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The controversy surrounding rapid-onset gender dysphoria: gender critical commentary on gender affirmative care for transgender adolescents

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The Controversy Surrounding Rapid-Onset Gender Dysphoria:

Gender Critical Commentary on Gender Affirmative Care for Transgender Adolescents

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Chapter 1: Introduction

Like most of the gender critical individuals whose views are central to my thesis, I stumbled upon their community online. It started with endless Facebook arguments about gender neutral bathrooms with a radical feminist that was running for a local school board seat. As a liberal arts student in the middle of a queer studies class, I remember asking my professor for advice. The right answers in this debate seemed apparent to me, and yet these women online so adamantly disagreed. It was as if they had stopped reading feminist theory in the 70s, still rallying behind the essentialist value of women as a biological category defined by their wombs. They claimed that transgender women were predators undeserving of sympathy, that Judith Butler was not a feminist, and a host of other alien ideas. Seeing that their position arose not from mere ignorance, but a fundamentally different worldview, I eventually moved on. All the queer theory in academia had failed to provide me with the praxis for engaging in such dialogues across difference.

Following the Facebook profiles of people supporting this school board candidate, I found myself in a public group titled “Transgender Questions (Parents)” (Transgender Questions). Having previously conducted workshops about transgender allyship, I thought this was the perfect soap box to enlighten those with genuine curiosity about transgender people. And yet, the matter-of-fact answers I replied to anonymous questions were met with derision. Instead, the questions which concerned this group were more deeply skeptical of “the transgender narrative”. “Who’s profiting financially?” “Is gender affirmative surgery a form of self-harm?” “What evidence shows that being transgender is congenital?” Rather than continuing to argue or leaving altogether, I chose to quietly remain with the hope of better understanding their

perspective. Reading the articles and blog posts linked within the group has formed a significant portion of my background research about the gender critical movement.

The group is united around a common interest in helping parents of transgender children form their opinions outside of dominant medical and social understandings. For them, the space provides a sense of community in a world that they feel labels them as transphobic and silences their voices. And yet, the group is just one small node in a larger network of blogs and discussion forms that span a wide range of genres and disciplines. In addition to concerned parents, there are radical feminists, psychoanalysts, and other professionals bringing their opinions and experiences to bear on the gender critical movement. In their eyes, this movement is acting in the best interest of gender nonconforming children. Their primary concern is the increased number of youths, particularly those assigned female at birth, that are presenting at gender clinics for care. They want to protect these kids from what they perceive as an overly medicalized, paternalist system which seeks to police nonnormative gender expression back into the binary through biological manipulation. Furthermore, they argue that many cases of dysphoria can be attributed to underlying psychopathology or trauma, requiring therapy and social solutions instead of medical treatment. They worry that enterprising physicians and advocates are recklessly ushering vulnerable children down a path to irreversible experimental interventions with potentially harmful side-effects which they may eventually come to regret. While the full range of consequences have not been adequately studied, the possibility of lifelong infertility has already led some to invoke the history of eugenic campaigns targeting perceived “gender inverts”. Gender critical individuals are shocked that this insidious industry has so unquestioningly become part of a liberal, progressive agenda.

There is certainly a need for more research in the area of adolescent gender dysphoria, and the medical community is far from reaching consensus on best practices. However, the field is generally moving towards greater acceptance of a plurality of transgender identities as natural human variation rather than psychopathology. There is also substantial evidence regarding the medical necessity of transitioning for transgender adults with dysphoria by improving long-term mental health outcomes. For adolescents, the issue is complicated by the perceived instability of gender identity among youth and the fraught nature of informed consent for minors. The priorities of medical practitioners are not uniform, and some are more hesitant to proceed than others. That said, many transgender people and advocates of the gender affirmative approach deem members of the gender critical movement to be transphobic for threatening the well-being of transgender youth by seeking to foreclose their access to such medically necessary procedures.

In 2018, the gender critical movement started to move from anonymous online forums to mainstream publications. In a collection of essays titled *Transgender Children and Adolescents: Born in Your Own Body*, a group of gender critical parents and professionals alike reflect on their concerns about the treatment of transgender children and adolescents from their own perspectives. Two authors included in the book, one of whom was also an editor, are mentioned in the acknowledgements of a recent scientific publication, "Rapid-onset gender dysphoria in adolescents and young adults: A study of parental reports" (Littman, 2018). Written by Lisa M. Littman, a physician researcher at the Brown University school of public health, the study recruited parents from three gender critical blogs. In translating the narrative and anecdotal experiences discussed by parents into quantitative and qualitative data, Littman ultimately attempts to characterize a novel presentation of gender dysphoria among adolescents that does not fit existing literature. Instead, she hypothesized that increasing rates of gender dysphoria,

particularly among teenage girls, can be attributed to social contagion and maladaptive coping mechanisms. This can be taken as justification for increased caution and gatekeeping prior to permitting adolescents to transition. Such conclusions have already found a home among more conservative researchers and political pundits.

The more common reaction to Littman's publication was harshly critical. The scientific integrity of her methods was called into question. This prompted PLOS ONE, the online journal that published her article, to conduct a follow up review and eventually republish a revised version. These methodological concerns also lead Brown University to retract their press release about her research (McCook, 2018). And yet, the more pressing issue for many has been the potentially transphobic implications of her work and the views of the sites that gave rise to it. Transgender activists and gender affirmative professionals contend that her findings pathologize transgender identity, delegitimize the authority of transgender youth, and justify cutting them off transgender communities online and in person. This resulted in a position statement of condemnation from the World Professional Association of Transgender Health (WPATH). It also led many to call for Littman's position at Brown to be terminated. Such condemnation has been deemed ideologically motivated censorship by supporter of Littman, with an online petition garnering over 5,000 signatures in her defense.

In *The History of Sexuality*, Foucault writes, "The sex of children and adolescents has become, since the eighteenth century, an important area of contention around which innumerable institutional devices and discursive strategies have been deployed," (Foucault, 1985, p. 30). While Foucault employs the word "sex" in reference to sexuality, more recent debates center the biological sex of youth and its relation to their gender identity (although sexuality remains relevant in this discussion). Rapid-onset gender dysphoria (ROGD) presents one such

scientifically based controversy with great potential to make explicit the various assumptions that implicitly motivate the actors at play (Brante, 1993, p. 186). This cast includes transgender and gender nonconforming individuals both young and old, the parents of dysphoric youth whether affirming or critical, and a host of clinician-researchers from various disciplines and conflicting schools of thought. By exposing the interests at stake, discourses surrounding ROGD reveals unexpected lines of affiliation arising from common goals.

In the struggle for control over the production of scientific knowledge regarding adolescent gender dysphoria, important questions of authority are raised. What role should self-help groups and activists play in the scientific process? Does the internet democratize or distort the creation and distribution of scientific literature? What standards of evidence are in place and whose voices do they exclude? Beyond contributions to scientific knowledge, the very ability to determine the medical care of gender variant youth is at issue. When parents and experts disagree about how to proceed, the meaning of "supportive parenting" becomes contested. Who should have the final say about the appropriate course of treatment? Ultimately, the bodies of gender variant youth are reduced to a battle ground for the enactment of competing ideological and scientific theories.

Delving into this controversial subject, I have attempted to maintain a degree of impartiality by employing a sociology of science framework. Applying Bloor's principle of symmetry at the heart of the strong programme, I will delay any a priori determinations of which side should be favored (Bloor, 1991, p. 7). Instead the scientific evidence and social factors bolstering each position will be considered on their own terms to illuminate their significance for their respective adherents. That said, the strong programme has received valid criticism for potentially collapsing to relativism, rendering it difficult to determine what is "true" or "right" in

any absolute sense (Bloor, 1991, p. 158-159). This may certainly prove frustrating when attempting to choose which side should be favored. However, my primary goal is not to weigh in on this controversy: a position I feel unqualified to assume. Instead, the strong programme provides precisely the tools necessary for impartially analyzing scientific controversies from the outside (Brante, 1993, p. 186).

That being said, I must confirm my unwavering support for transgender people. At a time when this highly politicized identity is being recurrently called into question, I do not want it to appear as if the validity of transgender identification is up for debate. Taking the proponents of each group at their word, I will begin from the assumption that both gender affirmative and gender critical individuals are acting in good faith with the best interest of dysphoric and gender variant youth at heart. Even as this motivation is shared, the two positions have very different understandings of what constitutes the best interest of these youth and how to go about achieving it. If, in the process of interrogating these conflicting assertions, evidence is found to be lacking or claims are deemed misleading, this will be noted in accordance with what I feel are my obligations as a researcher. Furthermore, I will take the fifth and final chapter as an opportunity to insert myself into this dialogue by highlighting potential points of agreement and diagnosing sources of conflict as a means of synthesizing and concluding.

Before then, each position and their collision in the Littman publication must be described in detail. The next two chapters will provide essential background for contextualizing each side of the debate. Chapter two focuses on the medical management of gender dysphoria among youth, from a history of shifting paradigms to the three conflicting treatment approaches that characterize current practice, concluding with a nod toward questions for future research. Chapter three describes the ideological underpinnings of the gender critical movement and then

proceeds to outline the concerns and the rhetorical strategies used to convey them as well as the alliances forged in the process. Finally, chapter four considers the circumstance surrounding the creation and publication of the Littman article, as well as its reception by popular and academic audiences.

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Chapter 2: The (Conflicted) State of the Literature

To understand the concerns of gender critical parents, it is essential to first establish what the clinical management of adolescent gender dysphoria looks like in the status quo. The field is already marked by a great degree of contention, having recently undergone what some label a paradigm shift. In this new landscape, there are at least three distinct camps vying for dominance in the struggle to solidify consensus or potentially disrupt the trajectory of emerging paradigms. Each group has a fundamentally incompatible perspective on how to best care for gender variant youth, derived from their own bodies of research and underlying value systems. The vast chasm between the worldviews of each group has created a state of interpretative flexibility in which epidemiological data often raises more questions than it answers, with each camp taking the evidence as support for their own claims. As the search for answers continues in this developing field, the perspectives of gender critical parents may contribute a handful of as yet unconsidered alternatives

This chapter will begin with a brief overview of the way transgender people have been treated by the medical profession historically in order to understand how the current state of the field has arisen. It will then proceed to outline the positions held by the differing factions alluded to above, beginning with specific treatment protocols and moving to the bioethical principles that justify them. Finally, a few topics in need of further research will be reviewed for their relevance to the Littman publication and their ability to highlight the conflicting understandings generated by each approach. By first laying out the major players in the literature and describing salient points of contention, the following discussion of rapid-onset gender dysphoria can be given appropriate context.

From Reparative Therapy to WPATH

When modern medical establishments were first confronted by gender variant patients, they were generally considered in terms of psychopathology. It was presumed that something must have "gone wrong" to prevent the development of normative gender among these individuals. As such, psychotherapy and psychoanalysis were deemed appropriate tools to reveal underlying pathology and resolve nonnormative gender presentation. Among youth, such reparative therapy typically manifests through a system of incentives that rewards gendered behavior deemed conventionally appropriate for their sex while punishing behavior deemed inappropriate (Ehrensaft, 2017, p. 61). Today, this approach is more commonly referred to as conversion therapy and often discussed in the context of gay and lesbian youth. However, given the inversion hypothesis of same-sex desire that prevailed at the time, gender and sexuality cannot be considered in isolation. This conceptual framework held so firmly to heteronormative ideals that same-sex desire was only conceivable if the homosexual was considered a "gender invert": truly a member of the opposite sex deep down (Von Kraft-Ebing, 2011). Therefore, the prevention of homosexuality and gender variance were intimately intertwined.

In the 1950s, endocrinologist Harry Benjamin put forth an alternative understanding of "transsexuality" that emphasized biology over psychology (Castañeda, 2015, p 263). He proposed that transgender individuals' distress was based in physical incongruities, both neurological and hormonal. As such, biomedical interventions could potentially alleviate their distress. Now hormone replacement therapy (HRT) and surgical gender confirmation were added to the list of potential treatment options. However, these therapies have not been adopted without contest. For example, in 1979 Dr. Paul McHugh closed the gender clinic at Johns Hopkins which provided these services for supposedly "cooperating with a mental illness" (qtd. in Long Chu,

2018). The dichotomy between biology and psychology also resonates with underlying debates about the relative contribution of nature and nurture to the formation of gender identity. This rift dates back to the infamous biomedical interventions of Dr. John Money, who unsuccessfully attempted to reassign the gender a baby boy after a botched circumcision, resulting in suicide (Dreger, 1998, p. 25). To this day, there has been no firm resolution on this question.

The psychopathological understanding of nonnormative configurations of gender and sexuality was codified through their inclusion in the Diagnostic and Statistical Manual for Mental Disorders (DSM), first published by the American Psychiatric Association (APA) in 1952 (Drescher, 2015, p. 569). Homosexuality was included in the first and second editions, then reclassified in the third and ultimately removed from the revised version of the third edition published in 1987 (ibid., p. 566). Conversely, "transsexualism" was first included in the 3rd edition in 1980, then retitled as "gender identity disorder" in the 4th edition, and most recently labeled "gender dysphoria" (GD) in the latest edition, which is defined as "A marked incongruence between one's experienced/expressed gender and assigned gender"(Hausman, 1995, p. 126; APA, 2013, p. 452). These revisions represent more than nominal changes, with diagnostic criteria changing enough to cast doubt on the current relevance of research conducted under previous definitions (Temple Newhook et al., 2018a, p. 4). The dynamic history of these criteria reveals their fundamentally subjective nature, relying heavily on value-based clinical judgement which is subject to shifting cultural context (Seedhouse, 2005, p. 42). Current DSM criteria for a diagnosis of childhood gender dysphoria are reproduced below:

Gender Dysphoria in Children	**302.6 (F64.2)**

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 month's duration, as manifested by at least six of the following (one of which must be Criterion A1):
    1. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
    2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls, (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
    3. A strong preference for cross-gender roles in make-believe play or fantasy play.
    4. A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.
    5. A strong preference for playmates of the other gender.
    6. In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
    7. A strong dislike of one's sexual anatomy.
    8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.
B. The condition is associated with clinically significant distress or impairment in social, school, or other important areas of functioning.

The criteria for adolescents and adults are similar, with the same requirement of "clinically significant distress". It is this distress that differentiates being transgender from being simply gender non-conforming, usually with an attended desire for medical intervention. However, adolescents and adults have less stringent diagnostic requirements: only six criteria are listed and only two must last for six months to qualify (qtd. in Littman, 2018, p. 8). Some of these standards have been charged with codifying stereotypical understandings of gendered behavior, by advocates and critics of transgender individuals alike (Fausto-Sterling, 2012, p. 406).

Recognition in the DSM is a mixed bag for transgender individuals. On the one hand, it is accompanied by a significant degree of stigma given the association with psychopathology (Clare, 2013, p. 265). This is precisely the reason that gay activists sought to remove homosexuality from the DSM (Drescher, 2015, p. 570). For those experiencing same-sex desire, this certainly made sense: reparative therapy was the only "treatment" medicine could offer, and it's been shown to be ineffective and harmful (APA, 2018). Conversely, transgender individuals often seek medical interventions to proceed with rather than prevent their transition,

necessitating continued reliance on physicians even after their identity has been depathologized. In this context, a DSM diagnosis can be essential in verifying the medical necessity of transition related services to receive reimbursement from insurance companies (Rudacille, 2005, p. 194). All this being said, it should be noted that not all transgender individuals experience dysphoria, and even among those who do, not all seek to medically transition. Furthermore, the common rhetoric of being born in the wrong body is not universally shared. Instead, the ubiquity of this narrative has arisen out of relation to medical discourse, with patients essentially saying what physicians wanted to hear in order to receive care (Rudacille, 2005, p. 196). In this way, medicine has socially constructed transgender individuals, and through their bodies medicine has more broadly constructed conceptions of gender. This is not to say that transgender identity is therefore not real, only that the terms through which it is understood have thus far been intimately tied to the discourse of medicine.

Despite the continued inclusion of gender dysphoria in the DSM, there has been a notable paradigm shift from understanding gender variance as pathology to natural human difference (Pyne, 2014, p. 2). In 1979, the Harry Benjamin International Gender Dysphoria Association was formed, which has since been retitled the World Professional Association for Transgender Health (WPATH). Their standards of care maintain that reparative therapy is "no longer considered ethical" (qtd. in ibid.). They also affirm the medical necessity of transition related services by referencing their effectiveness in improving quality of life among transgender people (Coleman, 2012, p. 170). These are only a handful of the formative controversies have set the stage for present understandings of how medicine should approach gender dysphoria and they remain bubbling just under the surface of current contentions.

Three Disparate Approaches

Even with the recent revolution in medical understandings of transgender people in general, there is still a fundamental lack of consensus about how to best care for gender variant youth in particular (Drescher & Byne, 2012, p. 1). For those who identify as transgender from a young age, it can be optimal to begin transitioning early to minimize the period of time spent experiencing dysphoria and to prevent the development of secondary sex characteristics which may exacerbate dysphoria (Coleman et al., 2011, p. 178). And yet, there are unique challenges posed by this approach, with complications that are both biological (such as lifelong infertility) and bioethical (how well can a minor understand and communicate the desire to transition?). Three distinct camps are described in the literature based on their goals for treatment and the protocols by which they pursue these goals. Each will be discussed in order of increasingly permissive and progressive frameworks. While differences are emphasized and geographic centers specified, it should be noted that proponents of all three groups are usually members of WPATH, and some methods are employed fluidly across national and ideological borders.

The first group has the longest history and is arguably the most conservative. Referred to by some as the "live in your own skin" approach, this movement is headed by Kenneth Zucker[1] from the Centre for Addiction and Mental Health (CAMH) in Toronto (Ehrensaft, 2017, p. 61; Zucker et al., 2012, p. 369). Based on his own research, Zucker holds that only 12-13.3% of children with gender identity disorder in childhood will have it persist into adulthood (ibid, 392). Those who "desist" will more than likely come to identify as cisgender homosexuals (Drescher & Pula, 2014, p. 17). This is taken as evidence of gender's malleability in early childhood, which is then combined with the presumption that it is preferable to avoid medical transition if at all

[1] Zucker also chaired the Workgroup for Sexual and Gender Identity Disorders that determined the diagnostic criteria for gender dysphoria in the DSM-5 (Davy, 105, p. 1165).

possible (Ehrensaft, 2017, p. 60; Zucker et al., 2012, p. 375). Therefore, the clinic has attempted to consolidate identification with birth assigned sex by guiding children towards same-sex peers (Zucker et al., 2012, p. 389). For patients that continue to experience dysphoria past puberty and into adolescence, persistence rates are deemed high enough to justify social and medical transition (Ehrensaft, 2017, p. 61). At this point, adolescents are permitted to initiate hormone replacement therapy.

While this approach differs from reparative therapy in several key respects, the two have become closely associated. This is particularly the case in popular media, which often loses sight of nuance in appealing to broad audiences. Widespread disapproval of the similarities to a defunct paradigm now considered to be unethical eventually led to external review of CAMH which ultimately resulted in Dr. Zucker's position being terminated (Singal, 2016). Further investigation deemed the decision to be pre-mature, and Zucker was compensated, however the youth clinic had already been closed (Hayes, 2018). Although distinct from reparative therapy, the "live in your own skin" model still runs the risk of instilling shame in gender variant children (qtd. in Newhook, 2018b, p 333-334). Furthermore, it is particularly concerning that Zucker sees transgender identification in and of itself as a negative outcome to be avoided when possible (Pyne, 2014, p. 3). This runs counter to the more popular understanding of transgender identify as natural human variation.

The second approach is generally considered to be the most neutral. Arising from the Netherlands starting in 1987, this method is referred to as "the Dutch protocol" or the "watchful waiting model" (De Vries & Cohen-Kettenis, 2012, p. 301-303; Ehrensaft, 2017, p. 61). It is similar to the previous method in that social and medical transition are not initiated until the onset of puberty. However, there are key differences in the protocols prior to transition. First, as

the name suggests, the period prior to puberty is characterized by passive observation rather than overt suggestions. In fact, much of this period is spent managing parents' expectations and giving them resources to support their children (De Vries & Cohen-Kettenis, 2012, p. 308). Second, the Dutch approach is notable for the introduction of off-label prescription of GnRH agonists such as Lupron to suppress puberty (ibid., p. 312-313). This fully reversible intervention can begin as early as 12 and last for up to two years, buying more time for exploration while preventing the development of sex characteristics associated with birth sex that may exacerbate dysphoria if adolescents eventually transition (ibid). At 16, transgender patients can begin hormone replacement therapy which is considered partially reversible, and at 18 they are eligible for gender confirming surgeries (ibid., p. 313-314).

This methodical approach involves a significant degree of gatekeeping, with the diagnostic period lasting up to 1.5 years (ibid., p. 312). This allows adequate time to conduct thorough psychological screening to illuminate any comorbid mental illness and determine its relationship to dysphoria: whether it is a cause, effect, or ultimately unrelated (ibid.). This may prove important in complicated cases, but many gender affirmative parents express frustration with the recommendation to delay transition when their children so explicitly express desires to live as another gender (Ehrensaft, 2017, p. 64). Conversely, adherents of the "live in your own skin" model criticize puberty blockers for preventing the full experience of puberty associated with birth assigned sex, which can be a critical time for gender variant youth who will desist to determine that they are cisgender and do not want to transition (Kaltiala-Heino, 2018, p. 33). Pointing to near 100% rates of persistence among some cohorts of youth on puberty blockers, it is argued that rather than a reversible intervention that allows youth more time to decide, blockers are simply the first step on a sure-fire path to transition (de Vries et al., 2011, p. 6;

Marchiano, 2017, p. 352). However, it could also be argued that this is merely evidence of strict screening procedures that ensure likely desisters are detected before puberty blockers are administered.

The third and final approach represents the direction in which the field is moving, particularly in the United States. Deemed the "gender affirmative" model, this method primarily differs from the others by endorsing social transition at whatever age children express dysphoria (Ehrensaft, 2017, p. 60). It is also marked by its acceptance of gender diversity, supporting children in with a myriad of transgender identities that fall outside the binary: whether non-binary, genderfluid, or otherwise (Ehrensaft, 2012, p. 348). This camp is taking up an informed consent model of treatment which eschews previous WPATH requirements for transition: psychotherapy, two doctor's letters, and "real life experience" as one's desired gender (Cavanaugh et al., 2016, p.1148-1149). Instead, transition is treated as any other medical procedure: patients are permitted to choose for themselves after being informed of the benefits and risks posed by treatment. While this is becoming more common among adults, minors still require additional psychological screening and parental consent (idib., p. 1151-1152). In these ways, the gender affirmative model takes seriously the idea that gender variance is most often natural difference and not a sign of pathology.

The gender affirmative approach is the primary site of gender critical parents' criticism, which will be discussed at length in the next section. However, the model has also been subject to critique within scientific literature. For example, adherents of the Dutch approach warn that when social transition occurs too early, children may encounter confusion about the biological reality of their body, making it more difficult for them to understand future medical interventions (De Vries & Cohen-Kettenis, 2012, p. 308). Furthermore, enthusiastic support in social transition

may backfire if children desist but fear disappointing their support system or coming out a second time (ibid.). Zucker has also proved to be a harsh critic of the gender affirmative approach, likening social transition to a form of conversion therapy that instead pressures gender nonconforming children to medically transition (Zucker, 2018, p. 7). His camp also charges the status quo with insufficient screening for underlying mental illness prior to providing transition related services given the high degree of psychiatric comorbidities in the patient population (Bechard et al., 2016, p. 679).

Bioethical Justifications

The various treatment protocols employed by these approaches are informed by their appraisal of the bioethical issues at play. Given the degree of uncertainty regarding long-term outcomes for the interventions at issue, a physician's assessment of risk can vary greatly depending on their relative prioritization of nonmaleficence and beneficence. This disposition will in turn condition the level of caution and gatekeeping they deem necessary before providing care. Furthermore, whether an adolescent should be considered capable of conducting this cost-benefit analysis for themselves presents an additional question, and potentially another barrier to care. As such, it becomes difficult to determine what is in the best interest of gender variant youth and who is best equipped to make such decisions: providers, youth, or their parents?

Both the "live in your own skin" and "watchful waiting" models tend to prioritize nonmaleficence, as indicated by their desire to delay transition. They are very cautious in providing biomedical interventions for fear of unnecessarily exposing youth to potentially adverse outcomes. For example, puberty suppressants can lead to bone demineralization, however this is typically reversed by the onset of hormone replacement therapy (Vlot et al.,

2017). That said, a regimen of puberty suppressants followed by hormone replacement therapy will result in infertility (Marchiano, 2017, p. 358). Additional side effects of lifelong exposure to artificial hormones are not fully understood but could be widespread given the systematic nature of hormones' function. Increased risk of cancer and cardiovascular complications have been suggested as conditions for further research (Coleman et al., 2011, p. 223-226). While the medical necessity of transitioning may outweigh these potential harms, for those who come to desist they represent a preventable burden. Even barring unintended consequences, irreversible changes may be cast as a harm if patients come to regret them later in life. And yet, this case for non-maleficence may be more insidious: it can manifest as a paternalist denial of transgender individuals' current requests in favored of what professionals determine to be in their long-term best interest (Long Chu, 2018). Whether this is justifiable in cases concerning minors is an issue of autonomy and informed consent, considered at the end of this section.

Conversely, the gender affirmative model is more concerned with upholding beneficence at the time of patients' presentation. Adherents of this framework cite immediate threats to the health of adolescents experiencing dysphoria, including very high levels of distress, as reasons for prompt action (qtd. in Vrouenraets et al., 2015, p. 371). Such distress results in rates of self-harm and suicidality that are consistently at least double that of cisgender adolescents (Peterson et al., 2016). Furthermore, access to transition related services has been shown to improve mental health and quality of life among transgender individuals (White Hughto & Reisner, 2016). In this light, potential future harms are de-emphasized as primarily cosmetic compared to the dire risks in the present (Turban & Keuroghlian, 2018, p. 453). At some point, the principle of justice also comes into play. Too heavily favoring non-maleficence just in case a gender nonconforming child turns out to be cisgender runs the risk of depriving transgender children of essential care

(Temple Newhook et al., 2018a, p. 9). This may reveal a systemic prioritization of cisgender children, further marginalizing an already vulnerable population of transgender youth.

The principle of autonomy presents another point of contention. Informed consent necessitates respecting individuals' capacity to make their own decisions, but it also requires protecting those deemed incapable of doing so. Young children clearly fall into the latter category, so the responsibility for consenting to their medical procedures falls to parents, sometimes accompanied by children's assent if they are of an appropriate age (Cavanaugh et al., 2016, p.1152). Adolescents present a more complex case, as the mature minor doctrine holds that there are at least some instances in which a minor may be able to make their own medical decisions without parental oversight (Stein, 2012, p. 489). Those on the conservative end of the spectrum hold that pre-teens just entering puberty cannot meaningfully comprehend the life-long consequences of medically transitioning (Cretella, 2016, p. 52). By contrast, a gender affirming approach centers youths' right to self-determination, maintaining that they are most qualified to make decisions about something as personal as their own gender (Temple Newhook, 2018b, p. 334). When parents, their children and physicians are in agreement about how to proceed, the question is moot. However, real issues arise when parents disagree with their children or physicians about the best course of treatment (Cavanaugh et al., 2016, p. 1152). Such a case is presented by the objections of gender critical parents outlined in the Littman article.

Future Research?

There are still significant gaps in professionals' knowledge of adolescent gender dysphoria. As of now, there is no objective measure to determine if a patient is "truly" transgender or if they are simply gender nonconforming (Laidlaw et al., 2018). Furthermore,

there is no concrete way to predict which transgender children will maintain a stable identity into adulthood and which will continue to develop their gender identity over time (Drescher, 2014, p. 18). As such, there are unanswered questions about the ethical implications of administering interventions whose long-term effects are also in need of more research. And yet, a degree of uncertainty is inherent to the everyday practice of medicine (Montgomery, 2006, p. 37). Even when epidemiological trends are understood, their application to particular instances requires that physicians exercise clinical judgement (ibid.). This chapter will conclude by considering areas of evolving evidence in the field and the orientations of various models in addressing these questions.

Disagreements about the etiology of gender dysphoria trace all the way back to early arguments about nurture versus nature and psychology versus endocrinology. Current evidence suggests, "a complex interaction between a biological predisposition in combination with intra- and interpersonal factors contribute to a development of gender dysphoria," (DeVries 2012). Ultimately, determining the exact cause of dysphoria may lie "beyond the evidence" at this point in time, resting instead in the realm of human interpretation (Seedhouse, 2005, p. 59). For most doctors, determining the absolute, scientific cause of disease is outside their scope of practice: they are concerned only will appropriately managing the symptoms they are presented with (Montgomery, 2006, p. 81). Indeed, most clinicians agree that understanding the etiology of gender dysphoria is inessential for providing quality care (Vrouenraets, 2015, p. 369). And yet, knowing the cause of disease can confer authority upon physicians, particularly when the disease is new and strange, or the narrative of its causality has recently changed (Montgomery, 2006, p. 66). In the case of gender dysphoria, where clinical judgement is paramount, such uncertainty may contribute to providers' lack of legitimacy among gender critical parents.

Comorbid psychopathology presents another vexing epidemiological question. There is consensus that dysphoric youth typically have higher rates of mental illness than their cisgender peers: particularly anxiety and depression (Bechard et al., 2016, p. 685). However, the causal relationship between dysphoria and these other DSM diagnoses is still contested. It may be the case that underlying psychopathology leads people to identify as transgender, as was previously common knowledge. However, the explanation that is currently more popular posits that distress associated with dysphoria manifests as mental illness. This begs the additional question of the degree to which such distress is inherent to the internal experience of dysphoria and how much is externally imposed through mechanisms such as minority stress. Indeed, there is evidence to suggest that affirming families and social environments can go a long way in improving mental health outcomes among dysphoric youth. For example, a study by Olson et al. found that transgender youth that are supported through social transition have levels of depression and anxiety comparable to the general population (Olson et al., 2016, p. 5). However, this should not be taken as evidence that medical interventions are therefore unnecessary, as the underlying diagnosis of dysphoria remains.

There are additional comorbidities that require further research. For example, some have described a disproportionate rate of autism spectrum disorder among trans and gender-nonconforming youth (de Vries et al., 2010) The validity of this association is still far from determinate (van Schalkwyk, Klingensmith & Volkmar, 2015; Turban & van Schalkwyk, 2018). However, if proven, the increased prevalence of such a congenital condition would suggest a mechanism other than minority stress since autism is congenital. While most agree that an autism spectrum disorder should not preclude youth from receiving transition related services, such complex cases require additional consideration before proceeding with transition. A second set

of confounding comorbidities among transgender people is presented by the category of dissociative conditions. One study of individuals with gender dysphoria found that one in three suffered from a comorbid dissociative disorder (Colizzi, Costa, & Todarello, 2015). However, the authors note the difficulty in distinguishing between the two conditions when attempting to attribute symptoms to one cause or the other. This raises the question of whether dissociative disorders maybe sometimes be misdiagnosed as dysphoria.

Finally, the frequency of desistance and its implications for treatment are emerging as the newest contentious topic. As mentioned, Zucker has long conducted research on the issue, arguing that most children with gender dysphoria will desist. Indeed, it is generally agreed that children show much higher rates of desistance than adolescents or adults (Coleman et al. 2012, 172). This is employed by those calling for judicious screening and cautious provision of medical interventions for youth. Recently, this data has been called into question by Newhook et al., who highlight methodological and interpretative issues with four recent studies most commonly used as evidence of an 80% desistance rate (Temple Newhook et al, 2018a, p. 3-5). Furthermore, they question the necessity of desistence research under a gender affirming paradigm, reorienting focus from how children's identity should typically develop over time to how they can best be supported though the process (ibid., p. 10). In defending his research, Zucker cites this second observation as an instance of "intellectual no-platforming," (Zucker, 2018, p. 11). Additionally, Turban and Keuroghlian have argued that desistance should not be considered inherently bad, and that early experience of transition can be a productive part of a nonlinear gender journey towards self-discovery (Turban & Keuroghlian, 2018, p. 453). When it comes to desistance, consensus cannot even be reached on the data itself, much less how it should be interpreted.

Conclusion

The divisive nature of research concerning the clinical management of gender dysphoria among youth illustrates that science alone is incapable of providing solutions biosocial issues. Instead, there is a fundamental reliance upon ideological commitments and ethical principles to guide action. Given the high degree of uncertainty with regard to this particular issue, there is less firm ground for science to speak with a unified voice and more room for subjective orientations to stand in. The next section will introduce a foreign set of criticisms to the field in order to unsettle some of the assumptions that have been taken for granted to this point. Applying such stress to the web of scientific understanding will not only test its strength, but further reveal its unspoken comittments..

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Chapter 3: The Concerns of Gender Critical Parents and Professionals

After observing this contest from the side lines, reading relevant literature and seeking professional advice, gender critical parents have inserted themselves into the dialogue as a relevant interest group. They question where exactly the distress that is characteristic of dysphoria comes from and suggest that it more socially imposed than anything else. Sharing experiences and interpretations, often using pseudonyms and anonymous accounts, these individuals have fostered their own value community in opposition to a gender affirmative majority. Transgendertrend and 4thwavenow are two sites that have provided fertile ground for the construction of ROGD and the recruitment of concerned parents for the Littman study. From this position at the margins, gender critical individuals have made unexpected bed fellows: from radical feminists to religious conservatives. They have also revived the relevance of psychoanalysis as a method for understanding gender dysphoria in terms of psychology rather than biology. Many of these themes come together in the 2018 book *Transgender Children and Young People: Born in Your Own Body,* with chapters contributed by various members of the gender critical community (Brunskell-Evans & Moore, 2018). The rhetoric of this subtitle echoes sentiments behind the "live in your own skin" model of care, which has provided an evidence base in opposition of transition for the gender critical movement to draw from, even if the two groups ultimately pursue different goals.

This chapter will begin with a brief genealogy of second-wave, radical feminism. Then definitions of sex and gender from the movement will be explicated for their use-value in current gender critical feminist circles. Finally, attention will turn to the blogs in question. Once their complaints have been considered, the blogs themselves will be analyzed as discursive communities with consideration for their unintended audiences. By explicating the ideological

underpinnings of interlocutors' worldviews and analyzing the rhetorical strategies of the genre, I hope to reveal how the individuals engaged in these online discussions see themselves as members of critically reflective counter-publics rather than dogmatic adherents of transphobic conspiracy theories.

Radical Feminist Genealogy

For feminism, the second wave (from the 60s to the early 90s) represented an especially generative period. Valuable insights arose during this time that have since been employed in varying, contradictory ways by the feminisms that have followed. For example, the family and the workplace became central points of contest as it was shown that the "personal is political". As women stepped out of the subordinate roles that society had long assigned them, they demonstrated that "biology is not destiny": challenging the supposedly scientific claims of women's inferiority by demonstrating their capabilities outside of domesticity (qtd in Pyne 2014, p. 2). Furthermore, the women's health movement arose, unsettling the masculinist institution of medicine's monopoly over information about women's bodies by upholding women's own perspectives and experiences of birth and menses (Starr, 1982). Much of this groundwork has proven essential for the development of third wave feminisms, including trans feminism. And yet, some of the more radical aspects of the second wave have developed along an alternative trajectory that has placed them in opposition to transgender individuals. This section traces the development of radical feminism from its origin in the second wave to the current manifestations that are most hostile to transgender people.

I am particularly interested in the radical strands of feminism, standing against liberal and Marxist feminisms by locating the roots of women's oppression in patriarchal gender relations

rather than systems of law or class (Thompson, 2017). Beyond reproductive autonomy, issues of primary concern for radical feminists include pornography, sex work, BDSM, violence against women, lesbianism, and "transsexualism". Radical feminists are further divided among themselves, with lesbian radical feminism representing a significant faction. Aside from their separatist movements, lesbian radical feminists are noted for arguments over butch gender presentation. Some contend that butch/femme relationships mirror the very model of heterosexual domination that political lesbianism seeks to undo, while others hail being butch as the ultimate rejection of desirability standards defined by men (McBride, 2008). The figure of the butch has been further complicated in relation to transgender men, inciting what Halberstam has described as a border war (Halberstam, 1998). Both trans men and butch women may present or be read similarly, leading to a crisis of identity in which either group may feel threatened by the existence of the other and attempt to subsume them.

"Trans-exclusionary radical feminists" (TERFs) form another camp worth noting, with the term coined by two radical feminists in 2008 as they sought to differentiate themselves from radical feminists that condemn transgender individuals (McKinnon, 2018). Few women actually identify as TERFs, and many referred to as such claim that the term is a reductive slur used to oversimplify and silence the concerns of outspoken women (Allen et al., 2019). Regardless of how they are referred to, the radical feminists most relevant to gender critical ideology are those who eschew acceptance of transgender individuals. Janice Raymond, author of *The Transsexual Empire: The Making of the She-Male*, happens to be a lesbian radical feminist as well as a canonical critic of transgender people. Her 1979 work represents the only "book-length critique of transgenderism [that] was written in second wave feminism," (Jeffreys, 2014, p. 6). Raymond sees transition related care as an enterprise created by male physicians in service of male

patients, with being transgender defined as "a male problem" (Raymond, 1994, p. 24-26). Such a medical model is criticized for offering individual, surgical solutions to more fundamental social issues. Furthermore, Raymond famously argued that transgender women "rape women's bodies by reducing the real female form to an artifact, appropriating this body for themselves," objectifying their biology in a manner akin to the fetishistic gaze of pornography (Raymond, 1994, p. 104, 30). Transgender women are also accused of attempting to infiltrate women's spaces through deception. Raymond's appraisal of transgender men is only slightly more generous: they are either victims of tokenism or suffering from false consciousness (Raymond 1994, p. 27). It is no wonder that some radical feminists have sought to distance themselves from this rhetoric.

However, in 2014, Sheila Jeffreys wrote *Gender Hurt*s as an updated tribute to Raymond's work in the wake of changing feminist and medical landscapes. As the third wave superseded the second, mainstream feminism took a post-modernist and post-structural turn, beginning to hail the subversive potential of transgender identities rather than deriding them as appropriation or imitation (think Judith Butler). Jeffreys bemoans this transition in academic feminism, which she sees as prioritizing theoretical insights over women's material realities. In this way, Jeffreys tells the genealogy of recent feminism through a framework that Claire Hemmings has identified as one of "loss" (Hemmings, 2011). Jeffreys cites feminist blogs as the real cutting edge of radical analysis at a moment when academia has been co-opted. She mentions two blogs in particular as influential in her analysis: "GenderTrender"[2] and "Dirt from Dirt[3]" (Jeffreys 2014, p. 2). Today the hot spots for feminist criticism of transgender politics are

[2] GenderTrender had their blog suspended by Word Press since I began work on this thesis for extensively publicizing the "dead name" of a transgender woman (4thWaveNow, 2018b).
[3] Although Dirt is no fan of Jeffreys, labeling her a "straight-bian" for claiming to be a political lesbianism without actually being a lesbian in the more conventional sense of the term (Dirt, 2018).

"Transgender Trend" and "4thWaveNow", both of which were used to recruit concerned parents as participants for the Littman study on ROGD (Littman 2018a, 2018b). In turn, this new generation of blogs upholds *Gender Hurts* as necessary introductory reading for those entering the gender critical movement (Transgender Trend, n.d.,; Gender Critical Dad, 2016).

Communities of anti-trans feminists are not contained to the internet, particularly in the UK, where the very literal exclusion of transgender women from "women's only spaces" has become a feminist issue (Lewis, 2019). In the US, this concern is also espoused by far-right conservatives through the drafting of "bathroom bills," sometimes explicitly drawing on the work of Raymond and Jeffreys as justification (Michaelson, 2016). And yet, this same goal embodies the foundational mission of "Woman's Place UK", a feminist organization founded in 2017 to advocate for cisgender women in the consultation process for reforming the Gender Recognition Act of 2004 (Woman's Place UK, 2018). This UK law grants legal recognition of transgender individuals' gender identity providing they meet necessary requirements (Mordaunt 2018). However, Woman's Place UK casts the provision of such rights for transgender individuals as necessarily trading off with protections for cisgender women in a sort of zero-sum game. Allowing transgender women in bathrooms, locker-rooms, and prisons that correspond with their gender identity is seen as posing a threat of predation to cisgender women by allowing "men" to infiltrate their spaces[4]. How these feminists determine that a transgender woman is actually a threating man instead of a fellow woman in need of protection is discussed next.

Paradoxical Conceptions of Sex and Gender

Radical feminist definitions of sex and gender must be pinned down, since defining each term and differentiating between them is crucial to any productive discussion of transgender peoples' experience. Incompatible understandings of sex, gender, and the differences between them cut deep to the core of conflicting worldviews in this controversy. Since these concepts are elusive and subject to variation between individuals, no comprehensive definition is sought. However, Jeffreys does provide a clear articulation that resonates with the spirit of many gender critical individuals, if not their specific diction.

Jeffreys refers to sex as "sex-caste" to characterize it as an immutable category determined by birth with lifelong ramifications for opportunity and oppression (Jeffreys, 2014, p. 5). A binary model follows, in which the ruling caste of "natal males" universally dominates over the subordinate caste of "natal females". The source of all female oppression is determined to arise from the conditions of female biology: sex-selective infanticide and denial of access to abortion are presented as just two examples (ibid.). The experience of being socialized under such patriarchal oppression is seen as a defining feature of being a woman in such a way that transgender women could never meaningfully shed their "male privilege" and actually be women (Raymond, 1994, p. 103, 111). Since Jeffreys holds that sex cannot be changed, she continuously refers to transgender people using the pronouns associated with their sex assigned at birth even after they've transitioned (Jeffreys, 2014 p. 9). Although both Raymond and Jeffreys both pay lip-service to intersex individuals, their existence does nothing to destabilize a two-sex models: chromosomes are seen as the ultimate arbiter of sex (Raymond, 1994, p. 116). Jeffreys further differentiates intersexuality from "transgenderism" by arguing the former is a group defined by a biological condition and an opposition to genital reconstruction, whereas

those who are transgender suffer from a mental condition which leads to misguided demands for psychosurgery (Jeffreys, 2014, p 9).

As for gender, Jeffreys defines the term as a set of "sex roles" deemed appropriate for either sex-caste by a world steeped in patriarchy (Jeffreys, 2014, p. 4). For Jeffreys, these roles were created with the explicit intention of restricting women's behavior and life chances, so therefore gender must be abolished as an organizing principle of society (Jeffreys, 2014, p. 4). She claims that transgender individuals are right in feeling discomfort with the gendered expectations imposed upon them, but holds they are wrong to seek liberation from these roles by exchanging them for a different set of expectations (ibid., p. 8). For her, the very existence of transgender people necessitates essentialist definitions of gender by associating certain behaviors with certain identities and sets of genitals.

It should be noted that plenty of transgender people also reject gender, with many identifying as agender, non-binary, or gender fluid. These individuals either eschew gender roles as Jeffreys recommends or subvert their binary division by enacting a multitude of roles regardless their traditional connotations. And yet, a significant portion of transgender people assert that they have a deeply internal sense of their own gender identity[5]. It is sometimes described that, "sex typically…represents what is between one's legs while gender represents what is between one's ears," (qtd. in Ehrensaft, 2012, p. 45). While the brain science behind gender identity is far from conclusive, most radical feminists reject the entire enterprise as essentialist and unscientific (4thWaveNow, 2014; Transgender Trend, 2017b). And yet, most transgender people who experience dysphoria contend that is a deeply bodily experience. This subset does not simply feel discomfort with the sex roles expected of them, but with the very

[5]It should be noted that even binary transgender people may reject gender roles, for example plenty of transgender women that see themselves as tomboys.

bodies they inhabit. Since Jeffreys siloes all biological considerations into the realm of sex, which she defines as immutable, it is not surprising that her writing pigeon-holes dysphoria accordingly. She can only ever conceive of transgender individuals as simply gender nonconforming and mistakenly projecting discomfort onto their bodies.

This reflects broader commitments among radical feminists to maintaining the "natural" with respect to human bodies. In this way, they enact their own form of essentialism, centering the womb or XX chromosomes as defining features of being a woman. Suddenly, one of the central tenets of second wave feminism is inverted: in a sense, biology becomes destiny. If sex is all that matters and it is deemed to be unchangeable, everyone is locked-in to their sex assigned at birth and the attendant position within patriarchy. I do not mean to imply that women should simply transition to avoid oppression, only that the decision to transition should not be foreclosed. It was these very limitations with holding fast to nature that lead Donna Haraway to espouse that she'd "rather be a cyborg than a goddess" (Haraway, 1987, p. 181). Rather than clinging to a static, given model of femininity, the transition to post-modern feminism broke from the radical second-wave by endorsing the ability to perform and construct our bodies as we desire (resonating with argument from the much-derided Judith Butler). And yet, such paradigm shifts are rarely so clean-cut on the ground, with late-adopters and resisters holding fast to their previous values even as the tides change. The next sections will consider the lasting impact of second-wave radicalism on some feminists' conceptions of gender, with major implications for their framing of transgender issues.

The Blogs

Gender critical advocacy has arisen on various places throughout the internet. As mentioned in the introduction, Facebook groups host some of this discourse (Transgender Questions, 2017). Similarly, there is a rather active r/GenderCritical subreddit with over 30,000 members and a "Gender Critical Support Board" where individuals can post and respond to each other's threads (r/GenderCritical, Gender Critical Support Board). While these websites and a myriad of others could have been used to garner information about the gender critical movement, the rest of this chapter will focus on the three blogs where Dr. Littman initially posted recruitment information for her study of ROGD. These websites are unique from those mentioned above in that they are blogs, where all content is posted by a set of moderators. While anyone can comment on these posts, there is not the same level playing field as an online group or forum where anyone can create a post. These three blogs (4thWaveNow, Transgender Trend, and Youth Trans Critical Professionals) will be summarized in this section, and then their content, rhetoric, and alliances will be elucidated the final sections of this chapter.

4thWaveNow is a WordPress blog that was created in 2015 by the concerned mother of a child who once identified as a transgender boy, but then ultimately desisted (4thWaveNow, 2018a). While initial posts were all written by a single, anonymous creator, contributors have since expanded to include other concerned parents, people that have detransitioned, and professionals working in the field (Littman, 2018a, p. 9). The blog's name denotes the creator's identification with the second wave of feminism and dissatisfaction with the current state of the third wave (4thWaveNow, 2015c). The site focuses on connecting parents of transgender children to alternative sources of support and information if they find themselves questioning dominant understandings of how to treat transgender children (4thWaveNow, 2018a). The

authors minority perspective initially justified her anonymity and various pseudonyms, but since Littman's publication was released, she has revealed that her name as Denise (4thWaveNow, 2019). Furthermore, her daughter Chiara has come out as a public figure, joining three other young women who claim to have suffered from ROGD and subsequently desisted or detransitioned that are now raising awareness through the "Pique Resilience Project" (Pique Resilience Project, 2019).

Transgender Trend is different in that it appears to be more of an organization than a personal project. The UK based site founded by a group of parents has its own domain name and emailing list with almost 1,000 subscribers (Transgender Trend, 2018b). It also accepts donations from users and provides printable flyers and resource packets for parents and schools (ibid.). The website is clearly designed to be more outward facing, with a series of stock photos and a colorful logo. The information is well organized and provides a good introduction for those new to the gender critical movement, whereas 4thwavenow is more esoteric and self-referential in its posting. Transgender Trend also seems to be more action oriented, with a tab concerning UK legislation (ibid.). Beyond these aesthetic and organizational differences, the two websites have similar concerns and functions.

Youth Trans Critical Professionals also pursues similar goals but targets a different audience. As its name suggests, the site is for professionals working in fields relevant to the care and study of transgender youth. As such, I have been unable to gain access to the private WordPress site despite multiple requests (Protected Blog, n.d.). That said, Dr. Littman includes an excerpt from the website's about section in the revised version of her paper (Littman, 2018a, p. 9). Furthermore, when the site was created in 2016, the anonymous founder of Youth Trans Critical Professionals was interviewed on 4thWaveNow and posted a statement on Transgender

Trend (4thWaveNow, 2016b; Transgender Trend, 2016a). From this information, I have surmised that the website includes anonymous "psychologists, social workers, doctors, medical ethicists, and academics" that share similar concerns about the pressure for children with various underlying issues to pursue medical transition despite the supposedly experimental nature of such interventions (ibid). The full extent of these concerns will be described next.

Gender Critical Concerns

With a firm grounding in the history and terminology of radical feminism, we now turn to its modern manifestations in the internet age. This has primarily taken the form of publicly available blogs directed at parents of transgender children who have questions about the process of transitioning. These parents, whether genuinely curious or already skeptical, find themselves in a parallel universe of heavily interfaced websites that readily refute any proposition presented by their clinician, the popular media, or even their own child. While these websites rarely deny the existence of transgender children outright and certainly never call for conversion therapy, they foster a sense of uncertainty and skepticism that has the effect of advocating for an eternal extension of the "watching and waiting" period. By questioning the sources of dysphoria, the motivations of physicians, and the consequences of medically transitioning, these websites convince parents that their children's best interests require an utter disregard for the very interventions they explicitly request.

Depending on the site, bloggers may concede that at least a fraction of dysphoric individuals have a medical condition. Furthermore, they often endorse adults' ability to seek medical transition if they desire (qtd. in Littman 2018a). Yet gender critical individuals are primarily concerned about the growing number of children (particularly girls) presenting to

gender clinics for care (4thWaveNow, 2015e). This is in direct contrast to Raymond's previous observation that being transgender is "a male problem" (Raymond, 1994, p. 24-25). While some may argue that increased acceptance has led to greater visibility for an always prevalent condition, these parents see such explanations as insufficient in explaining the specific phenomenon among teenagers assigned female at birth (Littman 2018a). Instead, they argue that the ubiquity of transgender representation[6] is leading more girls with diverse issues to understand their bodily dissatisfaction (fueled by culture of pornography) through the lens of gender dysphoria, with transition as the only solution (4thWaveNow, 2016d, Transgender Trend, 2016b). For example, anecdotes abound regarding young girls that feel dissociated from their bodies after sexual trauma and mistakenly seek transition instead of therapy (Marchiano, 2016).

Dirt, a butch lesbian blogger, summarizes this sentiment in the about section of her blog: "Change YOUR world-NOT your body! We are born in the WRONG Society-NOT the WRONG body!" (Dirt 2016). This statement strategically co-opts the "wrong body" narrative used to describe gender dysphoria then subverts it by externalizing the source of the problem[7]. This argument is frequently illustrated with reference to annorexia, a different form of body dysphoria. Both conditions are claimed to disproportionately afflict teenage girls, who internalize patriarchal societal messages about their bodies, whether those messages mark their bodies as too masculine or too fat (Transgender trend, 2016b). It is then argued that gender affirming care is "akin to if society decided that the best course of 'treatment' for anorexia was diet pills, laxatives, WLS and liposuction. you wouldn't give an anorexic liposuction," (qtd. in

[6] "The children's picture book "I am Jazz" and the TV show that it has inspired are a primary example of the representation that is seen as dangerous to gender nonconforming youth (4thWaveNow, 2017)

[7] It should be noted that many transgender people have contested this narrative and its application to their personal experience. Rather, the ubiquity of this framing can be attributed to its resonance with medical professionals more than

4thWaveNow, 2015b). Instead, they claim that normalizing gender nonconformity (and body positivity) would obviate the need for such medical interventions in the first place. These arguments are reminiscent of Raymond's concern that transgender people seek individual, medicalized solutions to societal problems. In place of transitioning youth, "pink boys" and "blue girls" are upheld as the truly subversive heroes that are changing society, deserving more recognition and support (Dreger, 2015).

Not just girls, but lesbians in particular, are seen as primary victims of the increased prevalence of transgender identification. If the websites that Littman used for recruitment are critical of transgender people, they are fiercely supportive of homosexuals. In their about section, Youth Trans Critical Professionals explicitly states that they are "pro-gay rights" (qtd in Littman, 2018a, p. 9). Similarly, the founder of 4thWaveNow also proclaims that she is a "strong supporter of gay, lesbian, and bisexual people," (4thWaveNow, 2018a). Gender critical individuals are concerned that the supposedly increasing popularity of being transgender alongside a continued culture of compulsory heterosexuality is leading to the disappearance of lesbians, particularly butches. Internalized homophobia is cited as a motivation for young butch lesbians that come out as transgender men, supposedly attempting to resolve discomfort with their gender nonconformity by transitioning (4thWaveNow, 2016c). Similarly, one anecdote recounts a homophobic Texas mother so uncomfortable with her gay son's femininity that she preferred he transition to be a feminine, transgender girl (Marchiano, 2016). Remember Zucker's desistance data indicating that most youth who consider transitioning but ultimately decide against it will end up as homosexual, cisgender adults (Drescher & Pula, 2014, p. 17) In this light, each child that persists is seen as a potential gay man or lesbian that was lost to the transgender narrative. Furthermore, the unintended sterility that results from a regimen of

puberty blockers followed by hormone replacement therapy is used to invoke the specter of eugenics (Worriedmom, 2018a). In this way, transitioning is cast as a modern means of eradicating those who challenge binary, heteropatriarchal notions of gender.

By changing bodies instead of society, doctors are charged with endorsing the status quo at the expense of children's wellbeing. Physicians are inevitably blamed for all these instances of potential misdiagnosis. Those willing to proceed with treatment are cast as irresponsibly lazy at best, for failing to consider all possible etiologies, and maliciously greedy at worst. The experimental nature of the interventions at issue is taken as evidence of doctors' failings. Indeed, Lupron is being prescribed off-label for puberty suppression (Transgender Trend, 2017a). Additionally, the suggestion that youth and young adults may undergo gender confirmation surgery has sparked comparisons to lobotomy (Overwhelmed, 2017). Both interventions are seen as experimental psychosurgery that disproportionately seeks to control the behavior of women (ibid.) Just as lobotomy was once widely accepted and has since become a stain on the face of medical history, so too do gender critical parents expect that we will come to regret the current ubiquity of surgically transitioning (ibid.). Furthermore, a few highly publicized instances of malpractice committed by gender affirming physicians have been mobilized to undermine the legitimacy of the entire approach (Worriedmom, 2018b).

Perverse incentives are also thought to fuel this faulty clinical judgement. Providing transition related services is seen as a source of profit for enterprising physicians. Recognizing a growing demand in the market, providers could certainly benefit from catering to young transgender patients (4thWaveNow, 2017). If money were their sole motive, the most profitable option would be to provide hormones and surgery as soon as possible, since interventions typically receive more compensation than screening or counseling. Furthermore, monetary

interests are also thought to play a role at the level of directing research. Pharmaceutical companies could profit greatly from transgender individuals that require lifelong prescriptions for hormones. Transgender Trend provides one example of a Dutch study concerning the use of puberty blockers that was funded by Ferring Pharmaceuticals, a company that markets a GnRH agonist (Transgender Trend, 2018a). Even government funded research has been dismissed as biased, with an ongoing NIH study of transgender youth accused of only enrolling at centers that provide gender affirming care from researchers that have "made the biggest names for themselves on the new frontier of transgender pediatric 'treatment'" (4thWaveNow, 2015d).

The ultimate concern with this perceived lack of screening and oversight is that some children will come to regret transitioning once irreversible changes have already occurred. This phenomenon has been termed "detransition," in which desistance occurs *after* transition has already been initiated. The narratives of detransitioners are plastered over the blogs as anecdotal evidence of gender affirmative care's pitfalls. In 2018 one narrative of detransition posted on Gender Trender was eventually published as a case study in *Archives of Sexual Behavior* (Levine, 2018). The dearth of clinical research on the matter has led gender critical communities to generate their own data, with a SurveyMonkey study garnering 200 responses from women that have detransitioned (GuideOnRagingStars, 2016). Dr. Littman has also recognized the paucity of scientific writing on detransition, and her next article will look into detransition using similar methods of snowball sampling on blogs (L. Littman, personal communication, April 11, 2019). From what is known, it seems that regretting transition or seeking to reverse it is a relatively rare phenomenon: only reported by 8% of transgender people, the majority of which did so temporarily (James et al., 2016, p. 111). So, while detransition should not eclipse the vastly more common experience of transgender people lacking access to care, it still greatly

affects the lives of those who experience it and therefore merits further investigation. Narratives of detransition tend to emphasize some underlying issue which initially went unnoticed or undiagnosed, resulting in symptoms that were perceived as dysphoria and treated as such. At some later date, after surgery and/or hormones, the affected individual comes to regret these procedures, ultimately experiencing a sense of discomfort that is not unlike dysphoria. Crucially, gender critical blogs approach this sense of discomfort with a sense of seriousness and gravity not granted to the discomfort experienced by dysphoric individuals. Some have argued that the gender critical movement may be more interested in politicizing the stories of those who de-transition for their own personal gain, rather than sincere concern (Serano, 2016). Indeed, detransition is cast as the ultimate consequence of a reductive and hasty industry that is revealed as fundamentally unsustainable.

Unexpected Bedfellows

To bolster its perspective on transitioning during childhood, the gender critical movement has drawn upon an eclectic array of approaches and forged surprising associations in the process. In turn, the rhetoric and evidence marshalled by gender critical sites has been employed by those who may not share their goals. It seems that ideological purity is a privilege not easily indulged by a minority view. So, while these allies share a desire to prevent children from transitioning when possible, they often do so based on reasons or methods that may contradict other aspects of the gender critical worldview. In reviewing these interesting inconsistencies, my intention is not to defame the gender critical movement by association, but rather to explore the way different goals are prioritized by different actors and how the same evidence is used to achieve disparate ends.

A return to psychoanalytic understandings of gender dysphoria has been useful in redirecting the requests of dysphoric youth away from somatic intervention. In *Born in Your Own Bodies*, Jungian psychoanalyst Lisa Marchiano's chapter argues that symptoms of dysphoria should be taken seriously but not literally and instead be interpreted as signs of deeper psychic distress (Marchiano, 2018). A desire explicitly expressed as a wish to be boy may in fact reflect dissatisfaction with the roles attributed to girls. In another psychoanalytic chapter from the same book, Robert Withers acknowledges that some may harbor intuitive discomfort with psychanalysis for its previous association with the practice of reparative therapy, androcentrism, and normative conceptions of gender (Withers, 2018). Certainly not all of psychotherapy is gender critical: I had the chance to attend the Transgender Mental Health Symposium by the Institute for Contemporary Psychotherapy and the Psychotherapy Center for Gender and Sexuality in March of 2019. Across the board, all of the speakers were avidly gender affirming. However, in one workshop I did observe a disgruntled participant raise unanswered questions about the role of unresolved trauma in fostering dissociation. This certainly seemed to resonate with gender critical concerns of more sinister pathology underlying the desire to transition.

Zucker and the "live in your own skin" camp presents another approach whose image has been tethered to reparative therapy, but none the less performs important work for the gender critical movement. Recall Zucker's efforts to consolidate cisgender identification prior to adolescence by fostering same-sex friendships and confiscating toys deemed to be gender nonconforming (Zucker et al., 2012, p. 389). This approach normatively enforces the very sex-roles which many gender critical people seek to abolish. And yet, Zucker's extensive research on the phenomenon of desistance and its apparently high likelihood forms a corner stone of the gender critical movement's call for caution prior to medical intervention. The author of

4thWaveNow has acknowledged this inconvenient tension: “Zucker and [his collogue] Bradley subscribe to more conventional views about gender and sex role conformity than I’m comfortable with, yet they seem to be some of the only medical professionals who are questioning the rush to pediatric transition,” (4thWaveNow, 2015a). Such sentiments highlight the tensions inherent in this alliance, with bonds forged from necessity instead of philosophical compatibility.

In turn, recent arguments from the gender critical movement have been cited and deployed by others that would not likely agree with underlying gender critical conceptions of gender and sexuality. This is illustrated by an article titled, “Gender Dysphoria in Children and Suppression of Debate” that was written by Dr. Michelle Cretella, the president of the American College of Pediatricians (ACPeds). She identifies both Zucker and the website Youth Trans Critical Professionals as representing appropriately skeptical physicians that have traditional interpretations of the principle to “First do no harm” (Cretella, 2016, p. 50). Conversely, Cretella reproduces a quote from the gender affirming physician Johanna Olson-Kennedy that was initially published on the now defunct blog “Gender Trender” in an attempt to frame her as a post-modernist with “a subjective view of ‘First do no harm’” (ibid.). In addition to referencing gender critical blogs, Cretella refers to the same radical feminist writing that they draw from. Two works by Sheila Jeffreys are cited, with *Gender Hurts* attributing a conception of “feminine essence” to transgender activists, and *Gender Eugenics* used to establish the sterilizing effects of life-long HRT (Cretella, 2016, p. 51, 52). And yet, the American College of Pediatricians is a deeply socially conservative organization. They have released position statements denouncing legal bans on psychotherapy for minors with “unwanted homosexual desire”, asserting that same-sex attraction can and may reasonably be prevented, recommending abstinence only

education, and asserting that life begins at conception (ACPeds, 2018). Conversely, Transgender Trend has an about section which says they "reject current conservative, reactionary, religious-fundamentalist views about sexuality," (qtd in Littman 2018a, p.9). Similarly, the author of 4thWaveNow proclaims that she is "not personally in accord with conservative, religious-fundamentalist views about sexuality," in her about section (4thWaveNow, 2018a). And so, despite the wide gulf between their ideological commitments, conservative physicians have found useful intellectual allies in gender critical feminists.

Conservative news outlets have also taken an interest in gender critical organizing. Consider the far-right website Breitbart for example. When the Gender Recognition Act went up for review, they commented that the overseeing panel contained "not a single gender critical feminist" (Deacon, 2015). They also published an article when Transgender Trend had their page removed from the website Crowdfunder, denouncing the decision as an act of silencing (Deacon, 2018). They've also frequently pull quotes and anecdotes from 4thWaveNow, with stories about detransition, autism, and general gender critical concerns (Munro, 2018; Ruse, 2016; Berry, 2017). As the comments on one of these articles demonstrates, citing gender critical blogs bestows great rhetorical power (Berry, 2017). The claim that these parents must be conservative and transphobic can be dismissed using the blogs explicit identification as "left-leaning" and feminist (4thWaveNow, 2018a). If "even feminists" are against transgender people, this grants credence to the far-right's anti-trans crusade, giving it the appearance of factuality and legitimate concern beyond mere bigotry.

Genre Analysis

These blogs represent a fusion of radical feminist theory and current clinical research. Furthermore, their interactive nature and open availability render them significantly more accessible than either of the genres they draw from. This has greatly expanded their reach among the general population even as it has diluted their academic rigor. With strong desires for certainty regarding their particular child that physicians are not entirely trusted to provide, many parents turn to the internet in search of their own answers. Such encounters with evidence that they are not fully equipped to interpret is often detrimental (Montgomery, 2006, p. 194). And yet, the community that is fostered in the process of seeking answers creates a space for the exchange of anecdote and personal experience that may ultimately be more valuable.

New publications from various medical journals are frequently linked and commentary is provided, sometimes with excerpts reproduced on the blog. But the comments make clear that most readers do not have access to the original source due to paywalls. Instead, findings are often filtered through the interpretations of the blogger or other commenters. There is a feeling of authority derived from this position, with the author of 4th Wave Now writing, "I've spent thousands of hours marinating in gender dogma and research studies," (4thwavenow, 2016a). And yet, Thomas Nichols warns against precisely such illusions of proficiency in *The Death of Expertise*, writing "Knowing things is not the same as understanding them. Comprehension is not the same thing as analysis. Expertise is not a parlor game played with factoids," (Nichols, 2017, p. 37). He argues that the internet has exacerbated the problem, mobilizing massive amounts of information divorced from its original context and amplifying the voices of the partially educated (Nichols, 2017, p. 15-16). In this unstable environment, how should parents decide who to trust? Rachel McKinnon, a transgender theorist and critic of "TERF propaganda"

has similar concerns (McKinnon, 2018, p. 485). For her, "the primary worry is that those who know a little, but not enough, will hear a supposed epistemic authority say something that, to their lights, is plausible, but aren't epistemically situated well enough to question the epistemic authority or the veracity of the underground ideology," (McKinnon, 2018, p. 488). This is particularly dangerous when those with flawed information are more easily accessible than peer-reviewed literature.

That said, Nichols does acknowledge that experts may also blinded to their potential mistakes (Nichols, 2017, p. 36). Indeed, Transgender Trend recently retweeted researcher Ray Blanchard saying "In most areas, I would automatically take the opinion of an expert over that of a lay person. In the field of gender/trans, however, many "experts" are ideologues and activists, and they cannot be relied on for objective opinions," (Blanchard, 2019). There is certainly a way in which those with perspectives from outside of existing scientific consensus can raise questions and problems with assumptions which may be taken for granted within the field (Harding, 1992, p. 446). This has led some to argue that more strongly contextualized knowledge will be more reliable since it has already been field-tested outside of the clinic or lab by those for whom it is most relevant (Nowotny, Scott, & Gibbons, 2001, p. 168).

Perhaps the greatest strength of these forums is the production of new knowledge rather than interpretation of existing literature. While these parents may not be experts in clinical research, they certainly know their own experience better than anyone else[8]. Exchanging their stories and advice has given rise to new perspectives outside the establishment of scientific knowledge. Indeed, statistics and narratives present two very different, yet valid, means of beginning to explore issues that are not well understood (Montgomery, 2006, p. 79). Narrative

[8] Which is not to say that they have a complete understanding of their children's experiences, particularly concerning the subjective feeling of gender dysphoria.

can be an especially valuable method in medicine, when outliers represent not just numbers to be excluded, but the lives of people who may feel underserved by existing models (ibid., p. 50). While physicians are trained to be warry of anecdotal evidence in general, attention to individual cases becomes essential when considering emerging phenomena (ibid., 46). In this way, researchers could do well to take note of the perspectives of those that are differently situated. Such positions often illuminate problems that have been deemed to be settled by professional consensus. Indeed, there is a precedent for patient self-help movements giving voice to medical issues overlooked by institutions of medicine to help shape research questions (Von Gizycki, 1987). By providing resources, whether in the form of funding or data, these groups can influence the direction that future research takes by engaging researchers with shared values. The next chapter will consider the Littman article on ROGD as a case study of one such encounter.

Conclusion

This chapter has sought to provide adequate historical and rhetorical context to reveal that concerns regarding "rapid-onset gender dysphoria" have not arisen out of nowhere. Rather, they are just a single aspect of a broader worldview that sees transgender rights as a threat to feminist progress. In this struggle, gender critical parents find themselves to be an outnumbered by developing medical consensus. Their concern for the wellbeing of their children provides the moral high ground and motivation necessary to remain skeptical in the face of progressive advocacy. They seek to challenge and redefine what it means to be an accepting and supportive parent. Dissatisfied with the current options of transitioning or committing suicide, they attempt to open up space for new ways of being gender non-conforming.

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Chapter 4: Rapid-Onset Gender Dysphoria

On August 16th of 2018, an article by physician researcher Lisa Littman was published to the online journal PLOS ONE with the title "Rapid-onset gender dysphoria in adolescents and young adults: A study of parental reports" (Littman, 2018b). She defines the newly coined term, ROGD, as "adolescent-onset or late-onset gender dysphoria where the development of gender dysphoria is observed to begin suddenly during or after puberty in an adolescent or young adult who would not have met criteria for gender dysphoria in childhood," (ibid., p. 2). After conducting quantitative and qualitative analysis of anonymous parental reports, Littman proposes two potential hypotheses for the origin of ROGD: social contagion and maladaptive coping mechanisms. The implication is that ROGD may be a novel presentation of gender dysphoria for which previous research and protocols are not necessarily applicable. The polarizing piece immediately drew much attention from diverse audiences. It quickly circulated through transgender circles online, eliciting outrage and calls for Dr. Littman's position at Brown University to be terminated. In response, a petition in support of Dr. Littman has garnered over 5,000 signatures. Concerns about the academic rigor the Littman's methods also caused PLOS ONE to subject the piece to post-publication follow up, resulting in revisions and republication with a new title: "Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria" (Littman, 2018a). In addition to reframing the study's limitations, the revised version contains a third hypothesis: that parental conflict explains the findings. And yet, the work had already been widely written about in the popular media and cited in a handful of academic publications.

This chapter will consider both iterations of Littman's article and the context surrounding their creation and reception. First, the original article will be discussed, followed by the initial

criticism and support it received. Next, the process and results of republication will be analyzed. Finally, Littman's ideological commitments will be considered and her relation to the gender critical community interrogated. The entire endeavor presents an illuminating case study in the sociology of scientific controversies while also demonstrating the role of non-scientists and activists in the process of producing and distributing knowledge.

The Initial Publication

The article's sole author is Dr. Lisa Littman, a physician-researcher at Brown University. The publishing journal is PLOS ONE, an online, open access publication. The original paper begins with a background section that discusses the increased prevalence of GD among adolescents, particularly those assigned female at birth (AFAB), and then explains social contagion in the context of annorexia (Littman, 2018b, p. 4). The data for this study was gathered using an anonymous online survey of parents that were recruited through information initially posted on three gender critical blogs followed by snowball sampling (ibid., p. 5). After establishing demographic data, Littman's findings can be grouped into three broad categories: information about dysphoric adolescents and young adults (AYA) themselves, their interactions with peers, and their engagement with medical professionals. This data is conveyed using a combination of traditional quantitative methods and grounded, qualitative analysis. From this information, two hypotheses regarding the origin of ROGD are proposed: social contagion, and maladaptive coping. Ultimately the paper attempts to differentiate ROGD as a novel presentation of gender dysphoria during adolescence, not described in the literature and necessitating new, more cautious standards of care (ibid., p. 3).

Some demographics are worth noting, especially because participants were self-selected through voluntary response to a rather lengthy online survey expected to take 30-60 minutes (ibid, p. 5). Participating parents and their children were both overwhelmingly female (91.4% and 82.8% respectively) (ibid. 4-5). This is predictable, given the radical feminist nature of the movement and their particular concerns about the recent inversion in the sex ratio of youth seeking to transition. Furthermore, parents were highly educated, with 37.8% having earned a bachelor's degree and 33.1% having earned a graduate degree[9] (ibid., p. 5). This aligns with theoretical insights that predict criticism of science will typically arise from well-educated groups (Nowotny, Scott, & Gibbons, 2001, p. 204). Finally, respondents are cast as socially liberal, since 85.9% support same-sex marriage and 88.2% affirm transgender individuals' entitlement to equal right and protections[10] (Littman, 2018b, p. 6). Thus, in many respects, the study sample is not representative of the general population, but rather the gender critical movement more specifically.

All information about adolescents is conveyed through parental perspectives and must therefore be considered provisionally. As a matter of inclusion criteria, no AYA met diagnostic criteria for childhood gender dysphoria (at least six out of eight indicators), and 80.4% did not have *any* of the eight DSM-5 indicators (Littman, 2018b, p. 10). However, Littman does note that at least three indicators are subjective feelings and not observable by parents (ibid., p. 9). The average age of coming out was 15.2 years old, with most disclosures coinciding with requests for medical intervention (ibid., p. 11,15). This data is accompanied by anecdotes that suggest trauma, mental illness, or peer pressure are at play in some of the reported cases (ibid, p.

[9] In the US, the numbers of women with these degrees are 32.7% and 12% respectively according to the 2016 census (Ryan & Seibens, 2016)

[10] Although 63.8% had been called transphobic or bigoted by their transgender children (Littman, 2018b, p. 21).

15). As for mental health, 62.5% of AYAs had diagnosed psychopathology or neurodevelopmental disability prior to expressing their experience of gender dysphoria (ibid., 10). Desistence data is provided indicating that at least 83.2% of AYAs still identified as transgender during the time of survey (ibid., 28). However, t-test showed that desisters had significantly longer duration of transgender identification, leading Littman to predict that a longer follow-up period would yield higher desistance rates (ibid., 28, 31).

On social contagion, peer influence is discussed at length. Transgender friends came out before or after 69.3% of AYAs considered, with an average of 3.5 people in their friend group experiencing dysphoria (Littman, 2018b, p. 16). Further analysis contends that youth received popularity and other benefits from coming out as transgender, and that their friend groups maligned cisgender people (ibid., p. 17). In addition to friend groups, internet communities were implicated, with 63.5% of AYAs increasing online activity prior to coming out (ibid., p. 18). Websites such as Tumblr and YouTube were accused of providing teens with information about how to proceed with transitioning, including narratives deemed most successful in receiving treatment (ibid., p. 18-21). These sites were granted a great deal of authority, with 46.6% of AYAs only trusting other transgender people as sources of information and 51.8% of not trusting information from mainstream doctors and psychologists (ibid., p. 22). It therefore seems that transgender youth share their parents' skepticism of mainstream medicine and preference for online communities.

As for medical practice, Littman's respondents accuse both AYAs and their clinicians of misconduct. Of the parents who were privy to their child's initial consultation, 84.2% reported that their child misrepresented their history (ibid., p. 25). While some claims may be verifiably false, such as academic performance or psychiatric history, arguments over toy and playmate

preference devolve into conflicting personal accounts. Parent were also dissatisfied with the rigor of evaluations, claiming that AYA's accounts were taken on face value without soliciting opinions from parents, medical records, or primary care providers. Mental health and trauma were not considered in 71.6% of cases of which parents had knowledge (ibid., p. 24). Ultimately, physicians were described as incompetent, unprofessional, and overly eager to initiate hormone replacement therapy (ibid, p. 27). A picture of clinical encounters emerges in which AYAs and providers collude to expedite an unproblematic progression towards transition despite parent's insistence that their children present atypical cases in need of additional consideration.

From this data, Littman suggest two alternative explanations for the dysphoria that presented by these adolescents. First, on social contagion, Littman argues that groups of transgender friends may proliferate understandings of nonspecific symptoms as dysphoria with transition as the only form as recourse while instilling a distrust of any disagreement as transphobic (Littman, 2018b, p. 34). With reference to annorexia, she explains that online communities can be particularly damaging in amplifying these echo chambers (ibid.). As for maladaptive coping, Littman cites the prevalence of trauma and psychopathology in the sample as indication of underlying issues. As such, she thinks that some AYAs may displace these issues onto their gender and seek transition as a convenient means of escape rather than the more difficult work of confronting their true sources of distress (ibid., p. 35). She even goes as far as suggesting that transition may be pursued as a form of self-harm, an equivocation that Sheila Jeffreys also indulges (ibid.; Jeffreys, 2014, p. 66). Ultimately, Littman calls for caution before trusting youths' reports and claims that while some may benefit from transition, others may be mistaken in their self-assessment (Littman, 2018b, p. 34-37). While she acknowledges the limitations of using only targeted sampling and parental reports, Littman argues that parents may

be the most knowledgeable about their children's experiences, but they have been excluded from research and clinical decisions, perhaps because of the very truths they know (ibid. 34). She also calls into question the way children's accusations of parental transphobia may be illegitimately employed to silence valid concerns (ibid.)

Criticism

On August 28th, just twelve days after the article was published, PLOS ONE commented on the article to announce that "further expert assessment on the study's methodology and analyses" would be sought (PLOS ONE Staff). In an official statement, the publication clarified that their intention was only to "ensure the integrity of research," without "censoring academic freedom" (Personal Communication, Knutson, October 9th, 2018; McCook, 2018). As a result, Brown University took down a press release they had written about Littman's article on their blog (McCook, 2018). In an official statement, the university explained that the news coverage was taken down due to "questions raised about research design and data collection" (News Staff, 2019). The dean of the Brown School of Public Health went on to acknowledge concerns on campus "that the conclusions of the study could be used to discredit efforts to support transgender youth and invalidate the perspectives of members of the transgender community," but clarified that such concerns are independent of the decision to retract the press release (ibid.). One week later, in a follow-up statement, Brown reiterated that the issue does not concern "academic freedom", but rather "academic standards," (ibid.). This PR strategy attempts to depoliticize the issue by emphasizing supposedly neutral concerns over scientific method rather than the stickier issue of potentially transphobic content. And yet, these objections still invoke value-based judgements about the standards of what counts as evidence in debates about

scientific knowledge. A few of these pressing methodological issues will be reviewed before turning to criticism of the content of the article and its political implications.

The primary methodological concerns have focused on the participants recruited. Parents were surveyed exclusively, without the perspectives of the youth or clinicians they reported about. As a result, some critics have claimed that the data gathered cannot be used as evidence of a new epidemiological phenomenon, instead they merely indicate that a group of parents feels a particular way about their transgender children. In the words of Julia Serano, "this is not a new type of gender dysphoria, but rather a new name for a recurring parental dynamic" (Serano, 2018). Furthermore, the parents recruited were found through websites that express a very strong and specific ideological orientation towards childhood transition. Anticipating this criticism, Littman defends such targeted sampling as standard for first, descriptive studies, mentioning a gender affirming study of social transition that used targeted sampling from gender expansive summer camps (Littman, 2018b, p. 36). Furthermore, she admits the limited generalizability of her findings until further research is conducted (ibid.). However, Littman maintains that her sample did not differ from the general population in their appraisal of transgender individuals' entitlement to equal rights and protections and argues that both statistics are affected by social desirability bias (ibid.). This point seems debatable: because participants in this study have a particular interest in appearing objective to lend credibility to their testimony, they have a unique form of response bias not accounted for in general surveys of attitudes regarding transgender people. As such, many have still claimed her sample is biased, distinguishing between a convenience sample and a biased sample sought to confirm one hypothesis (Restar, 2019). Furthermore, the language used in the informed consent section of the recruitment information explicitly states the hypothesis of social contagion from increased internet usage (4thWaveNow,

2016; Transgender Trend, 2016). This introduces a real risk of self-selection bias by encouraging parents that agree with this narrative to participate or otherwise priming participants to frame their experience through this narrative (Restar, 2019)

These flaws have led Julia Serano to suggest that Littman intentionally sought publication in PLOS knowing that they have unique standards for publication (Serano, 2018). PLOS ONE is a "megajournal," representing a unique in a form of publication that lends itself to the interests of gender critical individuals. The journal is only published online, so there are no page limits restricting how long articles can be or how many articles get published (Journal Information). As such, submissions are reviewed solely to confirm the academic rigor of their methods and not the relevance of their findings: it is left for readers to determine the importance of the research through academic debate (ibid.). This novel method allows new researchers to break into the field by providing a platform for lines of inquiry not traditionally encouraged or rewarded by existing institutional mechanisms. Furthermore, the journal is open access, so anyone can read and comment on their publications for free. These processes both democratize the production of knowledge as well as access to information. This seems particularly appealing to an ideological community explicitly intent on disrupting common scientific knowledge and primarily composed of laypeople connected via the internet.

On September 4th, 19 days after the Littman article was published, WPATH released a position statement on ROGD (WPATH, 2018). Their concern with the publication was primarily rhetorical, arguing that the "official-sounding" terminology of "rapid-onset gender dysphoria" evoked a degree of scientific authority which the concept was not due (ibid.). Instead, they hold that diagnostic categories are to be determined by medical associations composed of working groups with expert scientists. This represents an explicit struggle over who has access to the

means of legitimating scientific knowledge. Towards the end of their statement, WPATH implies that ROGD may be an attempt "to instill fear about the possibility that an adolescent may or may not be transgender with the a priori goal of limiting consideration of all appropriate treatment options," (ibid.). It is the point that most transgender individuals are most concerned about.

The concept of ROGD seems to present a convenient method for denying adolescents access to gender affirming care and cutting them off from transgender communities. By simply contesting early signs of dysphoria, which critical parents may be apt to discount, ROGD triggers a return to pathologizing understandings of dysphoria. This is true even of the rhetoric Littman employs (Restar, 2019). Social "contagion" evokes a feared pathogen from the outside that children must be protected from. Furthermore, "rapid-onset" is reminiscent of "early-onset" as in "early-onset Alzheimer's". This makes it sound as though being transgender is an unfortunate condition which children eventually underwent instead of a constitutive or congenital feature of their identity. Proposing that dysphoria begins later in life cements the idea that any psychopathology was necessarily prior and therefore causal, allowing dysphoria to be explained away as maladaptive coping for underlying issues. Furthermore, the social contagion hypothesis concludes that having transgender friends will make you transgender, whereas others would argue that transgender youth seek out others with similar experiences for support. Similarly, teens already experiencing dysphoria may turn to the internet to make sense of their condition, rather than contracting it online. This allows access to transgender communities and resources to be foreclosed in the name of preventing contagion. Finally, the implication that being transgender is now trendy or rewarded with popularity papers over the vastly more common experience of transgender youth being ostracized and victimized for their identity.

Support

Even before publication, Littman's work on ROGD received support from the "live in your own skin" camp. Her abstract summarizing the ROGD research that was published in 2017 was cited by Zucker in his article "Epidemiology of gender dysphoria and transgender identity," which Littman then cites in the full version of her paper (Littman, 2017; Zucker, 2017; Littman 2018b). One of Zucker's former colleagues from the Centre for Addiction and Mental Health, Ray Blanchard, also coauthored a post on 4thWaveNow in 2017 explaining the implications of Littman's work on ROGD (Blanchard & Bailey, 2017). Like Zucker, Blanchard has faced controversy for drawing unpopular conclusions about transgender people, particularly on the topic of autogynephilia. Feminist historian of science Alice Dreger came to Blanchard's defense in her 2015 book *Galileo's Middle Finger*, arguing that in the case of autogynephilia, activist pressure was suppressing the pursuit of scientific inquiry (Dreger, 2015). Dreger has also thrown her hat into the ring on ROGD, providing the following statement for Retraction Watch less than two weeks after the article was published: "What researcher would want to work at Brown when the value of your work is determined by political pressure...The research of supposedly unpopular ideas should be our goal in academia, not a source of shame. This is very worrisome indeed," (qtd.in McCook, 2018). It is therefore clear that Littman does not stand alone among academics and clinicians.

Even before post publication review had been completed, the article had already been integrated into the literature. At the time of writing, six articles have been published that reference the original version of Littman's work (Scopus, 2019). The first provides an overview of trends in the treatment of gender variant youth, mentioning parental concerns of social contagion in the context of shifting sex-ratios among youth presenting to gender clinics (de

Graaf, & Carmichael, 2018, p. 356). The second article concerns diagnosis of dysphoria and uses Littman's research to build an argument for more stringent screening procedures prior to transition (Meyer-Bahlburg, 2019). This may lend credence to transgender activists fears of a reactionary return to gatekeeping in the wake of ROGD's description. A third, coauthored by Cretella from the ACPeds, is titled, "The Right to Best Care for Children Does Not Include the Right to Medical Transition," (Laidlaw, Cretella, & Donovan, 2019, p. 76). A fourth is a letter to the editor of The Journal of Clinical Endocrinology & Metabolism, arguing that being transgender should not be seen as an endocrine condition (Laidlaw et al., 2018). A fifth uses the Littman article to argue that the increasing interest in transition among youth is a result of factors other than being transgender (Brewley et al, 2019). And the sixth is the formal comment released by PLOS ONE in the process of republication, which will be discussed in the next section (Costa, 2019). Therefore, ROGD has already entered the literature and been built on by those who see it as justification for various ends.

Popular support has also been garnered through an online petition. At the time of writing, over 5,000 signatures have been collected in affirmation of Littman's research (ipetitions, 2018). At least part of this attention can be attributed to 4thwavenow and transgendertrend mobilizing their communities to sign (4thWaveNow, 2018; Transgender Trend 2018). This represents the symbiotic relationship between scientist and self-help movements, wherein representation in research is rewarded with capital, in this case social capital (Von Gizycki, 1987, p. 79). Signatories' comments portray a mix of gender critical parents, including those surveyed for the study, and credentialed professionals who share their concerns. The petition requests that both PLOS ONE and Brown "resist ideologically-based attempts to squelch controversial research evidence," (ipetitions, 2018). For all the discussion of censorship by gender critical individuals,

the publication was never removed from PLOS ONE during the seven-month process of re-review. It was only ever a press release by Brown University that was taken down after methodological issues were raised.

In the popular press, Littman's work was picked up by conservative publications, especially Breitbart. They have been quick to jump on the narrative of social justice censorship violating first amendment rights and interrupting the conduct of objective science (Ciccotta, 2018; Berry, 2018b). Furthermore, they reference Littman's work as evidence in other publications about transgender people that are not directly related to her study (Berry 2018a, Berry, 2018c) The implications of social contagion have also begun to enter the toolbox of conservative policy makers. For example, in South Dakota there was a recent attempt to ban discussion of transgender identities in schools, with the bill's sponsor arguing that we need to stop "teaching and confusing our young children to be more susceptible to this dysphoria," (qtd in Murguia, 2019). In this way, denial of access to informational resources is cast as necessary for protecting children's best interests. At least one commentator has drawn a direct relationship between this rhetoric and Littman's research (Manzella, 2019). Naming rapid-onset gender dysphoria as a new phenomenon has therefore had very real consequences for transgender youth.

Republication

On March 19th, seven months after the original article was published, a revised version was republished on PLOS ONE (Littman, 2018a). The updated version was accompanied by a correction notice written by Dr. Littman, a formal comment by one of the four reviewers, and a post on PLOS ONE's blog (Littman, 2019; Costa, 2019, Heber, 2019). The blog post provides necessary damage control in the realm of public relations, explaining the process and findings of

the much-anticipated review (Heber, 2019). Littman's correction notice serves to summarize that changes that were made in the revised version, and it is accompanied by the original version for reference (Littman, 2019). Finally, the formal comment by Dr. Angelo Brandelli Costa provides an outside perspective on the initial study's aims and limitations, as well as "additional viewpoints and context" (Heber, 2019). Taken together, these documents illustrate the ongoing process of scientific deliberation, as well as its communication with broader, lay audiences.

The blog post was authored by Joerg Heber, the editor-in-chief of PLOS ONE. He acknowledges the wave of concerns that precipitated the post-publication review and the journal's obligation to ensure the accuracy of its publications. To do so, two academic editors, a statistics reviewer, and an academic with experience treating gender variant adolescents were enlisted. Heber conveys their determination of the paper as "a valid contribution to the scientific literature," that was "not adequately framed in the published version" (Heber, 2019). That these issues of presentation were not corrected prior to publication is noted as a shortcoming of the review process, particularly given the wide circulation of the study outside of the immediate scientific community. For this failure, Heber apologizes to the transgender community and outlines how the review process will change going forward.

The findings of the follow-up have the potential to satisfy both supporters and critics of Littman. As one comment on the blog post notes, the very act of correcting the paper can be taken by its critics as a concession that the initial iteration was flawed (Heber, 2019). However, in an interview published on Quillette[11] Dr. Littman has stated that she is, "very pleased with the final product and [with the fact] that my work has withstood this extensive peer-review process," (qtd. in Kay, 2019). Indeed, the article emerged from its second round of peer review with the

[11] The progressive, media watchdog Media Matters" has identified Quillette as "Right-wing media" with an anti-trans bias (Pelz, 2019; Tannehill, 2019).

results section mostly unchanged (Littman, 2019). That said, every other section underwent revision, in addition to the title and the rhetoric employed throughout. The background has an added subsection about "Demographic and clinical changes for gender dysphoria" to more clearly frame the research question as concerning the increasing number of AFAB individuals seeking to transition at after puberty (Littman, 2018a, p. 4). The new methods section contains descriptions of the sites used for recruitment, admitting that the initial three sites mentioned describe themselves as "cautious," "questioning," and "concerned" about the current state of medical transition among youth (ibid., p.9) However, the private Facebook group named "Parents of Transgender Children" is listed as a new fourth site used for recruitment that has been deemed to be more gender affirming (ibid). Apparently, a link to the recruitment survey was posted in the Facebook group during the first week of recruitment as a result of snowball sampling (Littman, 2019). Finally, an additional emerging hypothesis is added in the discussion section: "Parental conflict might provide alternative explanations for selected findings" (Littman, 2018a, p. 34). This alternative explanation is elaborated on by Dr. Costa in his formal comment as a counterpoint to the focus of Littman's article.

The other significant revisions concern the issues of presentation that Heber highlights. In general, they emphasize the study's status as descriptive and exploratory and the limitations of parental reports. For example, the first objective in the purpose section previously read, "to describe an atypical presentation of gender dysphoria occurring with sudden and rapid onset in adolescents and young adults," whereas it now reads "collect data about parents' observations, experiences, and perspectives about their AYA children showing signs of a rapid onset of gender dysphoria that began during or after puberty" (Littman, 2018b, p. 4; Littman, 2018a, p. 5). This points to the study's inability to describe an actual epidemiology phenomenon, instead

acknowledging the more limited goal of relaying parents' perceptions. Littman hopes that future studies will solicit information from "AYAs and from third party informants" such as clinicians and teachers (Littman, 2019). Furthermore, the reflections at the end of the revised article make clear that no conclusions about prevalence or causality can be drawn from the present study[12] (Littman, 2018a, p. 38). These disclaimers have been written off by some of Littman's supporters as an Orwellian correction (Jussim, 2019)

Finally, the revisions' rhetorical changes are exemplified by the new title and take a variety of forms throughout. The new title reads "Parent reports of adolescents and young adults *perceived to show signs of* a rapid onset of gender dysphoria" (emphasis added). Other qualifying phrases that were added include, "apparent", "what seemed to be," "reportedly," "as perceived by parents," and so on (Littman, 2018a, p. 1, 6, 2, 32). Furthermore, the new title does not include the term "rapid-onset gender dysphoria," that was critiqued by WPATH for sounding overly official. Indeed, it appears much less frequently in the revised version, variously replaced with "adolescent onset gender dysphoria," "late onset gender dysphoria," and "signs of a rapid onset of gender dysphoria" (ibid., p. 5, 40, 33). In the correction notice, Littman clarifies that ROGD is not a formal diagnosis and that it should be used cautiously and certainly not as a means to "stigmatize vulnerable individuals," (Littman, 2019). In her Quillette interview, she explained that she initially coined the term because it "seemed descriptive and neutral" (qtd. in Kay, 2019). Similarly, the revised article clarifies the use of the term "contagion" has no intention of denoting pathology or value judgment (Littman, 2018a, p. 4). Still the terms "peer influence" and "social influence" often replaces "social contagion" in the new version (ibid. p. 5,

[12] That said, the revised publication still includes a chi-squared test of the association between exposure to social influence and various negative outcomes with some significant results (Littman, 2018a, p. 29-30). This is more than a merely descriptive statistic and it attempts to show a statistical association using data that is likely insufficient.

40). Furthermore, the alarmist word “outbreak”, which was used five times in the initial publication, has been completely removed from the revised version (Littman, 2018b, p. 2, 3, 31, 32, 38).

The formal comment provides some of the necessary counter points offered by Littman’s critics, and a few that have been incorporated into her revised article. First and foremost, Costa highlights the necessity of involving children in research and medical decisions that concern them in a way that accounts for their developmental capacities (Costa, 2019, p. 1). Furthermore, he underscores research indicating a low degree of agreement between parents’ and children’s responses in studies of mental health (ibid., p. 1-2). Given the gulf that can separate parents and children, Costa notes the established body of literature that suggests transgender kids without parental acceptance have greatly acerbated mental health issues and suggests this as an alternative explanation for some of Littman’s findings (ibid.). This could both explain the high rates of mental illness in children, as well as parent’s failure to perceive or admit signs of dysphoria. Finally, Costa notes that many transgender people have non-linear paths of gender identity formation, and clinicians’ goals should be to help manage uncertainty and anxiety throughout this process rather than normatively enforcing a single narrative of the appropriate timing for transgender identification (ibid., p. 3). All in all, the revised edition of Littman’s publication has left the content of her arguments intact but provided the necessary context for lay readers to more accurately form their own opinions about how those findings should be interpreted.

Value Communities

At the time of initial publication, Littman's interest in the gender critical movement was unclear, and no competing interests were declared (Littman, 2018b, p. 2). While the revised version lists her affiliations with a number of professional organizations, including WPATH, it does little to illuminate her position in relation to gender critical blogs (Littman, 2018a, p. 2). In her interview on Quillette, Littman explains her position as a "mother, a spouse, a daughter and sister" whose "core beliefs about the importance of family relationships comprise a central part of who" she is (qtd. in Kay, 2019). From this perspective, her interest in ROGD first arose after observing the phenomenon among youth in her own community: leading her to the sites used for recruitment (ibid.). As a clinician and public health researcher, she felt she had the necessary skills to shed light on the issue (ibid). Littman's training as a physician-researcher has included a residency in obstetrics and gynecology as well as a Master of Public Health (ResearchGate, 2018). While the ROGD publication is her first concerning gender dysphoria or transgender medicine, she has a clear interest in women's perspectives on their own health issues: writing extensively about patients' experiences and sources of knowledge regarding contraception and abortion (ibid). This has led some to claim she is not qualified to write about transgender health, as she has no professional experience with transgender patients (Psycritic, 2018). However, she argues that because she does not earn a living "providing transition services or referrals for transition," she has "far fewer conflicts of interest than many of the current researchers in this field" (qtd. in Kay, 2019).

I am more interested in the ways that Littman's prior work speaks to her value commitments than her qualifications. Indeed, reviewing a scientist's previous writing can be a valuable means of gauging their orientation towards a particular controversy (Szanto, 1993, p.

250). So, while Littman explicitly states that she is not a radical feminist, her attention to her standpoint as a mother and to women's perspectives on health issues more broadly potentially place her in the same "value community" as gender critical parents (qtd. in Kay, 2019; Szanto, 1993, p. 259). This could explain her commitment to the movement, allowing her to act as a bridge between gender critical, feminist dialogues and official, scientific research. Feminist researchers are known to hold such "bifurcated consciousness," simultaneously inside and outside of conventional scientific discourse (qtd. in Harding, 1991, p. 68). Such individuals, acting as dual members of self-help and scientific communities, can play a powerful role in communicating across difference. Littman certainly found that the discourse on these blogs resonated with her personal convictions and concerns, finding the stories to be "compelling and heartbreaking" (qtd. in Kay, 2019). This motivated her to employ her professional expertise as a means of translating the questions posed by these anecdotes and narratives into quantitative and qualitative data in pursuit of scientific answers.

And yet, it seems that these gender critical communities online did more than present research questions and data for analysis. There are additional contributors at the margins of Littman's article that play central roles in the gender critical movement. Michelle Moore is described as "a second reviewer with expertise in qualitative methods" who helped conduct the grounded analysis of parental narratives (Littman, 2018b, p. 9). She is also credited in the acknowledgements "for her assistance in qualitative data analysis and feedback on an earlier version of the manuscript" (Littman, 2018b, p. 38). What goes unmentioned in both versions of the article is Moore's experience in organizing and publishing as a member of the gender critical movement. In fact, the book she coedited, *Transgender Children and Young People: Born in Your Own Body,* is cited in the background section of Littman's article as having "raised the

question about the role of social media and online content in the development of gender dysphoria," in the first place (ibid., p. 43). Furthermore, Transgender Trend has a video of her speech for *A Woman's Place UK* posted on their page of "Resources for Parents" (Transgender Trend, n.d.). This is the previously mentioned organization that advocates against transgender individuals' right to access facilities in accordance with their gender identity[13].

A second gender critical figure is presented in the acknowledgements without further explanation. Lisa Marchiano is thanked for "feedback on earlier versions of the manuscript," (Littman, 2018b, p. 38). Marchiano also happens to have authored a chapter in Moore's book from the perspective of Jungian psychoanalysis (Marchiano, 2018a). More importantly, Marchiano has been published on 4thwavenow at least five times and had written articles about ROGD up to two years prior to Littman's "first, descriptive study" which are extensively linked to on both Transgender Trend and 4thwavenow (Littman, 2018b, p. 36; (Marchiano, 2016a, 2016b, 2017a, 2017b, 2017c, 2017d, 20173, 2018b). It seems plausible to suggest that Marchiano has played a significant role in fostering parents' understandings of their children's experiences through the very phenomena being studied. Such intimate involvement in both the websites being targeted and the research being conducted raises questions about ability to separate the subjects and objects of study.

Conclusion

This chapter has sought to provide an in-depth case study of the interaction between academic institutions and parents as concerned members of self-help organizations. The symbiotic relationship between these participants and the researchers that study them proves

[13] Had Moore been surveyed, I'm curious how she would answer the question regarding transgender individuals' entitlement to equal rights and legal protections,

mutually beneficial. Parents receive peer-reviewed legitimation and recognition for their concerns, while researchers are provided with the data and support necessary to pursue their projects. These groups are brought together on the basis of shared values that provide a common source of motivation. Furthermore, open access publishing has permitted unprecedented, direct access to results of such ongoing scientific discourse. And yet, the process of interpreting and proliferating this information is still heavily mediated by the popular press and other outward-facing blogs (such as those written by Brown and PLOS ONE). While it is certainly encouraging to see the avid involvement of citizens in research, there is ample opportunity for misinterpretation and misuse of findings when they are not appropriately reported. It may be the case that the role of laypeople is best left to the generation of research questions and not the interpretation of results.

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Chapter 5: Conclusion

In outlining the state of the field in the research and treatment of adolescent gender dysphoria I have tried to demonstrate the problems and questions that still need to be addressed, as well as the current approaches that are attempting to do so. I have then sought to introduce the perspectives of gender critical parents and professionals, with all of their criticism of the status quo. Finally, Littman's publication on ROGD has provided one case study with insight into the ways these two discourses can interact and the fallout that ensues. The resulting conflicts have been divisive and arguably generated more heat than light. After analyzing this controversy and the commitments of each side, I hope to provide suggestions for how future dialogue can proceed productively. Indeed, I think that both gender critical parents and their transgender children can agree that there is room for improvement in the field of medicine as it stands. Just as Littman reports that around half of AYAs in her study were distrustful of information from mainstream medical providers and preferred to receive their education from transgender people online, so too do gender critical individuals use online communities to question mainstream physicians' motives and expertise (Littman, 2018, p. 24). This crisis of legitimacy in the field of transgender medicine indicates a need for significant changes.

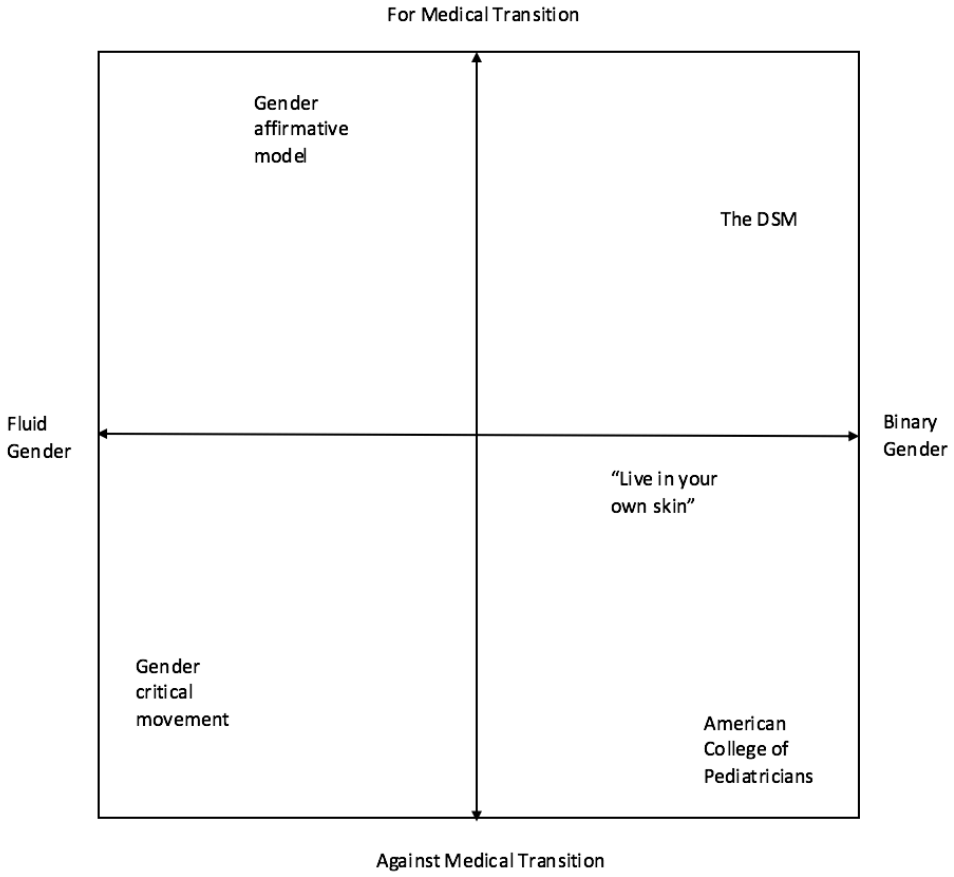
In summarizing the differing perspectives of gender affirming and gender critical individuals, I find that the conceptual categories of bioethicist Erik Parens provide a useful shorthand. Writing about debates over surgical normalization of children (such as limb lengthening surgeries for those born with dwarfism), Parens puts forth a framework with two axes: orientations of gratitude versus creativity and solutions that are social versus medical (Parens, 2014). The gender affirmative movement tends to embrace an orientation of creativity and employ medical solutions, endorsing individuals' ability to reshape their bodies as they see

fit using hormones and potentially surgical interventions. Conversely, the gender critical movement embraces an ethic of gratitude, accepting that you were "born in your own body" and learning to "live in your own skin", while pursuing a social revolution to normalize gender nonconforming embodiments. While Parens notes that these orientation and types of solutions are typically paired as above, he acknowledges we could imagine a medical solution based in gratitude or a social one that employs creativity (Parens 22). Indeed, one could argue that the gender critical movement actually uses creativity to imagine new conceptual categories of gender not authorized by dominant gendered categories even if they seek to actualize them through social and not medical changes.

Regardless of how it is framed, I think this impulse for gender non-conformity in the gender critical movement is one worth pursuing. Even if many transgender people disagree with the particular rhetoric of the gender critical movement, I think they can affirm the value of opening up gendered categories of behavior and destabilizing their association with biology. Indeed, the gender affirmative movement acknowledges a wide range of non-binary gender identities. That said, since we have yet to undergo the massive social changes that the gender critical movement desires, moving through the world as a visibly gender nonconforming person can entail great violence and distress. It is therefore a great burden to place on transgender people to expect that they never embody normative conceptions of gender or attempt to pass. Furthermore, the ability to be gender nonconforming is a privilege not always afforded to transgender people. Consider a young transgender girl that acts like a tomboy: if she fails to express a desire for typically feminine clothes and toys, then she may not be afforded a DSM diagnosis of dysphoria and she will be denied access to medical interventions. This highlights the

need to reconsider the deeply understanding of gender that still underlies much of the medical field.

And yet, the gender critical movement has not ended up in alliance with those who share their underlying values of freeing up gender expression. Instead, their additional desire to prevent children from transitioning has taken priority and placed them in closer relationships with the likes of Kenneth Zucker and the American College of Pediatricians. These groups have fundamentally different conceptions of gender that are deeply binary and traditional. The relations between these various groups are charted in a modified political alignment chart below. Rather than attempting to liberalize the conservative conceptions of gender held by their current allies, I think that the gender critical movement would be better served by recognizing the common values they share with the gender affirmative approach and attempting to temper the vigor with which medical intervention is pursued in the status quo



Ultimately, the goal should be to make room for those who are gender nonconforming to flourish without medical intervention in a way that does not deny access to transition related services for those who want and need them. This is certainly easier said than done and will require nuanced standards of care that account for the particularities of individual circumstances. WPATH has not released guidelines since 2012 and producing a satisfactory 8th version that is mutually agreeable will be a tall order. Gatekeeping has become a charged word in this debate, often denounced as transphobic in principle. And yet, there remains a need to parse out who will benefit from medical intervention. For adults, the growing ubiquity of the informed consent model is answering this question: let patients decide for themselves. Children and adolescents continue to present a more vexing question. I am inclined to agree with Turban and Keuroghlian,

who argue that screening and provision of care for gender variant youth should be about helping them to decide what exactly it is that they want, rather than attempting to predict who is most likely to desist and screening them out (Turban & Keuroghlian, 2018, p. 453). That said, in the same article, the authors also down play the irreversible effects hormones as primarily cosmetic to indicate that detransition can be a healthy part of a lifelong gender journey (ibid., p 452-453). I find this contradictory, in that these same cosmetic changes in vocal chords and hair thickness are also cast as life or death issues for dysphoric youth. So just as gender critical individuals down play the misery dysphoria and highlight the perils of detransition, some gender affirming individuals may be guilty of the converse.

We can whole heartedly endorse the need to take youths' perspectives seriously in determining their own care, while also acknowledging the gravity of this decision. It is this very gravity that gender critical individuals stress, and it should give us reason to consider every alternative and contributing factor. Erik Parens convincingly argues for a binocular method which I will paraphrase (Parens, 2014, p. 17). At the beginning of the day, we should treat people as objects and encourage them to consider all of the various societal forces weighing down on them and influencing their decision. And yet, at the end of the day, we must treat them as subjects and respect their agency to make decisions about their own bodies, even if we know that no person acts purely as an individual in a vacuum devoid of social context. In the case of ROGD, it is clear that these external forces are presented under the label of social contagion or peer influence. Littman and the gender critical movement have excelled at treating transgender youth as objects, invoking the hermeneutics of suspicion in considering every possible wrong-headed motivation they may have to transition (Parens, 2014, p. 12). Indeed, the status of youth as objects is embodied though a study design in which parents report on their children without

ever soliciting the perspectives of the children in question. Furthermore, I shudder at the Foucauldian implications of future research where Littman suggest soliciting information "from third party informants such as teachers, pediatricians, mental health professionals, babysitters, and other family members to verify the presence or absence of readily observable behaviors and preferences during childhood," (Littman, 2018, p. 35). This exemplifies the paternalist model that Turban and Keuroghlian criticize, in that it attempts to determine whether someone is "truly transgender" before providing transition related services instead of working with them.

Given their modes of reasoning and intervening, those in the gender critical movement appear to be conspiracy theorists at times. One is left wondering if they ask questions in the hope of finding satisfactory answers, or if they are simply critical as an end in itself. While it is clear that they advocate for more caution before proceeding with transition, it is unclear if there is a bright line at which they will concede that a particular child has undergone sufficient screening to determine that they would benefit from transitioning. WPATH already has screening guidelines in place, such as evaluating mental health, but these are non-binding suggestions (Coleman et al., 2011, p. 174-175). From Littman's reports of providers promptly intervening with little to no consideration of patients' background, it may be the case that what is happening on the ground does not reflect the best practices set forth by professional organization like WPATH. In such instances, it may be valuable to solicit the perspectives of lay people for assistance in formulating research questions. Their narrative experiences may be informative for improving issues previously overlooked by the institution of medicine. That said. the danger comes when their anecdotes are blown out proportion, losing appropriate context and running wild in the popular press.

My work on this project is far from done. There are certainly more issues to be explored as it stands, and the controversy is continuing to unfold. The first peer-reviewed commentary on Littman's work (other than the formal comment from PLOS ONE) was just released earlier this week (Restar, 2019). This reflects a discrepancy in the instantaneous pacing of the blogosphere and the meticulous process of peer review. Furthermore, Dr. Littman's next publication on detransition is already in the works and will likely follow a similarly controversial trajectory once published. Continuing this project, I hope to keep an eye om the popular press and its interpretations of Littman's work, while potentially translating my analysis into a contribution for popular consumption.

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