THE EUROPEAN SOCIETY OF MEDICINE
Medical Research Archives, Volume 14 Issue 4

RESEARCH ARTICLE

Controversies About the Genesis of Adolescent Gender Dysphoria: A Hypothesis

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OPEN ACCESS

PUBLISHED
30 April 2026

CITATION
Levine, S.B., 2026. Controversies About the Genesis of Adolescent Gender Dysphoria: A Hypothesis. Medical Research Archives, [online] 14(4).

ISSN
2375-1924

ABSTRACT

Aims: Weak evidence exists to justify each extreme position on the controversy between supportive and exploratory psychotherapy for transgender identified youth. These positions differ in presumptions about the mechanisms of formation of a post-pubertal new gender identity. The question remains--which approach maximizes the patients' long-term mental and physical health benefits?

Methods: The two forms of psychotherapy's assumptions, content, duration, settings, and purpose are explained. The varied education of psychotherapists and the diversity youth themselves are also presented. This review reminds that patients are in control of their gender identity and gender expressions and that no therapeutic technique for inducing desistance exists.

Results: A new hypothesis is generated to include biological contributions (predisposing factors) and psychosocial factors (precipitating and maintaining factors): A new transgender identity is a private, creative, unconscious, intrapsychic, often maladaptive solution to existential pain deriving from intense disappointment with oneself or trauma outside or within the family. The utility of this hypothesis is explained.

Conclusions: There is no long-term evidence to support either opposing belief systems. Psychiatric tradition argues that clinicians should remain interested in the mechanisms of symptom formation, including major identity shifts, to ameliorate distress. It is not likely that science will be able to settle the fundamental disagreements.

Keywords: Supportive Psychotherapy, Exploratory Psychotherapy, Controversy, Transgender youth, New multifactorial hypothesis

Introduction

Unlike other uncertainties within Medicine, the controversies concerning the management of adolescent gender dysphoria are passionately held. This affective intensity tends to obscure objectivity. The divergent positions differ about etiology, the role of scientific findings in clinical decision making, applicable ethical principles, and the rights of minors to self-determination[1]. In all medical specialties understanding pathogenesis is the preferred basis for treatment. When the etiology is completely unknown treatment must be directed at symptoms. The disagreements on etiology focus on the relative importance of pre-natal versus post-natal development. Recently, the prenatal biology-is-the-cause position has offered a paradigm shift that asserts that there are more than two sexes[2]. Polarization and cancel culture has made it difficult for clinicians to understand the two positions. The recent dramatic rise in new gender identities among adolescents has made understanding these controversies into a vital topic for patients, their immediate families, and the professionals who provide their care. This article's purpose is to clarify the therapeutic implications of the disagreements.

On the surface, all clinicians agree that some form of psychotherapy is useful for transgender-identified youth. Beneath this fragile concordance, meaningful disagreement exists concerning what type of psychotherapy, if any, should be provided to these minors and young adults. Each side believes that its therapeutic approach maximizes mental and physical health benefits and reduces future harms. Neither side has convincing evidence to support its beliefs about the "best treatment" approach for long-term outcomes[1]. Each only has convictions. This review summarizes the opposing concepts of care, examines "psychotherapy" in a realistic practical manner, and offers a new hypothesis to recognize biological givens and post-natal influences, thereby bridging the gap somewhat between extreme positions.

SUPPORTIVE-ONLY PSYCHOTHERAPY

Many professionals are skeptical about psychotherapy as a treatment of gender distress. The World Association for Transgender Health (WPATH), for instance, considers that the role of psychotherapy is to support the patients through their transitions and to modify their minority stress.[3] This organization has been immensely successful in influencing professional education throughout the world. Early in this century, WPATH began to assert that traditional psychotherapy did not cure the problem, but sex trait modification did. This overarching generalization seems to be associated with other assumptions:

1. The origin of transgender identities is largely biologic;
2. Once established and declared, the identity is relatively immutable;
3. All transgender identities are normal variations of gender identity development without inherent limitations;
4. A transgender identity is compatible with a long, successful social and vocational life;
5. Emotional harm ensues when affirmative care is delayed or prevented;
6. Any attempt to investigate the developmental or social antecedents of a young person's transgender identity is harmful, unethical, and should be outlawed as conversion therapy;[4]
7. Most American medical organizations support social transition and sex trait modification.

These seven concepts are extreme positions. Many who favor efficient social transition, hormones and surgery for minors and young adults may want to add, "yes, but…"

TRADITIONAL PSYCHOTHERAPY

Adolescence has long been understood as a prolonged period of exploration and expansion of many dimensions of the physical and psychological self. Personality change is necessary, expected, and should be protected. Precluding the multiple aspects

of identity exploration that occur during the eight or more years of post-pubertal psychological maturation via medicalization prematurely consolidates a trans-identity. Medical interventions defy the time-honored basic medical principle that the least invasive interventions should precede more invasive ones. Life-constricting harms can only be fully appreciated in the future.

At least eight organizations have asserted that youthful gender dysphoria should not be viewed as an exception to centuries of medical wisdom. These include the national health services of the UK, Finland, Norway, and Sweden, the Society for Evidence-Based Gender Medicine; Genspect, Do No Harm, and Therapy First. Within many other countries, such as the United States and Australia, clinicians line up with either the affirmative care model or the position that these patients require a separate comprehensive mental health evaluation followed by exploratory psychotherapy.[5] The proponents of traditional psychotherapy point to four major independent publications that diminished the authority of WPATH's affirmative care advocacy: the Cass Report,[6] the findings of WPATH's suppression of scientific findings that emerged in an Alabama trial,[7] Block's BMJ analysis,[8] and the U.S. Health and Human Services report.[9]

PSEUDO-AGREEMENT ABOUT EVALUATION

Every one of the 23 treatment guidelines for gender dysphoria, including WPATH, states a recommendation for a comprehensive psychiatric evaluation.[10] This should be rephrased as a comprehensive mental health evaluation so as not to imply that only a psychiatrist can do the evaluation. The affirmative care evaluation process seeks to define the patient's readiness for sex trait modification. It enables transgender-identified youth who currently desire bodily change to have hormonal therapy if associated psychiatric problems are under reasonable control.

Those who support traditional psychotherapy define a far more extensive comprehensive mental health evaluation followed by a long-enough duration of psychotherapy for patients to learn about the antecedents of their gender change, to improve their mental health, and to grapple with their hoped-for benefits and to understand the possible harms of social transition and sex trait modifications.[5]

Before becoming committed to either extreme position, it may be useful to consider certain realistic practical aspects of what is glibly referred to as "psychotherapy."

Examining Psychotherapy

CAVEATS

There is no single psychotherapeutic technique or method for curing gender dysphoria. Any desistence from a new gender identity is under the control of the patient, not the therapist. Traditional psychotherapy recognizes that the forces that created and maintained the transgender identity exerted their influence within the developing mind of the young person. The traditional form of psychotherapy gradually illuminates some of these intrapsychic forces. It does not deny biogenic predispositions such as temperament, autism, or learning disabilities, for instance. It recognizes that some unknown biogenic causal factors may be operative in some cases.

The mental health professional should not be opposed to the patient's current identity nor devoted to its desistence. Patients must determine how they express themselves socially, scholastically, vocationally, and intimately. The psychotherapist's goal is to modify the commonly observed obstacles to better mental health and to improve function in the patients' world. These obstacles begin to be clarified during the family's comprehensive evaluation. Psychotherapists can only do what they have been educated to do—illuminate their patients' understanding of their feelings, conflicts, behaviors, and aspirations. They assume that improved self-understanding promotes psychological growth. It provides the patient with more power to decide how to live in the future. When young patients realize their desire to avoid repeating the helplessness of a prior sexual victimization, their error in thinking that it was possible to change sex, or that they once abhorred being gay or lesbian, their

grip on their gender identity may gradually loosen or intensify.

A CLOSER SET OF OBSERVATIONS

1. Psychotherapy is an umbrella term. Many schools of thought have long existed under its canopy.[11] "Splitters" have identified over 200 forms, but "lumpers" have recognized that the major approaches are psychoanalytic, psychodynamic, cognitive behavioral, dialectical behavioral, family systems, interpersonal, and, more recently, social justice. These schools of thought generate differing ways of thinking about the sources of behavior.

2. Mental health professionals (MHPs) in the United States who practice psychotherapy are variably educated. They have either a master's or a doctorate degree. The master 's group typically includes social workers, counselors, family and marital therapists, nurse practitioners, and psychologists. The doctorate group primarily consists of PhD's, PsyD's, MDs, and DOs. Their fields of study may be clinical psychology, social psychology, educational psychology, counselling, psychoanalysis, or psychiatry. They have had a varying educational emphasis on child and adolescent development. All, however, were required to be familiar with the DSM in place during their formal education.

3. The settings in which MHPs work allow them to varying degrees the freedom to determine the length, goals, and techniques of psychotherapy. When a health organization also has an affirmative care clinic transgender-identified patients are often quickly referred there for evaluation, support of social transition, and the possibility of hormonal interventions. Clinicians in private practice have more freedom to make decisions, but they, too, may share one side of the basic controversy.

4. There are no published controlled studies of psychotherapy for this group of patients. There also are no long-term follow-up studies of large cohorts of patients who have undergone psychotherapy for any condition. While there is much clinical experience with gender dysphoria, there are few case reports and fewer case series published. No one should assume that what MHPs do with gender patients is based on firmly established science or is uniform.

5. As MHPs accumulate more clinical experience, they tend to become less ideologic, more eclectic, and less certain as to the best way to approach these patients. They may be more influenced by the patient's situation than by the diagnosis of gender dysphoria.

6. The formats of intervention vary among individual therapy, parent guidance, family therapy, medication-assisted therapy, group therapy, and in some suicidal crises, hospitalization. The outpatient formats may be done in combinations of in-person and virtually, or less occasionally, by phone. In the post COVID world, many therapists never meet their patients in person.

7. Graduate education requires students to pass examinations based on what their teachers currently understand. Students trust this information. No student has an in-depth understanding of what generated the presented material. Few psychotherapists have an in-depth exposure to the literature in this arena of care.

8. Many parents complain that it is difficult to find a therapist in their community who does not think that immediate support for the new gender identity is the best approach. This reflects what the professionals have taught.

9. Most psychotherapeutic processes are relatively brief during one phase of a person's life. The fundamental issue at stake is long-term mental and physical health. For the treatment of transgender-identified adolescents, "long-term" might mean be anywhere between a few to 10 years. Such desired studies are conspicuously lacking. What is at stake, however, is the next six or more decades of life.

FIVE ARGUMENTS FOR PSYCHOTHERAPY PRIOR TO AFFIRMATIVE CARE

1. Cultural Knowledge. It is well-known that maturation, improved functional capacity, dissipation of symptoms, and emotional stability are facilitated by respectful, stable, human attachments. Committed traditional psychotherapy provides these features.

2. Precedent. Within Child and Adolescent Psychiatry and Psychology, all other subjective and behavioral disturbances are first evaluated, then treated with some form of psychotherapy, with or without medications. Such work also lacks significant scientific long-term follow-up information. The focus is usually on short-term goals.

3. Ethical principles and intuition converge to remind all concerned that permanent change of healthy anatomy and physiology to treat adolescent discomfort with oneself is fraught with long-term dangers.

4. The lack of compelling scientific evidence of benefits of affirmative care. All the systemic reviews of affirmative care interventions (at least 17) of minors and young adults have reached the conclusion that there is a low certainty of lasting benefit. These reviews have clarified the limitations of the studies previously used to support affirmative care interventions by advocates who declare that the "science is settled."[12] These advocates have attacked the conclusions of The Cass Report.[13] Five groups have independently found their arguments unconvincing.[14,15,16,17, 18]

5. Denial that gender dysphoria is a mental disorder. In 2010 advocates of affirmative care posited that it was stigmatizing to view the pain of sex/gender incongruence as a mental disorder.[19] In response, the DSM-5 and ICD-11 placed these diagnoses in new sections called Conditions Affecting Sexual Health so that patients would be able to obtain insurance coverage. This shift was a well-intentioned change aimed at eradicating stigma, discrimination, and to lessen patient's transphobia. It did not alter the presence of psychiatric problems that almost invariably accompany a new gender identity, however.[20]

Mental disorders are so labelled because they share adaptive disadvantages. All other psychiatric diagnoses are associated with an inherent functional disadvantage in life. Schizophrenia, bipolar disorders, and exhibitionism, for example, are also stigmatized, but this is not a reason to deny they are mental disorders.

Exploratory Psychotherapy's Focus is not on the Gender Dysphoria

Studies from North America, Europe, and Australia have consistently shown that the vast majority of those requesting social transition, hormonal intervention, or sex trait surgery have significant mental health challenges.[20, 21, 22] Such findings have been documented before the appearance of the new gender identity, at the time of initial evaluation, and after affirmative care. The maladaptive patterns may play a causal role in the production of the new identity. Transgender identities are epiphenomena created by many coalescing factors anytime they occur in the life cycle. This is not different than the understanding of the genesis of other forms of psychopathology.[23]

Patients are Individuals

THE CHALLENGE OF THE INDIVIDUAL PATIENT

The variability of MHPs is exceeded by the variability within transgender-identified youth. The minors are typically brought by their parents who express not only concern about the meaning of the new gender identity, but also their child's developmental challenges. While parents often want the new identity to disappear, it is usually apparent to them that their child's functioning is significantly impaired. These young patients differ from one another in age, psychological maturity, intelligence, character structure, physical health, forms of psychopathology, verbal capacity, family dynamics, relational capacity, and

trauma history. The MPH's approach to the patient rests upon the perception of these variable factors. This is why there can be no single approach to psychotherapy when gender distress seems to be the presenting problem. The patient, the parents, the clinician, and policy makers should understand that the fundamental issue is what is best for the patient's future.

TOWARDS UNDERSTANDING THE DRIVEN PATIENT

Some young individuals with a new transgender identity are impatient, insistent, and exert pressure for quick medical treatment. They expect the initial clinician to refer them to one who can provide access to the hormones or surgery. They present with certainty about the wisdom of what they desire, state the absence of ambivalence, and are initially resistant to the evaluation. "I know what I need!"

Professionals should not lose sight of their age! Adolescents can be charming or exasperating depending on their mood and the contexts in which they find themselves. During the eight or so years of adolescence, many characteristics exist, all of which dissipate with maturation.

1. Certainty
2. Emotionally intensity (passionate)
3. Secretiveness
4. Fragile self-esteem responsive to their status with their peer group
5. Porously absorbent of youth culture of the Internet, music, clothing, and politics
6. In search of a trustworthy authority figure such as a parent, teacher, therapist, politician, coach, or clergy while evidencing distrusting cynicism
7. Actively seeking to incorporate new ways of being through identification with others
8. Changeable

A CENTRAL ORGANIZING HYPOTHESIS

After many years of providing care for transgender identified adults and adolescents and participating in reviews of the care of other individuals in carceral institutions and in lawsuits, I have developed a guiding hypothesis for all concerned to answer the question, "What is going on here?"

A new transgender identity is a private, creative, unconscious, often maladaptive intrapsychic solution to existential pain deriving from intense disappointment with oneself or trauma outside or inside the family.

For the clinician, this hypothesis enables a focus on the defenses employed to deny these forces and to hide ambivalence. It can help parents to recognize and empathize with the suffering of their child. It can eventually help patients to have an improved understanding of themselves and to increase their autonomy. It can enable researchers to study specific prognostic factors in successful and unsuccessful transitions.

AN ELABORATION OF THE TERMS IN THE HYPOTHESIS

Private: Knowledge of the self, one's experiences, influences, behaviors, criticisms, and attractions are in conscious awareness but are not extensively revealed to any but the most trusted individuals. In fact, among trusted individuals—for example, a parent, best friend, or valued therapist, only sectors of oneself are shared. No one of any age reveals all the contents of personal privacy.

Creative: a new identity represents self-reinvention, a rebirth that involves leaving some aspects of the past behind, cutting the anchor to these encumbrances. Hope is at the center of the new passionately held overvalued idea, "I'm a trans person." The reinvention of the self is far from unique to the transgendered. Changes of religious, political, addiction, intrafamilial interactional patterns are common creative identity shifts.

Unconscious: The reasons for changing identity often cannot be explained by patients, even those who change in adulthood. Psychotherapy has the capacity to illuminate events, mood states, or concerns that were previously unappreciated. It brings hidden factors into awareness. A trans identity

is not an exception to all other aspects of human identity that are recognized to be continually shaped after birth.

Often: Given the variability in the capacities and mental health of trans-identified youth, it is possible that some individuals may be able to successfully master the future challenges that face them. Their new identity may not compromise them socially, interpersonally, or vocationally, even though most patients appear to be symptomatic and dysfunctional.

Maladaptive: This means the new identity carries a substantial risk of adverse consequences. Some of these disadvantages involve the future bodily function: infertility/sterility, vaginal atrophy, loss of libido, increase of libido, erectile dysfunction, anorgasmia, inability to lactate, and shortened life expectancy. Others are social, such as discrimination, changed friendship patterns, and familial alienation. Yet others are psychological such as depression, suicidality, and substance abuse. No one negative outcome is invariable because transgender medical and surgical interventions vary from patient to patient and individuals are different from one another. Cross-sectional studies of transgender adults create the impression that many are not having full, successful social, relational, and vocational lives.[24, 25]

The safest scientifically justified conclusion about the long-term outcomes of those who remain transgendered is that no one can be certain what percentage of these adults will lead highly problematic lives.[26] This conclusion was made based on clinical observations and research before the systematic reviews were published. What is emerging from the increasing awareness of those who detransition is that their original hopes were not realized, and that now they live with the irreversible anatomic and physiological consequences.[27,28]

Intrapsychic: Every individual is influenced by life experiences, events, and relationships. These interactions are taken in, given meanings, and are processed within awareness and the unconscious mind.

Existential pain: this is a summary phrase for the commonly observed patterns referred to as depression, anxiety disorders, eating disorders, self-harm patterns, suicidality, loneliness, social isolation, sexual fears, impact of ADD, autism, and learning problems.[29] The patient's pain is based on how he or she functions in the world, even when the patient cannot verbalize this. It is based on pessimism about being a successful woman or man in the future.

Trauma outside or inside the family: Within the family, clinicians are sensitive to neglect and abuse--sexual, physical, and psychological. Other events, like parental illness, absence, separation, permanent abandonment, and loss of important others, can overwhelm and lead to the wish to reinvent oneself. Outside the family, sexual victimization, peer rejection, and bullying may or may not be known to parents.

TWO PROVOCATIVE QUESTIONS ABOUT PSYCHIC STRUCTURE

Is a new transgender identity an example of the psychopathology known as an extreme overvalued belief?[30] In 1892, this pattern was distinguished from a delusion and an obsession. It is commonly employed to explain conspiracy theories and violence.[31] When applied to transgender identities, the term captures the intensity, conviction, and rigidity. Extreme overvalued ideas can readily be shared with others, creating a cult of support.

Is a new transgender identity the product of a borderline personality structure? Is it a solution to the inability to form a cohesive sense of self in this disorder? Every person has a large variety of aspects of the self that appear in different contexts of their lives. Rather than cohesion, there is uncertainty about which aspects of the self is "me." The frequent changes of names and transgender categories reflect the lack of self-cohesion. This is presumably motivated by the wish to repudiate some aspects of the self.

These two ideas locate the problem within the person rather than simply in society's nonacceptance.

EVEN IF CORRECT, THE HYPOTHESIS CANNOT ACCOMPLISH GOALS QUICKLY.

There are obvious obstacles to the efficient applicability of this hypothesis. Transgender minors and young adults, simply because of age and life experience, typically do not yet possess the psychological sophistication to quickly understand the hypothesis.

Even among the very bright minors on the autism spectrum, understanding is often delayed by their cognitive rigidity concerning the beliefs underlying their wish for sex trait modification. They have been abetted by assuming: 1. That affirmative care is life-enhancing; 2. That they have discovered their true, authentic, or genuine self; 3. That a transgender identity is permanent; 4. That affirmative care prevents suicide.

We clinicians erroneously assume that the patient understands our comments or explanations. Even among the many non-autistic young people, the danger of a vocabulary mismatch exists. Most will not ask the meaning of a word they do not understand. Clinicians must sensitively explain psychological concepts which they only deeply understood during graduate school. Words like intrapsychic, subjectivity, conflict, ambivalence, defense, projection, fear of homoerotic desire, resistance, boundary violations, neglect, and abuse often require explanation to strengthen the therapeutic alliance.

SUSTAINED COMMITMENT

The work of traditional psychotherapy not only aims to improve mental health and function of the patient; it also seeks to mentally categorize the predisposing, precipitating, and maintaining factors unique to this person's new identity. The work can be arduous if the patient perceives that the clinician is the enemy of his right to direct his own life. We teach patients that they are the captains of their ship. Psychotherapy provides the therapist with pleasure as the patient gradually evidences attachment, spontaneity, and gratitude. Patients should feel that they gain something from each session. The MHP must be patient, persistently attentive, appreciative of the patient's strengths, and allowing the patient to know about his or her own adolescent feelings. This indicates an empathic understanding. These abilities transcend ideology.

NOT ENOUGH IS KNOWN ABOUT OUTCOMES

In systematic reviews, this idea is communicated by listing methodologic limitations of studies showing benefits.[32, 33] The studies were characterized by short follow-ups, lack of comparison groups, employment of inconsistent measures, high rates of lost to follow-up, biased samples, and investigator conflict of interest. These reviews were designed, however, to show the efficacy of adolescent treatment interventions rather than the adult fates of former patients.

The field would benefit from multiple studies from several countries at intervals such as two, five, and 10 years after various interventions for adolescents. This should ideally include transition only, psychotherapy only, hormones only, hormones and surgery, and concomitant psychotherapy with affirmative care. Outcomes should be segregated by sex and autism spectrum. Given today's politics, the costs of studies, and the need of investigators to be committed for years, there is no reason to be optimistic that the necessary scientific processes will take place.

Conclusion

Neither the advocates for psychotherapy nor the advocates of efficient medical and surgical treatment can scientifically support a claim that their interventions have the best mental or physical health outcomes. Each camp operates on a faith in their assumptions. I am uncertain that this is recognized.

While I have a belief that traditional exploratory psychotherapy has the potential to improve the course of a person's life, such psychotherapy does not guarantee an emotionally rich, long, successful life. I have the ethical responsibility to my patients and their parents to make my knowledge, opinions, values, uncertainties, and ethics clear. This is my understanding of informed consent.[34]

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