Affirmation and Social Transition

The practices of 'affirmation', social transition and chest binding are often promoted as harmless as they do not involve any medical treatment or intervention. Here we look at the evidence of the safety and potential effects of these very recent developments which have quickly become widespread.

Read our two articles by an experienced clinical psychologist on the risks of social transition here:

Pre-pubertal children: **A childhood is not reversible**

Adolescents: **When a teenager says they're transgender**

What is affirmation?

Affirmation, or the 'gender affirmative' approach, is the affirmation of a child's gender identity. In practice this means affirmation of a boy's belief that he is really a girl, or affirmation of a girl's belief that she is really a boy.

What is a social transition?

A social transition is when someone decides to live in the role of their chosen sex. This can involve a name change and use of different pronouns. A person's new gender can be expressed by the use of hairstyles and clothes. It can be full-time, only exhibited in certain settings or just at home. These transitions do not involve any medical, physiologic or hormone intervention.

Social transition is currently controversial in clinical psychology and psychiatry, but is increasingly being pursued by parents. More and more paediatricians, therapists and teachers are supporting these transitions. Schools are increasingly accommodating the social transition of pupils with name changes, uniforms and toilet provision. There are some examples of social transitions occurring in children as young as 2-3 years old.

It is unknown how many children have already socially transitioned or if these children do so under the guidance of gender specialists or do so independently. We recently submitted a Freedom of Information (FOI) request to the children's gender identity clinic (Tavistock). We asked how many children referred last year had already undergone a social transition before attending their first appointment. We are told they do not hold any records of this information.

It may appear harmless and easily welcomed as a beneficial approach that can relieve gender dysphoria symptoms in children. However, it is currently unclear what the long-term psychological effects will be for children who undergo social transitions for some or all of their childhood and how this impacts on the development of their sense of self.

What little evidence we do have indicates that affirmation and social transition may fix a child into an identity they may have grown out of if left alone.

To understand the impact of the very recent trend to affirm and socially transition a child (known as the 'gender affirmative' approach) we compared the research and evidence for this approach v the previous 'watch and wait' approach.

The Watchful Waiting Approach

Under the globally established model of 'watchful waiting' children were not affirmed as the opposite sex or socially transitioned. They may have been given some developmentally-informed counselling/family therapy to assess the possible factors which may have led to a cross-sex identity, but were otherwise left alone. At that time transsexualism was seen as a possible adult outcome, not a childhood condition. Eleven published studies exist relating to rates of desistance v persistence of gender dysphoria starting in early childhood. This analysis of all these studies shows that **around 80% grew out of these feelings during puberty** and the most likely outcome is that these children will turn out to be gay.

The most recent study (Singh et al, 2021) replicates these findings. Using the largest sample to date, with a follow-up mean age of 20.58 years, the study found only a 12.2% persistence rate. 87.8 % desisted and 63.6% grew up to be gay.

A review of the literature (Korte et al, 2008) found:

> *'Only 2.5% to 20% of all cases of GID in childhood and adolescence are the initial manifestation of irreversible transsexualism.'*

There are no published studies showing that the watchful waiting approach caused harm or had any negative consequences for children. The majority of children desisted during puberty and it was considered that children who persisted in a cross-sex identity into adolescence were likely to be transsexual as adults. Children were offered puberty blockers at age 16 after puberty – and fertility – had become well established. The approach changed not because of clinical research and evidence of harm, but because of adult activism and the reframing of this group of children as 'transgender' and their treatment as a political rights issue.

The Affirmation and Social Transition Approach

There have been various claims made that these previous studies are unreliable and this has been termed 'the desistance myth' by activists. **A rebuttal** to one paper making such claims was written by Dutch researchers (Steensma, Cohen-Kettenis, 2018), which references the very recent phenomenon of social transition in a 2011 study (**Steensma & Cohen-Kettenis, 2011**):

> *'With regard to the topic of social transitioning, one should bear in mind that before the year 2000 we only saw one pre-pubertal child who desired a social transition and the number only slowly increased in the next few years'*

And goes on to state:

> *'Recently the number of children who already had transitioned at their first visit to the clinic has exploded. For these families the question of whether or not the child should transition is obsolete.'*

The findings of a **2013 research study** by Dr Steensma indicated that social transition is the most powerful predictor of persistence of childhood gender dysphoria. There is now strong evidence that puberty blockers also increase persistence, as evidenced by the results of the **Tavistock GIDS Early Intervention study**:

> *'44 patients had data at 12 months follow-up, 24 at 24 months and 14 at 36 months. All had normal karyotype and endocrinology consistent with birth-registered sex. All achieved suppression of gonadotropins by 6 months. At the end of the study one ceased GnRHa and 43 (98%) elected to start cross-sex hormones.'*

Various clinicians and researchers have expressed the need for caution in socially transitioning pre-pubertal children.

A paper by De Vries (2012) warns of the danger that a young child who is unduly affirmed may not really understand the concept of natal sex:

> *'Another reason we recommend against early transitions is that some children who have done so (sometimes as preschoolers) barely realize that they are of the other natal sex. They develop a sense of reality so different from their physical reality that acceptance of the multiple and protracted treatments they will later need is made unnecessarily difficult. Parents, too, who go along with this, often do not realize that they contribute to their child's lack of awareness of these consequences'.*

Tavistock GIDS Consultant clinical psychologist Bernadette Wren also expressed the need for caution in her **paper** for the Journal of Clinical Child Psychology and Psychiatry (2019):

> *'It is my belief that we need to make creative opportunities for the open, accepting exploration of the gender experience and gender expression of these younger children; my fear is that to proceed to a full emphatic social transition may hamper their development'.*

In a 2020 paper 'Different strokes for different folks', Dr Kenneth Zucker pointed out that:

> *'A gender social transition in prepubertal children is a form of psychosocial treatment that aims to reduce gender dysphoria, but with the likely consequence of subsequent (lifelong) biomedical treatments as well (gender-affirming hormonal treatment and surgery). Gender social transition of prepubertal children will increase dramatically the rate of gender dysphoria persistence when compared to follow-up studies of children with gender dysphoria who did not receive this type of psychosocial intervention and, oddly enough, might be characterized as iatrogenic.'*

and concluded that:

> *'If this is, in fact, the case, one might ask why would one recommend a first-line treatment that is, in effect, iatrogenic.'*

A recently published study 'Gender Identity 5 Years after Social Transition' (Olson et al 2022) appears to confirm Dr Zucker's prediction. In contrast to the historic average 80% desistance rate, this new study of socially-transitioned children who were affirmed in their opposite sex identity shows a desistance rate of only 6%. After 5 years of affirmation and social transition, 94% of these children were living as transgender and almost two-thirds were using either puberty-blocking medication or sex hormones to medically transition.

Although previous desistance studies are critisised on the basis that some of the children studied were not 'truly trans' but just gender non-conforming, in this study it is reported that children did not even meet the criteria for diagnosis, but only displayed gender non-conforming behaviour:

> *'This study did not assess whether participants met criteria for the DSM-5 diagnosis of Gender Dysphoria in Children. Many parents in this study did not believe that such diagnoses were either ethical or useful and some children did not experience the required distress criterion. Based on data collected at their initial visit, we do know that these participants showed signs of gender identification and gender-typed preferences commonly associated with their gender, not their sex assigned at birth.'*

Parents had clearly diagnosed their children as 'transgender' and supported their child's social transition. The inevitable pathway to medical intervention was also communicated to the children through the course of this study, so children were not presented with other options or ways to conceptualise their feelings:

> *'As part of the larger longitudinal study, parents and youth were regularly asked about whether they had begun using puberty blockers and/or gender affirming hormones.'*

Dr Hilary Cass, who was commissioned by the NHS to carry out an independent review of the Tavistock gender clinic, published an **interim report** this year which included this on social transition:

> *'Social transition – this may not be thought of as an intervention or treatment, because it is not something that happens within health services. However, it is important to view it as an active intervention because it may have significant effects on the child or young person in terms of their psychological functioning. There are different views on the benefits versus the harms of early social transition. Whatever position one takes, it is important to acknowledge that it is not a neutral act, and better information is needed about outcomes.'*

Social transition may fix a child's (and parent's) certainty about treatment with puberty blockers as the child approaches puberty, as acknowledged in the interim report:

> *'From the point of entry to GIDS there appears to be predominantly an affirmative, non-exploratory approach, often driven by child and parent expectations and the extent of social transition that has developed due to the delay in service provision.'*

And that:

> *'By the time they are seen in the GIDS clinic, they may feel very certain of their gender identity and be anxious to start hormone treatment as quickly as possible.'*

Although not covered in the interim report, the Cass Review final report will include "the important role of schools and the challenges they face in responding appropriately to gender-questioning children and young people." In schools across the UK it is now commonplace to socially transition children, often without informing parents. This policy urgently needs to be reviewed in light of the lack of evidence to support this approach as safe.

Adolescents

What we don't have is any research on the affirmation and social transition of adolescents. This group represents an entirely new cohort of children (around 70% girls) who develop gender dysphoria or adopt a transgender identity around puberty or during adolescence. This cohort did not experience gender dysphoria in childhood so are not part of the earlier-studied group who persisted from an early age into adolescence.

The Cass Review interim report references this recent change in the case mix:

> *'This increase in referrals has been accompanied by a change in the case-mix from predominantly birth-registered males presenting with gender incongruence from an early age, to predominantly birth-registered females presenting with later onset of reported gender incongruence in early teen years. In addition, approximately one third of children and young people referred to GIDS have autism or other types of neurodiversity. There is also an over-representation percentage wise (compared to the national percentage) of looked after children.'*

And points out that for this group:

> *'It is not unusual for young people to explore both their sexuality and gender as they go through adolescence and early adulthood before developing a more settled identity.'*

The new gender affirmative approach has not been studied for this group so the approach is entirely experimental. It is a serious issue because this is the age at which medical interventions in the form of blockers and hormones are available for these young people to access (either at a clinic or increasingly, online).

From the Cass Review interim report:

> *'It is also important to note that any data that are available do not relate to the current predominant cohort of later-presenting birth-registered female teenagers. This is because the rapid increase in this subgroup only began from around 2014-15. Since young people may not reach a settled gender expression until their mid-20s, it is too early to assess the longer-term outcomes of this group.'*

And that:

> *'At present we have the least information for the largest group of patients – birth-registered females first presenting in early teen years.'*

Although there is no research on outcomes for this new group, we do have some studies of detransitioners, or those who regret their transition, along with testimonies of a growing group of detransitioners who are speaking out across social media platforms about the harms of the unquestioning 'affirmative' approach they experienced.

Keira Bell legally challenged the Tavistock clinic for prescribing her puberty blockers without thorough investigation into the underlying reasons for her wish to transition.

Writing about her case Keira said:

> *'A lot of girls are transitioning because they're in pain, whether it's from mental-health disorders, or life trauma, or other reasons. I know what it's like to get caught up in dreaming that transitioning will fix all of this.'*

And she makes this plea:

> *'I also call on professionals and clinicians to create better mental health services and models to help those dealing with gender dysphoria. I do not want any other young person who is distressed, confused, and lonely as I was to be driven to conclude transition is the only possible answer.'*

When asked for reasons for detransitioning in **this study** (Littman, 2020), the majority (60%) cited "becoming more comfortable identifying as their natal sex." 49% reported having concerns about potential medical complications from transitioning and 38% said they came to the view that their gender dysphoria was caused by something specifc such as trauma, abuse, or a mental health condition.

Homophobia or difficulty accepting themselves as lesbian, gay, or bisexual was expressed by 23.0% as a reason for transition and subsequent detransition. The majority (55.0%) felt that they did not receive an adequate evaluation from a doctor or mental health professional before starting transition.

In **this study** (Vandenbussche, 2021) around half (51%) of the respondents started socially transitioning before the age of 18, and a quarter (25%) started medically transitioning before that age as well.

The study found:

> *'The most common reported reason for detransitioning was realized that my gender dysphoria was related to other issues (70%). The second one was health concerns (62%), followed by transition did not help my dysphoria (50%), found alternatives to deal with my dysphoria (45%), unhappy with the social changes (44%), and change in political views (43%). At the very bottom of the list are: lack of support from social surroundings (13%), financial concerns (12%) and discrimination (10%).'*

We don't know how many of this recent cohort will subsequently regret their medical transition; published regret studies do not include this group and typically measure regret rates of men who transition in middle age, not children.

But the testimonies of detransitioners should give us pause for thought about the new model of affirmation and social transition, suggesting that there are different reasons for seeking gender change which 'affirmation' may serve to cover up.

What evidence is there that social transitioning is helpful?

A study was published in 2016 that is often cited as proof that gender affirmation within the family and allowing children to socially transition will resolve their gender dysphoria. It is used to support the concept that gender dysphoria is not an inherent part of being transgender. This sets it apart from many other disorders because if someone is depressed, for example, he or she is, almost by definition, distressed as a result of the depression. In contrast, the distress that accompanies gender dysphoria arises as a result of a culture that stigmatises people who do not conform to gender norms.

The study looked at depression and anxiety scores of 73 pre-pubescent children who had been supported by their parents to socially transition. They compared this to age-matched non-transgender siblings and non-transgender peers. No major differences were seen in depression or anxiety in any of these groups. Slightly higher levels of anxiety were shown in the trans group but still only a low level. This contrasted with other studies that have shown that transgender kids who don't socially transition do show elevated depression and anxiety. Link to study is **here**.

However, this study is often misinterpreted because it does not mean social transitioning itself stops the depression or anxiety. It could simply mean that supportive and loving parents reduces the risk. There is no data here on outcomes for gender dysphoria in children with supportive parents who promote a gender non-conforming lifestyle but WITHOUT denying the reality of their biological sex.

- This study also does not prove that gender dysphoria is a not a mental health pathology any different from any other body dysphoria. It simply shows that gender dysphoria is relieved by support and/or social transition as measured by symptoms such as depression and anxiety. An anorexic who was supported and validated in their desire to lose weight may well also present with reduced levels of depression and anxiety. This remains untested as such a study would rightly be deemed unethical.
- This study does not tell us about longer term outcomes of socially transitioning. All these children are pre-pubescent (ages 3-12yrs). This is a time when depression and anxiety levels are generally fairly low anyway. They rise steeply when children hit adolescence. We do not know how these children will fare during this high risk phase and beyond when the consequences of transitioning will really start to hit them. Follow up studies will be done but we won't see those results for at least another 5 years.
- There are also some major limitations inherent in the design of this study. Depression and anxiety scores are based on surveys carried out by their parents. It is likely there will be some unconscious reporting bias here as parents who have decided to actively support social transition will really want their transgender kids to be seen as psychologically healthy.
- It must also be noted that the transgender children in this study are among the first to convince their parents and society to let them socially transition so young. These children may well be unusually articulate/emotionally aware. We can't rule out some unknown confounding factor that is unique to this 'first mover' group that will not been seen as socially transitioning becomes more common and widespread.

Evidence suggests that for pre-pubertal children affirmation and social transition followed by puberty blockers may prevent a natural resolution of gender dysphoria in the adolescent years.

Evidence from detransitioners suggests that for teenagers who develop gender dysphoria during puberty, affirmation and social transition may cover up underlying mental health problems and encourage a child towards a medical 'solution' with lifelong consequences.

The fact remains that the move towards gender affirmation in children is not an evidence-based approach and is experimental. Long-term studies are urgently needed in this area.

Further reading

See related articles:

The Gender Affirmative Model or 'Affirmation' Approach

Johanna Olson-Kennedy and the US Gender Affirmative Approach

Is 'affirmation' an appropriate approach to childhood gender dysphoria? by Stephanie Davies-Arai for Civitas

A History of Affirmation by Bayswater Support Group.

Chest binding

This is an increasingly popular way for females to flatten the appearance of their breasts. Social media and magazines like Cosmopolitan are full of advice on chest binding for young people. As a result it is now very common practice for young females in the transgender community.

Some children have been known to use duct tape wrapped tightly around their torso. Alternatively chest binders and/or multiple sports bras can be used to achieve a flatter profile. Known health risks associated with chest binding include compressed or broken ribs, punctured or collapsed lungs, back pain, compression of the spine, damaged breast tissue, damaged blood vessels, blood clots, inflamed ribs and heart attacks. Link to article here.

A recent study has been conducted to assess the health impact of chest binding in the transgender community. Of the 1800 participants with experience of binding, 51.5% reported daily binding. Over 97% reported at least one of 28 negative outcomes attributed to binding. Compression methods associated with symptoms were commercial binders (20/28), elastic bandages (14/28) and duct tape or plastic wrap (13/28). Larger chest size was primarily associated with dermatological problems.

Chest binding results in difficulties in breathing so will affect levels of activity and overall health in females who choose to bind their breasts. Schools in the UK have been advised to offer longer P.E. breaks to accommodate this.

Further reading:

See related articles:

Breast Binding, Sexual Objectification & Grooming

Breast binders in UK schools