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BRIEF REPORT



Informed Consent or Scare Tactics? A Response to Levine et al.'s "Reconsidering Informed Consent for Trans-Identified Children, Adolescents, and Young Adults"

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ABSTRACT

This responds to "Reconsidering Informed Consent for Trans-Identified Children, Adolescents, and Young Adults" by Levine et al., part of a small but growing, critical response to contemporary treatments of gender dysphoric/incongruent (GD/GI) children and adolescents. This author, while disagreeing with Levine et al. and other critics, hopes that with dialogue, research and engagement with the wider world, needs of all children, adolescents and young adults—those who have GD/GI and those who may not—will be best served. Critics of gender affirming treatments cite growing numbers of cases, "low level of evidence" supporting treatment, irreversible side effects and expressing regrets as reasons to oppose gender affirmative treatments. Although sharing similar concerns, the author does not conclude treatments should not be offered when appropriate. The critics' alternative reads as "just talk to the young people and find out what is really bothering them." Lacking empirical evidence for that approach does not appear to trouble them.

Levine et al.'s caricature of informed consent, which this author parodies, would dissuade anyone from treatment. Their approach does not appear to be written for purposes of engaging frontline clinicians with the aim of improving treatment. Instead, they read as appeals to third parties unfamiliar with the clinical presentations of these children—parents, caretakers courts, legislatures, state health departments and national health care systems—to discourage treatments from proceeding. This impression is further buttressed by a declaration of financial support from The Society for Empirical-Based Gender Medicine, a small group of outliers from mainstream clinicians treating minors with GD/GI who present as "truth-speaking" experts regarding "facts" being ignored, elided over or perhaps even covered up by the mainstream.

The author concludes by noting that clinicians who advocate for delaying treatment to GD/GI minors who need and may benefit from it to "protect" those who "aren't really" transgender is an ethically troubling issue. In other words, "first, do no harm" is a sword that cuts two ways.

I wish to thank the *Journal of Sex and Marital Therapy* for inviting me to respond to Levine, Abbruzzese, and Mason (2022) in what I perceive to be a small but growing, critical response from mental health professionals to contemporary treatments of gender dysphoric minors (Bell, 2020; Evans, 2021; Schwartz; 2021).¹

While I do not treat children or young adolescents, I am a psychiatrist and psychoanalyst who served on the committees that revised the diagnosis of Gender Dysphoria (GD) in the DSM-5 (Zucker et al., 2013) and Gender Incongruence (GI) in the ICD-11 (Reed et al., 2016). I also served as Section Editor of the chapter on Gender Dysphoria in the recent DSM-5 Text Revision (DSM-5-TR; American Psychiatric Association, 2022).

My interest in the treatment of children and adolescents first arose during the controversies surrounding the DSM-5 revision process. At that time, charges were made that Kenneth Zucker, who chaired the DSM-5 Sexual and Gender Identity workgroup, was practicing “conversion therapy” of transgender minors (Drescher, 2010). As I have written about the harms of conversion therapies for more than two decades (Drescher, 1998; Drescher et al., 2016b), I was surprised by this allegation because “conversion therapy,” at that time, usually referred to attempts to change a homosexual orientation to a heterosexual one and did not refer to changing gender identities.²

My curiosity piqued, I tried to learn more about the treatment of children and adolescents with GD/GI. Toward that end, my colleague William Byne, MD,³ and I invited clinicians of different viewpoints to engage in a non-polemical discussion surrounding these clinical issues. Five clinical papers, followed by six scholarly discussants, were first published in a special issue of the *Journal of Homosexuality* (Drescher & Byne, 2012a, 2012b) and subsequently reissued as an edited book (Drescher & Byne, 2013). We also organized and co-chaired a scientific symposium at the 2014 meeting of the American Psychiatric Association (Drescher & Byne, 2014), inviting proponents of different treatment approaches for prepubescent children to share their views (de Vries & Cohen-Kettenis, 2012; Ehrensaft, 2012; Zucker, Wood, Singh, & Bradley, 2012). I have also written about controversies surrounding the treatment of children and adolescents diagnosed with GD/GI and/or other gender concerns as well as gender atypical children who did not grow up to be transgender, sometimes referred to as desisters (Drescher, 2013; Drescher & Pula, 2014; Drescher, Cohen-Kettenis, & Reed, 2016a). While I share concerns about the treatment of children and adolescents, I have not yet succumbed to the culture war’s growing “transgender panic.”

This article aims to identify areas of disagreement with Levine et al. and other critics (Bell, 2020; Evans, 2021; Schwartz, 2022) in the hope that these differences might be addressed through dialogue, research and engagement with the wider world that best serves the interest of all children, adolescents and young adults—those who have GD/GI and those who may not.

The emerging criticism

In a small but emerging literature warning of the dangers of providing gender dysphoric children and adolescents with any kind of gender affirming services, several authors, now including Levine et al., assert that no gender affirming treatment should be given for some of the reasons listed below:

Numbers of young people diagnosed with GD/GI have risen dramatically in recent years

The critics interpret this fact as meaning thorough evaluations are not being done and that it is unlikely these young people meet diagnostic criteria for DSM’s GD or ICD’s GI diagnosis. Therefore, they assert, young people should not receive any gender affirmative services that involve body changes such as puberty blockers or hormones (presently, it is rare for anyone under the age of eighteen to receive surgery). Further, while the origins of GD/GI remain unknown, some critics have offered psychoanalytic formulations and their own anecdotal clinical experiences as to what the “actual: causes of these gender presentations might be,⁴ despite the “low level of evidence” to support their own theories (Bell, 2020).

“Low Level of Evidence”

A low level of evidence usually means an absence of randomized clinical trials (RCTs). Further, it is true that the “level of evidence” supporting current treatments for minors with GD/GI meet this definition of “low” (Hembree et al., 2017). However, there are many medical treatments routinely prescribed by physicians despite their having a low level of evidence to support them. As Howick et al. (2020) have noted, “The quality of evidence supporting most health care interventions remains low; higher-quality evidence is required.” Or as the University of Oxford Medical Sciences Division announced in promoting this meta-analysis on their website,⁵ “Only one in ten medical treatments is backed by high-quality evidence.” Despite such sober assessments regarding the state of modern medicine, Levine et al. use the term “low level of evidence” as an argument, perhaps even a scary buzzword, to discourage providing any gender affirming treatment at all.

Treatments may have irreversible side effects

The current Standards of Care (SOC) of the World Professional Association for Transgender Health (World Professional Association for Transgender Health (WPATH), 2011, p. 25) refer to three kinds of somatic treatments:

1. Fully reversible interventions. These involve the use of GnRH analogues to suppress estrogen or testosterone production and consequently delay the physical changes of puberty. Alternative treatment options include progestins (most commonly medroxyprogesterone) or other medications (such as spironolactone) that decrease the effects of androgens secreted by the testicles of adolescents who are not receiving GnRH analogues. Continuous oral contraceptives (or depot medroxyprogesterone) may be used to suppress menses.
2. Partially reversible interventions. These include hormone therapy to masculinize or feminize the body. Some hormone-induced changes may need reconstructive surgery to reverse the effect (e.g., gynecomastia caused by estrogens), while other changes are not reversible (e.g., deepening of the voice caused by testosterone).
3. Irreversible interventions. These are surgical procedures

However, many routinely performed medical procedures can have irreversible side effects. The risk of a side effect, in a true informed consent model (see below), must always be considered together with the risk of not receiving treatment and the possible benefit of treatment. Further, according to the WPATH SOC (2011), irreversible surgical treatments are not given to prepubescent children although some adolescents may receive surgery at the age of sixteen.

Regrets

Beard growth and voice deepening, for example, may be desired, intended effects of hormone therapy in birth assigned females. In other words, they are not undesired side effects. However, while it is true that some individuals later regret some of the impacts of and changes wrought by endocrinological or surgical interventions they previously desired, it is reasonable to question the ethics of denying treatment to everyone seeking treatment because some people who received treatment later expressed regrets.

Shared concerns

I do share concerns raised by the critics:

- The numbers presenting for treatment are growing—however, we don’t know why, nor should we pretend that we do;
- Historically, anyone seeking gender affirming treatments required an evaluation from a mental health professional to attest to the necessity of treatment. The WPATH SOC (2011) no longer make such evaluations a requirement, although in my clinical experience, many surgeons do want a letter from one or even two mental health professionals attesting to an adult patient’s GD/GI diagnosis. Some within the transgender community refer to this as a “gatekeeping model.” There is a growing perception that this process of attesting that an adult patient has been evaluated and meets criteria for a GD/GI diagnosis is in decline. That this may be happening in children and adolescents as well has created the impression, although not necessarily the fact, that young people are being prematurely rushed to endocrinological and surgical treatments;
- When making any major life decision, making time for self-reflection and, in some cases, lengthy evaluations are important—however, how long one should reflect or be evaluated is not clearly stated by the critics;
- That there is a small research literature showing most prepubescent children diagnosed with GD/GI⁶ grow up to be cisgender and gay, not transgender (Cantor, 2018; Ristori & Steensma, 2016)—however, the critics sometimes either elide over or confound the fact that this literature refers to prepubescent children and not adolescents or young adults.

While I have every reason to believe the emerging critics’ genuine concerns for young people, I do question how they write about the issue. For example, my provocative friend and colleague David Schwartz (2021) writes, “So my narrow purpose today is to persuade you that in the treatment of children and adolescents, no matter what the diagnosis, encouraging mastectomy, ovariectomy, uterine extirpation, penile disablement, tracheal shave, the prescription of hormones which are out of line with the genetic make-up of the child, or puberty blockers, are all clinical practices which run an unacceptably high risk of doing harm” (p. 442). He further adds, “You have no doubt noticed that I have gone out of my way to name the procedures that hormonal and surgical transitioning entails. I do this deliberately to avoid the obfuscating euphemisms which tend to hamper a clear view of what we are talking about” (p. 443). For the sake of “clarity,” however, none of the surgical procedures Schwartz mentions are performed on children with GD/GI.

Further, from what I can gather, the critics’ alternative to offering gender affirming services, sometimes stated explicitly (as Schwartz does) and sometimes implicitly (as in Levine et al.), is “just talk to the young people and find out what is really bothering them.” However, a lack of empirical evidence for the efficacy of that approach does not appear to trouble the critics, who couch their opposition to endocrinological services for minors in the medical dictum to “first do no harm” (Bell, 2020).

Further, and speaking from a longtime editorial perspective, the critics’ warnings do not appear to be written for purposes of engaging the frontline clinicians treating this patient population with the aim of improving treatment. That makes me think and wonder, as I read what they write and publish (and in some cases testify about in court⁷), “who is their audience?” I read what they write as appeals to third parties who are unfamiliar with the clinical presentations of these children—that is parents, caretakers courts, legislatures, state health departments and national health care systems—to prevent these treatments from proceeding. In support of this theory, on April 20, 2022, the Florida Department of Health issued a controversial statement regarding treatment of gender dysphoria in children and adolescents that echoed many of the points made by Levine et al., including “anyone under 18 should not be prescribed hormones or puberty blockers.”⁸ In other words, rather than defining what might constitute best practices for children and adolescents with GD/GI, critics like Levine et al., whether willingly or otherwise, now find themselves aligned in the culture wars with those who wish to stop these clinical practices entirely.⁹

Informed consent parody

As a psychiatrist in private practice, I engage in providing informed consent about medications and psychotherapy with patients all the time. The goal is to use the informed consent process to educate patients about the risks and benefits of accepting a suggested treatment as well as the risks and benefits of not accepting treatment. However, Levine et al.'s caricature of the informed consent process brought to mind the following imaginary scenario between a middle-aged woman and her primary care physician:

Patient: Doctor, I am calling you because I have a headache that won't go away.

Physician: Did you try taking some aspirin?

Patient: As you know, Doctor, I've never taken any medications and don't like the idea of doing so. Does aspirin have any side effects?

Physician: Yes. Aspirin can cause nausea, vomiting, stomach pain, heartburn, hives, rash, swelling of the eyes, face, lips, tongue or throat. It can cause wheezing or difficulty breathing, hoarseness, fast heartbeat, loss of hearing, ringing in the ears, bloody vomit, or bright red blood in the stools.¹⁰

Patient: That's horrible. Isn't there anything else I can take, Doctor?

Physician: Yes, there's also acetaminophen, which is the generic form of Tylenol. That might relieve your headache.

Patient: What kind of side effects does Tylenol have?

Physician: Tylenol can cause red, peeling or blistering skin; rash, hives, itching; swelling of the face, throat, tongue, lips, eyes, hands, feet, ankles, or lower leg. It can cause hoarseness, difficulty breathing or swallowing.¹¹

Patient: But Doctor, that also sounds terrible. What do you think I should do?

Physician: Oh, that's not for me to say. According to Levine et al.'s model of "informed consent," I only have to warn you about the worst case scenarios and risks of treatment. I don't have to offer my opinions or recommendations about the best course of action for you, my individual patient. Further, following this model of informed consent, perhaps the best thing I can suggest is to just live with your headache and talk about it for some unspecified period of time with a mental health professional. In that way, you don't have to accept the risk of taking any medications at all.

This physician does not assist his patient, as one routinely does, on deciding what might be the best course of action to take after outlining the risks and benefits of accepting treatment versus the risks and benefits of not getting the treatment. Instead, in the guise of providing "informed consent," inadvertently or otherwise, this physician, by emphasizing the most serious side effects, frightens the patient from accepting any treatment at all. Levine et al., however, go even a step further and argue that there are no proven benefits to gender affirming treatment at all.

Unfortunately, Levine et al.'s distortion of a more commonplace approach to informed consent is not altogether unsurprising. There is a precedent for distortions of the traditional informed consent concept on the gender-affirming side of clinical debates surrounding provision of transition services for gender dysphoric individuals. As mentioned above, while once an evaluation by mental health professionals was seen as a requirement for access to hormones and surgery, the WPATH SOC (2011) guidelines eschew such "gatekeeping":

Criteria for Hormone Therapy: Initiation of hormone therapy may be undertaken after a psychosocial assessment has been conducted and informed consent has been obtained by a qualified health professional, as outlined in section VII of the SOC. A referral is required from the mental health professional who performed the assessment, unless the assessment was done by a hormone provider who is also qualified in this area (p. 34).

In other words, and as is frequently the practice in many "gender affirming" settings today, patients are assumed in this version of "informed consent" to be eligible almost immediately

for hormone treatment because they provide a history that might be consistent with a GD/GI diagnosis—that is if any DSM or ICD diagnosing is being done at all. In fact, the prescriber (endocrinologist, general practitioner, nurse practitioners, physician’s assistant) does not have to do any kind of psychiatric assessment. This approach has greatly advanced the rights of adult transgender people to obtain needed care without the stigma and obstacle of a mental health evaluation. However, in my opinion, the application of this approach to minors under the age of eighteen may be one of the factors that may have triggered an unintended backlash in an increasing number of bills in US state legislatures not only condemning the practice, but also making it a crime to provide such treatment.¹²

The society for evidence-based gender medicine

Levine et al. declare under “Funding,” that their paper “was supported by the Society for Evidence-based Gender Medicine” [SEGM] and that one of the authors, E. Abbruzzese,¹³ lists their affiliation as the SEGM.¹⁴ Never having heard of SEGM and curious about who they are, I looked them up online (<https://segm.org/>). There they declare themselves to be an organization whose “aim is to promote safe, compassionate, ethical and evidence-informed healthcare for children, adolescents, and young adults with gender dysphoria [GD].” That sounds like my kind of organization as I entirely concur with the need for such care for people diagnosed with GD/GI.

However, while their “donate” button was immediately accessible, I could not find any recommendations on the SEGM website that explained how people with GD/GI might get the kind of quality, evidence-based care for which they are advocating; or exactly what kind of treatment the SEGM would recommend for them. The website, however, is replete with warnings about the harms of gender affirmation—by which the group seems to refer to any kind of endocrinological or surgical intervention—while entirely lacking in alternative recommendations.

In a further search of the internet, I learned that in 2021, the American Academy of Pediatrics (AAP) first accepted and then rejected the group’s application to have an exhibit booth at their annual meeting. This occurrence was reported on *Medscape* (Nainggolan, 2021). It was also reported in an opinion piece in *The Wall Street Journal* with the provocative headline, “A Pediatric Association Stifles Debate on Gender Dysphoria” (Shreir, 2021).¹⁵ That opinion piece echoes many of the talking points made in the Levine et al. paper.

However, using the social conservative editorial page of *The Wall Street Journal* to address a clinical issue brought to mind the late psychiatrist Charles Socarides, who co-founded a now-defunct organization called the National Association for Research and Therapy of Homosexuality. NARTH operated from 1992-2014 and its professional practitioners were advocates of so-called conversion therapy or sexual orientation change efforts (SOCE) for homosexuality.¹⁶ I have outlined previously some of NARTH’s origins and history (Drescher, 1998) as well as its political role as self-appointed “experts” in the anti-gay culture wars in the United States and abroad (Drescher, 2009). Similar to SEGM’s opposition to gender-affirming policies of mainstream professional groups like the AAP, Socarides and other NARTH members challenged the gay-affirming positions of the mainstream American Psychiatric Association with an editorial in *The Wall Street Journal* defending sexual orientation conversion efforts (Socarides et al., 1997). Socarides also provided legal testimony in legal cases opposing gay and lesbian civil rights, such as *Romer v. Evans* in Colorado (Socarides, 1993).

NARTH deliberately took upon itself the role of providing “scientific experts” who would testify in courtrooms and legislatures against gay rights. Is SEGM following a parallel path regarding transgender rights? Perhaps. As noted above, one of the “Clinical and Academic Advisors” listed on their website¹⁷ is Marcus Evans (2021) who has also raised concerns about gender affirmation and who, in his Declaration of Interest states he “provided witness statements for a UK judicial review [of a case against the Tavistock Clinic] examining whether minors are able to provide informed consent for gender-affirming treatments” (p. 289). In addition, a search of the internet found Levine et al., 2022 expert witness testimony in the case of *B.P.J. v. West*

Virginia Board of Education¹⁸ where he makes similar points to Levine et al., 2022 apparently in support of a WV law banning transgender girls from playing on girls' sports teams.

Here, as in the case of NARTH, a small group of outliers from the mainstream of clinicians who treat children (and perhaps even adults) with GD/GI present themselves as “truth-speaking” experts who will provide parents, caretakers, journalists, educators, legislators and courts with “facts” being ignored, elided over or perhaps even covered up by the mainstream. Again, while I have no reason to doubt the beneficent, authentic wishes of these professionals to protect children from the gender affirmative treatments they oppose, any more than I had reason in the past to doubt the good intentions of conversion therapists who believed that being gay was a tragic and unacceptable way to live one's life (Nicolosi, 1991), I do question the way they choose to go about expressing their concerns.

Concluding remarks

At the risk of repeating myself, I wish to conclude by restating my final remarks in my recent response to Evans (2021):

Evans writes: “Whatever decisions are made regarding medical treatment, a thorough psychotherapeutic and psychiatric assessment is essential to enable us to help these vulnerable young people, their families and their clinical teams make informed decisions.” I completely agree with this statement. However, what he does not specify is how long such an evaluation should last. A month? Three months? A year? Longer? A longer approach may benefit children who might *not* grow up to be transgender. However, delaying treatment for all children inevitably comes at the expense of those who will remain gender dysphoric. In my opinion, clinicians delaying treatment to GD/GI adolescents who need it and may benefit from it in order to “protect” those children who “aren't really” transgender is an ethically troubling issue. In other words, “first, do no harm” is a sword that cuts two ways (Drescher, 2022, pp. 2-3).

Notes

1. This is the second time I have been asked to respond to these kind of criticisms (c.f. Evans, 2021; Drescher, 2022).
2. In subsequent years, the term “conversion therapy” evolved into two terms: sexual orientation conversion efforts (SOCE) and gender identity conversion efforts (GICE). The history and distinctions between these two terms is worthy of a paper in itself at some future date.
3. Dr. Byne also chaired the American Psychiatric Association Task Force on *Treatment of Gender Identity Disorder* (Byne et al., 2012) and he and I have authored the GD/GI chapters in two editions of Kaplan and Sadock's *Comprehensive Textbook of Psychiatry* (Drescher & Byne, 2017 and in press).
4. The DSM-5-TR (APA, 2022) does offer differential diagnoses for GD. These include (1) Nonconformity to gender roles; (2) Transvestic Disorder; (3) Body Dysmorphic Disorder; (4) Autism Spectrum Disorder; and (5) Schizophrenia and other psychotic disorders.
5. <https://www.medsci.ox.ac.uk/news/only-one-in-ten-medical-treatments-are-backed-by-high-quality-evidence>
6. These studies were done using diagnostic criteria of gender identity disorder of childhood (GIDC). Critics of these studies (Temple Newhook et al., 2018) believe they are unreliable. Responses to those criticism include Steensma and Cohen-Kettenis (2018) and Zucker, et al. (2018).
7. According to his disclosure, Evans (2020) “and his wife Sue Evans have provided witness statements for a UK judicial review examining whether minors are able to provide informed consent for gender-affirming treatments” (p. 289).
8. Accessed online on April 23 at <https://www.floridahealth.gov/newsroom/2022/04/20220420-gender-dy-sphoria-guidance.pr.html>
9. At the time of this writing, several US states have passed legislation making it a crime for health care practitioners to provide transition services. The Governor of Texas issued a 2022 executive order making transitioning of one's child a reportable case of child abuse. All of these actions are presently being challenged in the courts.
10. <https://medlineplus.gov/druginfo/meds/a682878.html#side-effects>; National Library of Medicine, Accessed online on April 6, 2022
11. <https://medlineplus.gov/druginfo/meds/a681004.html#side-effects>; National Library of Medicine, Accessed online on April 6, 2022
12. I do not think this is the only reason for the emergence of these bills. Politicians on the right have found that creating fear and arousal around transgender issues, as with LGB issues, is a way to fire up their base and do fundraising.

13. It is unclear if Abbruzzese is a medical professional; information about their professional credential were not easily discoverable on the internet.
14. It is also not clear who funds SEGM, as noted by one transgender advocacy organization. See <https://transsafety.network/posts/segm-uncovered/>
15. The writer of the opinion piece is author of a book called, “Irreversible Damage: The Transgender Craze Seducing Our Daughters.”
16. In 2014, NARTH rebranded itself as the Alliance for Therapeutic Choice and Scientific Integrity (ATCSI) which “exists to encourage human flourishing by promoting a more complete truth, informed by natural law, about the science of sexual orientation and biological sex, through education, advocacy, clinical training and therapy.” Accessed online April 6, 2022 at <https://www.therapeuticchoice.com/>
17. https://segm.org/about_us
18. <https://adfmmedialegalfiles.blob.core.windows.net/files/BPJ-LevineDeclaration.pdf>

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