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Do we want to know?

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ABSTRACT

The weak evidence base and profound consequences of gender-affirming interventions for youth call for a particularly sensitive and complex psychoanalytic exploration. However, prohibitions on knowing at the individual and social levels significantly constrain psychoanalytic work with trans-identified youth. Barriers to exploration and thinking that patients bring to treatment are reinforced and reified by the dominant socio-political trends that saturate the contexts in which young people dwell. These trends increasingly frame any attempt to deeply explore why a young person is seeking medical or surgical gender-affirming interventions as “off-limits” and a form of conversion therapy. Furthermore, politically driven clinicians who promote medical gender-affirming interventions misrepresent and attempt to discredit clinicians who explore the meaning and function of trans identification, or who express concern that transitioning may be a drastic solution to various forms of psychic pain. In doing so, they minimise the significance of the weak evidence base for these interventions and their serious, known risks. At the same time, they obscure or deny the psychic pain that is sometimes humming beneath the experience of gender dysphoria. The author asks: If there are significant uncertainties and risks of harm associated with medical interventions for young people, *do we want to know?*

KEYWORDS

Transgender; LGBT;
psychoanalysis; transition;
detransition

Prohibitions on knowing in psychoanalytic work

Elly¹ initially seemed like many of the other teen transgender-identified (“trans”) adolescents I had seen in my practice. She had thought a lot about gender and had researched trans identities and medical interventions extensively online over the past two years. There was a self-assured certainty in how she spoke about herself as a transgender person that indicated it was no longer in question, and, really, there was nothing more to think about. What was important to her was to get on with living as a trans woman.² Like many of the other teens I have seen, she was in conflict with her parents about starting cross-sex hormones, which they opposed. She also wanted to have

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¹The views presented in this paper apply to trans-identified adolescents and youth only. They should not be assumed to apply to trans adults. Elly was given an opportunity to read this paper and provided informed consent for its publication.

²“Trans woman” refers to someone identified as male at birth who presently identifies as a woman.

"bottom surgery"³ and facial feminisation surgery as soon as she turned 18. Despite the relatively predictable way we began the psychoanalytic treatment, the unpredictable, non-linear analytic process eventually opened areas that, for some time, we had not been able to know about. These zones had crucial relevance for the life-altering choices Elly was about to make. There was much more to the story than we had ever imagined.

In a paper that was in dialogue with non-analytic approaches to gender dysphoria in young people, David Schwartz (2012) wrote: "There is much more to children than what they say. We owe them a deeper listening than a literal one ... [or] we will miss whatever story they are telling or protest they are making" (478). This powerful statement reminds us that *when thinking psychoanalytically*, there is *always* more to the story than what is apparent in the patient's presenting symptoms and spoken narrative. All conscious experience, including gendered experience, is shaped by and infused with material that is outside of our awareness: painful, frightening, confusing, or destabilising material that we may not want to know. Much of the mutative power of psychoanalysis is generated by its ability to reach and illuminate zones that are off-limits: unconscious, dissociated, unformulated, or "not-me", depending on the analyst's particular theoretical lens.

Psychoanalysis attempts to discover what else is being communicated within and beyond the spoken text. What is it that patient and analyst do not yet know, and how do we help the patient access and think about this material or these parts of themselves? While the spoken narrative may contain important information, often, it is what is being left out which is the most crucial. It may be that the spoken narrative, or the preoccupying symptom, obscures what is going on, diverting both the patient and the therapist away from more painful but crucial issues. Equally important is the power of psychoanalysis to deconstruct the fixed ways in which we have come to understand ourselves. This is particularly important for young people with gender dysphoria, who often present with a constrained, one-dimensional narrative account of the nature of their difficulties: that their sex is the problem and that changing the body is the singular solution. Patient and therapist may struggle to open things up to consider broader, previously unknown issues and possibilities. In a successful analysis or psychoanalytic therapy, these "constrictions in the field" (Stern 2013, 236) loosen, and patient and analyst become able to think in more complex ways about what is generating distress in the patient's life. They may begin to question beliefs that were previously held with certainty and might grow curious about why gender has become so preoccupying.

These concepts are the bread and butter of analytic work. However, when it comes to youth with gender dysphoria, analytic freedom and integrity can be constrained so that certain questions are not permitted, potentially derailing a more thoroughgoing analytic exploration. These constraints operate both on the individual level and, more generally, within the contemporary socio-political discourse about gender diversity. There is a *prohibition on knowing* wherein certain zones are kept "off limits" to exploration and thinking. Nothing is surprising about the existence of prohibitions on knowing in individual analytic work: they are arguably a fundamental aspect of the functioning of human subjectivity.

³"Bottom surgery" is a colloquial term that refers to genital surgery and involves varying combinations of: construction of a neo-vagina, orchiectomy, penile inversion, hysterectomy, oophorectomy, vaginectomy, metoidioplasty or construction of a neo-phallus.

They are not particular to work with young patients experiencing gender dysphoria. Loosening such prohibitions is at the heart of the analytic project. However, we are currently immersed in a wave of political activism that regulates how gender identity can be understood – allowing a certain discourse and prohibiting others. Questioning *why* someone feels such unbearable distress that hormonal and surgical intervention seems like the only solution is framed by advocates as *transphobic* and a disguised form of *conversion therapy*: a targeted strategy to talk them out of their trans identification and to eradicate any gender diversity (American Psychoanalytic Association Committee on Gender and Sexuality 2023; Ashley 2022; Drescher 2022; Saketopoulou 2022):

“asking the question ‘why’ of non-normative sexualities and genders too often occurs in the service of illuminating their origins in order to ‘cure’ and, effectively, eradicate them ... etiological quests function as stealthy starting points for the motor of conversion therapies” (Saketopoulou and Pellegrini 2023, 13).

Elly⁴

When I first met Elly, she was unable to articulate what it was about her developing pubescent body hair, deepening voice, and growing penis that was so abhorrent to her. Similarly, she could not articulate why altering her body and “passing” as female felt so urgent and compelling. “It just feels nice to present as fem, and masc feels gross”. I asked her to help me understand more about what that meant, but she said that was all she could tell me. She said there really was nothing more to it and reminded me that being trans is just as valid as being cis.⁵ Why were we talking about this, anyway? She had no anxiety or concerns about being trans or transitioning, she told me, as she had worked it all out herself. Further attempts to explore her gendered experience continued to be met with similar responses that felt circular and contentless, leaving me feeling that we had reached a dead end along that line of inquiry.

Having demarcated what was off-limits, Elly and I mostly spoke about other things: school, her parents, politics, her struggles with her older sister, and the clothes she wanted to buy. She often spoke about the pleasure she obtained from wearing edgy, female clothing. Feeling I was taking a risk, I asked whether she could imagine experiencing the joy that wearing her favourite clothes made possible without altering her body. Elly looked frustrated and said, “No. If I don’t change my body, I will just look like a tragic fag”. I was momentarily stunned by her blatantly homophobic response, which I saw in retrospect as having several functions. It introduced a degraded, feminine male figure into the room which I suspected was a “not me” part of herself. It was also a thinly veiled attack on her “fag” therapist, a subtle warning to me that questioning the need for medical transition was absolutely off-limits.

Elly always moved quickly away from my opening question about how she was doing. This became a repetitive sequence consisting of a rapid shift away from the possibility of personal dialogue towards a monologue about political issues and social justice. Elly was a wealth of information about conservative newscasters and bloggers, about privilege, about capitalism and its problematic consequences, about gays who she saw as

⁴Elly was seen twice a week, face to face.

⁵“Cisgender” and “cis” are terms that refer to a gender identity which aligns with one’s birth sex.

conventional and boring, and, of course, about trans rights and transphobia. Her parents, progressive left-leaning medical professionals, did not support her trans identity, believing she had been indoctrinated by peer influence. Elly spent many sessions describing with anger and contempt their anti-trans views. I often felt flooded with information, unable to keep up, and out of touch, and her use of abbreviated jargon sometimes felt like a foreign language. I knew I was being kept at a distance but felt helpless to break through this monologue. Very occasionally, painful experiences fleetingly emerged but then evaporated. I caught momentary glimpses of her anxiety, her concern about being ugly, her constant exhaustion and need to sleep, and her sense that she was likely to kill herself at some point in the not-too-distant future. We always rapidly returned to politics.

Elly's previous name was Elliott. During his early life while living in the UK, Elliott had not displayed or expressed any gender non-conformity or gender distress. He came to Australia at age 10 with his parents and two older sisters and seemed to adjust easily to the change. In his early teens, he had become progressively more withdrawn, anxious, and depressed, with increasing absences from school. He was being bullied at school, and his hearing impairment meant he struggled to keep up with schoolwork. He spent a year at home, unable to attend school, mostly unable to get out of bed, and never returned to full functioning. He became increasingly absorbed in the online gaming world and struggled to engage with the real-time world. Elly had just told her parents that she was trans and was still seriously incapacitated when I began to work with her 18 months ago. Despite complaining about how intolerable her home environment was, she seemed stuck and unable to engage in life outside the home in any real way. I was struck by the juxtaposition between the confident, often entitled person who lectured me almost every session and the lonely, vulnerable person who rarely left her room. I felt barred from making real contact with either.

Whenever there was an opening, I would comment that it sounded like she was anxious or insecure, or I would use other words with a similar implication of her vulnerability. Usually, she would change the subject, but sometimes she would pause and smile at me, saying, "Nice try. I know where you are going with this!" or "Boring!". "Where do you think I am going, and why can't we go there?" I would ask, and she would smile knowingly. Sometimes, she was more disparaging and said those feelings were "cringe" or "pathetic", but she never elaborated on what that meant. We would then return to the political discourse, in which I often found myself participating. I learned it was the way she characteristically interacted with her parents. Nothing in the family resembled real contact between people who cared about or were even curious about each other's feelings.

Elly's gender identity was not the focus of treatment then, and after my initial attempt, I did not actively pursue an inquiry about it. Instead, I became more preoccupied with how hamstrung and silenced I felt by the barrage of political talk. I was learning from how she structured our relationship, her responses to my attempts to reach her emotionally, and my countertransference struggle that there was something about vulnerability and closeness that felt dangerous. I wondered what we could not talk about, assuming she was keeping us away from something I presumed she did not want to know. Clinically, I was attending to how she managed her emotional world and controlled emotional contact with others. My interventions involved illuminating the impersonal nature of

our conversations and how she seemed to prefer to talk to me about politics rather than feelings, highlighting how this was exactly how things worked at home. I commented that she did not seem interested in what I thought, which was the very thing she accused her father of. I thought of Mitchell, who likened the psychoanalytic relationship to a dance in “The Wings of Icarus” (Mitchell 1986). He recommended the analyst participate in the dance as offered whilst at the same time questioning “the singularity of the style” (p. 130). I wondered out loud why we could only talk in this robust, intellectual way and why Elly was not open to other ways that we might come to know each other.

Elly’s spoken narrative felt impenetrable and repetitive, and engaging with the content did not progress the analytic work. I would repeatedly get lost in the political material while intermittently feeling anxious that we were no closer to understanding why she felt suicide was inevitable. Attending to the interpersonal process, rather than the spoken content, “working at the intimate edge”⁶ (Ehrenberg 1992, 2010), I attempted to articulate the quality and structure of our current relatedness and my response to feeling locked out of more personal contact. Progressive revelations of recurrent, painful experiences with her parents emerged in which Elly’s states of fear and vulnerability, as well as bids for closeness, evoked dismissing, contemptuous or shaming responses from them. Fears were attributed to Elliott being “too sensitive”, “like a girl”, or “a prima donna”. Struggles with friends were dismissed with comments like “We all go through tough times, and you have to try harder”. His progressive decline at school was met with accusations of laziness. Elly shared many more examples. I asked her whether she was reluctant to tell me about these feelings because I might respond in the same dismissive and shaming way. She looked at me and shrugged her shoulders, but she did not look away, nor did she change the subject.

As she became more able to talk with me about her anxieties, she spoke about her fears of moving out of home and getting a job. She said she was afraid people would be mean to her and abuse her – “lash out at me, whack me” – if she was not performing as expected. I was struck by her graphic, violent choice of words and asked her whether this had ever happened. She recounted many episodes of her mother’s rage, verbal abuse and physical violence, hitting her at a young age for reasons she could not recall. She shared many memories of being alone in her room, sobbing, hyperventilating, and pulling her hair to calm herself. I communicated my horror at what she was telling me. Elly said that talking about this had made her feel shaky and awful. She looked devastated. “Isn’t this normal?” she asked tentatively. I shook my head. There was a long pause as we absorbed what she had just described. Spontaneously, she said,

If I had been born a girl, I would have been forgiven for being emotional. They would have raised a daughter differently and not verbally abused the fuck out of her like they did to me. They would have been loving and kind. Oh my God ... they transified me!

I was surprised and moved by the understanding Elly had spontaneously generated. She had developed her own theory about how her history had shaped her gendered

⁶Ehrenberg has described an approach to psychoanalytic work which she terms “working at the intimate edge”. The “intimate edge” is “that point of maximum and acknowledged contact at any given moment in a relationship without fusion, without violation of the separateness and integrity of each participant” (Ehrenberg 2010, p. 127). It involves attending to the co-constructed interactive process and its ongoing shifts and is contrasted with an interpretive approach which focuses on spoken content.

experience. During the following session, I shared my sense that what she had told me about was very painful and important. Elly said she thought it was interesting but didn't think it changed anything as she was still trans. In her familiar, confident way, she backtracked and dismissed the relevance of those experiences, and the moment receded into the background for both of us. Around this time, Elly was able to move out of home and began a sexual relationship with a woman. These important developmental steps seemed to coincide with the opening up of Elly's traumatic history. However, we had now shifted our focus to her excitement at having her own space, developing a crush, exploring sexuality, and discovering that she enjoyed penetrative sex with her partner, while previously, she had always maintained that sex was "ewwww gross".

Elly obtained and commenced oestrogen therapy when she turned 18 and no longer needed her parents' consent. Being aware of the emerging evidence of the long-term sequelae of hormone therapy, I checked whether Elly was aware of the risks.⁷ She said she was and that she didn't care, reminding me that she would probably be dead in a few years anyway. "When you're barely hanging on to life, getting heart disease or cancer in the distant future is the least of your worries". I felt alarmed about the way she connected oestrogen with suicide. Given everything that had transpired in the past few months, I wondered where she was regarding her gendered experience. I attempted again to explore what fem and masc meant to her and was met with the same empty responses. This time, I persisted and asked her to think about it and try to tell me whatever she could about it. My question clearly made her anxious, particularly when I said that I still felt unclear and confused about what gender meant to her and that I really wanted to understand. Elly responded with a stern warning: "You are questioning my gender identity. You are walking a very fine line. This feels very close to conversion therapy. I would be careful about what you say next".

I was alarmed, feeling increasing confusion and a sense of dread in response to Elly's threatening comment. At that moment, I didn't understand what I was feeling or why I was being attacked, and I didn't know how to respond. After a few moments, I calmed down and decided to ask Elly to help me understand how my asking her these questions felt like conversion therapy. She said, "You are making me second-guess myself. You are making me have doubts about my gender". I asked, "Do you think it's possible that those doubts are your own and my questions have made you aware of them?". She then clarified that she was not actually saying it was conversion therapy, but what I had asked made her feel very uncomfortable. I responded that I was not trying to change her gender. However, given that she was embarking on major medical and possibly surgical interventions, I wanted her to be clear about why those profound physical changes were necessary. I asked, "If, by chance, your gender dysphoria was being caused by something else, would you want to know?" She said she would but reminded me that this was scary terrain and that we would need to go slowly.

During this initial work with Elly, my experience was that she consistently blocked my attempts to get closer to her. We were enacting and repeating crucial relational sequences involving bids for closeness followed by shaming rejection, with the roles

⁷Long-term hormone therapy has been associated with increased risks of cardiovascular disease, myocardial infarction, stroke, venous thromboembolism, and cancer. These risks are so significant that the Food and Drug Administration has applied a black box warning to exogenous estrogen and testosterone (Jeffrey 2003; Togun, Sankar, and Karaca-Mandic 2022).

constantly shifting between us. Elly seemed to want to connect with me but also dreaded it and, therefore, controlled our contact. I wanted to reach her but felt controlled, coupled with anxiety before each attempt, to the point that I sometimes chose to submit to her control rather than experience the vulnerability that such a move entailed. I also felt a subtle sense of shame and that my desire to get to know her was somehow pathetic. These feelings erupted when Elly reprimanded me. This was, I believe, a response to our interaction, which had led Elly to become conscious of a painful “not-me” (dissociated or unformulated) state (Stern 2010, 2013). This state was infused with need, shame, fear and vulnerability. It was so intolerable to her that it resulted in an enactment, during which the state that was dissociated for Elly was explicitly experienced by me. The way Elly had formulated her gender seemed to fortify this dissociative process, allowing her to effectively quarantine or banish a part of herself, a part of her that held self-states infused with intolerable affects. Perhaps her sense that she was at risk of suicide was an acknowledgement of how catastrophic it would feel to be that helpless person that she could not bear to be.

Elly is still in treatment and has continued exploring herself and her history, motivations, and desires. Neither of us knows where this journey will lead, but I continue to be curious about the hopes, fantasies, and realities associated with the changes occurring in her life.

Prohibition on psychological exploration in work with people with trans identities

There is a commonly held view that the psychoanalytic investigation of trans identities is based on the notion that these identities are pathological (Ashley 2022; McGleughlin 2024; Saketopoulou and Pellegrini 2023). Some argue that if we accept that trans identification is non-pathological, it does not require exploration, just as there is generally no need to explore the psychological formation of cisgender identities. It has been pointed out that this argument does not hold, as it is based on a misunderstanding of the literature, certainly the analytic literature (Saketopoulou and Pellegrini 2023). There are many examples of analytic work with normatively gendered patients that explore the historical factors and contextual influences that have shaped their gendered experience (Saketopoulou and Pellegrini 2023). Deep, psychoanalytic work is therefore just as important and relevant for people with trans identities as it is for normatively gendered patients, and perhaps it can be argued that it is even more so: that, after all, the profound consequences of medical and surgical intervention do necessitate a particularly sensitive and complex psychoanalytic exploration.

However, our current health care system and popular discourse have increasingly rejected the notion that psychotherapeutic exploration is an essential aspect of the clinical response to young people with trans identities. The frequently cited treatment guidelines produced by the World Professional Association for Transgender Health (Coleman et al. 2022) eschew the need for psychotherapeutic exploration before any medical intervention and consider this a form of “gatekeeping”. Even routine psychological assessment is increasingly being conflated with gatekeeping. Gender health care for those 18 and over in the USA is increasingly moving towards a model based on “informed consent”, which requires no psychological evaluation before starting treatment. Advocates of this

approach recommend that it should also be considered for adolescents (Cavanaugh, Hopwood, and Lambert 2016). Even when psychological exploration is required, it often involves perfunctory evaluations and only a handful of sessions, with the goal of “affirming” a young person’s self-declared identity (Levine, Abbruzzese, and Mason 2022a).

Numerous jurisdictions worldwide have passed legislation that bans conversion therapies, and some appear to purposefully conflate psychotherapy with conversion therapy, specifically mentioning psychoanalysis as a problematic practice (Equality Australia 2022; Movement Advancement Project 2022; Queensland Government 2019). These developments constitute an increasing rejection of, and prohibition of, exploratory, analytic thinking when applied to trans identities. It is hard to imagine any other clinical situation where the prohibitions on knowing that patients bring to treatment are reinforced and reified by the dominant socio-political trends that saturate the contexts in which young people dwell. Elly’s warning that I am treading on thin ice is a vivid example of this problematic phenomenon.

Gender-affirming medical interventions: The contested evidence base

Like Elly, many young individuals who identify as trans will, at some point, undergo hormonal and/or surgical interventions, which have profound, irreversible effects. While these interventions have enjoyed widespread support from professional medical bodies, particularly in the USA (American Psychiatric Association 2020; American Psychoanalytic Association 2023; American Psychological Association 2015; Hembree et al. 2017; Rafferty 2018), they are, at the same time, amongst the most controversial and contested treatments in contemporary health care today (Block 2023). On the one hand, advocates of gender-affirming medical interventions argue that there is no question that they have been proven to be helpful, even life-saving (Forcier, Van Schalkwyk, and Turban 2020; The Lancet Child & Adolescent Health 2021). On the other hand, a growing number of health authorities have stopped providing youth with broad access to hormones and surgeries. This has occurred in the United Kingdom (NHS England 2023), Sweden (Socialstyrelsen [National Board of Health and Welfare of Sweden] 2022), and Finland (COHERE (Council for Choices in Health Care 2020)), with many other countries likely to move in a similar direction in the near future.

These decisions were made following systematic reviews of evidence (Ludvigsson et al. 2023; National Institute for Health and Care Excellence 2021a, 2021b; Pasternack et al. 2019) that show that the evidence of the benefit of puberty blockers and cross-sex hormones is highly uncertain. At the same time, the harms are established and clear. These conclusions were recently affirmed by a German systematic review, which concluded that young people with gender dysphoria should primarily receive psychotherapeutic interventions, as the evidence for medical interventions is very limited (Zepf et al. 2024). Most significantly, systematic reviews commissioned by the UK’s Cass Review (The Cass Review 2024), the most extensive review of gender medicine ever undertaken, came to the same conclusion: that gender medicine is “built on shaky foundations”. This resulted in the National Health Service (NHS) restricting endocrine interventions and recommending a holistic approach to the care of young people with gender dysphoria that prioritises psychological interventions.

How do we make sense of such wildly divergent appraisals and positions? Advocates for gender-affirming interventions argue that attempts to highlight the poor evidence base and risks amount to scaremongering, fuelled by heteronormative assumptions, anxiety, and transphobia (Drescher 2022). Critics who have scrutinised the outcome research point to severe methodological problems in the outcome data and conclusions that overstate the evidence of benefit and minimise or obscure the limitations (Abbruzzese, Levine, and Mason 2023; Clayton 2022; Clayton et al. 2021; Levine and Abbruzzese 2023; Levine, Abbruzzese, and Mason 2022a, 2022b). Similar observations have been made by existing systematic reviews as well as an overview of systematic reviews, which universally conclude that the evidence quality is *very low* (Brignardello-Peterson and Wiercioch 2022; National Institute for Health and Care Excellence 2021a, 2021b; Pasternack et al. 2019; SBU [Swedish Agency for Health Technology Assessment and Assessment of Social Services] 2022). A grading of very low indicates that the actual effect of these interventions is likely to be markedly different from what the studies purport to have found (Balshem et al. 2011; Reed and Guyatt n.d.).

The perspective outlined in this paper is shaped by a critical reading of the literature and concern about the risk of the iatrogenic harm of irreversible treatments with an inadequate evidence base. However, many clinicians reject this position. The safety and effectiveness of gender-affirming treatments for youth is the fault line at the heart of much of the controversy and social division concerning youth with gender dysphoria. It seems that clinicians and researchers are either on one side of the divide and believe that medical treatments are now “settled science” and essential for the well-being of young people with gender dysphoria, or on the other, and point to the significant problems with the outcome literature and question whether the uncertain benefits outweigh the risks. This central question, however, is often obfuscated by politically driven clinicians who reframe it as a question of human rights or as a “culture war” (Drescher 2022, 2). Others distort concerns about medical interventions, dismissing them as alarmist and hostile to trans experience, i.e. covert manoeuvres aimed at “eliminating” trans altogether (Saketopoulou 2022, 4). The result is that honest debate about the potential benefits and harms of gender-affirming treatments is subverted. If clinicians have difficulty navigating this socio-political minefield to zero in on what the science says, how do young people and their families have any hope of making informed decisions about their lives?

The importance of psychoanalytic exploration for young people with gender dysphoria

At this time, we have neither criteria nor models to predict who will be helped by hormonal or surgical intervention, who will not be helped, and who will subsequently detransition⁸ and/or regret these interventions. Many people who have detransitioned have reported that they were not offered adequate exploration nor were they challenged prior to transition, with many subsequently realising that their gender dysphoria was caused by something else, such as mental health conditions, trauma, conflicts around

⁸“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 (Irwig 2022; Jorgensen, 2023b).

same-sex attraction, or internalised misogyny (Littman 2018; Vandenbussche 2022). Not everyone who detransitions necessarily regrets their transition; however, it is likely that some will. Despite claims that regret and detransition are vanishingly rare, the true detransition and regret rates are unknown (Cohn 2023; Jorgensen, 2023b, 2023a; The Cass Review 2024). The studies that report low regret rates have significant methodological flaws, including high loss to follow-up rates and inadequate follow-up durations, which undermine the reliability of their conclusions (Cohn 2023). There is, however, emerging evidence that up to 30% of young people will discontinue hormone treatment within a few years of commencing (Boyd, Hackett, and Bewley 2022; Hall, Mitchell, and Sachdeva 2021; Roberts et al. 2022). By this time, their bodies are likely to have been irreversibly altered. Recent data from Germany indicates that 73.6% of young people aged 5–24 with gender dysphoria no longer have the diagnosis after five years (Bachmann et al. 2024). How many of these young people received exploratory psychotherapy versus how many received standard gender-affirming care, with minimal or no exploration, is not known. Concerningly, regret and detransition have been largely “excluded and erased” from the medical literature (MacKinnon, Expósito-Campos, and Gould 2023).

This controversy and uncertainty around the benefits and harms of these treatments is a compelling reason for making analytic exploration available to young people with gender dysphoria. Beyond its capacity to facilitate growth and freedom from constraint, psychoanalytic exploration can allow patients to discover for themselves whether trans identification and hormonal/surgical intervention will indeed allow them to thrive in the ways that they hope (D’Angelo 2023). Ideally, those young people most likely to benefit from these interventions would receive them, while those who will not be helped or may be harmed will make other choices that protect them from harm. It is important to note that Elly’s disclosures about her history only emerged after 18 months of clinical work. There was no suggestion of trauma in the history she and her parents gave during our initial meetings, nor in the first year or more of treatment. This case, which is just one of many, highlights the inadequacy of assessments performed at many gender clinics, which are generally completed in a handful of sessions (Barnes 2023; Levine, Abbruzzese, and Mason 2022a; Terhune, Respaut, and Conlin 2022).

A psychoanalytic process is arguably the best and only way to explore whether trans identification is a carrier or proxy for other difficulties (for example, see Bell 2020; D’Angelo 2020a, 2020b; Evans and Evans 2021; Harris 2022; Korte and Gille 2023; Lemma 2018; Lemma and Savulescu 2023), in which case medical/surgical interventions would be a diversion that leaves the core problems unaddressed. Even Diane Ehrensaft, one of the most vocal advocates for the gender-affirming approach and associated medical interventions, has argued that psychoanalysts “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” (Ehrensaft 2021, 77). At its most extreme, trans identification may be a form of violence against the self, a way of killing off a part of the self that is infused with painful feelings and memories and an attempt to begin anew (D’Angelo 2020b). Elly’s ongoing relationship with suicide raises questions about whether transitioning is, for her, a form of internal suicide, an attempt to eliminate the person who had felt so powerless, abject, shameful, and alone.

Further, a critical controversy in the field of youth gender medicine is whether young people can provide informed consent to interventions that have adverse effects on fertility and sexual function long before the patients are typically mature enough to contemplate such matters outside of the transgender medicine context (Levine, Abbruzzese, and Mason 2022a). This is particularly concerning if one accepts that the benefits of these interventions may not outweigh the harms and that treating clinicians may exaggerate the benefits and underplay the risks, as occurs when these treatments are described as “lifesaving”. To make an informed decision, we must be in possession of the facts so far as is reasonably possible. Aside from the lack of sufficient and/or accurate evidence that is necessary for informed consent, if we accept that some of the driving factors leading to decisions about medical transition are unconscious, then truly informed decision-making is not possible without a psychoanalytic process that attempts to open prohibitions on thinking and knowing (Lemma and Savulescu 2023).

While some analysts might find this argument reasonable or even compelling, others counter that it is impossible to know whether a patient may regret their transition and that analysts do not have the power to predict the future. Saketopoulou has asserted that transition is an experiment that individuals undertake with their own lives, so the outcome is always unknown and unpredictable (Saketopoulou 2023). This position minimises and elides the life-altering and sometimes traumatic consequences of this “experiment” for some people. While it is self-evident that we cannot predict the future, we *can* help young people think deeply about the choices they are making and why, which must include an honest exploration of the unknowns, risks, and irreversibility of medical and surgical interventions. While this may strike some readers as obvious, some critics have described such a clinical approach as a new version of the practices carried out by analysts attempting to make gay people straight, now termed “conversion therapy” (American Psychoanalytic Association Committee on Gender and Sexuality 2023; Drescher 2022) or even as unethical and “eugenicist” (Saketopoulou and Pellegrini 2023, 14).

Prohibitions on knowing in clinical and psychoanalytic discourse about trans

Honest appraisal of the state of knowledge about gender-affirming interventions has become a zone that is off-limits within much contemporary clinical and analytic discourse. I have noted how raising concerns about the limitations of the evidence base and the potential real harms is reframed by some clinicians as prejudice and transphobia. Even more notable is the erasure of any sense of alarm clinicians might feel in response to young people undergoing major medical and surgical procedures. If mentioned, these responses are routinely drained of any significance by being recast as transphobic countertransferences (Hansbury 2005, 2017; Saketopoulou and Pellegrini 2023). This shutdown and subsequent erasure of inchoate feelings of dread and helplessness (amongst other disturbing feelings) has similar qualities to the phenomenon I have described in clinical work with trans youth where certain zones containing overwhelming or traumatic material are quarantined and fiercely defended.

The distortions and prohibitions on knowing in this domain are widespread. British analytic clinicians David Bell, Marcus Evans, and Susan Evans were amongst the first to speak out and raise concerns about the poor standards of clinical care and the

safeguarding of children being treated at the Tavistock Gender Identity Development Service (GIDS) in London. Their concerns were subsequently borne out by the Cass Review (The Cass Review 2024) and NHS Care Quality Commission report (Care Quality Commission 2023). Both publications raised serious concerns over standards of care, the effectiveness and safety of gender-affirming medical interventions, and the inadequate data collection and record-keeping in the NHS. This led to the closure of the Tavistock GIDS and a significant restructuring of the service, hopefully leading to better care for youth with gender dysphoria. Their crucial contribution has been distorted and misrepresented by a group of analytic clinicians with a broad political agenda as a “psychoanalyst-induced controversy” (American Psychoanalytic Association Committee on Gender and Sexuality 2023, 4) and as a misuse of analytic authority (American Psychoanalytic Association Committee on Gender and Sexuality 2023, 5), presumably because they publicly raised concerns about the safety and appropriateness of hormonal and surgical treatment for many of the young people being treated at GIDS.

I have been raising concerns about the potential for harm since 2018, primarily asking how we determine which individuals will be helped and which will be irreversibly harmed, pointing to the significant limitations of the outcome literature. Some critics (American Psychoanalytic Association Committee on Gender and Sexuality 2023; Drescher 2022; Saketopoulou 2022; Saketopoulou and Pellegrini 2023) attempt to discredit analysts like me, who believe it is preferable for young people to avoid medical and surgical body alteration that entails serious risks, including death. This position – that extreme caution is warranted before administering gender-affirming medical interventions – is routinely recast as unethical conversion therapy (Drescher 2022; Saketopoulou 2022; Saketopoulou and Pellegrini 2023) or, more recently, as “trans-denying” (Pellegrini 2024). This represents a collapse in thinking where helping patients avoid medical interventions necessarily means promoting a normative, cisgender identity. In the process, a prohibition on knowing is powerfully reinforced. This position is perplexing as one assumes even these authors would agree that there are many ways to embrace and express gender diversity and embody authenticity that do not require medical intervention.

Some analysts confidently assert that hormonal and surgical treatments are life-saving (Ehrensaft 2016; Saketopoulou 2020) and ignore the uncertainty of the evidence base as well as the emerging concerns that medical/surgical interventions may be unhelpful for or harmful to many. Notably, the most robust data does not support the common assertion that medical interventions for gender dysphoria are life-saving, as there is no evidence that they reduce the risk of completed suicide (Baker et al. 2021; Ruuska et al. 2024; The Cass Review 2024). Others make authoritative statements that co-occurring psychological issues in young gender-diverse individuals are related to interpersonal and cultural reactions to the child, not pre-existing psychopathology (Ehrensaft 2021), ignoring data that suggest psychopathology may precede gender dysphoria (Becerra-Culqui et al. 2018; Kozłowska et al. 2021; The Cass Review 2024; Thompson et al. 2022). Whilst clinicians are entitled to their own perspective, the certainty with which these statements are made and presented as unquestionable facts speaks to the problem I am illuminating.

These kinds of assertions, reflective of an unacknowledged bias in some contemporary analytic literature, involve the erasure or deletion of certain kinds of knowledge involving trauma or harm. In relation to the risks of gender-affirming medical interventions, it

manifests in the following consistent way throughout the literature. Firstly, any mention of the risks and potential harms of gender transition is wholly omitted. Subsequently, any clinician who tries to bring the risks of harm to consciousness is discredited. We see this happening to clinicians who alert readers to the weakness of the evidence base for youth gender transition. Moreover, we see the same attacks directed at clinicians who explore the psychological underpinnings of trans identification. If trans identification is, in fact, a response to various forms of psychic pain, this means our gender-affirming clinicians and medical systems have been inflicting unnecessary harm on many young people. Instead of considering this possibility, prominent voices in the field shut down thinking and maintain a prohibition on knowing about danger and harm.

Readers unfamiliar with the literature may not detect the bias infusing it, particularly if produced by senior clinicians. An example is *Gender Without Identity*, the recent book by Saketopoulou and Pellegrini (2023). In this volume, any discussion of the realities of medical and surgical transition, especially the risks of harm, is glaringly absent. A prohibition on knowing about trauma and harm infuses the entire text. This is particularly striking in the way the authors trivialise and distort a 2020 case report of a young person (“Josh”) who was not helped by transition (D’Angelo 2020b) and now feels irrevocably damaged by gender-affirming treatments. They elide the very real suffering that gender-affirming treatments have caused Josh and ignore the traumatic history that Josh came to feel had led to his transgender identification. They misrepresent the paper’s content, claiming instead that it promotes a dangerous bias that analysts should “fix” queerness and transness. “Is it not clinically indicated to help individuals find ways to live in their assigned gender so they may be ‘spared’ medical interventions and the anguish of being, for example, trans (D’Angelo 2020)?” (Saketopoulou and Pellegrini 2023, 14).

The authors appear to imply that helping people avoid serious, irreversible medical interventions is an inconsequential or even misguided aim. The scare quotes around the word “spared” suggest that the risks and harms of gender-affirming interventions are of little concern. Here we also see the implication that clinicians who wish to protect young people from unnecessary medical interventions are practising conversion therapy. A detransitioned patient of mine, who experienced profound regret about medical and surgical interventions she had undergone, found this language *insulting, patronising, and dangerous* when I asked her to read the above quote.

The authors consistently neglect the suffering experienced by Josh and instead alarm the reader with numerous incorrect citations of this case report, which frame it as transphobic. For example, they claim that when working with Josh, I felt my “mind and reality are under attack when asked to use new pronouns to refer to and think about a patient” (99). The paper they cite does not mention the use of new pronouns; in fact, the word “pronoun” is nowhere to be found in the text. The introduction of pronoun use, a very emotive and highly politicised issue, distracts the reader and maintains the erasure of the pain and devastation that Josh had endured prior to, and as a consequence of, medical and surgical gender transition.

The authors continue to cite and consistently misrepresent this single case report to warn the reader about the dangers to trans individuals posed by therapeutic approaches that attempt to explore the unconscious dynamics of trans identity. Their charge is that clinicians like me are anti-trans and believe that trans is “acquired-and-therefore-possible-to-eliminate” (21).

We can hear it humming beneath anxieties over “social contagion” and rapid-onset gender dysphoria (Bell 2020; Evans and Evans 2021) and in work that sees transness as a deviation from “normal gender” caused by trauma, as if atypical genders are those bent out of gender’s proper shape (D’Angelo 2020). (Saketopoulou and Pellegrini, 2023, 21)

Their comments about gender normativity are even more perplexing given that I make it clear that I hope Josh will accept the uniqueness of his own gender shape, “bent” or not, and define himself in a way that rejects social pressures to conform to gender regulation: “I wanted Josh to struggle with these questions and come to a liberating resolution in the end as I did, when I became able to define what kind of man I would be, *irrespective* of the culture’s gender prescriptions” (D’Angelo 2020b) (Original emphasis).

These misleading interpretations of my work and the work of others, which distort the intent of the cited writing, are prevalent throughout their new volume. For example, they allege that I and other analysts are making “panic-driven and panic-inducing” (Saketopoulou and Pellegrini 2023, 85) statements, such as: “that gender diversity is ‘an epidemic’ comparable to that of the opioid crisis (Evans and Evans 2021, 217) to which female-assigned and gay children are particularly vulnerable (D’Angelo 2020)” (Saketopoulou and Pellegrini 2023, 85).

While I have never claimed this in any of my writing, some aspects of this statement are objectively true. Based on the data from gender clinics around the world, the number of young people with gender dysphoria and/or who identify as trans has indeed risen sharply, representing a dramatic, unprecedented and unexplained change in the incidence of this phenomenon (Aitken et al. 2015; Kaltiala et al. 2020; Zhang et al. 2021). These clinics have also reported, and have not been able to explain, a reversal in the sex ratio so that natal female teens presenting with gender dysphoria now far outnumber natal boys (Aitken et al. 2015; Kaltiala et al. 2020; Zucker 2019). Additionally, both detransitioners and clinicians who worked at the Tavistock GIDS have reported that conflicts around same-sex attraction frequently find expression as trans identification (Barnes 2023; Vandebussche 2022). These dispassionate facts carry no judgement about the experience of trans-identified youth. However, they demand attention, thoughtfulness, and exploration if we want to ensure the best care for these individuals.

Saketopoulou and Pellegrini (2023) warn that psychoanalytic theorising has been compromised by binary thinking – that either we see trans as immutable, or we see trans as acquired and possible to eliminate, and that therapies which seek to understand the psychological origins of trans identification are really “stealthy starting points for the motoring of conversion therapies” (Saketopoulou and Pellegrini 2023, 13). Other psychoanalysts who have written about the exploration of the developmental underpinnings and psychic functions of a trans identity have been subject to similar attempts to discredit their work via misrepresentation.

Alessandra Lemma is one such analyst. In a recent critique of her work, McGleughlin (2024) opines that Lemma’s approach is based on “normative theory”, alleges that she is anti-LGBTQ+ and surmises that she has no appreciation of the beauty of transgender life. No evidence for any of these spurious claims or assumptions about Lemma’s beliefs can be found in the paper being critiqued. McGleughlin nevertheless insists that work like Lemma’s is a “danger” to trans people. Once again, we see multiple misrepresentations which distort and discredit the work of an analyst who carefully explores the meaning and function of trans identification. Lemma (2018) has previously described

her work with a 17-year-old natal female who decided not to transition after 5 years of psychoanalytic treatment. Lemma wonders whether the outcome might have been different if the patient had seen a therapist who only mirrored her feelings without exploring why she felt the way she did. McGleughlin distorts this statement by alleging that in doing so, Lemma “strikes at the integrity of LGBTQ+ psychoanalysts”. McGleughlin admonishes Lemma for inferring that LGBTQ+ therapists are harmful and unreflective. There is no mention of LGBTQ+ psychoanalysts in Lemma’s paper; instead, Lemma raises questions about a *specific clinical approach*.

Nevertheless, this sets the tone for the remainder of the paper, which is an extended polemic promoting the “beauty” of transgender life and the benefits of gender-affirming interventions, while simultaneously discrediting anyone who might have a more nuanced perspective. McGleughlin deploys the same trope as Saketopoulou and Pellegrini when she claims that Lemma’s curiosity about the psychological function of the patient’s trans identity is all about making the patient cisgender and heterosexual. This is a troubling misrepresentation of her work as a form of conversion therapy, which alarms and misleads readers. McGleughlin seems to claim to know what is in Lemma’s mind, despite no evidence to support this claim in the text. There is no mention of Lemma’s preferred outcome for this patient; in fact, the word heterosexual does not appear at all. Ironically, this superior, knowing position is the very stance she accuses Lemma of taking with her patient.

Given the obvious agenda and bias of McGleughlin’s paper, it is not surprising that it is replete with inaccuracies, notably about the nature of the evidence base for gender-affirming interventions. She states authoritatively that adolescents who receive gender-affirming care grow into well-functioning adults, ignoring the growing number of systematic reviews that show the evidence for this claim is very weak. McGleughlin also attacks the theory of rapid-onset gender dysphoria (ROGD), claiming it has been discredited, repeating an oft-recited, misleading activist mantra. When Littman (2018) published her paper outlining the ROGD hypothesis, it was met with outrage and widespread calls for it to be retracted. As a result, the paper went through a second, extensive round of peer review, which is almost unheard of in research publishing. Despite some amendments to the paper, her hypothesis was accepted by the additional reviewers and remains unchanged from its original version. Littman suggested that some cases of trans identification may be a product of social influence, mainly mediated through exposure to online content. Her hypothesis has been relentlessly attacked, presumably because if she is correct, some young people may have been undergoing irreversible medical interventions unnecessarily.

In another paper, Lemma (2013) explores the relationship between the desire for gender-affirming interventions and experiences of parental misattunement to painful experiences of bodily incoherence. She reports on the case of Ms A, a young trans woman struggling with depression, panic attacks and agoraphobia who was raised in a violent household by emotionally unavailable parents and an alcoholic mother. Lemma explores the way the patient’s need to be seen is reactivated in the transference and how this evoked difficult countertransference experiences in the analyst. These countertransferences were highly relevant to the patient’s struggles and psychic pain. Langer (2016) discredits Lemma’s attempts to understand the traumatic and developmental origins and meaning of the patient’s gendered experience as pathologising, despite

Lemma making it clear that she does not view trans identity as pathological. Regardless, Langer rejects Lemma's speculative ideas and observations out of hand and dismisses her countertransference as "transphobic" and damaging. Langer works from a perspective that reifies trans identity: a "trans essence", in her words. For her, the patient's difficulties are a consequence of inadequate mirroring and acceptance of the patient's trans identity, a simplistic formulation that ignores the relational and historical shaping of gendered experience. Here, we see another example where psychoanalytic exploration is cast as pathologising and harmful. Further, it represents a shut-down of thinking about the possibility that trauma and psychic pain may sometimes underpin trans identity.

Saketopoulou and Pellegrini's citation of my 2020 paper similarly edits out the traumatic history and psychic suffering that predated Josh's trans identification. This is a striking blind spot in their writing, one which overlooks that Josh was suffering enormously and was dangerously suicidal. There is a reversal in their thinking, which leads them to assume that analysts like me see transness as the problem for people like Josh and believe that addressing their trauma will eliminate their transness. The main problem for Josh was, in fact, trauma, and it was only when his trauma became accessible to remembering that he spontaneously began to wonder about why he had transitioned. Importantly, these memories only became accessible after extended work involving powerful resistances to exploration and difficult countertransferences.

It is perplexing that Saketopoulou and Pellegrini mount such vehement opposition to analysts who seek to understand the traumatic shaping of gendered experience, when they acknowledge in their 2023 book that developmental trauma such as parental intrusiveness and sexual violation may be linked to the formation of atypical genders. Further, they seem to be in agreement with me that gendered identification can shift because "the analytic work galvanises new self-theorizations" (Saketopoulou 2023, 25). This is in fact what happened in the work with Josh. Accessing previously unavailable traumatic material resulted in an unexpected state-shift and the emergence of a different sense of gender identity. It seems we are on the same page here. However, Josh wishes that these insights had been available to her *before* she underwent medical and surgical treatment. Where I differ from Saketopoulou and Pellegrini is *not* that I believe a cisgender heterosexual outcome is preferable to a queer or "bent" life. It is that I wish to help my young patients avoid the known, serious risks of treatments with a weak evidence base, *if this is possible*.

How do we understand such repeated and consistent misrepresentation? At first glance, these authors' misleading statements might be assumed to be deliberate attempts to discredit those who express concerns about gender-affirming care and thereby challenge their position. This is too simplistic and does not explain the force with which the attributions of harm are projected onto those who raise questions. The assertions and omissions in some psychoanalytic writing, such as those outlined above, might be understood to be a manifestation of unconscious processes that maintain a powerful prohibition on knowing. What is consistently kept out of consciousness is any sense of *alarm* about the potential harms of medical gender-affirming interventions and any curiosity about whether for some people gender transition might be a risky and drastic solution to various forms of psychic pain. The psychic pain that is so obviously humming beneath the surface for some gender-diverse young people such as Elly and Josh is itself exiled from consciousness.

The danger is consistently projected onto others via the claim that individuals like my colleagues and me are the source of danger to trans people by promoting panic-inducing misinformation about the possible harms of gender medicine. Saketopoulou and Pellegrini (2023) are, in fact, creating panic by using language that implies murderous intent when they claim the views I share with other analysts are “eugenicist” and about “eliminating transness”. This is not only a profound misrepresentation. The “eugenicist” allegation strongly suggests that there is projection at work here: It is an undeniable fact that the gender-affirming interventions supported by Saketopoulou and Pellegrini will lead to the sterilisation of many gender-distressed and gay young people. Panic is also generated by comparing those who express concerns about gender-affirming interventions to members of discredited groups like NARTH, who viewed homosexuality as a severe pathology (Drescher 2022). I have never claimed that trans identification is always a manifestation of pathology. I have, in fact, consistently argued that the crucial issue for clinicians is to help individuals determine whether or not they will be helped by irreversible medical transition (D’Angelo 2018, 2020a, 2023; D’Angelo et al. 2021).

As I have noted before, it is striking that there is no acknowledgement of the suffering Josh has endured, even though the authors cite this paper several times as an example of *dangerous* psychoanalysis (Saketopoulou and Pellegrini 2023). In this way, the harm done to Josh by potentially *dangerous* gender-affirming medical interventions is erased, as is any consideration of the possibility that gender-affirming medical care may also be harmful to other young people. One can speculate that the purpose of this psychic foreclosure is to prevent the devastation experienced by people like Josh, and therefore their vulnerability, from becoming conscious. It begs the question: Do they want to know?

Josh has now detransitioned and is struggling to rebuild her life. She is taking legal action against the clinicians who authorised her medical and surgical interventions. She is still struggling with profound grief and loss some 12 years on. Her words speak to the concerns outlined above, particularly the disavowal of the potential dangers of gender-affirming interventions, the absence of any sense of alarm in her treating clinicians, and the erasure of the profound harms that she endured as a consequence of unquestioning gender affirmation.

Why did people allow me to do this? *Nobody seemed alarmed*, and nobody encouraged me to seek psychological help. How could no one question the state of my mental health? How could they leave that up to me? *I feel like I have destroyed my body, and these doctors aided me in this*. They helped me destroy myself. Even if regret is rare, the impact on an individual is profound. There is a lot of grief and loss about the parts of your body that you lost. I see the mastectomy scars every day, and it’s a reminder of what I have done. *Why didn’t anyone question me?*

The unconscious determinants of prohibitions on knowing

It is essential to acknowledge that concerns about the persecution and pathologisation of people with diverse sexualities and gendered experiences have a factual basis and contribute to the resistance to acknowledging the realities of the evidence base and the real possibility of harm. As I will outline, psychoanalysis has a troubled history in terms of how it responded to people who are same-sex attracted. There are real fears that conservative political forces will lead to the complete removal of all access to gender-

affirming interventions for adolescents *and* adults. Many LGB and transgender people feel threatened by the possibility of a resurgence of homophobia and transphobia in our culture. Psychoanalysts working in this area face the challenge of holding in mind our profession's troubling history and prejudice alongside the potential harms of gender affirming care. Open access to information and honest discussion and debate are essential if we want to ensure that human rights are protected, that those people most likely to be helped by gender-affirming interventions receive them and that those who will be harmed are protected.

The prohibitions on knowing that I have outlined, which manifest as a refusal to acknowledge the potential harms of gender-affirming interventions, have both conscious and unconscious underpinnings. Before exploring the unconscious factors, it is important to be aware of the professional and political forces at play that shape the context in which psychoanalysts work with trans-identified young people. Most professional medical bodies, particularly in the USA, Australia and many other countries, have refused to accept the significance of the growing number of systematic reviews which all show that the evidence base for gender-affirming interventions is weak. Even the Cass Review, the most extensive review of paediatric gender medicine, is being challenged by the British Medical Association (2024). Most troubling, however, is recently emerging evidence which strongly suggests that the World Professional Association for Transgender Health purposefully suppressed research that was not supportive of medical gender transition (Paul 2024; Selin Davis 2024), raising serious questions about the organisation's credibility and the nature of its agenda. This manipulation of the public's access to crucial information by the peak body for transgender health care is the fertile ground in which complex unconscious forces have taken root.

While debate and disagreement are routine in clinical and psychoanalytic theorising and practice, the omissions and distortions in the work of supporters of medical intervention, along with the *ad hominem* attacks directed at those who hold differing perspectives and report on the state of the evidence for youth gender medicine, have the driven quality of a countertransference-fuelled enactment. It maintains a prohibition on knowing and thinking at multiple levels: clinical, theoretical and socio-political. For those who promote and practice gender-affirming medicine and who have supported the medicalisation of many young people, there is likely to be immense resistance to acknowledging that this approach may be doing harm to many. On a more profoundly unconscious level, however, there are manifold contributions to this prohibition on knowing, including the denial of psychic pain, avoidance of countertransference, guilt about our history in relation to homosexuality, and submission to social pressure and political activism. I will explore these issues in turn.

A recent paper on countertransference in work with trans persons acknowledges that the complexities of this work and resultant complex countertransferences are "among the most challenging clinical circumstances most of us in this generation will experience" (Harris 2022, 285). Indeed, countertransference responses are frequently heightened by the high stakes these patients bring to the treatment situation. They are often highly distressed, suffering from more than one psychiatric diagnosis, their relationships with family members are deteriorating, and they may be self-harming or suicidal and pushing for medical intervention. It can be alarming to listen to young people talk about major surgical procedures as though they are selecting a new item of clothing. Therapists can feel

fear at the prospect of a young person undergoing irreversible body modification, particularly mastectomy or genital surgery.

While some argue this is a transphobic response (Hansbury 2005, 2017), it is perhaps more accurately seen as an appropriate response to irreversible treatments that entail serious risks, including loss of sexual function, infertility, poor aesthetic results, rectovaginal fistula, urinary incontinence or stenosis, numbness or chronic pain, and even death (Bustos et al. 2021). In addition to their more concrete origins, these kinds of countertransference responses may simultaneously hold keys to important, unformulated historical or traumatic material. I have previously noted that assuming that difficult countertransferences in work with trans people are driven by transphobia can maintain a prohibition on knowing that erases complex, painful and unformulated material that these phenomena encode and communicate (D'Angelo 2020b).

One of the central contributions of psychoanalysis towards the understanding of difficulties in living is that our problematic ways of experiencing and relating are attempts to manage psychic pain. However, as I have pointed out, understanding the historical and relational origins of psychic pain of young people with gender dysphoria is now viewed by many as a dangerous practice intended to eliminate transness. Further, the current dominant understanding of trans identification in young people entails a very specific way of formulating (I would argue distorting) psychological distress, described in The Cass Review (2024) as “diagnostic overshadowing”. In effect, what this means is that any suffering, manifesting as anxiety, depression, eating disorders, etc, is subsumed under the diagnosis of gender dysphoria or “massive gender trauma” (Saketopoulou 2014). This reconfiguration effectively trivialises and even erases these problems and their meaning, viewing them as secondary phenomena that will evaporate once gender transition has occurred. This clinical process reshapes psychic pain, which is difficult for both patient and analyst to bear, into a concrete problem with a concrete solution. Those who raise concerns about the quality of the evidence base for this concrete solution present a threat to this defensive phenomenon and are attacked with the same ferocity encountered when a patient becomes aware of dissociated material or “not-me” states (Stern 2010). The net effect is that both analyst and patient can avoid and deny the psychic pain that is “humming” beneath the experience of gender dysphoria, maintaining a powerful prohibition on knowing.

Barriers to exploration and thinking are some of the most challenging aspects of all psychotherapeutic work. Elly recruited gender to shut down exploration at a moment when we had begun to open up something that had been “off-limits” for some time. The power of her response to my question was amplified by the current socio-political climate in which questions about trans identification have become increasingly prohibited. It evoked complex, painful countertransference responses and a desire to move away from the difficult moment we found ourselves in. I have written about my work with Josh (D'Angelo 2020b), who responded in similarly assertive ways in order to shut down exploration, generating complex emotional responses and states of confusion in me. Nevertheless, continuing to explore difficult terrain within myself, within Josh, and between the two of us while experiencing these countertransferences was pivotal in terms of ultimately accessing material that presented Josh with profound questions about the motivations for her transition. I believe there would have been no analytic progress had I avoided difficult gender-related questions. Josh would not have been able to

move towards integration and gender fluidity or to transcend the rigid binaries that had structured her life. Additionally, aspects of Josh's history and internal torment would have remained forever evacuated into a wordless somatic realm, powerfully sequestered by the modification of her body.

As already noted, some clinicians who support medical transition and minimise the risks would argue that the concerns articulated in this paper are fuelled by countertransference anxiety and transphobia (Drescher 2022; Saketopoulou 2022; Saketopoulou and Pellegrini 2023). However, the affirming approach these clinicians promote is arguably motored by countertransference enactment of a different kind. Their approach, which prescribes how gender should be thought about and responded to and which prohibits specific questions, effectively bypasses the difficult countertransferences I have described in my work. Countertransference may, in fact, be a central factor in why affirmation has become the dominant approach to trans-identified youth and why gender-affirming medical interventions have become increasingly routine. Tolerating and utilising complicated feelings such as confusion, disorientation, shame, fear, despair, and dread in the context of a therapeutic relationship is extremely difficult. Unquestioningly accepting the patient's stated gender or referring the patient for medical interventions, rather than struggling to build or keep open a space for exploration in the face of explicit and implicit prohibitions against exploration, can relieve us of being in the room with patients who often have complex difficulties and evoke complex reactions.

My own personal conversations with affirming clinicians who do not question the psychic and contextual origins of diverse gender identities have confirmed my prediction that they avoid the powerful interactive binds and difficult therapist affective responses I have outlined in this paper. When describing my clinical experiences to the lead clinician at a prominent European gender clinic, the response I received was: "Why don't you give them what they want? Then you will not have those difficult interactions". Affirming clinicians often describe gratifying countertransferences that confirm their role as liberators, coupled with primarily positive transferences, suggesting that the analyst's needs and vulnerabilities are implicated in this kind of enactment. Unfortunately, this collusion with the patient's defences can become an analytic abandonment that leaves the patient's core issues and psychic pain unaddressed. Is the socio-political turn, which increasingly rejects psychoanalytic exploration of gender or alternately prescribes what constitutes permissible psychoanalysis (perhaps a new iteration of arguments about what is analytic), a defensive phenomenon increasingly infusing our entire profession, one that avoids difficult countertransferences? Moreover, consequently, does such a defensive phenomenon abandon patients in their struggles to understand themselves, to find meaningful relief from pain and creative ways to flourish?

Proponents of gender-affirming care warn that any attempt to explore the origins of trans experience is a repetition of the way homosexuality was responded to by psychoanalysis last century. Homosexuality was only removed from the Diagnostic and Statistical Manual (DSM) in 1973. Up until that time and for some time after, many psychoanalysts, perhaps even the majority, believed homosexuality was pathological (Macintosh 1994; Mitchell 2002). Psychoanalytic writing about gay men and lesbians from the mid to late twentieth century was mainly pathologising and recommended that clinicians should actively discourage homosexual behaviour. Gay men and lesbians

were excluded from psychoanalytic training for decades after homosexuality was depathologised (Drescher 2008; Twomey 2003). In the following decades, many reports emerged of patients who had undergone pathologising analyses or more explicit conversion therapies. The shadow of this part of our history still hangs over our profession, and for many, there is a collective sense of shame and guilt about how we treated gay men and lesbians.

This unconscious guilt likely drives the current impassioned and single-minded, arguably unreflective, defence of trans rights and trans medicalisation by psychoanalysts and mental health clinicians. Being loudly and proudly pro-trans may be a way to make amends for the way our profession colluded with the persecution of that other sexual minority group whilst at the same time demonstrating moral virtue, signalling to our colleagues that we are on the right side of history this time. This over-correction, involving aggressive refusal to acknowledge any doubts about the safety and effectiveness of gender-affirming interventions, is a way to keep the phantom of the past at bay, ensuring that our professional “not-me” state, which did much harm to gay men and lesbians, remains safely unformulated and projected onto others. This defensive process can be seen in the writing of analysts who promote medical gender affirmation, according to whom it is not the invasive and risky interventions that are dangerous; the danger is located in the therapist who tries to think about what is going on or who raises concerns about the poor evidence base. The message is: I am *not* like those clinicians who persecuted homosexuals; the persecutors are those who raise concerns about the current state of trans health care.

Another question demands attention: Is this abandonment and prescription of a particular kind of incuriosity a consequence of privileging political advocacy over fact? Is psychoanalysis in danger of jumping on a politically and morally fuelled bandwagon as it did with homosexuality – except this time pro rather than against? While psychoanalysis came to oppose interventions to make same-sex-attracted people become normative (“straight”), are some members of our community now supporting medical interventions that make gender non-conforming individuals “pass”, i.e. appear more normative? To what degree is our profession being influenced by social and political pressure, abandoning psychoanalytic thinking in the process? What is certain is that the stakes are arguably different and much higher this time around, as the interventions involve irreversible body modification, which entails significant risks. Is psychoanalysis being recruited to power what is, in fact, a political agenda rather than optimal clinical care? Are any of us truly able to remain outside the disturbing polarisation in this field, most visible in the USA, where some states are attempting to ban gender-affirming treatments for minors while other states are making these treatments easier to access and introducing models of care that no longer require any psychological evaluation or even minors’ parental support? Both positions bypass thinking and erode our sensitivity to the complexity of individual human subjectivity.

Do we want to know?

As psychotherapists and as a community, if there are significant uncertainties and risks of harm associated with gender-affirming medical interventions for young people, *do we want to know?* A psychotherapeutic process that privileges growth, expanded awareness,

and integration is not a stealthy form of conversion therapy, as some might claim, but a safer alternative to the highly medicalised affirmative approach. The ability of psychoanalysis to loosen prohibitions on knowing can help young people think deeply about why they feel the way they do, the choices they are making and whether those choices will ultimately be helpful or harmful. Psychoanalysts have an ethical responsibility to evaluate the outcome literature rigorously, critically, and accurately, because how we read the research ultimately shapes how we think about and work with our patients with gender distress. Also, ongoing consideration of how our own prohibitions on knowing and blind spots may be shaping how we think about theory and our patients' experiences is crucial to this work. Most importantly, we have a responsibility to engage in a thoroughgoing psychotherapeutic process with our patients, one that does not shy away from difficult interactions or painful content. This will necessarily require us to tolerate and think about difficult countertransference experiences rather than privileging a clinical stance that allows us to bypass these challenging responses but that may ultimately deprive our patients of a transformative psychotherapeutic experience.

Psychoanalysis has arguably never had to grapple with social changes that are both so dizzyingly rapid and so intensely politicised. Whilst prohibitions on knowing are ubiquitous in psychic life, the zones of unconsciousness that clinicians encounter when working with trans youth are particularly challenging because they are maintained on multiple interacting levels: the intrapsychic, the socio-political and within some contemporary psychoanalytic theory. The result is that any sense of alarm about the harms of medical gender-affirming interventions is kept out of consciousness, and any curiosity about whether gender transition might be a risky and drastic solution to various forms of psychic pain is foreclosed. This reverberates with and reinforces the individual defences against knowing painful, unformulated or traumatic material that our patients present us with in analytic work. In the emotionally charged political climate surrounding trans issues, can we think about these issues without being overwhelmed by powerful affects ourselves? Are these conversations so threatening that they can only occur backchannel rather than openly in our professional listservs and journals? Do we want to know?

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Patient anonymisation

Potentially personally identifying information presented in this article that relates directly or indirectly to an individual, or individuals, has been changed to disguise and safeguard the confidentiality, privacy and data protection rights of those concerned, in accordance with the journal's anonymisation policy.

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References

- Abbruzzese, E., S. B. Levine, and J. W. Mason. 2023. "The Myth of "Reliable Research" in Pediatric Gender Medicine: A Critical Evaluation of the Dutch Studies—and Research That has Followed". *Journal of Sex & Marital Therapy* 49 (6): 1–27. <https://doi.org/10.1080/0092623X.2022.2150346>.
- Aitken, M., T. D. Steensma, R. Blanchard, D. P. VanderLaan, H. Wood, A. Fuentes, C. Spegg, et al. 2015. "Evidence for an Altered Sex Ratio in Clinic-Referred Adolescents with Gender Dysphoria". *The Journal of Sexual Medicine* 12 (3): 756–763. <https://doi.org/10.1111/jsm.12817>.
- American Psychiatric Association. 2020. *Position Statement on Treatment of Transgender and Gender Diverse Youth*. <https://www.psychiatry.org/getattachment/8665a2f2-0b73-4477-8f60-79015ba9f815/Position-Treatment-of-Transgender-Gender-Diverse-Youth.pdf>.
- American Psychoanalytic Association. 2023. *Position Statement Opposing Anti-trans Legislation*. <https://apsa.org/wp-content/uploads/2023/05/APsA-Position-Statement-5.30.23.pdf?ver>.
- American Psychoanalytic Association Committee on Gender and Sexuality. 2023, May. *Message from COGS*. <https://drive.google.com/file/d/1-Q19fjGBB7ugNdtXmrGvutRu-ovXTKC/view>.
- American Psychological Association. 2015. "Guidelines for Psychological Practice with Transgender and Gender Nonconforming People". *American Psychologist* 70 (9): 832–864. <https://doi.org/10.1037/a0039906>.
- Ashley, F. 2022. "Interrogating Gender-Exploratory Therapy". *Perspectives on Psychological Science* 18 (2): 472–481. <https://doi.org/10.1177/17456916221102325>.
- Bachmann, C. J., Y. Golub, J. Holstiege, and F. Hoffmann. 2024. "Störungen der Geschlechtsidentität bei Jungen Menschen in Deutschland: Häufigkeit und Trends 2013–2022". *Dtsch Arztebl International* 121 (11): 370–371. <https://doi.org/10.3238/arztebl.m2024.0098>.
- Baker, K. E., L. M. Wilson, R. Sharma, V. Dukhanin, K. McArthur, and K. A. Robinson. 2021. "Hormone Therapy, Mental Health, and Quality of Life Among Transgender People: A Systematic Review". *Journal of the Endocrine Society* 5 (4): 1–16. <https://doi.org/10.1210/jendso/bvab011>.
- Balshem, H., M. Helfand, H. J. Schünemann, A. D. Oxman, R. Kunz, J. Brozek, G. E. Vist, Y. Falck-Ytter, J. Meerpohl, and S. Norris. 2011. "GRADE Guidelines: 3. Rating the Quality of Evidence". *Journal of Clinical Epidemiology* 64 (4): 401–406. <https://doi.org/10.1016/j.jclinepi.2010.07.015>.
- Barnes, H. 2023. *Time to Think: The Inside Story of the Collapse of the Tavistock's Gender Service for Children*. London: Swift Press.
- Becerra-Culqui, T. A., Y. Liu, R. Nash, L. Cromwell, W. D. Flanders, D. Getahun, S. V. Giammattei, et al. 2018. "Mental Health of Transgender and Gender Nonconforming Youth Compared With Their Peers". *Pediatrics* 141 (5): e20173845. <https://doi.org/10.1542/peds.2017-3845>.
- Bell, D. 2020. "First do no Harm". *The International Journal of Psychoanalysis* 101 (5): 1031–1038. <https://doi.org/10.1080/00207578.2020.1810885>.
- Block, J. 2023. "Gender Dysphoria in Young People is Rising—And so is Professional Disagreement". *BMJ* 380: 382. <https://doi.org/10.1136/bmj.p382>.
- Boyd, I., T. Hackett, and S. Bewley. 2022. "Care of Transgender Patients: A General Practice Quality Improvement Approach". *Healthcare* 10 (1): 121. <https://doi.org/10.3390/healthcare10010121>.
- Brignardello-Peterson, R., and W. Wiercioch. 2022. Effects of Gender Affirming Therapies in People with Gender Dysphoria: Evaluation of the Best Available Evidence. https://ahca.myflorida.com/letkidsbekids/docs/AHCA_GAPMS_June_2022_Attachment_C.pdf.
- British Medical Association. 2024, July 31. *BMA to Undertake An Evaluation of the Cass Review on Gender Identity Services for Children and Young People*. <https://www.bma.org.uk/bma-media-centre/bma-to-undertake-an-evaluation-of-the-cass-review-on-gender-identity-services-for-children-and-young-people>.
- Bustos, S. S., V. P. Bustos, A. Mascaro, P. Ciudad, A. J. Forte, G. Del Corral, and O. J. Manrique. 2021. "Complications and Patient-Reported Outcomes in Transfemale Vaginoplasty: An Updated Systematic Review and Meta-Analysis". *Plastic and Reconstructive Surgery - Global Open* 9 (3): e3510. <https://doi.org/10.1097/GOX.00000000000003510>.
- Care Quality Commission. 2023, May 10. *Tavistock and Portman NHS Foundation Trust*. Care Quality Commission. <https://www.cqc.org.uk/provider/RNK/inspection-summary#genderis>.

- The Cass Review. 2024, April. *Independent Review of Gender Identity Services for Children and Young People: Interim Report*. <https://cass.independent-review.uk/publications/interim-report/>.
- Cavanaugh, T., R. Hopwood, and C. Lambert. 2016. "Informed Consent in the Medical Care of Transgender and Gender-Nonconforming Patients". *AMA Journal of Ethics* 18 (11): 1147–1155. <https://doi.org/10.1001/journalofethics.2016.18.11.sect1-1611>.
- Clayton, A. 2022. "Commentary on Levine: A Tale of Two Informed Consent Processes". *Journal of Sex & Marital Therapy* 49 (1): 88–95. <https://doi.org/10.1080/0092623X.2022.2070565>.
- Clayton, A., W. J. Malone, P. Clarke, J. Mason, and R. D'Angelo. 2021. "Commentary: The Signal and the Noise—Questioning the Benefits of Puberty Blockers for Youth with Gender Dysphoria—A Commentary on Rew et al. (2021)". *Child and Adolescent Mental Health* 27 (3): 259–262. <https://doi.org/10.1111/camh.12533>.
- COHERE (Council for Choices in Health Care). 2020. *Medical Treatment Methods for Dysphoria Associated with Variations in Gender Identity in Minors—Recommendation*. https://palveluvalikoima.fi/documents/1237350/22895008/Summary_minors_en.pdf/aaf9a6e7-b970-9de9-165c-abadfae46f2e/Summary_minors_en.pdf.
- Cohn, J. 2023. "The Detransition Rate Is Unknown". *Archives of Sexual Behavior* 52: 1937–1952. <https://doi.org/10.1007/s10508-023-02623-5>.
- Coleman, E., A. E. Radix, W. P. Bouman, G. R. Brown, A. L. C. de Vries, M. B. Deutsch, R. Ettner, ... J. Arcelus. 2022. "Standards of Care for the Health of Transgender and Gender Diverse People, Version 8". *International Journal of Transgender Health* 23 (sup1): S1–S259. <https://doi.org/10.1080/26895269.2022.2100644>.
- D'Angelo, R. 2018. "Psychiatry's Ethical Involvement in Gender-Affirming Care". *Australasian Psychiatry* 26 (5): 460–463. <https://doi.org/10.1177/1039856218775216>.
- D'Angelo, R. 2020a. "The Complexity of Childhood Gender Dysphoria". *Australasian Psychiatry* 28 (5): 530–532. <https://doi.org/10.1177/1039856220917076>.
- D'Angelo, R. 2020b. "The man I am Trying to be is not me". *The International Journal of Psychoanalysis* 101 (5): 951–970. <https://doi.org/10.1080/00207578.2020.1810049>.
- D'Angelo, R. 2023. "Supporting Autonomy in Young People with Gender Dysphoria: Psychotherapy is not Conversion Therapy". *Journal of Medical Ethics* 0: 1–7. jme-2023-109282. <https://doi.org/10.1136/jme-2023-109282>.
- D'Angelo, R., E. Syrulnik, S. Ayad, L. Marchiano, D. T. Kenny, and P. Clarke. 2021. "One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria". *Archives of Sexual Behavior* 50 (1): 7–16. <https://doi.org/10.1007/s10508-020-01844-2>.
- Drescher, J. 2008. "A History of Homosexuality and Organized Psychoanalysis". *The Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry* 36 (3): 443–460. <https://doi.org/10.1521/jaap.2008.36.3.443>.
- Drescher, J. 2022. "Informed Consent or Scare Tactics? A Response to Levine et al.'s "Reconsidering Informed Consent for Trans-Identified Children, Adolescents, and Young Adults"". *Journal of Sex & Marital Therapy* 49 (1): 1–9. <https://doi.org/10.1080/0092623X.2022.2080780>.
- Ehrenberg, D. 1992. *The Intimate Edge: Extending the Reach of Psychoanalytic Interaction*. New York: W.W. Norton.
- Ehrenberg, D. 2010. "Working at the "Intimate Edge". *Contemporary Psychoanalysis* 46 (1): 120–141. <https://doi.org/10.1080/00107530.2010.10746043>.
- Ehrensaft, D. 2016. *The Gender Creative Child: Pathways for Nurturing and Supporting Children WHO Live Outside Gender Boxes*. New York: The Experiment.
- Ehrensaft, D. 2021. "Psychoanalysis Meets Transgender Children: The Best of Times and the Worst of Times". *Psychoanalytic Perspectives* 18 (1): 68–91. <https://doi.org/10.1080/1551806X.2021.1845022>.
- Equality Australia. 2022. *End LGBTQ Conversion Practices*. Equality Australia. <https://equalityaustralia.org.au/endconversionpractices/>.
- Evans, S., and M. Evans. 2021. *Gender Dysphoria: A Therapeutic Model for Working with Children, Adolescents and Young Adults*. Oxfordshire: Phoenix Publishing House.
- Forcier, M., G. Van Schalkwyk, and J. Turban. 2020. *Pediatric Gender Identity: Gender-Affirming Care for Transgender & Gender Diverse Youth*. Cham: Springer.

- Hall, R., L. Mitchell, and J. Sachdeva. 2021. "Access to Care and Frequency of Detransition among a Cohort Discharged by a UK National Adult Gender Identity Clinic: Retrospective Case-Note Review". *BJPsych Open* 7 (6): e184. <https://doi.org/10.1192/bjo.2021.1022>.
- Hansbury, G. 2005. "Mourning the Loss of the Idealized Self: A Transsexual Passage". *Psychoanalytic Social Work* 12 (1): 19–35. https://doi.org/10.1300/J032v12n01_03.
- Hansbury, G. 2017. "Unthinkable Anxieties". *TSQ: Transgender Studies Quarterly* 4 (3-4): 384–404. <https://doi.org/10.1215/23289252-4189883>.
- Harris, A. 2022. "Transgender and Analytic Countertransference". *The Psychoanalytic Review* 109 (3): 277–286. <https://doi.org/10.1521/prev.2022.109.3.277>.
- Hembree, W. C., P. T. Cohen-Kettenis, L. Gooren, S. E. Hannema, W. J. Meyer, M. H. Murad, S. M. Rosenthal, J. D. Safer, V. Tangpricha, and G. G. T'Sjoen. 2017. "Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline". *Endocrine Practice* 23 (12): 1437–1437. <https://doi.org/10.4158/1934-2403-23.12.1437>.
- Irwig, M. S. 2022. "Detransition Among Transgender and Gender-Diverse People—An Increasing and Increasingly Complex Phenomenon". *The Journal of Clinical Endocrinology & Metabolism* 107 (10): e4261–e4262. <https://doi.org/10.1210/clinem/dgac356>.
- Jeffrey, S. 2003, January 8. "Estrogen Formulas get FDA "Black box" Warning". *Medscape Psychiatry* 28 (3): 2022, e78–e79. <https://doi.org/10.37765/ajmc.2022.88841>.
- Jorgensen, S. C. J. 2023a. "Iatrogenic Harm in Gender Medicine". *Journal of Sex & Marital Therapy* 49 (8): 939–944. <https://doi.org/10.1080/0092623X.2023.2224320>.
- Jorgensen, S. C. J. 2023b. "Transition Regret and Detransition: Meanings and Uncertainties". *Archives of Sexual Behavior* 52 (5): 2173–2184. <https://doi.org/10.1007/s10508-023-02626-2>.
- Kaltiala, R., H. Bergman, P. Carmichael, N. M. de Graaf, K. Egebjerg Rischel, L. Frisén, M. Schorkopf, L. Suomalainen, and A. Waehre. 2020. "Time Trends in Referrals to Child and Adolescent Gender Identity Services: A Study in Four Nordic Countries and in the UK". *Nordic Journal of Psychiatry* 74 (1): 40–44. <https://doi.org/10.1080/08039488.2019.1667429>.
- Korte, A., and G. Gille. 2023. "Wahlverwandtschaften? Trans-Identifizierung und Anorexia Nervosa als Maladaptive Lösungsversuche für Entwicklungskonflikte in der Weiblichen Adoleszenz [Elective Affinities? Trans-Identification and Anorexia Nervosa as Maladaptive Attempts to Resolve Developmental Conflicts in Female Adolescence]". *Sexuologie / DGSMW* 30 (3–4): 105–122. <https://doi.org/10.61387/sexuologie.2023.34.27>.
- Kozłowska, K., C. Chudleigh, G. McClure, A. M. Maguire, and G. R. Ambler. 2021. "Attachment Patterns in Children and Adolescents With Gender Dysphoria". *Frontiers in Psychology* 11: 1–21. <https://doi.org/10.3389/fpsyg.2020.582688>.
- The Lancet Child & Adolescent Health. 2021. "A Flawed Agenda for Trans Youth". *The Lancet Child & Adolescent Health* 5 (6): 385. [https://doi.org/10.1016/S2352-4642\(21\)00139-5](https://doi.org/10.1016/S2352-4642(21)00139-5).
- Langer, S. 2016. "Trans Bodies and the Failure of Mirrors". *Studies in Gender and Sexuality* 17 (4): 306–316. <https://doi.org/10.1080/15240657.2016.1236553>.
- Lemma, A. 2013. "The Body one has and the Body one is: Understanding the Transsexual's Need to be Seen". *The International Journal of Psychoanalysis* 94 (2): 277–292. <https://doi.org/10.1111/j.1745-8315.2012.00663.x>.
- Lemma, A. 2018. "Trans-itory Identities: Some Psychoanalytic Reflections on Transgender Identities". *The International Journal of Psychoanalysis* 99 (5): 1089–1106. <https://doi.org/10.1080/00207578.2018.1489710>.
- Lemma, A., and J. Savulescu. 2023. "To be, or not to be? The Role of the Unconscious in Transgender Transitioning: Identity, Autonomy and Well-Being". *Journal of Medical Ethics* 49 (1): 65–72. <https://doi.org/10.1136/medethics-2021-107397>.
- Levine, S. B., and E. Abbruzzese. 2023. "Current Concerns About Gender-Affirming Therapy in Adolescents". *Current Sexual Health Reports* 15 (2): 113–123. <https://doi.org/10.1007/s11930-023-00358-x>.
- Levine, S. B., E. Abbruzzese, and J. W. Mason. 2022a. "Reconsidering Informed Consent for Trans-Identified Children, Adolescents, and Young Adults". *Journal of Sex & Marital Therapy* 48 (7): 706–727. <https://doi.org/10.1080/0092623X.2022.2046221>.

- Levine, S. B., E. Abbruzzese, and J. W. Mason. 2022b. "What Are We Doing to These Children? Response to Drescher, Clayton, and Balon Commentaries on Levine et al., 2022". *Journal of Sex & Marital Therapy* 49 (1): 1–11. <https://doi.org/10.1080/0092623X.2022.2136117>.
- 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. <https://doi.org/10.1371/journal.pone.0202330>.
- Ludvigsson, J. F., J. Adolfsson, M. Höistad, P.-A. Rydelius, B. Kriström, and M. Landén. 2023. "A Systematic Review of Hormone Treatment for Children with Gender Dysphoria and Recommendations for Research". *Acta Paediatrica* 112 (11): 2279–2292. <https://doi.org/10.1111/apa.16791>.
- Macintosh, H. 1994. "Attitudes and Experiences of Psychoanalysts in Analyzing Homosexual Patients". *Journal of the American Psychoanalytic Association* 42 (4): 1183–1205. <https://doi.org/10.1177/000306519404200412>.
- MacKinnon, K. R., P. Expósito-Campos, and W. A. Gould. 2023. "Detransition Needs Further Understanding, not Controversy". *BMJ* 381: 1–4. e073584. <https://doi.org/10.1136/bmj-2022-073584>.
- McGleughlin, J. 2024. "Transgender Imagining and the Danger of Normative Theory". *Studies in Gender and Sexuality* 25 (2): 129–142. <https://doi.org/10.1080/15240657.2024.2346458>.
- Mitchell, S. 1986. "The Wings of Icarus: - Illusion and the Problem of Narcissism". *Contemporary Psychoanalysis* 22 (1): 107–132. <https://doi.org/10.1080/00107530.1986.10746118>.
- Mitchell, S. 2002. "The Psychoanalytic Treatment of Homosexuality Some Technical Considerations". *Studies in Gender and Sexuality* 3 (1): 23–59. <https://doi.org/10.1080/15240650309349187>.
- Movement Advancement Project. 2022. *Conversion "Therapy" Laws*. https://www.lgbtmap.org/equality-maps/conversion_therapy.
- National Institute for Health and Care Excellence. 2021a, March 11. *Evidence review: Gender-Affirming Hormones for Children and Adolescents with Gender Dysphoria*. National Institute for Health and Care Excellence (NICE); NHS England; NHS Improvement. <https://arms.nice.org.uk/resources/hub/1070871/attachment>.
- National Institute for Health and Care Excellence. 2021b, March 11. *Evidence Review: Gonadotrophin Releasing Hormone Analogues for Children and Adolescents with Gender Dysphoria*. National Institute for Health and Care Excellence (NICE); NHS England; NHS Improvement. <https://arms.nice.org.uk/resources/hub/1070905/attachment>.
- NHS England. 2023, June 9. *Interim service specification: Interim Specialist Service for Children and Young People with Gender Incongruence*. <https://www.england.nhs.uk/wp-content/uploads/2023/06/Interim-service-specification-for-Specialist-Gender-Incongruence-Services-for-Children-and-Young-People.pdf>.
- Pasternack, I., I. Söderström, M. Saijonkari, and M. Mäkelä. 2019. *Lääketeolliset menetelmät sukupuolivariaatioihin liittyvän dysforian hoidossa. Systemaattinen katsaus*. 106. <https://app.box.com/s/y9u791np8v9gsunwgp2kqn8swd9vdtx>.
- Paul, P. 2024, July 12. Why Is the U.S. Still Pretending to Know Gender-Affirming Care Works? *New York Times*.
- Pellegrini, A. 2024, February 27. [Online post]. American Psychological Association Division 39 Listserv. <https://lists.apa.org/cgi-bin/wa.exe?A0=DIV39DISCUSS>.
- Queensland Government. 2019. *Health Legislation Amendment Bill 2019*. <https://www.legislation.qld.gov.au/view/pdf/bill.first/bill-2019-069>.
- Rafferty, J. 2018. "Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents". *Pediatrics* 142 (4): e20182162. <https://doi.org/10.1542/peds.2018-2162>.
- Reed, S., and G. Guyatt. n.d. *What is Grade?* BMJ Best Practice. Accessed July 3, 2023. <https://bestpractice.bmj.com/info/toolkit/learn-ebm/what-is-grade/>.
- Roberts, C. M., D. A. Klein, T. A. Adirim, N. A. Schvey, and E. Hisle-Gorman. 2022. "Continuation of Gender-Affirming Hormones Among Transgender Adolescents and Adults". *The Journal of Clinical Endocrinology & Metabolism* 107 (9): e3937–e3943. <https://doi.org/10.1210/clinem/dgac251>.
- Ruuska, S.-M., K. Tuisku, T. Holttinen, and R. Kaltiala. 2024. "All-cause and Suicide Mortalities among Adolescents and Young Adults who Contacted Specialised Gender Identity Services in Finland in

- 1996–2019: A Register Study". *BMJ Mental Health* 27 (1): e300940. <https://doi.org/10.1136/bmjment-2023-300940>.
- Saketopoulou, A. 2014. "Mourning the Body as Bedrock: Developmental Considerations in Treating Transsexual Patients Analytically". *Journal of the American Psychoanalytic Association* 62 (5): 773–806. <https://doi.org/10.1177/0003065114553102>.
- Saketopoulou, A. 2020. "Thinking Psychoanalytically, Thinking Better: Reflections on Transgender". *The International Journal of Psychoanalysis* 101 (5): 1019–1030. <https://doi.org/10.1080/00207578.2020.1810884>.
- Saketopoulou, A. 2022. "On Trying to Pass off Transphobia as Psychoanalysis and Cruelty as "Clinical Logic"". *The Psychoanalytic Quarterly* 91 (1): 177–190. <https://doi.org/10.1080/00332828.2022.2056378>.
- Saketopoulou, A. 2023, April 1. *Gender Without Identity, Psychoanalysis without Aetiology: On not Harming Trans Children and on the Flourishing of Trans Life*. Seminar for the AUstralian Chapter of the International Association for Relational Psychoanalysis and Psychotherapy, online.
- Saketopoulou, A., and A. Pellegrini. 2023. *Gender Without Identity*. New York: The Unconscious in Translation.
- SBU [Swedish Agency for Health Technology Assessment and Assessment of Social Services]. 2022. *Hormonbehandling vid könsdysfori—Barn och unga [Hormonal treatment of gender dysphoria—Children and Adolescents]*. SBU. <https://www.sbu.se/342>.
- Schwartz, D. 2012. "Listening to Children Imagining Gender: Observing the Inflation of an Idea". *Journal of Homosexuality* 59 (3): 460–479. <https://doi.org/10.1080/00918369.2012.653314>.
- Selin Davis, L. 2024, July 11. Gender-Distressed Youth Deserve the Truth about the Science. *The Hill*. <https://thehill.com/opinion/healthcare/4764222-youth-gender-care-censorship/>.
- Socialstyrelsen [National Board of Health and Welfare of Sweden]. 2022. *Care of Children and Adolescents with Gender Dysphoria. Summary*. <https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2022-3-7799.pdf>.
- Stern, D. 2010. *Partners in Thought*. New York: Routledge.
- Stern, D. 2013. "Relational Freedom and Therapeutic Action". *Journal of the American Psychoanalytic Association* 61 (2): 227–256. <https://doi.org/10.1177/0003065113484060>.
- Terhune, C., R. Respaut, and M. Conlin. 2022, October 6. *As More Transgender Children Seek Medical Care, Families Confront Many Unknowns*. Reuters Investigates. <https://www.reuters.com/investigates/special-report/usa-transyouth-care/>.
- Thompson, L., D. Sarovic, P. Wilson, A. Sämford, and C. Gillberg. 2022. "A PRISMA Systematic Review of Adolescent Gender Dysphoria Literature: 2) Mental Health". *PLoS Global Public Health* 2 (5): e0000426. <https://doi.org/10.1371/journal.pgph.0000426>.
- Togun, A., A. Sankar, and P. Karaca-Mandic. 2022. "FDA Safety Warnings and Trends in Testosterone Marketing to Physicians". *The American Journal of Managed Care* 28 (3): e78–e79. <https://doi.org/10.37765/ajmc.2022.88841>.
- Twomey, D. 2003. "British Psychoanalytic Attitudes Towards Homosexuality". *Journal of Gay & Lesbian Psychotherapy* 7 (1-2): 7–22. https://doi.org/10.1300/J236v07n01_02.
- Vandenbussche, E. 2022. "Detransition-Related Needs and Support: A Cross-Sectional Online Survey". *Journal of Homosexuality* 69 (9): 1602–1620. <https://doi.org/10.1080/00918369.2021.1919479>.
- Zepf, F. D., L. König, A. Kaiser, C. Ligges, M. Ligges, V. Roessner, T. Banaschewski, and M. Holtmann. 2024. "Beyond NICE: Aktualisierte Systematische Übersicht zur Evidenzlage der Pubertätsblockade und Hormongabe bei Minderjährigen mit Geschlechtsdysphorie". *Zeitschrift für Kinder- und Jugendpsychiatrie und Psychotherapie* 52 (3): 167–187. <https://doi.org/10.1024/1422-4917/a000972>.
- Zhang, Q., W. Rechler, A. Bradlyn, W. D. Flanders, D. Getahun, T. L. Lash, C. McCracken, et al. 2021. "Changes in Size and Demographic Composition of Transgender and Gender Non-Binary Population Receiving Care at Integrated Health Systems". *Endocrine Practice* 27 (5): 390–395. <https://doi.org/10.1016/j.epr.2020.11.016>.
- Zucker, K. J. 2019. "Adolescents with Gender Dysphoria: Reflections on Some Contemporary Clinical and Research Issues". *Archives of Sexual Behavior* 48 (7): 1983–1992. <https://doi.org/10.1007/s10508-019-01518-8>.