raises important questions about how best to facilitate the non-linear development of gender without prematurely foreclosing possibilities.

## PSYCHOTHERAPY AND INFORMED CONSENT

Informed consent for gender-affirming interventions in young people presents particular ethical dilemmas for clinicians. Young people, their families and clinicians are faced with decisions about treatments with uncertain long-term risks and benefits.[115] Furthermore, the age at which adolescents are considered developmentally capable to provide informed consent or assent varies and remains controversial. Specifically, in the context of gender-affirming care, younger patients may not understand the full range of possibilities of living as a gender non-conforming or queer person, or the sexuality options available to them.[115] They are also unlikely to appreciate the importance of fertility preservation as evidenced by the very low uptake of fertility preservation among trans-identified youth.[116] In addition, young patients seeking relief from distress may not understand or may disavow the potential seriousness of long-term adverse effects, such as bone loss, heart disease and loss of sexual function. The consent process is further complicated by differing opinions about the adequacy of the evidence base for gender-affirming medical treatments and emerging rates of detransition, which require balanced discussion and reflection.[111] The Cass Review highlighted this issue, finding that patients, families and carers did not have adequate access to accurate and balanced information to make informed treatment decisions.[2]

Most importantly, for the purposes of this paper, the fact that gender dysphoria may be related to other psychosocial problems in ways that are not initially apparent to the patient, clinician or family is crucial to the informed consent process. Informed consent is seriously compromised if the patient and clinician have an inaccurate or incomplete understanding of the cause of the patient's distress or problem. Currently, we have no screening tools or protocols to determine in which individuals' gender dysphoria is a carrier for another psychosocial or mental health issue. Similarly, we have no reliable way of predicting which young people will be helped by transition and which will not. The best, and arguably only, tool we have is detailed psychotherapeutic exploration that extends over a long enough period to allow significant, previously unknown or unconscious issues to become available for reflection. To make an informed decision, we need to have all the facts. This arguably includes those facts that are not 'readily apparent'[3] or outside awareness. If we accept that some of the factors that shape individuals' decisions about medical transition are not conscious and take time to access, then robust informed decision-making is not possible without a detailed psychotherapeutic process that attempts to open up previously unacknowledged difficulties or areas of experience.[98] Sensitive psychotherapeutic exploration is not about paternalism or gatekeeping. On the contrary, it protects autonomy by providing a space for careful, nuanced reflection in which complex, shared decision-making is encouraged and facilitated.

## PSYCHOTHERAPY AND GENDER NORMATIVITY

Finally, critics who claim that exploratory psychotherapy is conversion therapy argue that it imposes gender normativity on the patient.[68 80 82] This is a misrepresentation of contemporary psychotherapeutic practice. Psychotherapy has evolved dramatically in recent decades, interrogating its earlier normative assumptions, exploring sociopolitical influences on mental life, and addressing homophobia, misogyny, and the social construction of gender. An essential aspect of psychotherapeutic work with young people with gender dysphoria is to explore the specific, idiosyncratic meanings associated with the unwanted gender and the desired gender and how regressive ideas about gender may underpin them. Psychotherapy provides a space in which patient and therapist can question the assumptions and regulatory discourses that underpin why certain qualities, behaviours, identities and sensibilities are associated with particular body configurations, types of dress, gender signifiers, etc. They may question whether transition is truly gender expansive or whether it perpetuates those very norms that the young person finds oppressive. Thinking critically about these gender norms invites young people to generate heretofore unimagined ways of embracing gender diversity that are arguably safer than gender-affirming interventions.

## CONCLUSION

To suggest that exploratory therapy or psychotherapy for gender dysphoria is de facto conversion therapy is to mischaracterise psychotherapy as a process that seeks to impose gender conformity and normative sexuality on the patient. This misunderstanding is a consequence of the mid-20th century psychotherapeutic approach to homosexuality, which was pathologising, morally driven and *ignored the science*. In contrast, the rationale for psychotherapy for young people with gender dysphoria emerges from *a careful appraisal of the science* highlighting the uncertainties and risks of gender-affirming treatments. The inclusion of psychotherapeutic exploration in the response to young people with gender distress is not based on a moral imperative but on an ethical one. Any intervention, including psychotherapy, can be misused to exert undue influence and impose a preferred outcome. Public and clinical discourses that emphasise the misuse of psychotherapy over the wide-ranging benefits of a rigorous psychotherapeutic process effectively throw the unjustly demonised baby out with the bathwater. Importantly, for gender-distressed youth and their families, this mischaracterisation creates a barrier to accessing a valuable therapeutic modality that supports autonomy, gender diversity, the provision of appropriate care and fully informed consent.

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**ORCID iD**
Roberto D'Angelo http://orcid.org/0000-0003-2929-3831

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