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# The Science is Not Settled: An American Skeptic's View of Trans Care for Youth

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## ABSTRACT

**Aims:** This paper defines the disagreements that have deeply divided American clinicians about the prescription of puberty blockers, cross sex hormones, and various surgeries for trans-identified minors. The basic question is what types of evidence should determine clinical management. The issue has not been resolved. Its attendant cultural controversies have spawned lawsuits on ten separate topics in the United States.

**Method:** This paper presents the current arguments of the proponents of affirmative care and those of skeptics. These arguments are found in professional literature and in court documents.

**Results:** Twelve of the most contentious issues are discussed: trustworthiness of the benefits; permanence of a trans identities; biological determinism; ethical priorities; informed consent; impact on suicidality; significance of co-morbidities; autism; processes of evaluation; hegemony of the World Professional Association for Transgender Health; childhood social transition. Despite scientific skepticism, major American medical institutions view these arguments as biased.

**Conclusions:** Perspectives of patients, parents, sociologists, anthropologists, and spokespersons for moral, religious, social justice, and political considerations contribute to the polarized culture. Court decisions are subtly influenced by these perspectives, but their judgments are based on constitutional interpretations. The recent United States Supreme Court ruling upholding Tennessee's ban on hormonal and surgical care does not mean that all affirmative care is banned throughout all 50 states. The author's view is that since outcomes are uncertain, parents, not professionals, should be more widely recognized as key decision makers.

**Keywords:** gender dysphoria, evidence-based medicine, controversies, bias

## Introduction

Only a small percentage of physicians and mental health professionals in the United States ever provided intensive services for trans-gender identified minors and young adults. Such services consist of comprehensive psychiatric evaluations, psychotherapy, parental guidance, hormonal therapy, or surgical interventions. This was remarkable considering the rising incidence of youthful trans identities during the last 15 years. The number of gender specialty clinics in the United States grew along with the incidence and were quite busy. Four forces contributed to the general paucity of professional experience with this growing phenomenon.[1] A policy by the American Psychiatric Association in 2012 that all emerging gender identities were normal and compatible with a full life.[1,2] The 1998 judgment of World Professional Association for Transgender Health's ((WPATH) 5th Standard of Care that these patients required care by specially educated professionals.[2,3] Widespread intuitive unease about sex trait chnges among laypersons and professionals.[4] Professional fear of censure and job loss in an era of cancel culture.

It has been different recently. Controversy, debate, and distrust exist about the previous concept of "best practices."[3] Concerns about hormonal/surgical approach to adolescents and children beginning at Tanner 2 stage were initially muted by a powerful cultural shift of political, legislative, and educational support for trans adults during the 2010's. But now questions have been raised about the moral, scientific, and constitutional legitimacy of affirmative care.[4]

These have been evidenced in national and international media, US legislatures, courtrooms, scholarly reviews, and in other nations. President Trump's executive order on January 20, 2025 established an antitransgender zeitgeist that has further contaminated the previous politicized debate about how best to help young trans-identified persons and their families. The purpose of this paper is to delineate the clinical controversies that exist in this care. It does not directly deal with passionate disagreements from the religious right and the social justice political left. Clinicians, however, are subtly influenced by their political sensibilities.

## Poles of the Controversies

Evidence-Based Medicine (EBM) has created a hierarchy of trustworthiness of clinical research based on the methods employed.[5] Systematic reviews have the highest degree of trustworthiness. Despite inhabiting this pinnacle, EBM recognizes the conclusions only have a high probability, not a guarantee, of correctness. Opinions based on clinical experiences, whether by individuals or groups of individuals, provide the lowest level of certainty, regardless of the speakers' authoritative beliefs.

Two diametrically opposed positions clash. Proponents believe that since affirmative care is safe, effective, and enables a productive life, it should be widely made available. Skeptics assert that affirmative care for youth is not safe, is often ineffective, limits life possibilities, and should be banned. Most prefer that clinical scientific processes should create the change in treatment pattern rather than United States governmental bodies. Each group recognizes the long-honored ethical medical principle that therapeutic interventions should be based on the best available science.[6] Each claim to have science on its side. Proponents weigh clinical experience, parental and patient values over recent data that they argue are methodically flawed. Skeptics say the findings of systematic reviews are determinative, and it is the professional's responsibility to share what is known and not known about outcome so that parent and patient values are informed.

## What Constitutes Scientific Evidence?

Between these high and low levels on the hierarchy are increasingly sophisticated methodologies ranging from single case reports to randomized placebo-controlled trials. The march of clinical science inevitably refines therapeutic practices. In any type of outcome study, the measurement of benefits and harms at various time intervals is highly desirable. This standard has not yet been realized in this arena of care.

This was again illustrated when The Cass Review, the culmination of a four-year multidimensional scientific process appeared in April 2024.[7] Cass recommended psychiatric treatment of these vulnerable young persons before any hormonal treatment was considered. She did not completely exclude hormonal treatment, but she noted that it was unclear how to identify those who would benefit and those who would be harmed. She recommended hormones only in the context of a carefully planned research protocol or upon approval of a national committee after a long period of psychotherapy. Skeptics were relieved, although many thought that any use of puberty blockers was unacceptable.

Ten weeks later, nine proponents of affirmative care wrote that The Cass Review erred in its methods and conclusions and should be ignored.[8] The Cass Review included analysis of eight previous independent systematic reviews and commissioned six new ones. The paper that recommended rejection of the Cass Review was labelled The Integrity Project. It was not peer- reviewed. It appeared on the website of the Yale Law School. A council of the British Medical Association (BMA) immediately endorsed The Integrity Project's conclusions and recommended a pause the UK's new policy that followed Cass's recommendations. The objections of many BMA members led the organization to quickly restate its position as "neutral" and promised its own independent review.[9] Similar promises to provide new independent reviews had been made by American Academy of Pediatrics, The Endocrine Society and WPATH; none have been produced. [WPATH commissioned two reviews but suppressed their publication when the results did not support its recommendations.][10] Three independent peer-reviewed papers analyzed The Integrity Project's claims and found them unconvincing.[9, 11, 12] Ideally readers seeking clarity need to read The Integrity Project and one of its critical reviews lest a conclusion is drawn that the four-year project has no merit.

## Can US Courts Solve the Controversy?

Unable to settle this issue within the American health professions, US state, federal, and juvenile courts have been asked to make judgments. Courts are currently adjudicating ten challenges to:

1. states that have banned trans minor care (as of this writing, 27 states);
2. school districts that have fired teachers who express doubt about the correctness of what is being taught;
3. school districts who have a policy of changing the name of trans-identified student without informing the parents;
4. school districts that have a policy that guides sex/gender requirements for the use of bathroom and locker rooms;
5. school districts that have a policy about hormonally medicated trans-females participating in girls' sport teams;
6. departments of corrections who deny genital surgery to trans-female inmates;
7. post-surgical detransitioners who are bringing malpractice suits;
8. municipal laws that have outlawed "conversion therapy;"
9. parental custody of divorced parents of a trans-identified child;
10. insurance companies' coverage for surgical care.

These cases require legal judgments about constitutional issues about which I have no expertise. As a physician testifying in some of these cases, I can only opine what I understand, but participation has made clear to me that medicine operates within a much larger determinative sociocultural context. Opposing experts read and respond to each other's arguments. This is one of my major sources of my summaries of the views of the proponents of affirmative care. The other is the literature itself.

## 12 Issues of Professional Disagreement

*1. ARE THE STUDIES OF THE BENEFITS OF AFFIRMATIVE CARE TRUSTWORTHY?*

a. *Proponents* assert that EBM criteria have been met by numerous peer-reviewed studies that

have shown that hormonal and surgical treatment benefits minors by improving anxiety, depression, social functioning, diminishing self-harm, and lessening suicidal ideation. They posit that some minors would have committed suicide without these interventions. The studies closely respond to the clinicians' observations of minor and adult patients who highly desired sex trait modifications. "The science is settled" is the strongest assertion of this view.[13] They assert that the conclusions of systematic reviews are not determinant for many reasons including the exclusion of key studies showing benefits.[8]

b. *Skeptics* assert that 17 systematic reviews of puberty blockers, cross sex hormones, and surgery have consistently expressed no or uncertain support for the claimed benefits. Each has raised concerns about potential harms. Studies were judged to be too short-term; lacking suitable control groups; have large lost to follow-up numbers; and used unvalidated measurements to prove direct benefits. Analysis of the studies could not affirm the treatment itself was beneficial because of concomitant maturation, psychotropic drugs, psychotherapy, and placebo effects. Studies also minimized reporting on the adolescents whose mental or physical state worsened. When news of suppression of negative research results with puberty blockers and cross sex hormones surfaced in 2024, the argument that these treatments were evidence-based evaporated.[14]

*2. IS GENDER DYSPHORIA A PERMANENT STATE OF BEING?*

Since hormonal and surgical care permanently change anatomy, physiology, sexual and reproductive capacities, proponents must assume that a trans identity with dysphoria is a permanent state. It is tragic for an individual who after undergoing irreversible somatic changes decides to resume a cis identity.

a. *Proponents* assert that once accurately diagnosed, Gender Dysphoria is permanent among both childhood-onset and post-pubertal cases. The vast majority of patients will have a lifelong sense of being a binary or non-binary trans person. They claim that a careful diagnosis of Gender Dysphoria is the vital first step of affirmative care. The therapy enables these young persons to live their genuine, true, authentic selves. They assume that these children and adolescents themselves know best who they are. Clinicians should trust their statements.

b. *Skeptics* emphasize that the diagnosis provides no guarantee of its persistence throughout childhood or adolescence, let alone adulthood. Detransition after affirmative care demonstrates that meeting diagnostic criteria for Gender Dysphoria provides no assurance of permanence. Cohort studies and Internet testimonies of those who have stopped affirmative care are well known.[5, 16, 17] The 2% rate after genital surgery is not believable because it is based on unrealistic definition of regret or among groups with high lost to follow up rates.[18] Recent published rates of the discontinuance of affirmative care among young adults now range between 7% and 60% over up to a seven-year period.[19, 20, 21] Direct prospective rates of detransition are unknown among those who have had, and those who have not had, affirmative care. Because young people's current authentic self is in evolution, their life experience is limited, and their psychological sophistication is immature, it is not surprising that adolescents detransition.

*3. ARE TRANS IDENTITIES BIOLOGICALLY CAUSED?*

Most youthful behaviors flow in part from biological characteristics such as temperament, ease of childhood adaptation, and capacities to learn, socialize, and perform. The disagreement focuses on the degree of biological influence.

a. *Proponents* assume that prenatal biological processes have generated the many forms of trans identities. These conclusions appear in

published papers, expert reports, and in court testimony. They represent Gender Dysphoria as a serious medical condition that makes changing sex traits medically necessary, not because of gender dysphoria, per se, but because it is desired by the patient. These prenatal processes are thought to involve immunogenic, endocrine, genetic, and brain structural differences.

b. *Skeptics* agree with the possibility of a biological influence, but not at the level of causation. Gender Dysphoria is a psychiatric disorder. Hormonal or surgical treatment does not make its etiology biologic. A belief in biological determinism lessens ethical qualms about life-changing interventions. Gender dysphoria is constructed by the unconscious interplay of biological, developmental, psychological, interpersonal, and cultural processes. The degree of influence of these categories differs from person to person. Almost all professionals recognize that adverse childhood events contribute to many cases.

4. *JUSTICE HOW TO PRIORITIZED FIVE PRINCIPLES OF ETHICS.*

Above all do no harm, act in patients' best health interests, respect the patients' autonomy justice, and proportionality are embedded in all clinical care. Justice and proportionality are moot issues. Justice requires firm knowledge what is the "best treatment." Proportionality, weighing the tradeoffs of various approaches, requires parents to weigh their understanding of the short-term vs long-term benefits and harms and to grasp side effects can become long term harms.

a. *Proponents* prioritize respect for autonomy justice over other principles, assuming short-term benefits, tolerable side effects, and a minimum of harms. When doctors, parents, and patients share beliefs in the capacity of affirmative interventions to cure or significantly ameliorate the young person's distress, the principle of autonomy justice leads to the treatment that the minor desires. Psychiatric evaluation can be brief, efficient, and aimed at qualifying the minor for affirmative care.[22] Proponents assert great harms, including suicide, in delaying treatment. Their approach emphasizes respect for the parents' and patients' values, the minors' right to treatment of their choice, and the sanctity of the doctor-patient-parent relationship.

b. *Skeptics* state that the principle of autonomy must be viewed against the inherent changeability over time of children's and adolescents' interests, capacities, self-understanding, and sense of reality. Most aspects of identity evolve over time. They worry that some parents may not be informed about the long-term risks. They note that many providers in the over 100 US specialty clinics (as of 2024) just do what they were taught and are unaware of the controversies in the field. They argue that it is an error to privilege an inconsistently demonstrated short-term benefit (beneficence) over a multidimensionally difficult future that may unfold (maleficence). Children's right to determine their future in the future when they are more experienced with life's demands should not be denied by premature care.[23]

5. *DIFFERING VIEWS ON INFORMED CONSENT*

Parents or a guardian must consent to the minor's medical and surgical interventions. In most states in the US, the age of consent is 18. There are five issues of disagreement: 1). Should some cognitively mature adolescents be able to independently provide informed consent? 2). What information about the long-term risks of physical, mental, and social harms must be conveyed to the family? 3). Should parents be led to believe that puberty blockers are entirely reversible? 4). Should parents be told that the purpose of puberty blockers is to allow more time for the child to decide to live as a trans person? 5). Are parents led to believe that psychotherapy is a legitimate alternative to hormonal intervention?[24] Some have suggested

that the purpose of a thorough informed consent a tactic to prevent affirmative care.[25]

Informed consent presumes that parents and minors are equipped to process the relevant information. Parents may find it difficult to think about, let alone discuss, adult sexual dysfunction and a limited pool of others for romantic connection with their unhappy child or adolescent. Professionals and parents of daughters often subtly collude to avoid discussion of the sensual pleasures of the breasts. Professionals are unlikely to mention evidence of a limited life span.

a. *Proponents* thoughtfully scrutinize their patients' understanding of their discussions and often conclude they can legally consent. In family sessions, they discuss desired medical effects, side effects, untoward risks of hormones and surgery, and gamete preservation. The family can ask questions then or thereafter. Parents sign a consent document. Since affirmative care is life-changing, it is assumed that they have recurrently considered its pros and cons at home. The is why the multidisciplinary process is called the Informed Consent Model.[26] When one step, for example puberty blockers, is being considered, the consent process does not deal with a later steps.[27] Patients want these treatments and parents know that doctors cannot guarantee future events.

b. *Skeptics* emphasize that brains attain their mature judgmental capacity around age 25.[28] They note that society has age limitations for activities such as military service, driving, voting, drinking alcohol, sterilization, and tattooing. Adolescence is a years-long highly emotional phase characterized by certainty, changeability, formation of self-worth based on peer acceptance, and growth of realistic thinking and self-knowledge from emerging experience with eroticism, partner sex, and love. Affirmative care of minors precedes these maturational experiences. Most adolescents look back in embarrassment about some of their previous decisions.

6. *THE IMPACT OF AFFIRMATIVE CARE ON SUICIDALITY AND SUICIDE*

In exploring the common suicidal ideation found among trans-identified adolescents clinician must decide whether it is the untreated gender dysphoria or the preexisting psychiatric problems that largely contribute to suicidality.[29] They must have an opinion whether affirmative care prevents suicidality over the life cycle.

a. *Proponents* are certain that their care diminishes suicidality as soon as hormones are agreed upon and saves some minors from suicide.[30] They argue that any form of suicidality—thoughts, gestures, plans, attempts—indicates the need of affirmative care. They assert that such care leads to a greater commitment to live. Hormonal administration is life enhancing and sometimes is lifesaving.

b. Skeptics note that trans adolescent suicides have the same low incidence as diagnosed bipolar and schizophrenic adolescents. Although rare[31] these tragedies occur at every stage of affirmative care.[32,33] It is pronounced at 10+-years.[34] Co-morbid psychiatric problems are the rule, not the exception.[35] They do not inevitably disappear just because the minor is happy with hormonal treatment.[36] These psychiatric problems are often accompanied by suicidal thoughts, suicide attempts, and occasionally, suicide. Suicidality is an indication for time-honored psychiatric interventions.

7. *DIFFERENT VIEWS ON THE POOR MENTAL HEALTH OF YOUTH ASKING FOR AFFIRMATIVE CARE.*

a. *Proponents* assume that much of the accompanying psychiatric symptoms--eating disorders, depression, anxiety, social avoidance, self-harm--are either a consequence of the

gender incongruence or that they are irrelevant to treatment of gender dysphoria. If they assume the former, they hurry to treat. If they assume the latter, they see no reason to delay treatment. Would a doctor delay treatment of an ear infection because a child is diabetic?

b. Skeptics consider the possibility that the current gender identity is a creative intrapsychic solution to avoid facing the existential difficulties associated with their symptoms. Few patients are restored to normal by affirmative care and some deteriorate. Adult trans communities have many indicators of poor mental health.[37] Co-morbidities should be treated first to maximize future mental health regardless of the patients' ultimate gender expressions [38,7]

8. *DIFFERENT VIEWS OF THE TREATMENT SIGNIFICANCE OF AUTISM*

a. *Proponents* argue that these individuals should not be deprived of timely access to affirmative care.[39] Their distress may be even more intense than those who are not on the spectrum. In articulating the benefits of affirmative care, this group is not separated from those who are recognized as not on the spectrum.

b. *Skeptics* think that management needs to be more cautious. The new identity should be understood in terms of the social isolation, poor social skills, rigidity, loneliness, and idiosyncratic interests common among autistic persons. Autistic adults *without* gender dysphoria have a three-fold rate of suicide; the prevalence of autism among those seeking affirmative care is seven-fold its prevalence in the general population.[40] Many autistic people present themselves as asexual (not attracted to any person) and disinterested in romance during adolescence. They may masturbate for the pleasure of orgasm. Trans autistic patients may be seeking relief from their painful socially isolated lives.

*9. DISAGREEMENTS ABOUT THE PURPOSE OF THE REQUIRED COMPREHENSIVE PSYCHIATRIC EVALUATION*

Twenty-three treatment guidelines recommend a comprehensive psychiatric evaluation as the first step.[41] However, the purpose, the topics to be evaluated, and how to manage the co-morbidities differ.

a. P*roponents* perceive four purposes: ascertain the presence and stability of gender dysphoria; ascertain the state of any physical and mental co-morbidities; decide whether the patient understands the risks of affirmative care; recommend a prudent next step. If other problems are under good control, proceed. If not, refer for psychiatric care to attain better control.[3] The evaluation can be done with the adolescent patient, but parents must provide some history. The evaluation can often be accomplished in one or two 50-minute sessions.[42] Support for the current identity should always be provided.

b. *Skeptics* think the process should take several hours with the parents so that a history beginning in pregnancy can be taken, the family's interpersonal environment can be assessed, and the parent's separate attitudes toward the gender change can be understood. Four questions should be explored during the evaluation. Why is the person repudiating his or her biological sex? What is it about the opposite gender that patient wants to emulate? What has been the sequence of the various co-morbidities. Are the co-morbidities causative, consequential, or unrelated? Parents and some patients want to know "What is going on here? The purpose is to support and strengthen parent-child bonds.[22] Some older minors report being provided with recommendations for cross-sex hormones within 45 minutes.

10. *DISAGREEMENTS ABOUT THE ROLE OF PSYCHOTHERAPY*

a. *Proponents* promulgate that all forms of gender identity are normal, and that therapists must never question why the minor has assumed this identity. They must be supportive while allowing the minors to make up their minds about how to express their gender now and in the future.[3] They label any attempt to investigate the origins of the identity as "conversion therapy" and desire it to be outlawed. They describe claims of psychotherapy's effectiveness to be anecdotal and lacking in randomized controlled studies showing efficacy.

b. *Skeptics* remind proponents that all other psychiatric problems of youth can be explored in a psychotherapeutic process and ask why gender dysphoria is an exception?[38] Therapists are committed to neutrality, like proponents, about the minor's ultimate personal choice of gender expression.[43] They want to identify conflicts about homosexual desire, prior victimization, and disidentifications with a parent or sibling, self-hatred, pessimism, exposure to pornography and the Internet influences on the crystallization of the new identity. Parents often need help in dealing calmly with their child.[22] There are no placebo-controlled trials in any arena of trans care.

*11. IS WPATH's STANDARDS OF CARE, 8th EDITION, A SCIENTIFICALLY INFORMED SET OF GUIDELINES?*

The professional world looked to this multidisciplinary non-governmental organization for "best practices" for 50 years. Recent events have undermined its authority in many circles.

a. *Proponents* are the experts in this field. They have been the dominant writers of guidelines from the Endocrine Society and the 8th edition of the Standards of Care. WPATH's expertise is recognized by many American medical institutions. Many members specialize only in these patients. Evidence has accumulated over many decades that these patients want medical and surgical care and benefit from it. If the care was detrimental, it would have been evident years before among adults. Their recommendations are based on many studies using the respected Delphi method of creating recommendations by 75% consensus. The 8th edition represents a summary of the evidence-based advances in the field.

b. *Skeptics* note that six developments have steadily created doubt about the 8th version. These include: the Scandinavian and UK scrutiny of the poor results when they followed WPATH guidelines; the recognition of bias, conflict of interest, and contradictions within the 7th and 8th editions of WPATH's Standards of Care; the publication of the WPATH Files which was based on leaked discussions among the developers of the 8th edition;[44] the Cass Review's guidance;[7] the discovery that WPATH suppressed the findings of its commissioned systematic review of hormones; the 2025 United States Health and Human Services review of the topic.[45] WPATH, dominated by the ethics of patient autonomy, accepts creating both genital-less pelves and one that contains a vagina and a penis if a patient requests either. Support from other medical institutions should not be taken as evidence of effectiveness and safety since these groups did not review the relevant data.

*12. SHOULD CHILDREN WHO CROSS GENDER IDENTIFY BEFORE AGE 6 BE SOCIALLY TRANSITIONED?*

a. *Proponents* have suggested that it may be a good thing to do with these children whose gender atypicality was evidenced in the preschool years and who state that "I am a girl (or boy)" or I want to be a girl (or boy). The American Academy of Pediatrics in 2018 asserted that this was a preferred option although in 2023 the organization offered it

as one of several good options.[46] This is based on their future treatment with puberty blockers, hormones, and surgery because this is assumed to be a biogenic condition.

b. *Skeptics* point out that the desistence rate of these children ranges from 60 to 88% by middle adolescence and since no one can predict who will persist and who will desist, it is ethically wrong to socially transition a child.[47] Some data suggest that only 20% of those who are transitioned desist.[48]

## Discussion

These camps of disagreement are based on differing interpretations of the fundamental question, "What qualifies as compelling scientific evidence?" Twelve controversies derive from this question. While there is reasonableness to some of the proponents' arguments, I am generally skeptical because of my synthesis of the fundamental overarching issue. In this article I have aimed to simplify the complexity of this arena of care through clarity of the derivative clinical questions. Science does not advance from authority or fashion; it makes progress through skepticism. When a controversy is well defined, a researcher can design a study to generate new data that may illuminate its resolution.

The resolution of these twelve controversies will have great clinical significance. It will dictate how doctor-parent-minor patient teams should function. Caring parents should be presumed to know more about their child than the doctor, nurse practitioner, psychologist or counselor does. Parents are deeply aware of their offspring's strengths and limitations, long-standing behavioral patterns, and sources of tensions in the family. Professionals should be presumed to know more about gender dysphoria, its treatment possibilities, and the benefits and harms of affirmative and psychotherapeutic approaches. The interaction of the team has evolved over the previous decade; parental input is more valued today. Parents should be allowed to speak freely, give their account, and share their concerns rather than simply be questioned about their child's gender identity development. A goal of any initial evaluation is to establish trust between the practitioner and the family.

The sanctity of the doctor-patient-parent relationship has long been culturally and legally acknowledged. It is based on the family's assumption of the doctors' superior knowledge, beneficence, and their commitment to do no harm. It assumes that the guidance is based on modern agreed upon science. Today, when parents immerse themselves in modern pediatric trans care, some realize that doctors are not of one mind on how best to treat their children. Professionals should realize that two evaluations are simultaneously occurring; the second being that the family is evaluating the professional. In the United States skepticism of the medical profession has grown considerably from the passions related to COVID restrictions. Parental awareness of the disagreements among medical professionals about trans care of youth has added to this phenomenon. Their skepticism should not be viewed as negative. Much is at stake for them and their family now and for the distant future.

On a professional intellectual level, passionate beliefs, medical consensus, blanket endorsement of numerous health organizations, dismissal of the Cass Review, and methodologically limited scientific reports do not add up to "the science is settled."[8,12,13,45,49,50] Given today's medical cultural climate, it may be wise that all future informed consent processes should quote Hillary Cass as concluding that some minors might benefit from affirmative care but there is no certainty on how to identify them. Professionals do not have a crystal ball about the outcome in individual cases. It is reasonable for all professionals to try to answer the parents' question of "What is going on here?"

The field should recognize that parents, not professionals, should make the key management decisions after being informed about the state of knowledge. I sense this idea is gaining in ascendence of late. Previously, parents asked pediatricians and

gender specialists what they should do. The idea that one size fits all is both wrong for the treatment of diverse minors and for the approach to diverse parents. Parents arrive with various degrees of education, erudition, trust, and motivation. Clinical situations evolve based on the unique characteristics of minors and their families. In dealing with each family, professionals will recognize that many of the twelve issues quickly become relevant.

The fundamental question discussed in this paper has most commonly been recognized in some European countries' policies than in the United States. The United States is challenged by not having a single health agency reviewing emerging science to create a national policy. Here 50 states are influenced by their legislatures and governors. The result is a hodge podge of policies, based on political sensibilities rather than on science. Governments and the courts are more important in the United States than the processes of science, per se, as evidenced by President Trump's Executive Order and the Supreme Court's ruling upholding a state's ban on affirmative care.[51]

In the rush to promulgate affirmative care after the 2014 publication of the reported positive results of the Dutch Protocol,[52] many have recognized that today's modal patient does not resemble those originally treated in Amsterdam. In 2014 detransition was relatively unknown; today it is a major consideration.[53]

In American courts. one can get a sense that the legal issues can be illuminated by patient, parental, sociological, moral, anthropological, religious, social justice, and political perspectives. Decisions are presented, however, in terms of constitutional issues. The scientific debate may be factored into the decisions but seem to be secondary to legal interpretations.[54]

There remains a formidable wall of medical institutional resistance to recognizing, admitting, and changing official stances about affirmative care for youth. This is not restricted to the United States.

It is important not to confuse support for adults who decide to alter their sex traits from the ethical concerns about altering these traits in minors. This paper is focused only on issues related to minors.

## Conclusions

The basic and derivative controversies summarized here remind all readers that education and indoctrination have different meanings. Science advances by acknowledging uncertainties and controversies. Indoctrination creates enemies of those who disagree and retards the processes of improving care. The most civilized dismissive thing to say about those who disagree is that they are biased. One camp's facts are the other camp's fiction.[12] Much worse is said within the American cancel culture.[55] Mental health professionals and medical professionals, particularly when they are in training or new to their careers, should be introduced to this care as controversial and explained why. Many are being taught that affirmative care is how this condition is to be treated.

The intellectual debates among professionals in this arena of care are crucial to the care of minors and their families. Professional assumptions may not be apparent to patients and parents, but they are to other professionals. It is important to acknowledge one's biased inclinations about the controversies to family members and to admit uncertainty. Since decisions, ideally made within the family, have great short- and long-term consequences for every member of the family, professionals are expected to be honest, informed, and balanced, not authoritative. It is not fair to the profession, patients, their families, individual professionals, and culture to continue to assert that the science is settled. It is not.

## References:


1. Byne W, Bradley SJ, Coleman E, et al. Report of the American Psychiatric Association Task Force on Treatment of Gender Identity Disorder. *Arch Sex Behav*. 2012;41(4):759-796. doi:10.1007/s10508-012-9975-x

2. Levine, S. B., Brown, G. R., Coleman, E., Cohen-Kettenis, P. T., Van Maasdam, J., Pfafflin, F., & Schaefer, L. C. (1998, June 15). *The Standards of Care for Gender Identity Disorders, Fifth Edition*. HBIGDA/WPATH.

3. Coleman, E., Radix, A. E., Bouman, W. P., Brown, G. R., de Vries, A. L. C., Deutsch, M. B., Ettner, R., Fraser, L., Goodman, M., Green, J., Hancock, A. B., Johnson, T. W., Karasic, D. H., Knudson, G. A., Leibowitz, S. F., Meyer-Bahlburg, H. F. L., Monstrey, S. J., Motmans, J., Nahata, L., Nieder, T. O., … Arcelus, J. (2022). Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. *International journal of transgender health*, *23* (Suppl 1), S1–S259. https://doi.org/10.1080/26895269.2022.2100644

4. Block J. Gender dysphoria in young people is rising-and so is professional disagreement. *BMJ*. 2023;380:382. Published 2023 Feb 23. doi:10.1136/bmj.p382

5. Guyatt GH, Oxman AD, Vist GE, et al. GRADE: an emerging consensus on rating quality of evidence and strength of recommendations. *BMJ*. 2008;336 (7650):924-926. doi:10.1136/bmj.39489.470347.AD

6. AMA https://code-medical-ethics.ama-assn.org/principles

7. Cass, H. (2024). Independent review of gender identity services for children and young people: Final report. Available from: https://cass.independent-review.uk/home/publications/final-report/

8. McNamara M, Baker K, Connelly K, et al. 2024. An evidence-based critique of the "Cass Review' on gender-affirming care for adolescent gender dysphoria. Available: https://web.archive.org/web/20240702100251/https://law.Yale.edu/sites/default/files/documents/integrity-project_Cass-response.pdf

9. Cheung CR, Abbruzzese E, Lockhart E, Maconochie IK, Kingdon CC. Gender medicine and the Cass Review: why medicine and the law make poor bedfellows. *Arch Dis Child*. 2025;110(4):251-255. Published 2025 Mar 19. doi:10.1136/archdischild-2024-327994

10. Marshall S. May 1, 2025. Attorney General Steve Marshall Announces Victory in Defense of Alabama's Law Prohibiting Sex-Change Procedures for Minors

11. McDeavitt K, Cohn J, Levine SB. Critiques of the Cass Review: Fact-Checking the Peer-Reviewed and Grey Literature. *J Sex Marital Ther*. 2025;51 (2):175-199. doi:10.1080/0092623X.2025.2455133

12. Kingdon C, Stingelin-Giles N, Cass H. The Cass Review; Distinguishing Fact from Fiction. *Am J Bioeth*. 2025;25(6):5-10. doi:10.1080/15265161.2025.2504397

13. McNamara M, Lepore C, Alstott A. Protecting Transgender Health and Challenging Science Denialism in Policy. *N Engl J Med*. 2022;387(21): 1919-1921. doi:10.1056/NEJMp2213085

14. Boe v. Marshall, No. 2:22-Cv-00184: 700-18 (M.D. Ala. October 9, 2024).

15. Expósito-Campos P. A Typology of Gender Detransition and Its Implications for Healthcare Providers. *J Sex Marital Ther*. 2021;47(3):270-280. doi:10.1080/0092623X.2020.1869126

16. Littman L. Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners. *Arch Sex Behav*. 2021;50(8):3353-3369. doi:10.1007/s10508-021-02163-w

17. Vandenbussche E. Detransition-Related Needs and Support: A Cross-Sectional Online Survey. *J Homosex*. 2022;69(9):1602-1620. doi:10.1080/00918369.2021.1919479

18. Abbruzzese E, Levine SB, Mason JW. The Myth of "Reliable Research" in Pediatric Gender Medicine: A critical evaluation of the Dutch Studies-and research that has followed. *J Sex Marital Ther*. 2023;49 (6):673-699. doi:10.1080/0092623X.2022.2150346

19. Hall R, Mitchell L, Sachdeva J. 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*. 2021;7(6):e184. Published 2021 Oct 1. doi:10.1192/bjo.2021.1022

20. Boyd I, Hackett T, Bewley S. Care of Transgender Patients: A General Practice Quality Improvement Approach. *Healthcare (Basel)*. 2022; 10(1):121. Published 2022 Jan 7. doi:10.3390/healthcare10010121

21. Roberts CM, Klein DA, Adirim TA, Schvey NA, Hisle-Gorman E. Continuation of Gender-affirming Hormones Among Transgender Adolescents and Adults. *J Clin Endocrinol Metab*. 2022;107(9):e3937-e3943. doi:10.1210/clinem/dgac251

22. Levine SB. What is the Purpose of the Initial Psychiatric Evaluation of Minors with Gender Dysphoria. *J Sex Marital Ther*. 2024;50(6):773-786. doi:10.1080/0092623X.2024.2362774

23. Jorgensen SCJ, Athéa N, Masson C. Puberty Suppression for Pediatric Gender Dysphoria and the Child's Right to an Open Future. *Arch Sex Behav*. 2024;53(5):1941-1956. doi:10.1007/s10508-024-02850-4

24. Levine SB, Abbruzzese E, Mason JW. Reconsidering Informed Consent for Trans-Identified Children, Adolescents, and Young Adults. *J Sex Marital Ther*. 2022;48(7):706-727. doi:10.1080/0092623X.2022.2046221

25. Drescher J. Informed Consent or Scare Tactics? A Response to Levine et al.'s "Reconsidering Informed Consent for Trans-Identified Children, Adolescents, and Young Adults". *J Sex Marital Ther*. 2023;49(1):99-107. doi:10.1080/0092623X.2022.2080780

26. Cavanaugh T, Hopwood R, Lambert C. Informed Consent in the Medical Care of Transgender and Gender-Nonconforming Patients. *AMA J Ethics*. 2016;18(11):1147-1155. Published 2016 Nov 1. doi:10.1001/journalofethics.2016.18.11.sect1-1611

27. Parkinson P. Adolescent Gender Dysphoria and the Informed Consent Model of Care. *J Law Med*. 2021;28(3):734-744.

28. Baxendale S. The impact of suppressing puberty on neuropsychological function: A review. *Acta Paediatr*. 2024;113(6):1156-1167. doi:10.1111/apa.17150

29. Nunes-Moreno M, Furniss A, Cortez S, et al. Mental Health Diagnoses and Suicidality Among Transgender Youth in Hospital Settings. *LGBT Health*. 2025;12(1):20-28. doi:10.1089/lgbt.2023.0394

30. Matouk K, Wald M. Gender-affirming care saves lives. 2022. Available: https://www.columbiapsychiatry.org/news/gender-affirming-care-saves-lives [Accessed 17 Oct 2023].

31. Ruuska SM, Tuisku K, Holttinen T, Kaltiala R. 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 Ment Health*. 2024;27(1):e300940. Published 2024 Feb 17. doi:10.1136/bmjment-2023-300940

32. de Blok CJ, Wiepjes CM, van Velzen DM, et al. Mortality trends over five decades in adult transgender people receiving hormone treatment: a report from the Amsterdam cohort of gender dysphoria. *Lancet Diabetes Endocrinol*. 2021;9(10):663-670. doi:10.1016/S2213-8587(21)00185-6

33. Wiepjes CM, den Heijer M, Bremmer MA, et al. Trends in suicide death risk in transgender people: results from the Amsterdam Cohort of Gender Dysphoria study (1972-2017). *Acta Psychiatr Scand*. 2020;141(6):486-491. doi:10.1111/acps.13164

34. Dhejne C, Lichtenstein P, Boman M, Johansson AL, Långström N, Landén M. Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden. *PLoS One*. 2011;6(2):e16885. Published 2011 Feb 22. doi:10.1371/journal.pone.0016885

35. Edwards-Leeper, L. et al. (2017). Psychological Profile of the First Sample of Transgender Youth Presenting for Medical Intervention in a U.S. Pediatric Gender Center. *Psychology of Sexual Orientation and Gender Diversity* 2017: 4(3) 374.

36. Chen D, Berona J, Chan YM, et al. Psychosocial Functioning in Transgender Youth after 2 Years of Hormones [published correction appears in N Engl J Med. 2023 Oct 19;389(16):1540. doi: 10.1056/NEJMx230007.]. *N Engl J Med*. 2023;388(3):240-250. doi:10.1056/NEJMoa2206297

 

37. Liszewski W, Peebles JK, Yeung H, Arron S. Persons of Nonbinary Gender - Awareness, Visibility, and Health Disparities. *N Engl J Med*. 2018;379 (25):2391-2393. doi:10.1056/NEJMp1812005

38. D'Angelo R. Supporting autonomy in young people with gender dysphoria: psychotherapy is not conversion therapy. *J Med Ethics*. 2024;51(1): 3-9. Published 2024 Dec 23. doi:10.1136/jme-2023-109282

39. Turban JL. Potentially Reversible Social Deficits Among Transgender Youth. *J Autism Dev Disord*. 2018;48(12):4007-4009. doi:10.1007/s10803-018-3603-0

40. Rea HM, Øien RA, Webb SJ, Bansal S, Strang JF, Nordahl-Hansen A. Gender Diversity, Gender Dysphoria/Incongruence, and the Intersection with Autism Spectrum Disorders: An Updated Scoping Review. *J Autism Dev Disord*. Published online December 4, 2024. doi:10.1007/s10803-024-06650-6

41. Taylor J, Hall R, Heathcote C, Hewitt CE, Langton T, Fraser L. Clinical guidelines for children and adolescents experiencing gender dysphoria or incongruence: a systematic review of recommendations (part 2). *Arch Dis Child*. 2024;109(Suppl 2):s73-s82. Published 2024 Oct 30. doi:10.1136/archdischild-2023-326500

42. Damiano, M. (2024, December 20). A leader in transgender health explains her concerns about the field. *Boston Globe*. https://archive.is/HrnlK

43. Sinai J, Sim P. Psychodynamic psychotherapy for gender dysphoria is not conversion therapy. *J Can Acad Child Adolesc Psychiatry*. 2024;33(2):145-153.

44. Hughes M. The WPATH Files: Pseudoscientific surgical and hormonal experimental treatments of children, adolescents and vulnerable adults. Environmental Progress, March 4, 2024.

45. Health and Human Services. (May 1, 2025). Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices *https://opa.hhs.gov/sites/default/files/2025-05/gender-dysphoria-report.pdf*

46. Rafferty J; COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH; COMMITTEE ON ADOLESCENCE; SECTION ON LESBIAN, GAY, BISEXUAL, AND TRANSGENDER HEALTH AND WELLNESS. Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents [published correction appears in Pediatrics. 2023 Oct 1;152 (4):e2023063756. doi: 10.1542/peds.2023-063756]. *Pediatrics*. 2018;142(4):e20182162. doi:10.1542/peds.2018-2162

47. Cantor JM. Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy. *J Sex Marital Ther*. 2020;46(4):307-313. doi:10.1080/0092623X.2019.1698481

48. Zucker KJ. Debate: Different strokes for different folks. *Child Adolesc Ment Health*. 2020;25(1):36-37. doi:10.1111/camh.12330

49. McDeavitt K, Cohn J, Kulatunga-Moruzi C. Pediatric Gender Affirming Care is Not Evidence-based. *Curr Sex Health Rep. 2025;* **17**, 12-17. https://doi.org/10.1007/s11930-025-00404-w

50. McDeavitt K, Cohn J, Levine SB. Critiques of the Cass Review: Fact-Checking the Peer-Reviewed and Grey Literature. *J Sex Marital Ther*. 2025;51 (2):175-199. doi:10.1080/0092623X.2025.2455133

51. United States v. Skrmetti, 605 U.S.___,2025 WL1698785 (June 18, 2025)

52. de Vries AL, McGuire JK, Steensma TD, Wagenaar EC, Doreleijers TA, Cohen-Kettenis PT. Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics*. 2014;134(4):696-704. doi:10.1542/peds.2013-2958

53. Irwig MS. Detransition Among Transgender and Gender-Diverse People-An Increasing and Increasingly Complex Phenomenon. *J Clin Endocrinol Metab*. 2022;107(10):e4261-e4262. doi:10.1210/clinem/dgac356

54. Sutton C.J., White, J., Thepar J. 2023 *L. W., et al. v. Skrmetti, et al./ Jane Doe 1, et al. v. Thornbury, et al. Case Nos. 23-5600/5609. Tennessee/Kentucky*

55. Ashley F. Interrogating Gender-Exploratory Therapy. *Perspect Psychol Sci*. 2023;18(2):472-481. doi:10.1177/17456916221102325

 