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A critical commentary on “A critical commentary on follow-up studies and “desistence” theories about transgender and gender non-conforming children”

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The article entitled “A critical commentary on follow-up studies and “desistence” theories about transgender and gender non-conforming children” by Temple Newhook et al. (2018) is a plea to abandon longitudinal studies on the development of gender variant children as they do not respect children’s autonomy. A few relatively recent studies are criticized and it is concluded that conducting longitudinal psychosexual outcome studies and acknowledging the children’s feelings are contradictory. We agree that the longitudinal studies currently available have their limitations. We do, however, strongly disagree with the authors that studies on gender variant children’s development should be abandoned and that our studies do not take children’s needs and voices seriously or are unethical.

Before we address and discuss a number of specific criticisms in their paper, we first have two general, but crucial, remarks.

The authors claim in the very beginning of their paper that the 80% desistence rate of gender dysphoria (GD) is a number that is largely drawn on estimates from four follow-up studies: one from Canada (Drummond, Bradley, Peterson-Badali, & Zucker, 2008) and three from the Netherlands (Steensma, Biemond, de Boer, & Cohen-Kettenis, 2011; Steensma, McGuire, Kreukels, Beekman, & Cohen-Kettenis, 2013; Wallien & Cohen-Kettenis, 2008). Unfortunately, the authors do not seem to be entirely aware of the history behind the prevalence numbers. The first comprehensive and inclusive summary of historical follow-up studies on the psychosexual outcome in gender variant children was provided by Zucker and Bradley (1995). Later, these numbers were updated in Steensma et al. (2011)

and updated again and further discussed in Ristori and Steensma (2016). Important to mention here is that in the calculation of the *overall* persistence rate in the literature the two studies by Steensma et al. (2011, 2013) were *never* used. Including the two Steensma et al. studies in the discussion about persistence rates by the authors (particularly in Table 1 in Temple Newhook et al. 2018) is in our view an odd choice and a methodologically incorrect one. The reason why both studies were not included is obvious: both studies did not aim to report on the prevalence of desistence or persistence of GD. The qualitative study in 2011, conducted among 25 participants, aimed to:

obtain greater understanding of the processes and factors that may have contributed to the persistence and desistence of childhood gender dysphoria and sexual orientation development of gender dysphoric children (Steensma et al., 2011, p. 500).

As correctly indicated by the authors, this study offered some unique and valuable qualitative data. However, persistence rates of GD were never mentioned by Steensma et al. (2011). The quantitative study in 2013 aims were at the following:

[to examine] possible factors associated with persistence of childhood GD by comparing a number of childhood variables (e.g., demographic background, GD, gender-variant behavior, psychological functioning, and quality of peer relations) between adolescent persisters and desisters who were clinically referred to our gender identity service in childhood. In addition to this, we examined psychosexual outcomes, body image, and the intensity of GD at the time of follow-up in adolescence. (Steensma et al., 2013, p. 583)

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Again, because of the purpose and the design of this study we did not report prevalence numbers in the sample under study. Furthermore, the sample in the 2013 study did not include children in the younger age spectrum of the referred population to the Amsterdam clinic. Reporting prevalence of persistence and/or desistance in this sample would therefore not be reliable. The authors seem to have overlooked that both studies cannot be used “to support the 80% ‘desistance’ estimation.”

Second, the two remaining studies come from two clinics with very different social contexts. The Toronto and Amsterdam clinical populations are not similar. This is illustrated clearly by a number of comparative studies on the social and emotional functioning of children and adolescents who are referred to the two clinics: in all studies psychological functioning in children and adolescents (measured through parental, teacher and/or self-report) showed to be better in Amsterdam than in Toronto (Cohen-Kettenis, Owen, Kaijser, & Bradley, 2003; de Vries, Steensma, VanderLaan, Cohen-Kettenis, & Zucker, 2016; Steensma et al., 2014). As noted in the discussions of these papers, we believe that differences in the social climate regarding gender variance may be an important factor underlying the differences. A sociometric study on peer group status (Wallien, Veenstra, Kreukels, & Cohen-Kettenis, 2010) underscores this point. It was shown that there were no differences between gender-referred elementary school children and their classmates in victimization or bullying. Parents who come to our clinic are concerned about potential harm for their child if they would *not* acknowledge the child's gender experience. They are not focused on suppressing it, as the authors suggest by the sentence:

Furthermore, even within Toronto and the Netherlands, this research was limited to children whose parents chose to bring them to a clinic for diagnosis and treatment and thus may have believed the child's difference was a problem, and one that required psychological treatment.

Our group is indeed a clinical one, but not all clinical groups are characterized by a suppressing attitude of their environment. We feel that, besides the unfounded assumptions that are made by the authors about the intentions of the supporting and caring parents we see in our clinic, the difference in social context is not properly taken into account in the paper, and that the

conclusions that are drawn from our follow-up studies cast a very negative shadow on our clinical approach and the intentions of professionals in our clinic.

Methodological concerns

The authors claim to have identified strong methodological problems concerning the inclusion criteria for those children who were studied in childhood, the lack of acknowledgement of social context of the children, the age of the children at follow-up, and the misclassification of the adolescents who did not participate at the time of follow-up.

Although we do not believe that many of our non-responders are in fact persisters, we do agree with the authors that the persistence rates may increase in studies with different inclusion criteria. The classification of GD in the Wallien and Cohen-Kettenis (2008) study was indeed based on diagnostic criteria prior to DSM-5, with the possibility that some children were only gender variant in behavior. We have clearly described the characteristics of the included children (clinically referred and fulfilling childhood DSM criteria) and did not draw conclusions beyond this group, as has wrongly been done by others. The broadness of the earlier DSM criteria was also acknowledged by the American Psychiatric Association and World Health Organization. This was, among other things, a reason to tighten the diagnostic childhood criteria for DSM-5 and the proposed criteria for ICD-11. As we have stated elsewhere (Hembree et al., 2017; Steensma, 2013), we expect that future follow-up studies using the new diagnostic criteria may find higher persistence rates and hopefully shed more light on developmental routes of gender variant and transgender children.

When discussing the design of our studies (although the Wallien and Cohen-Kettenis (2008) is in fact the only one that should be discussed; see above), the authors question the actual persistence rate because of our classification of individuals who did not participate in the follow-up as desisters (the non-responders), and state that many (or all) of the non-responders at the time of follow-up may in fact be persisters. We agree that the current persistence rates may go up if a different methodology would be used (see above), but the suggested reasons why non-responders may actually be persisters are unlikely and farfetched. For instance, the authors suggested that children were lost at follow-up because they moved out of the country, were being treated elsewhere in the

Netherlands, or institutionalized. The chance that one of these situations occurred is, however, very low. The few families that had to go abroad for some time usually stayed in touch with the clinic, because in those days there were hardly any gender identity clinics for children and it was extremely difficult to get a prescription of puberty-blocking hormones. Besides language barriers and insurance problems, this would have been a major reason why going to clinics abroad out of dissatisfaction with the Dutch clinic would have been hard. Going to another Dutch clinic was not an option either. For a few years there was only one other child and adolescent clinic (which is now closed), but entrance to both clinics was centralized. So, if a child would reapply for treatment in adolescence in either one of the clinics, they would be recognized as a previously known child. Although it was not a favorable situation, there were—until fairly recently—few places families could go to if they wanted to avoid having contact with our clinic. If children were institutionalized and still wanted transgender care we usually collaborated with these institutions to see what could be done in terms of their medical treatment.

As suggested by the authors, it is possible that some of the adolescents classified as desisters at the time of follow-up were not following the straight transgender child-transgender adult path, but needed a much longer exploration time of their feelings before they decided they desired medical treatment. We were the first to report in the literature on children with GD who, in adolescence, indeed were not gender dysphoric to the extent that they wanted puberty blockers, gender affirming hormones, and surgery as soon as possible, but only came back to our clinic in adulthood (Steenma & Cohen-Kettenis, 2015). It is precisely this group that needs ample opportunity to explore the gender they feel comfortable with. For this reason, it would also be important to follow the development of transgender children over a much longer period than into young adulthood, instead of entirely refraining from developmental studies.

Theoretical concerns

The theoretical concerns brought up by the authors regarding the used terminology and the suggestion of an embedded pre-assumption in our studies that “stability of gender identity is a positive health outcome

that should be prioritized for all children” may in our view be the result of a major difference in the operationalization of terms.

Unlike what is suggested, we have not studied the gender identities of the children. Instead we have studied the persistence and desistence of children’s distress caused by the gender incongruence they experience to the point that they seek clinical assistance. As stated in our 2008 paper, we wanted to know more about the development of the children to find guidance in our clinical work.

Clinically, it is also important to be able to discriminate between persisters and desisters before the start of puberty. If one was certain that a child belongs to the persisting group, interventions with gonadotropin-releasing hormone (GnRH) analogs to delay puberty could even start before puberty rather than after the first pubertal stages, as now often happens. (Wallien & Cohen-Kettenis, 2008, p. 1413)

We did so by looking at children’s continuing (or discontinued) desire for medical gender affirming treatment when they entered puberty. This was a variable that could be relatively easy and reliably measured and was clinically highly relevant in the light of timing of puberty suppression decisions. Using the term desistence in this way does not imply anything about the identity of the desisters. The children could still be hesitating, searching, fluctuating, or exploring with regard to their gender experience and expression, and trying to figure out how they wanted to live. Apparently, they no longer desired some form of gender-affirming treatment at that point in their lives. The assumption that we considered all desisters as having a *fixed* cisgender identity is therefore an incorrect one.

We very much regret the assertion that we would only value certain “desisting outcomes” and the repeated suggestions by the authors that we would find cisgender outcomes “better” or “healthier.” Whatever the outcome, our clinical approach has always aimed to work towards an outcome of children that makes a good quality of life possible, no matter what the outcome is. What is complicated, however, is that a continuously changing identity, although not considered inherently unhealthy or unfavorable, makes it hard to know at what moment what type of intervention may be in the best interest of the child, as some medical interventions are hard or impossible to reverse.

Ethical concerns

Before responding to the ethical concerns raised by the authors regarding the treatment and testing of children, their opinion about the goals of treatment that is provided, and the lack of consideration of children's autonomy in the studies, one should realize that choices that have been made in the past need to be seen in a historical perspective.

The literature on transgender and gender variant children is rapidly expanding. This is a positive development. Unfortunately, with the recent fast changing views and insights, historical developments are often overlooked. With regard to the situation in the Netherlands, one can say that 30 years ago Dutch children who were struggling with gender identity issues and who were unhappy about their assigned gender were on nobody's agenda. At the time, they were occasionally seen by psychotherapists and psychiatrists and received various forms of therapy, very much depending on the theoretical or personal views of their therapist.

In the late 1980s families started to come to our clinic with pre-pubertal children, probably because they had heard that we were counseling (and later treating) transgender adolescents. They usually came with children aged 6 years or older (Cohen-Kettenis et al., 2003), asking for pedagogical advice. Behavioral or other problems (e.g., anxiety, depression, ADHD, or ODD) were another reason for seeking clinical support. Parents wanted to know whether these problems and the gender variance/GD of the children were related, and they preferred counseling or treatment for the general problems of the child by a clinic with experience in the field of transgender health.

As one of the first clinics for transgender children, we needed to develop our own approach. In order to provide personalized care, we not only needed information on the gender identity preferences, behaviors, and interests, but also about the general, psychological, and social functioning of the individual child. Obviously, an impulsive, oppositional child with ADHD and poor verbal skills needs a very different approach than an eloquent, withdrawn, and anxious child. Gathering such information (partly by psychological testing, which was carried out, according to the child psychology and child psychiatry standards, in a proper, safe, and child-friendly way and environment) provides useful information about the functioning of

the child. Besides the fact that psychological testing is a fundamental part of psychological assessment in (child) psychology (Cronbach, 1990; Saklofske, Reynolds, & Schwean, 2013), such an approach is efficient, useful, *and* ethical, also in case of children who have already socially transitioned. In our view, it has little to do with thwarting the child's gender experience.

Besides needing information on individual children's functioning, we also wanted to have a better idea about developmental trajectories of transgender children, their specific vulnerabilities that might need attention, and/or a clinical approach that could be beneficial for the children. As we were the first (in the world) to provide adolescents with puberty-blocking treatment, it was important for us to know more about the lowest age for responsibly starting with this treatment; one would not want to risk adverse effects by prescribing medication to children who would not benefit from it, and giving such medication is not something one would want to start and stop repeatedly. Longitudinal studies in children gave us some insight in the stability of the desire for treatment in adolescence and should therefore be seen as valuable in our field instead of ethically wrong or useless. Children were never involved in these studies against their will, as is suggested.

Interpretive concerns

The authors question our clinical approach which was (partly) relying on the findings of our own and other studies, in particular with regard to social transitioning in early childhood.

As described elsewhere by others (Byne et al., 2012; Drescher, 2013), the clinical approach in the counseling of pre-pubertal children in the Netherlands has always been primarily focusing on treating the co-existing problems and only monitoring the gender development of the children. However, such a summary is too limited and incomplete. Besides interventions that focus on the co-existing problems of the child and/or the family, we focused, among other things, on helping parents and the child to bear the uncertainty of the child's psychosexual outcome, provide psychoeducation to help the child and the family to make balanced decisions regarding topics such as the child's coming out or early social transitioning. In these discussions the child always had an important voice in the decisions that were made. We encouraged

parents to support the child's gender experience, while at the same time helping the child to deal with complex issues in their lives. However, the chance that the desire for a medical transition may desist in the future was a topic of discussion as well and something that had to be included in the decisions. Parents were encouraged to provide enough space for their child to explore their gender dysphoric feelings, while at the same time keeping all future outcomes open (e.g., de Vries & Cohen-Kettenis, 2012; Ristori & Steensma, 2016).

With regard to the topic of social transitioning, one should bear in mind that before the year 2000 we only saw one pre-pubertal child who desired a social transition and the number only slowly increased in the next few years (Steensma & Cohen-Kettenis, 2011). By listening closely to the children and their families, these children were not frustrated in their desire. Instead we gave support as well as advice based on what we knew about these children as a group. We certainly did not advertise that transitioning was good for all gender variant children, but stressed that such decisions should be personalized. We felt that the safest modus was to leave all possibilities open, irrespective of transitioning. For most children the situation changed dramatically when they approached puberty. Some were no longer interested in anything related to gender variance, some remained hesitant, whereas others intensified their contact with the clinic because they desired to proceed with medical interventions. As a high percentage did not stay with us for medical care we were quite careful not to impose any (gender) pathway. Recently the number of children who already had transitioned at their first visit to the clinic has exploded (Steensma & Cohen-Kettenis, 2011). For these families the question of whether or not the child should transition is obsolete.

Conclusion

Having responded to the many comments of Temple Newhook and colleagues we want to stress that we do not consider the methodology used in our studies as optimal (as previously indicated and discussed by ourselves in Ristori & Steensma, 2016), or that the terminology used in our communications is always ideal. As shown, it may lead to confusion and wrong inferences. We also agree that the persistence/desistence terms suggest or even

induce binary thinking. In the last few years many terms in our field have changed. Evidently, we need to look for better terms covering the various possible outcomes and better indicating possible fluidity in the "desisting" group.

We, however, very much regret that our careful search for optimal care of the gender variant child by trying to gain more insight in the development of this group is taken for unethical behavior. Instead of polarization and accusations that can be read so often in the literature, collaboration in gathering more (and better) information about the development of gender variant children in different social contexts will better serve the quality of life of transgender children. Children and their families do not need arguing clinicians, but responsible care that is based on good evidence.

Declaration of conflict of interest

The authors have no conflict of interest to declare.

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