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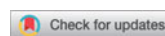
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Outbreak: On Transgender Teens and Psychic Epidemics

Lisa Marchiano

Having lived through both World Wars, Jung was aware of the dangers of what he termed “psychic epidemics.” He discussed the spontaneous manifestation of an archetype within collective life as indicative of a critical time during which there is a serious risk of a destructive psychic epidemic.

Currently, we appear to be experiencing a significant psychic epidemic that is manifesting as children and young people coming to believe that they are the opposite sex, and in some cases taking drastic measures to change their bodies. Of particular concern to the author is the number of teens and tweens suddenly coming out as transgender without a prior history of discomfort with their sex.

“Rapid-onset gender dysphoria” is a new presentation of a condition that has not been well studied. Reports online indicate that a young person’s coming out as transgender is often preceded by increased social media use and/or having one or more peers also come out as transgender. These factors suggest that social contagion may be contributing to the significant rise in the number of young people seeking treatment for gender dysphoria.

Current psychotherapeutic practice involves immediate affirmation of a young person’s self-diagnosis, which often leads to support for social and even medical transition. Although this practice will likely help small numbers of children, there may also be many false positives.

The earliest written record from the town of Hamelin in Lower Saxony is from 1384. It states simply, “It is 100 years since our children left.” Historical accounts indicate that sometime in the 13th century, a large number of the town’s children disappeared or perished, though the details of the event remain a mystery. “The Pied Piper of Hamelin” is, as far I as have been able to determine, the only Grimm’s fairy tale that is based substantially on a historical event. Both the actual event and the Grimm’s tale suggest an archetypal situation in which adults have allowed children to be seduced away into peril. This tale is a disconcertingly apt metaphor for various social contagions that have overtaken collective life throughout the centuries.

Color versions of one or more of the figures in the article can be found online at www.tandfonline.com/upyp.

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Having witnessed the destruction and horror of World War II, Jung had much to say about what he termed “psychic epidemics.” Several times throughout *The Collected Works*, he stressed that such “mass psychoses” are the main threat facing humanity today. “The gods have become disease,” Jung famously wrote. “Zeus no longer rules Olympus but rather the solar plexus, and produces curious specimens for the doctor’s consulting room, or disorders the brains of politicians and journalists who unwittingly let loose psychic epidemics on the world” (1967, p. 37). When we smugly imagine ourselves above the influence of contents from the collective unconscious, then we are most susceptible to possession by them.

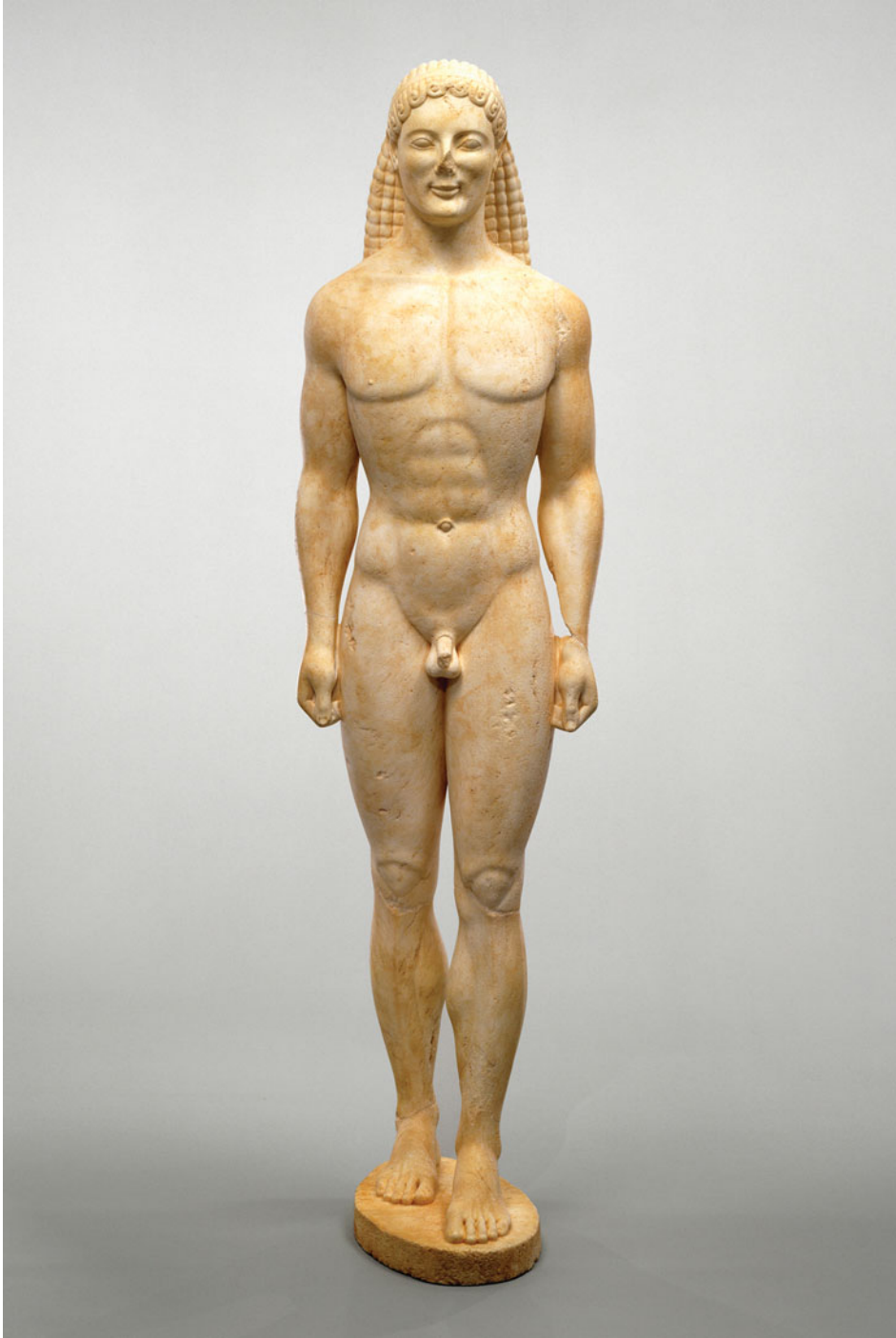
Jung discussed the spontaneous manifestation of an archetype within collective life as indicative of a critical time during which there is a serious risk of a destructive psychic epidemic. “Catastrophe can be avoided only if the effect of the archetype can be intercepted and assimilated by a sufficiently large majority of individuals” (Jung, 1970, p. 229). Jung stated that archetypal contents such as anima and animus are liable to escape from conscious control due to their numinosity, and as a result can lead to psychic possession.

Currently, we appear to be experiencing a significant psychic epidemic that is manifesting as children and young people coming to believe that they are the opposite sex, and in some cases taking drastic measures to change their bodies. I am particularly concerned about the number of teens and tweens suddenly coming out as transgender without a prior history of discomfort with their sex. “Rapid-onset gender dysphoria” is a new presentation of this condition that has not been well studied. Current psychotherapeutic practice involves affirmation of a young person’s self-diagnosis (<https://www.apa.org/practice/guidelines/transgender.pdf>). Although this practice will undoubtedly help a small number of children, I am concerned that there may be many false positives.

This topic first came to my attention in my practice. A patient reported that her daughter was identifying as transgender. I admired the way this mother attempted to support her child, and I marveled at the creativity of youth culture in challenging traditional conceptualizations of gender. My view of this cultural trend as benign collapsed in an instant, however, when I learned that young women were having mastectomies as young as 14 (Rowe, 2016). Realizing that the identity exploration of teenagers was being treated in a concretized way that would have drastic, permanent consequences for the young people involved immediately filled me with concern. Further research online and through speaking with people only increased my alarm. It quickly became clear to me that teens were coming out as trans in peer clusters, as we have seen happen before with suicide and eating disorder contagion.

From my perspective as a Jungian analyst, it isn’t wise to act on strong impulses without understanding them psychologically first. Jung well understood the dangers of collapsing any psychic experience too quickly into concrete form.

We should not begrudge ... the alchemists their secret language: deeper insight into the problems of psychic development soon teaches us how much better it is to reserve judgment instead of prematurely announcing to all and sundry what’s what. Of course we all have an understandable desire for crystal clarity, but we are apt to forget that in psychic matters we are dealing with processes of experience, that is, with transformations which should never be given hard and fast names if their living movement is not to petrify into something static. The protean mythologem and the shimmering symbol express the processes of the psyche far more trenchantly and, in the end, far more



Kouros, c. 530 B.C. or modern forgery. Dolomitic marble, 206.1 × 54.6 × 51 cm (81-1/8 × 21-1/2 × 20-1/16 in.). Artist unknown. From the collection of The J. Paul Getty Museum, Los Angeles.

clearly than the clearest concept; for the symbol not only conveys a visualization of the process but—and this is perhaps just as important—it also brings a re-experiencing of it, of that twilight which we can learn to understand only through inoffensive empathy, but which too much clarity only dispels. (Jung, 1967, p. 162)

By grasping for crystal clarity, we risk falling into the dangerous psychological sin of concretization. When an archetypal content cannot be held in the full multidimensionality of symbolic understanding, that is when it threatens to tear itself loose from its ballast in the collective unconscious, and go about our psychic countryside ravenously rampaging, giving rise to destructive contagions.

In recent years, there has been a sharp jump in the number of children and young people coming to identify as transgender. London's Tavistock and Portman clinic has seen referrals for trans patients under the age of 18 increase dramatically (Harvey & Smedley, 2015). Fourfold and fivefold increases of trans-identifying kids and teens are being reported in gender clinics in the United States and other countries (www.cbsnews.com/news/sex-change-treatment-for-kids-on-the-rise/). The first transgender youth clinic in the United States opened in Boston in 2007. Since then, 40 other clinics have opened that cater exclusively to children, with new clinic openings being announced frequently.

In addition to a huge spike in numbers of children and adolescents presenting with gender dysphoria, there has also been a dramatic, unexplained increase of females presenting to gender clinics, with significantly more female teenagers requesting services than males, a ratio historically unheard of. This is true in Canada, the United States, Finland, England, and The Netherlands (Kreher, 2016; see Figure 1).

Although researchers have put forward some theories as to why this rapid escalation in gender dysphoria might be the case, the flip has not been satisfactorily explained. My fear—and I am hardly alone in this—is that adopting a transgender identity has become the newest way for teen girls to express feelings of discomfort with their bodies—an issue adolescent girls typically experience. The problem here is that many young women are seeking transition after coming to identify as transgender, and transition can have extreme consequences.

How do we understand transgenderism? The current relevant DSM-5 diagnosis is gender dysphoria (American Psychiatric Association, 2013). This diagnosis refers to a marked discomfort with one's sex, and in children, a stated desire to be the opposite sex. Currently, we don't have a good understanding of what causes someone to experience gender dysphoria, although it is likely that the etiology of dysphoria will prove to have complex biological, social, and psychological influences. Although scientists acknowledge how little we understand this condition, the mainstream media and the medical and psychiatric establishment have seized upon an easily digestible narrative that is based in the ideology of innate gender identity.

Gender is between the ears, not the legs, we are told. Transgender author and activist Serano (2007) tells us that we all have a subconscious sex—a deeply innate sense of gender. It is this subconscious sex, rather than our physical sex, that determines who we really are. Therefore, “feeling like a woman” or “identifying as a woman” is to *be* a woman.

However, to date, the notion of an innate gender identity is not supported by science. Although there is some evidence of a biological basis for the development of gender

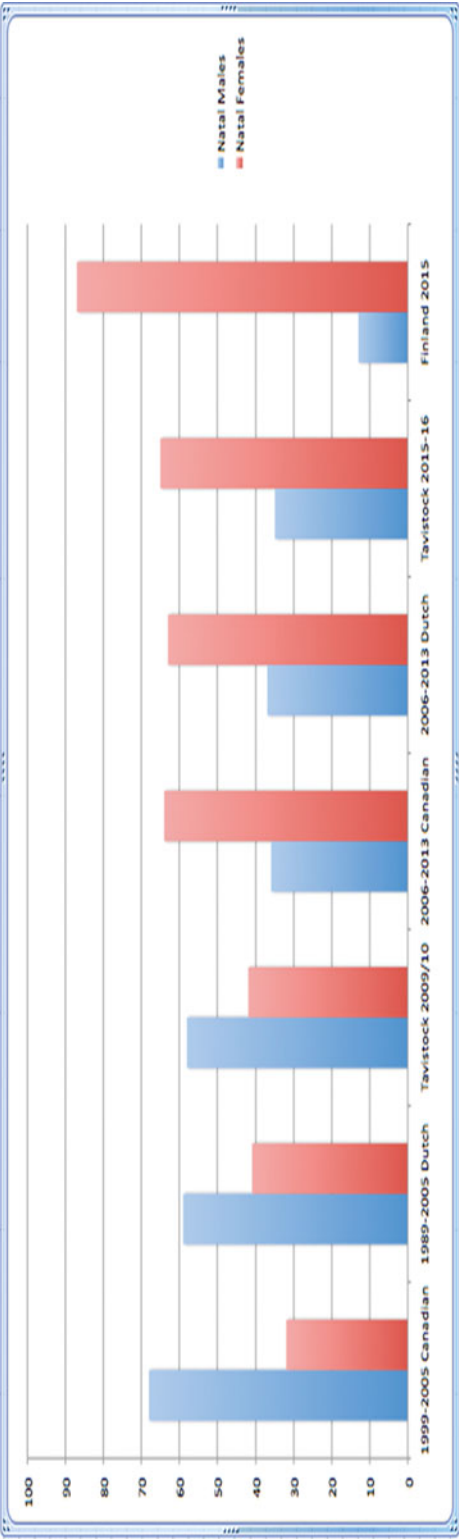


Figure 1. Gender clinic sex ratio reversal.

dysphoria (Heylens et al., 2012), we are far from being able to claim that there is an empirical basis for believing that one is “trapped in the wrong body,” has a “female” or “male” brain, or even a “gender identity” that doesn’t match one’s body. Though the concept of gender identity is currently being enshrined into law, the truth is that we have no meaningful definition of the term.

The ideology surrounding debates about transgenderism tends to be regressive, often invoking rigid sex role stereotypes. When trans-identified individuals are asked how they know they are transgender, they often answer by referencing sex role stereotypes. For example, a physician who prescribed cross-sex hormones to a 12-year-old natal female stated that the child had “never worn a dress.” This was offered as evidence of the child’s being “truly trans” and therefore needing these hormones (Lyons, 2016). I would strenuously argue that a child’s clothing preferences should not be a reason to permanently sterilize him or her.

There is some evidence that discomfort with children who cross gender norms is leading adults to encourage kids to transition. The following anecdote was documented in a 2013 piece in *The New Yorker*.

One mother in San Francisco, who writes about her family using the pseudonym Sarah Hoffman, told me about her son, “Sam,” a gentle boy who wears his blond hair very long. In preschool, he wore princess dresses—accompanied by a sword. He was now in the later years of elementary school, and had abandoned dresses. He liked Legos and Pokémon, loved opera, and hated sports; his friends were mostly science-nerd girls. He’d never had any trouble calling himself a boy. He was, in short, himself. But Hoffman and her husband—an architect and a children’s book author who had himself been a fey little boy—felt some pressure to slot their son into the transgender category. Once, when Sam was being harassed by boys at school, the principal told them that Sam needed to choose one gender or the other, because kids could be mean. He could either jettison his pink Crocs and cut his hair or socially transition and come to school as a girl. (Talbot, 2013)

Rather than doing away with the constrictions of gender, which limit and harm both men and women, transgender ideology serves to further reify these socially constructed stereotypes and roles and even to demand that we change our bodies in accordance with them. Instead, we ought to accept the material reality of the body while encouraging people to express themselves and their gendered feelings in whatever way they like. Boys and men ought not to be limited to wearing masculine clothes or pursuing “masculine” interests, and neither should women and girls be limited by sex. We ought to be trying to change society, not children’s bodies.

Many in the gay and lesbian community are upset about the rush to transition children who are gender nonconforming. There is a wealth of replicated research that tells us that 80–95% of children who experience a cross-sex identification in childhood will eventually desist and come to identify with their natal sex as adults (Singal, 2016). Most of those who desist will come to be lesbian or gay. Lesbians are particularly worried about the teen trans trend, as most girls coming out as transgender are same-sex attracted (Kreher, 2016). Many in the lesbian community are distraught to notice that butch lesbians are quickly disappearing.

There is evidence that some parents may feel more comfortable having a “straight” transgender child rather than a gay or lesbian child, and are therefore supporting their

child to transition. For example, Texas mom Kimberly Shappley's fight for her five-year-old transgender daughter to be allowed to use the girl's bathroom has been covered in local and national media. The following is a quote from an interview with Shappley.

"I am a devout and conservative Christian and an ordained minister," she said and explained that she tried to force Kai into being a boy when she was a toddler. "I knew my kid was different before the age of 2," Shappley said. "My child was very feminine, flamboyant and dramatic. No matter how I tried to punish, reshape or discipline her, she continued being very feminine." (Tan, 2016)

Now Shappley has gone from the being the embarrassed mother of a gender-nonconforming little boy—who likely would have grown up to be gay—to being the heroic mother of a very pretty gender-conforming girl.

British film star Rupert Everett gave an interview in 2016 in which he stressed his concern over the tendency to medicalize gender nonconformity in children. The 57-year-old gay star revealed that he spent his childhood wishing he were a girl and dressing as one. "I really wanted to be a girl. Thank God the world of now wasn't then, because I'd be on hormones and I'd be a woman. After I was 15 I never wanted to be a woman again" (The Press Association, 2016).

When we talk about transition, what do we mean? *Social transition* refers to steps one can take to present as the opposite sex. These might include making changes to one's hairstyle, makeup, name, pronouns, and dress. Companies are manufacturing "packers" for children as young as five. Natal females can wear such a device in their underwear to give the appearance of having male genitals. Natal females may also wear a binder to flatten their breasts.

Social transition is sometimes described as something that has few, if any, long-term consequences, and therefore can be recommended with minimal concerns, even for young children. However, in some significant percentage of cases, social transition leads to medical transition. It appears likely that being conditioned to believe you are the opposite sex creates ever-greater pressure to continue to present in this way, especially in young children. Once one has made the investment of coming out to friends and family, having teachers refer to you by a new name and pronoun, will it really be so easy to change back? Pediatric transition doctors in the Netherlands who first pioneered the use of puberty blockers in dysphoric children caution against social transition before puberty precisely because of high desistance rates and the likelihood that social transition will encourage persistence (de Vries & Cohen-Kettenis, 2012).

Moreover, at least some of the time, each step taken toward transition creates pressure to continue. Numerous blog posts from detransitioners (i.e., those who transitioned and then returned to identifying with their natal sex) explore how transition made their dysphoria worse, often because they became increasingly preoccupied with passing (e.g., see <https://thirdwaytrans.com>). This further discomfort created pressure to take more steps toward transition to present more convincingly as the opposite sex. To take just one example, breast binding may bring relief to some natal females who experience discomfort with their breasts, but binding in itself can be quite painful, restricting breathing and movement—thereby creating an incentive to take the next step—"top surgery"/double mastectomy. In a recent BBC radio program, one mother of a female-to-male (FtM) young person stated that this natal female "got his lungs back" after getting a double mastectomy because he no longer needed to bind (Frostrup, 2016). Additionally, anecdotal evidence

indicates that it is not uncommon for teens who socially transition to move on to hormones and/or surgery shortly after their 18th birthday, when they can access medical treatments without parental consent. It's clear that social transition must be viewed as a treatment that carries with it a significant risk of progressing to medical transition.

Medical transition refers to interventions undertaken to alter one's body. These interventions can include administration of hormone blockers to children and teens; administration of cross-sex hormones; and surgeries such as mastectomy, phalloplasty, orchiectomy, vaginoplasty, and others. These procedures can have permanent effects, and most of them carry significant risks. Even young teens are having some of these procedures performed. There are stories in the media of 14-year-olds having double mastectomies (Rowe, 2016).

Transgender activists are working to lower the age at which young people can access these services even without parental consent. In Oregon, there is now no lower age limit for surgery with parental consent, and the lower age limit is 15 without consent (www.medicaldaily.com/gender-reassignment-now-available-oregon-minors-without-parental-consent-342670).

Although it is still somewhat unusual for minors to undergo trans-related surgery, it is more common for minors to be prescribed hormone blockers and cross-sex hormones. Puberty blockers are prescribed to children as young as nine or ten and are often touted as being a safe and reversible way to “buy time” while the young person sorts out his or her identity. In truth, this intervention involves administering powerful medications such as Lupron to children for years at a time. These drugs may affect bone development, and they certainly prevent the surge of endogenous hormones at puberty that would normally rewire the brain in ways we don't fully understand. And although it is true that if the blockers are stopped, normal puberty resumes, in nearly 100% of the cases reported in the literature, children on puberty blockers have gone on to take cross-sex hormones (See <https://www.theguardian.com/society/2016/nov/15/transgender-children-the-parents-and-doctors-on-the-frontline>. See also, <https://gendertrender.wordpress.com/2016/05/04/dr-johanna-olson-kennedy-on-the-gender-barometry-of-children/>). Therefore, the claim that blockers are “100% reversible” is not accurate in practice. In fact, being on blockers appears to consolidate an investment in a cross-sex identification.

The research on outcomes post transition is mixed at best. It is well known that one study showed that 41% of transgender people had experienced suicidal ideation or self-harm (Haas, Rodgers, & Herman, 2014). It is less well known that the study gives no indication whether the attempt was before or after receiving transition care. Moreover, the report seems to suggest that self-harm among natal females does not appear to be reduced by passing as male. Several large studies show high rates of suicide among transgender people who have medically transitioned (Dhejne et al., 2011). It has been argued that suicide rates continue to be high after transition due to societal prejudice. Although this likely is true some of the time, post-transition transsexuals are more likely to “pass” as the target gender, and therefore ought to be less subject to discrimination. Given the undeniably high rates of suicide in post-transition transsexuals, it is disingenuous to claim that transition is a panacea that will prevent suicide. Childhood transition is a relatively new phenomenon that has not been well studied. The growing number of detransitioners is a possible indication that there are significant numbers of people who are not satisfied with transition outcomes.

Hormone blockers followed by cross-sex hormones result in permanent, lifelong sterility 100% of the time; furthermore, these drugs are being used off-label. We have almost no knowledge about the long-term effects of taking these drugs over the course

of decades, as anyone beginning transition as a young person will likely do. Even the top pediatric gender doctors admit that there's a dearth of good data on the long-term health outcomes of transition (www.pbs.org/wgbh/frontline/article/when-transgender-kids-transition-medical-risks-are-both-known-and-unknown/).

Cross-sex hormones change bodies fairly quickly. Some of these changes are irreversible, such as a deepened voice, facial hair, and baldness for testosterone, and breast growth and (potentially) infertility for estrogen. Natal females who take testosterone will be at increased risk for developing diabetes, cancer of the endometrium, liver damage, breast cancer, heart attack, and stroke (<https://apps.carleton.edu/campus/gsc/campus/gsc/assets/hormones-FTM.pdf>). There may be other adverse effects of which we are not aware, since long-term testosterone use in natal females is a relatively new phenomenon that has not been well studied.

I fear that there are young people transitioning—with the ready help of therapists and doctors—who may regret these interventions and need to come to terms with permanent and in some cases, drastic, changes to their bodies. In fact, I know this is already happening.

A detransitioned woman recently conducted a survey of detransitioners (Stella, 2016c). Though the survey was only open for two weeks, more than 200 women completed it. Clearly, there are more than just a handful of people who are coming to re-identify as female. The survey results are compelling.

- 92.5% of those who responded said that their dysphoria was the same or better after detransitioning than during transition.
- Only 8% of respondents felt somewhat or completely positive toward their own transition, whereas 60.2% felt somewhat or completely negative toward it.

Following are quotes from the individual comments included by survey respondents:

- “I used transition as self-harm. It destroyed so many parts of my life.”
- “My seeking medical and social transition led to a deep spiral of depression and lack of identity—and was probably also caused by those things. The social ostracization led to increased anxiety and my grades were devastated.”
- “It was a childhood/teen phase before I accepted myself as a lesbian as an adult.”
- “I was a train wreck waiting to happen and transition fed the insecurities, anxiety and hopelessness” (Stella, 2016c).

The following is a quote from detransitioner and blogger Max Robinson, with her permission:

I transitioned FtM (female to male) at 16, was on testosterone and had a double mastectomy by 17. I'm 20 now and back to understanding myself as a lesbian, like I was before I found out about transition and latched onto it as a way to “fix” body issues created by the challenges of growing up in a deeply misogynistic and lesbian-hating world.

I absolutely am traumatized by what happened to me, and I'm not the only one. I'm a part of support networks for women who stopped transition that have over 100 members, and that's just the individuals who have gone looking for others with this experience and found us.

Early in my transition, I went through menopause. This caused vaginal atrophy and drip incontinence that has persisted for years. I piss myself slowly all day now; it's really not cute or fun. I refused to acknowledge it was connected to the HRT-caused vaginal atrophy that immediately preceded its onset until months after going off testosterone. Yeah, I signed a paper saying I knew that could happen. I also thought this treatment was my only hope for coping with the intense feelings of alienation/disgust with my femaleness. I was wrong. Transition didn't help. It did harm, harm that I now have to learn how to live with on top of all the shit I thought transition would fix.

My double mastectomy was severely traumatizing. I paid a guy, a guy who does this every day for cash, to drug me to sleep and cut away healthy tissue. I did this because I believed it would heal all of the emotional issues I was blaming on my female body. It didn't work. Now I'm still all fucked up and I'm missing body parts, too.

There is no surgery that will undo what's been done ... adding synthetic materials to resemble the tissue of mine that was incinerated years ago would not help me. It took 3 years of stuffing down every negative feeling about my mastectomy before I was ready to face that what happened did harm to me. I was off hormones for months before I admitted to myself that I deeply, deeply regretted this surgery. The best way I can think of describing the loss is like killing a family member who I blamed for being a burden on me, and then realizing years later that the blame I put on them was extremely and tragically misplaced. It was not their fault, but they're gone now anyway, because I wanted them gone. I have lost my breasts and I have lost the chance to reconcile with my breasts. It wouldn't be easy, but it would be work worth doing. Now the work before me instead is reconciling with what I've done and with the chest I have now—flat, scarred, asymmetrical, and nerve-damaged. (Robinson, 2016)

Detransitioner and blogger Cari Stella went on testosterone and had a double mastectomy as a teenager. In a video she made, she lets viewers know that she is not just some statistic. Looking right at the camera, she tells us that “I’m a real live 22-year-old woman with a scarred chest, and a broken voice and a five o’clock shadow because I couldn’t face the idea of growing up to be a woman. That is my reality” (Stella, 2016a).

It has been demonstrated that pediatric transition can have serious side effects and comes with the possibility of a high incidence of regret. Now I would like to discuss how social factors and therapeutic practices are playing a role in encouraging young people to transition.

In recent years, young people (tweens and teens) have been presenting with dysphoria “out of the blue” without ever having expressed any gender variance before (<https://transgendertrend.com/rapid-onset-gender-dysphoria-research-study/>). An announcement of being transgender is often preceded by anxiety, depression, social isolation, loss, or trauma. This now-common presentation was virtually unheard of until a few years ago. The sudden onset of gender dysphoria seems to be correlated with a couple of factors.

One is social media use. On sites such as YouTube, thousands of homemade videos chronicle the gender transitions of teenagers. The Tumblr blog “Fuck Yeah FTMs” features photo after photo of young FtMs celebrating the changes wrought by testosterone. “I finally have freedom!” posters boast under photographs of their scarred chests post mastectomy. “I’m no longer pre-T!” boasts another under a video of someone injecting testosterone. “My name is Cameron! I’m a nineteen-year-old nonbinary/trans person living in Ohio! I’m excited to say that yesterday was my first injection! I am so happy with the person I am becoming.” Almost all of these posters are under 25 years of age.

Young people can find plenty of in-group validation online. There is an incredibly positive climate around being trans in many places on the Internet. On just one of the hundreds of thousands of YouTube videos that document the poster’s “top surgery,” there are 48 comments such as:

“Can’t believe how far you’ve come! You are amazing in every way!”

“So proud and happy for you.”

“You are totally rad.”

“By the way, you are totally attractive.”

Young people are also finding validation online for their self-diagnosis as transgender. The blog *transgenderreality.com* meticulously details the process by which a questioning young person is encouraged to understand his or her symptoms as evidence of being trans. Young people on reddit and other social media sites explain that they started wondering whether they were trans because they enjoyed creating opposite-sex avatars in online games and liked the clothing or hairstyles of the opposite sex. Commentators frequently respond by telling them they sound like a “textbook case” and congratulate them on “finding out early.”

The second correlative factor is having peers who also identify as trans. We are seeing kids coming out together in peer groups. The following quotes are all taken from parent comments on the blog *4thwavenow* unless otherwise noted.

We are a progressive family caught in the teenage transgender wave. It’s so scary. I can’t even put it into words. What we are seeing are pockets of teens in different towns who are declaring themselves either non-binary or transgender. In many cases, these are teens who showed no gender variance at all, and then they get connected with a group in their high school, and suddenly a large percentage of them are identifying this way. The information they find on the Internet convinces them that physical transitioning via hormones and surgery is not only the only way to go but should also be available to them right now, as soon as they want it. I am very concerned that the medical community is not looking at the sheer number of teens, post-puberty, who are making these kinds of declarations and asking whether this can be genuine or a temporary stop on the process of figuring out one’s identity as a teenager. Peer influence is just so huge in these kids. As soon as they turn 18, they are seeking medical intervention, and the model now is informed consent, so we have lots of teenagers and young adults making permanent changes to their bodies when their brains have not yet reached adulthood. Very, very scary.

In my daughter's extra-curricular activity, one of the groups has about 20 kids in it (all teenagers). Seven of those kids are natal females. THREE of those seven females are publicly out as FTM. This does not include my daughter, who has never come out publicly. So four of seven girls have some issue with gender identity. Of the three girls who have socially transitioned, one is on testosterone and has had surgery. All are under 18. All of them made this discovery after puberty.

My daughter befriended some trans kids from her acting troupe. When you look at this group, each year they are something different. There are kids who, upon joining, are just "allies," the next year they are bisexual, the next year they are gay, and then the final year, they are trans. And at every step of the way, they are being applauded and receiving so much positive support from themselves, each other, the group, the grownups, and the audiences they address (I call this the "echo chamber"). But it's fishy. Why are there so many kids who, the more they hang out, all of a sudden, they are trans too? It doesn't make sense.

My daughter, who is 17, told me last year on Mother's Day that she was now my son. Since I suspected that she might be a lesbian, it wasn't too much of a shock. However, when I began researching this subject, I was extremely concerned with the medical intervention that takes place with these children. Then when I went to a meeting for parents with transgender children, I was shocked about how all of these parents were jumping on the bandwagon of drugs and surgery without questioning. They even complain about wait times for surgeries! Unfortunately, here in Canada, children as young as 16 can make medical decisions for themselves and parents are not allowed to intervene (and surgeries are free).

My daughter decided she is transgender just as soon as she learned of it as a concept, in her senior year of high school. The previous school year she was dealing with a lot of anxiety and stress. She learned of transgender from a small high school group of friends. The university diversity center director took a group of transgender students to a free gender clinic, where my daughter then returned and received, after a single visit, a prescription for testosterone.

I am the mother of a young man in his late 20s who, within the space of just a few months of bingeing on reddit and YouTube transition videos, decided that he was transgender, and is undergoing transition at a frightening speed. Obviously, he is old enough to do whatever he pleases, and all I can do is grieve quietly as I watch him from afar as he destroys his physical and mental health.

In my local high school my daughter is in the marching band. She plays an instrument, but she is friends with many girls in the color guard. There are about 25 members of the color guard this year. All of them are natal female. Last year my daughter told me that almost all of them felt they were lesbian. This year, almost all of them feel they are transgender, agender, or, at the very

least, are questioning their gender identities. I've noticed that many of them have similar haircuts and that some of them are binding. Many constantly discuss their gender identities and agonize about "coming out" to their parents. Their lives seem to be focused on this subject 24/7, which has driven away certain non-transgender friends. No adults have stepped into help, even though they are aware of what is happening. (Anonymous, Private correspondence, 2016)

Now I would like to discuss how therapists are contributing to the rise in transitioning by quickly validating a young person's self-diagnosis as transgender without careful differential diagnosis, exploration of trauma, questions about sexual orientation, etc. Let me say at the outset that I believe most, if not all, therapists are well meaning in doing this. However, I also believe that we, as mental health professionals, need to think more critically about this trend. We are effectively encouraging young people to permanently alter their bodies when there may well be less invasive ways of dealing with their distress.

There is plenty of anecdotal evidence that young people are receiving hormone prescriptions without careful assessment. In the study of 200 detransitioned women, 65% of them responded that they had received no therapy before starting hormones. Most who had been to therapy had only a handful of sessions before being given a letter for hormones. The median age for starting transition among those who answered was 17 (Stella, 2016c). The website *transgenderreality.com* documents online reports of young people receiving letters from therapists for hormones after one, two, or three sessions. One poster explains why she got the required letter after just three sessions. "My therapist got her degree from a school with a strong social justice emphasis and so thankfully she emphasized that she didn't want to be a 'barrier' to me" (T, 2015).

Some therapists are calling themselves "gender therapists," although this is not a formal title and does not mean that the practitioner has had special training or earned an extra credential. As far as I am aware, most gender therapists see their role as affirming patients' preferred gender identity, and possibly helping them transition by providing letters for hormones and surgery. In other words, when a young person self-diagnoses as transgender and presents to a gender therapist, the gender therapist is likely to affirm rather than explore in an open-ended fashion.

The following quotes come from a presentation by developmental psychologist and gender specialist Ehrensaft, at a 2016 symposium in Santa Cruz, California. Dr. Ehrensaft is the author of *The Gender Creative Child*, and is considered a leading expert in the field of transgender children. She is Director and Chief Psychologist for the University of California–San Francisco children's hospital gender clinic, and is also Associate Professor of Pediatrics at UCSF. She sits on the Board of Directors of Gender Spectrum, a San Francisco Bay Area organization. We can learn a lot about the affirmative model even by reading a short excerpt of her talk.

Another thing that's a show-stopper around [parents'] giving consent is the fertility issue. That if the child goes directly from puberty blockers to cross-sex hormones, they are pretty much forfeiting their fertility and won't be able to have a genetically related child.

There's a lot of parents who have dreams of becoming grandparents. It's very hard for them not to imagine those genetically related grandchildren. So we

have to work with parents around, these aren't your dreams. [She laughs.] You have to focus on your child's dreams. What they want.

And what I will say about many of the youth who want puberty blockers is: I have never met such an altruistic group of kids around adoption! Never! "I will adopt because there are so many children who need good homes." And I think that's both heartfelt but also they're trying to tell us the most important thing to me right now is being able to have every opportunity to have my gender affirmation be as complete as possible. Anything else is secondary.

The question is, can an 11-year-old, 12-year-old at that level of development, be really thinking and know what they want at age 30 around infertility? The answer to that is: We don't think twice about instituting treatments for cancers for children that will compromise their fertility. We don't say, we're not going to give them the treatment for cancer because it's going to compromise their fertility. For some of the youth, having the gender affirmation interventions is as life-saving as the oncology services for children who have cancer.

Joel Baum, head of education for Gender Spectrum, speaks next:

I'll just add one thing here. When we're working with families, what is the leverage point for that family? ... The fact of the matter is at the end of the day, it is their decision and we just hope they're going to make an informed decision. Just make sure you have all the information you need. Which includes:

You can either have grandchildren or not have a kid anymore because they've ended the relationship with you or in some cases because they've chosen a more dangerous path for themselves. (Ehrensaft & Baum, 2016)

Here, Ehrensaft admits that the treatment toward which she often steers families—blockers followed by cross-sex hormones—causes infertility. She then dismisses this concern—rather insultingly, in my opinion—as nothing more than a parental desire to have a biologically related grandchild. In truth, sterilizing minor children—many of whom will likely grow up to be gay or lesbian—is a serious breach of medical ethics. Preserving the fertility of minors has always been considered a fundamental ethical principle.

Ehrensaft and Baum then play the "suicide card," implying that we wouldn't hesitate to administer treatment that would sterilize a child suffering from cancer—and transition, according to Ehrensaft, could be "just as life-saving." There are several things wrong with this assertion. Cancer treatments are undertaken only *after* confirming the diagnosis. Often, a biopsy is performed so that tissue can be examined under the microscope. Imaging studies may also be done, verifying the type of tumor and how far it has spread. Recall that we still have no meaningful definition of "gender identity," and no scientific understanding of its development. There is no lab test for gender dysphoria. Moreover, treatment for a child with cancer will likely involve choosing between several different treatment options. The family will be presented with the risks and benefits of each, based on the best medical evidence. When a child self-diagnoses as trans, parents are frequently steered toward transition as the *only* treatment option.

In addition, recall that there is no firm evidence that transition reduces suicidality. In fact, according to some studies, suicide rates after transition continue to be high (Asscheman et al., 2011; Dhejne et al., 2011). Finally, Ehrensaft's assertion that children really, really don't mind being sterilized because they altruistically want to adopt strikes me as ludicrous. It beggars the imagination to think that Ehrensaft, an expert in child development, does not understand that, just because a child passionately wants something, he or she can understand the full implications of that desire.

Ehrensaft is not a minor player in the field of transgender kids. She is considered a leading authority. She has substantial influence. She speaks and publishes widely. The quote referenced above exposes some of the attitudes and practices of mainstream clinicians regarding this subject.

The affirmative approach is even being codified into law. In recent years, there has been some good, much needed legislation passed making it illegal for therapists to try to change a client's sexual orientation. Unfortunately, activists have lobbied in some states to have the concept of gender identity inserted into these laws. In many cases, the resulting laws are unclear in meaning, leaving them open to interpretation. Some therapists are concerned that these laws make it illegal for them to explore a patient's feelings of dysphoria. Any approach other than affirmation then comes into question. And hormones and surgery are easy to access. Seventy-four American colleges have health insurance programs that cover both hormones and surgery. Another 21 cover hormones only (<https://www.campuspride.org/tpc/student-health-insurance/>).

To summarize, the preferred procedure for diagnosing gender dysphoria is to "affirm the identity." The first line of treatment for gender dysphoria involves invasive and permanent procedures for which there is scant evidence of their efficacy. And these treatments are easy to access.

The plight of parents who are dealing with teens coming out as trans suddenly, without a prior history of dysphoria, can be especially poignant. In my experience with this group, most of the parents genuinely want what is best for their child. They may have concerns about whether permanent medical intervention is the right course to follow, and frequently look to therapists to help them choose the best path. Many are surprised and dismayed by the heavy-handed approach of gender therapists who instruct them to immediately affirm the young person's identity without a process of exploration or differential diagnosis. The following quotes are taken from parent comments on the blog *4thwavenow.com*:

Just got off the phone with a therapist I was interviewing for my child who laughed at me when I wasn't telling a joke. I ended the call curtly, and hung up. She called back and started to lecture me on how I needed to be in therapy and how my child needed to be on hormone blockers and get into the gender program at a local hospital. When I asked her how she could so blatantly diagnose my kid who she's never met over the phone, she called me a transphobe.

My 15-year-old daughter came to us 6 months ago to tell us she is gender-fluid. Now she says she is transgender. She has a group of friends who are all gender-questioning and it seems the cool thing to do. We got her in therapy and, after just 10 visits, the therapist agreed with her. And while speaking with the therapist of my concerns, I felt shamed, like I had no right to have concerns. I will continue to support my daughter, but I will tell her that I will

question everything and that there will be no medical intervention done until she is an adult.

I recently sought help/advice from someone who specializes in trans issues. After one hour of talking to her she was pushing blockers, therapy, pride groups, etc. My son is not interested. At this point he merely cross-dresses in female undergarments in private. He did not express a desire to become a woman, but rather finds the idea “a turn on.” I barely told her what he said and what he was doing and she determined he has been suffering for years with this (he is 13, so we aren’t talking too long anyway). He is not suffering. She was more interested in her ideology than listening to the details of our individual situation. I am terrified to think what could have happened if I had walked into her office uninformed. I have not been able to find anyone else to talk to who knows about this (other than on the Internet). I do have another therapist, but she knows nothing about this and changes the subject every time I bring it up. I support my son whatever he decides or needs, but I don’t want him to be pushed into anything drastic for the wrong reasons. I feel like I won’t get honest information from providers. This stresses me out.

Like many who read this blog, I phoned gender therapists during the weeks after [my daughter’s] announcement that she is trans. *Without even meeting my child in the flesh*, all four of these therapists talked to me like this trans thing was a done deal. One very friendly therapist, who identifies as FTM and whose website stressed “his” commitment to “informed consent,” assured me that there was no need for my daughter to first experience a sexual or romantic relationship before deciding whether she was trans. “Most of the young people just skip that step now,” the therapist said.

Skip that step? I thought back to my own adolescence. I didn’t even begin to have a clear idea of who I was, as a sexual being, until after I’d had more than one relationship. It took years for me to come to know my body’s nuances and intricacies, its capacity for pleasure, how I might feel in relation to another. This same therapist signed my kid up for a “trans teen” support group scheduled for the following week—again, without ever having met her. “There’s nothing you or I can do about your daughter being trans,” said another therapist ... *on the phone, without having met my kid*. Yet another therapist refused to talk to me at all; insisted she’d have to have a private appointment with my kid first.

Contrary to the myth promulgated by the transition promoters, at least in the United States, there is no slow and careful assessment of these kids who profess to be trans. The trend is to kick out the gatekeepers, and move towards a simple model of “informed consent”: If you say you’re trans, you are—no matter how young and no matter when you “realized” you were trans (“Parents, keep listening to your gut—not the gender therapist,” 2016).

I would like to sum up this section with images created by Cari Stella, the young woman who created the survey of detransitioned women (see [Figures 2–5](#); Stella, 2016b). Cari received her letter for hormones and surgery after three therapy appointments with



Figure 2.

Sheryl, her gender therapist. During their work together, Cari began having flashbacks to a traumatic incident she had not previously remembered. These were only explored peremptorily, and there was no discussion about how trauma might impact feelings about one's body. As Cari depicts in this moving artwork, Sheryl never told her it might be normal to feel uncomfortable with your body as an adolescent female. Sheryl never asked Cari whether she had experienced trauma, nor assessed her for symptoms of PTSD. She never explored with Cari whether her dysphoria might be related to Cari's emerging lesbian sexual orientation, and she never helped Cari explore underlying psychological conflicts (Stella, 2016).

How can we do a better job of assessing and treating young people who are exploring a transgender identity? We can support and accept gender-nonconforming young people. We can do what we can to reduce bullying and social stigma to those who don't

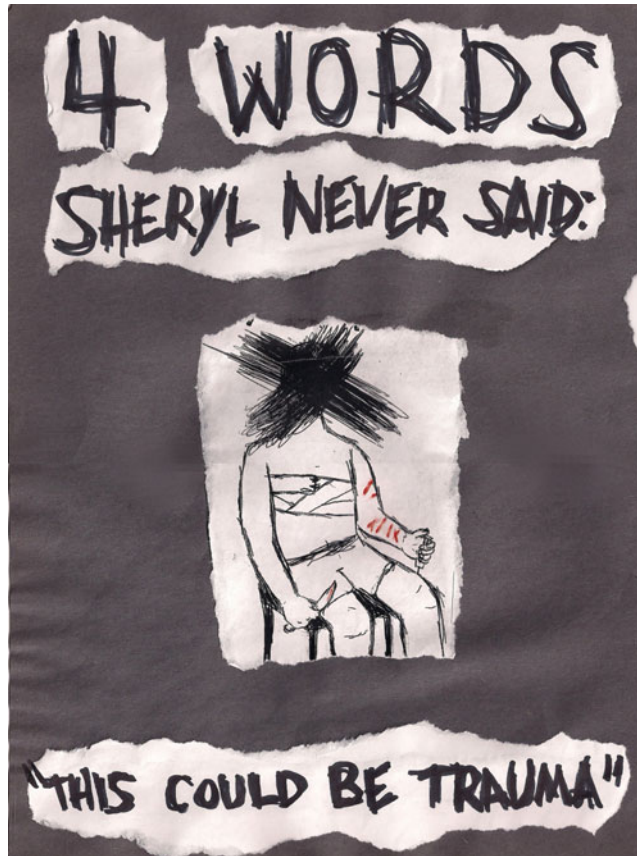


Figure 3.

conform to sex role stereotypes. We can present young people with a full range of options to deal with dysphoria, including treatment options in addition to transition. We can offer role models for living as a femme man or a butch lesbian. We can offer trauma-competent care and a thorough differential diagnosis that identifies cases where dissociation or other PTSD symptoms may be contributing to dysphoria. We can offer medical transition for adults, but ensure thorough and accurate information about side effects and risks of medical treatment, as well as potential downsides of transitioning.

With the best of intentions, the modern psychiatric and medical establishments have contributed to a situation in which minor children have been supported in believing that they are the opposite sex, and must alter their bodies drastically to ameliorate this situation. The mainstream media has quickly validated this line of thinking, and those who have doubts are reticent to express them for fear of being viewed as bigoted or being on the receiving end of career-altering attacks. How did we get here? Jung would not be surprised.

We can never be sure that a new idea will not seize either upon ourselves or upon our neighbors. We know from modern as well as from ancient history that such ideas are often so strange, indeed so bizarre, that they fly in the face of reason. The fascination which is almost invariably connected with ideas of

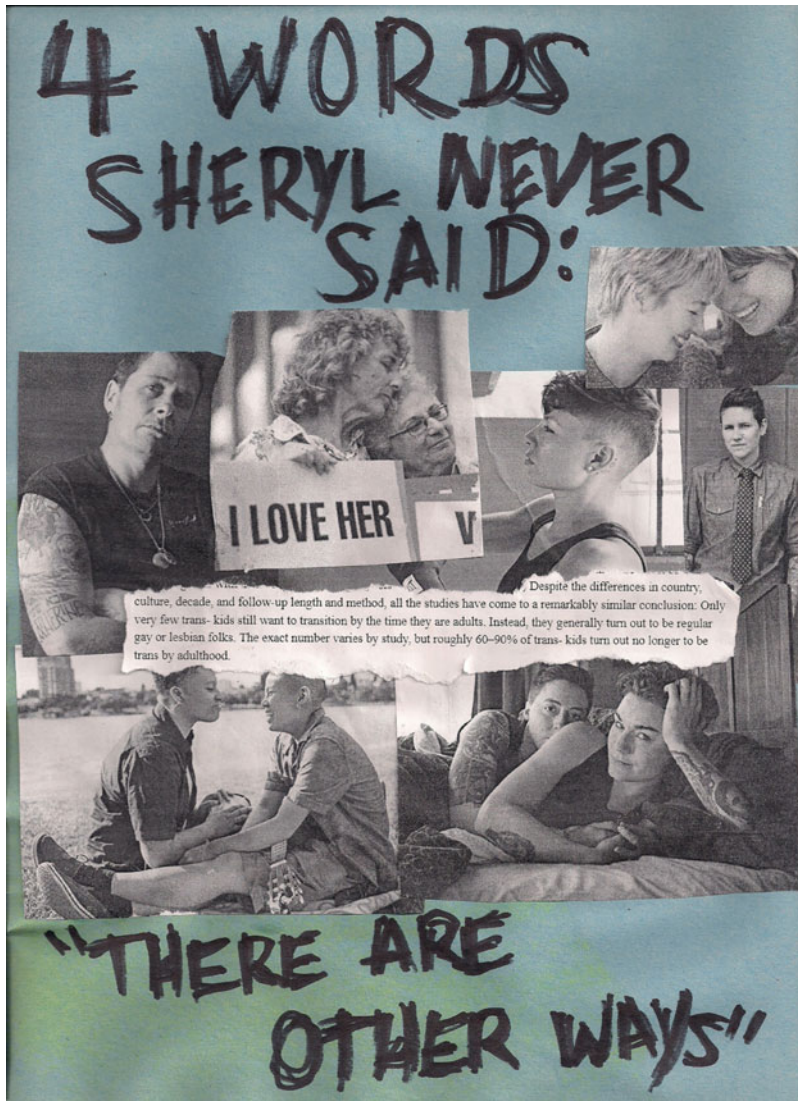


Figure 4.

this sort produces a fanatical obsession, with the result that all dissenters, no matter how well-meaning or reasonable they are, get burnt alive or have their heads cut off or are disposed of in masses by the more modern machine gun. (1970, p. 230)

Jung warns us that to resist the “all-engulfing force” of such attractive ideas, we must be rooted “not only in the outside world, but in the world within.” Since outside authority cannot be relied upon, we must put ourselves right by cultivating consciousness based upon “the eternal fact of the human psyche” (1970, p. 230). This advice seems fresh



Figure 5.

and relevant today in addressing the current sudden increase in trans-identified young people.

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