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The Battle Over Gender Therapy

More teenagers than ever are seeking transitions, but the medical community that treats them is deeply divided about why — and what to do to help them.

By Emily Bazelon

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Scott Leibowitz is a pioneer in the field of transgender health care. He has directed or worked at three gender clinics on the East Coast and the Midwest, where he provides gender-affirming care, the approach the medical community has largely adopted for embracing children and teenagers who come out as transgender. He also helps shape policy on L.G.B.T. issues for the American Academy of Child and Adolescent Psychiatry. As a child and adolescent psychiatrist who is gay, he found it felt natural to work under the L.G.B.T. "umbrella," as he put it, aware of the overlap as well as the differences between gay and trans identity.

It was for all these reasons that Leibowitz was selected, in 2017, to be a leader of a working group of seven clinicians and researchers drafting a chapter on adolescents for a new version of guidelines called the Standards of Care to be issued by the World Professional Association for Transgender Health (WPATH). The guidelines are meant to set a gold standard for the field of transgender health care, and this would be the first update since 2012. What Leibowitz and his co-authors didn't foresee, when they began, was that their work would be engulfed by two intersecting forces: a significant rise in the number of teenagers openly identifying as transgender and seeking gender care, and a right-wing backlash in the United States against allowing them to medically transition, including state-by-state efforts to ban it.

During the last decade, the field of transgender care for youth has greatly shifted. A decade ago, there were a handful of pediatric gender clinics in the United States and a dozen or so more in other countries. The few doctors and therapists who worked in them knew one another, and the big debate was whether kids in preschool or elementary school should be allowed to live fully as the gender they identified as when they strongly and consistently asserted their wishes.

Now there are more than 60 comprehensive gender clinics in the United States, along with countless therapists and doctors in private practice who are also seeing young patients with gender-identity issues. The number of young people who identify as transgender nationally is about 300,000, according to a new report by the Williams Institute, a research center at U.C.L.A.'s law school, which is much higher than previous estimates. In countries that collect national data, like the Netherlands and Britain, the number of 13-to-17-year-olds seeking treatment for gender-identity issues has also increased, from dozens to hundreds or thousands a year.

Just as striking, the *types* of cases have changed. Many of the current group of teenagers haven't told their families, from a young age, that they feel they are a different gender, though they often say they internalized such feelings for years. The average age when a young person first comes to a clinic tends to be around 14 or 15, according to some clinicians I talked to. Cases of teenagers coming out as trans aren't new. But their prevalence is. In addition, the current caseload is around two-thirds youths who were "assigned female at birth," in the current parlance of the field, and identify as trans boys — or as nonbinary, in a smaller but growing number of cases. In the past, by contrast, most patients at gender clinics were trans girls who were "assigned male at birth."

As they worked on a draft of the adolescent chapter of the Standards of Care, the big debate among clinicians was how they should respond to the thousands of teenagers who are arriving at their doors. Some are asking about medication that suppresses puberty or about hormone-replacement treatments. Leibowitz and his co-authors thought that the timing of the rise in trans-identified teenagers, as well as research from Britain and Australia, suggested that the increased visibility of trans people in entertainment and the media had played a major — and positive — role in reducing stigma and helping many kids express themselves in ways they would have previously kept buried. At the same time, the authors acknowledged that they weren't sure that visibility was the *only* factor at play.

As they wrote in their December draft chapter, part of the rise in trans identification among teenagers could be a result of what they called "social influence," absorbed online or peer to peer. The draft mentioned the very small group of people who detransition (stop identifying as transgender), saying that some of them "have described how social influence was relevant in their experience of their gender during adolescence." In adolescence, peers and culture often affect how kids see themselves and who they want to be. Their sense of self can consolidate, or they can try on a way of being that doesn't prove right in the long run as the brain further develops the capacity for thinking long-term. To make matters more complicated, as a group, the young people coming to gender clinics have high rates of autism, depression, anxiety and eating or attention-deficit disorders. Many of them are also transgender, but these other issues can complicate determining a clear course of treatment.

Without stating them outright, the draft raises tricky questions: Could some of the teenagers coming out as trans today be different from the adults who transitioned in previous generations? For them the benefits are well established and the rate of regret is very low. How many young people, especially those struggling with serious mental-health issues, might be trying to shed aspects of themselves they dislike?

Leibowitz and his colleagues knew these were delicate issues. They were deeply troubled when right-wing politicians grasped the unsettled nature of these matters — which barely registered for most Americans 10 years ago — and turned them into political dynamite. In 2019, right-wing groups, the Heritage Foundation and Family Policy Alliance, which fought for many years against same-sex marriage, held a meeting on "Protecting Children From Sexualization" that covered "controversial medical treatments to treat gender dysphoria," which is defined as a form of distress and is also a psychiatric diagnosis. Model legislation followed. Organizations like Family Policy Alliance helped state legislators draft a ban on gender-related medical treatment for anyone under age 18. Arkansas passed the first such ban in April 2021, and over the next months, similar bills were introduced in 18 other Republican-led state legislatures.

WPATH is a 3,300-member international organization, mostly made up of health care professionals. It came into existence in 1979, the year it issued its first Standards of Care. These standards influence the positions taken by major medical groups, including the American Academy of Pediatrics and the American Psychological Association, and the coverage offered by health insurers and national health services around the world. Trans and nonbinary practitioners are helping to write and oversee the new guidelines, called the SOC8 because it's the eighth edition.

Over the eight months I reported on this story, I talked to more than 60 clinicians, researchers, activists and historians, as well as more than two dozen young people and about the same number of parents. WPATH gave me exclusive access to the final SOC8 (which is divided into 18 chapters, most of which address treatment for transgender adults) and lifted some of the confidentiality agreements the authors signed. Now the final version of the new Standards of Care is scheduled to come out this summer — in the midst of a raging political battle.

When I started talking to Leibowitz last December, he was watching the political attacks unfold with growing alarm. In his own state, Ohio, there was a bill afoot to ban the care he himself provides to trans young people and sees as essential to their well-being. His group's job for the SOC8 was to be "as rigorous and scientific as possible," he said, about how to translate the evidence about gender care into clinical practice. But they were acutely aware that any unknowns that the working group acknowledged — any uncertainties in the research — could be read as undermining the field's credibility and feed the right-wing effort to outlaw gender-related care.

Scott Leibowitz, a child and adolescent psychiatrist, helped lead the working group writing a chapter on adolescents for the Standards of Care, a set of guidelines from the World Professional Association for Transgender Health (WPATH).
Maddie McGarvey for The New York Times

The group was stocked with experts, including Leibowitz's co-leader for the adolescent chapter, the Dutch child psychiatrist Annelou de Vries, who for 19 years has worked at what was the first transgender pediatric clinic in the world, and the clinical psychologist Ren Massey, who is a former president of the Georgia Psychological Association and is transgender. When WPATH released the draft of the SOC8 for public comment, Leibowitz and his co-authors braced for the inevitable conservative attack. For teenagers who have parental consent, the draft adolescent chapter lowered to 14 (from 16 in the previous guidelines) the recommended minimum age for hormone treatments, which can permanently alter, in a matter of months, voice depth and facial and body hair growth and, later, other features like breast development. It set a minimum recommended age of 15, for breast removal or augmentation, also called top surgery. (The previous standards didn't set a minimum age.)

Opponents of gender-related care did, indeed, denounce all of this. But Leibowitz and his co-authors also faced fury from providers and activists within the transgender world. This response hit them harder, as criticism from your colleagues and allies often does. It arose from two of the conditions the draft chapter established in order for young people to start taking puberty suppressants and hormones. First, the draft said, preteens and teenagers should provide evidence of "several years" of persistently identifying as, or behaving typically like, another gender, to distinguish kids with a long history from those whose stated identification is recent. And second, they should undergo a comprehensive diagnostic assessment, for the purpose of understanding the psychological and social context of their gender identity and how it might intersect with other mental-health conditions.

Assessments for children and adolescents have long been integral to the Standards of Care. But this time, the guard rails were anathema to some members of a community that has often been failed by health care providers. “The adolescent chapter is the worst,” Colt St. Amand, a family-medicine physician at the Mayo Clinic and a clinical psychologist, posted on the Facebook page of International Transgender Health, which has thousands of members and functions as a bulletin board for the field. (St. Amand is on the working group for another chapter in the SOC8 on hormone treatments.) In a publicly streamed discussion on YouTube on Dec. 5, activists and experts criticized the adolescent chapter, with the emotion born of decades of discrimination and barriers to care. “This statement sucks,” Kelley Winters, a moderator of International Transgender Health who is an interdisciplinary scholar and community advocate in the field, said of the assessment. “This is talking about singling out trans kids, and specifically with a mental-health provider, not medical staff, to interrogate, to go down this comprehensive inquisition of their gender.” The requirement for evidence of several years of gender incongruity before medical treatment is “harmful and destructive and abusive and unethical and immoral,” said Antonia D’orsay, another moderator of the group who is a sociologist and psychologist. In January, in a public comment to WPATH, International Transgender Health blasted the adolescent chapter for “harmful assertion of psychogatekeeping” that “undermines patient autonomy.”

And just like that, after four years of painstaking work, Leibowitz, de Vries and the rest of their group were being called out as traitors by peers and the community they sought to care for. “We understood the enormity of the need for these standards from the beginning,” Leibowitz told me. “I’m not sure we recognized the enormity of the controversy. It’s a result of the fact that our world, the world of gender care, has exploded.”

In the 1950s and ’60s, a small cadre of doctors in Europe and the United States started to talk about how to evaluate adults who wanted to medically transition. Harry Benjamin, the endocrinologist for whom WPATH was originally named, embraced the idea that the people he agreed to treat (mostly trans women) were “born in the wrong body.” Fearing lawsuits from dissatisfied patients, the doctors were quick to exclude patients for reasons of mental stability. And, arbitrarily, they only included those who they believed would go on to pass as the gender they identified with, as Beans Velocci, a historian at the University of Pennsylvania, wrote in an article last year in TSQ: Transgender Studies Quarterly. Some doctors made trans adults promise to live as heterosexuals after they transitioned.

The small group of clinicians who wrote the first Standards of Care were all cisgender. After WPATH was created in 1979, transgender advocates increasingly gained influence in the organization, but many transgender people viewed subsequent versions of the standards as imposing paternalistic and demeaning barriers to treatment. For some genital surgery, the standards required adults to live for a year as the gender they identified with and to provide referrals from two mental-health professionals. The SOC8 is the first version to dispense with these requirements, adopting a model of “shared decision-making” between adult patient and surgeon.

The leap toward medical transition for young people occurred in the Netherlands in the 1980s. Peggy Cohen-Kettenis, a Dutch clinical psychologist specializing in children, began receiving referrals of teenagers who were experiencing gender dysphoria (then called gender identity disorder). But therapy wasn’t the primary answer, Cohen-Kettenis, who is retired, told me over the phone this spring. “We can sit and talk forever, but they really needed medical treatment.” As their bodies developed in ways they didn’t want, “they only did worse because of that.” She decided to help a few of her patients start hormone treatments at 16 rather than waiting until 18, the practice in the Netherlands and elsewhere at the time. She monitored them weekly, then monthly. “To my surprise, the first couple were doing much better than when they first came,” she said. “That encouraged me to continue.”

Cohen-Kettenis helped establish a treatment protocol that proved revolutionary. Patient Zero, known as F.G., was referred around 1987 to Henriette A. Delemarre-van de Waal, a pediatric endocrinologist who went on to found the gender clinic in Amsterdam with Cohen-Kettenis. At 13, F.G. was in despair about going through female puberty, and Delemarre-van de Waal put him on puberty suppressants, with Cohen-Kettenis later monitoring him. The medication would pause development of secondary sex characteristics, sparing F.G. the experience of feeling that his body was betraying him, buying time and making it easier for him to go through male puberty later, if he then decided to take testosterone. Transgender adults, whom Cohen-Kettenis also treated, sometimes said they wished they could have transitioned earlier in life, when they might have attained the masculine or feminine ideal they envisioned. “Of course, I wanted that,” F.G. said of puberty suppressants, in an interview in “The Dutch Approach,” a 2020 book about the Amsterdam clinic by the historian Alex Bakker. “Later I realized that I had been the first, the guinea pig. But I didn’t care.”

Over the next decade, Cohen-Kettenis and Delemarre-van de Waal designed an assessment for young people who seemed like candidates for medical treatment. In questionnaires and sessions with families, Cohen-Kettenis explored the reasons for a young person’s gender dysphoria, considering whether it might be better addressed by therapy or medication or both. The policy was to delay treatment for those with issues like attention-deficit and eating disorders or who lacked stable, supportive families, in order to eliminate factors that might interfere with the treatment. “We did a lot of other work before letting them start, which created a lot of frustration for them,” Cohen-Kettenis said. “Maybe we were too selective in the early stages.” In retrospect, she says, she thinks young people who might have benefited were excluded.

The stringent screenings seemed critical, however, given the opposition they faced. Other doctors, in the Netherlands and outside it, publicly accused them of recklessness. At a low moment, at a medical conference in the late 1990s, she said, they were likened to Nazis experimenting on children.

Cohen-Kettenis stressed that she and her growing team at the Amsterdam clinic were not channeling children toward a particular outcome. The Dutch advised what they called "watchful waiting." Throughout his childhood, with his parents' support, F.G. lived as a boy, with short hair and a gender-neutral nickname. But Cohen-Kettenis counseled parents to "keep the door open, as much as possible, for children to be able to change back." Among the adolescents who came to the clinic beginning at the age of puberty, 41 percent went on puberty suppressants, and more than 70 percent received hormone treatments and went on to surgery.

The Amsterdam clinic attracted international interest. Norman Spack, an endocrinologist at Boston Children's Hospital who began treating transgender adults in the 1980s, and Laura Edwards-Leeper, then a child psychologist there, visited Amsterdam in 2007 for a gathering of clinicians from countries including Canada, Britain, Norway and Belgium. Spack and Edwards-Leeper went back to Boston, where they and another doctor were opening the first dedicated gender clinic for kids in the United States that provided medical treatment based on the fundamentals of the Dutch approach — a comprehensive assessment before patients could begin puberty suppressants or hormone treatments and close consultation between a clinic's mental-health professionals and medical doctors.

Scott Leibowitz joined the Boston clinic as a psychiatrist in training a year later. In the early days, families traveled long distances for appointments. The waiting list grew. Edwards-Leeper and Spack eventually shortened the period a child had to be in therapy before the clinic did its own assessment, from a year to between three and six months. "If a child was on the cusp of puberty, and anxious about how their body was about to change, we tried to squeeze them in faster, which I still think is really important," Edwards-Leeper says.

Tori (a nickname), who is 13 and lives outside Atlanta: "With gender, it has been more and more, wanting more things to happen. And luckily I have parents who are willing to let me describe myself and be whoever I want." Anne Vetter for The New York Times

In 2011, de Vries and her colleagues published the first of two landmark studies about medical interventions in adolescence. Among the first 70 patients who received puberty suppressants at the Amsterdam clinic after their initial assessment at the mean age of about 13½, the researchers found "a significant decrease in behavioral and emotional problems over time." A second study published in the journal Pediatrics in 2014, of about 55 of those who went from puberty suppressants to hormone treatments at the mean age of about 16½, showed that five years after starting hormone treatments and at least one year after surgery, they had the same or better levels of well-being as a control group of cisgender adults their age. None of the 55 regretted their treatment. (The 15 of the original 70 who were not included in the follow-up study did not take part mainly because of the timing of their surgery.)

For the first time, a long-term, peer-reviewed study showed positive outcomes after medical treatment in adolescent patients who'd gone through Cohen-Kettenis and Delemarre-van de Waal's protocol. They had all been through a version of the type of assessment the December draft of the SOC8 adolescent chapter would recommend years later. They had experienced gender dysphoria since childhood (according to their families), lived in supportive environments and had no interfering mental-health conditions. As is often the case in medicine, the question for those drafting the SOC8 would be how to apply the findings of a particular cohort to the growing numbers of teenagers lining up at clinics in a host of countries.

In the United States and Canada, meanwhile, two dueling approaches to therapy for young children, before they reached puberty, were vying for supremacy. At what is now called the Child and Adolescent Gender Center at the University of California, San Francisco, Diane Ehrensaft, a developmental and clinical psychologist, was counseling families to take what she and others called a "gender affirming" approach, which included a social transition: adopting a new name and pronouns for a child who expressed such a preference, along with letting kids dress and play as they pleased.

For years, Ehrensaft's intellectual foil was Ken Zucker, a psychologist and prominent researcher who directed a gender clinic in Toronto. Between 1975 and 2009, Zucker's research showed that most young children who came to his clinic stopped identifying as another gender as they got older. Many of them would go on to come out as gay or lesbian or bisexual, suggesting previous discomfort with their sexuality, or lack of acceptance, for them or their families. Based on this research, in some cases Zucker advised parents to box up the dolls or princess dresses, so a child who was being raised as a boy (a majority then) wouldn't have those things to play with.

In 2012, the last version of WPATH's Standards of Care, with Cohen-Kettenis and Zucker among the authors, cited his work 15 times and called social transition in early childhood "controversial." The American Psychological Association said in 2015 guidelines that there was no consensus about a best practice for children before puberty, describing both accepting children's "expressed gender identity" (citing de Vries and Cohen-Kettenis, Ehrensaft, Edwards-Leeper and Spack, among others) and, alternatively, encouraging them to "align with their assigned gender roles" (citing Zucker, among others).

At the end of 2015, the Canadian medical center that ran Zucker's clinic in Toronto shut it down because of complaints from activists about his method. (Zucker sued the center for defamation and later received an apology and a settlement of $450,000.) In February 2017, protesters interrupted and picketed a panel featuring Zucker at the inaugural conference of USPATH (the U.S. affiliate of WPATH) in Los Angeles. That evening, at a meeting with the conference leaders, a group of advocates led by transgender women of color read aloud a

statement in which they said the "entire institution of WPATH" was "violently exclusionary" because it "remains grounded in 'cis-normativity and trans exclusion.'" The group asked for cancellation of Zucker's appearance on a second upcoming panel. Jamison Green, a trans rights activist and former president of WPATH, said the board agreed to the demand. "We are very, very sorry," he said.

After that controversy, other providers were on notice that Zucker's methods were no longer acceptable. His approach was likened to conversion therapy, which treats being gay or trans as a mental illness to be cured, and which many states and localities have made illegal.

The Amsterdam clinic shifted, too. Some Dutch families socially transitioned kids on their own, which de Vries and her colleagues accepted; they began counseling other families about social transition too. Though the Amsterdam researchers' previous results, like Zucker's, showed that most kids who came to the clinic in elementary school later realigned with the genders of their birth, and often came out as gay, lesbian or bisexual, de Vries and her colleagues now see those findings as a product of their time, when the children whom parents brought to the clinic included many boys with an interest in wearing feminine clothing and playing with dolls that didn't turn out to be gender dysphoria. Today many Dutch parents are more accepting of this behavior, and the Amsterdam clinicians think that as a result, most of the children who come to the clinic are asserting a strong and persistent gender preference. It's more likely that such children will stay the course of being transgender, research shows. One long-term study, published in 2021, of 148 kids in the United States who socially transitioned with their families' support between the ages of 8 and 14, found that five years later their psychological well-being was on par with their siblings and a control group of cisgender peers.

There is a separate chapter in the SOC8 that focuses on young children and that recommends that health care professionals and parents support social transition when it originates with the child while also recognizing that for some kids, gender is fluid. An outstanding question, asked by gay commentators like the author Andrew Sullivan, is whether some kids who socially transition today, and remain trans, would have grown up to be gay or lesbian in previous generations. "I know there are worries that effeminate males can be assumed to be female or masculine girls can be assumed to be male," says Amy Tishelman, the lead author of the SOC8 chapter on children and a child psychologist who is the former director of clinical research at the gender clinic at Boston Children's Hospital. "That's not what we're advocating. Support for trans people should not be a way of limiting what a girl or a boy or a woman or a man or a person can be."

Marci Bowers, a gynecologic and reconstructive surgeon, is slated to be the next president of WPATH.
Ryan Young for The New York Times

A few months before the release of the December draft of the SOC8, WPATH had a preview of the firestorm to come. In October 2021, the journalist Abigail Shrier published a post called "Top Trans Doctors Blow the Whistle on 'Sloppy' Care" on the Substack of Bari Weiss, a former opinion editor and writer for The New York Times." The word "sloppy" was a quote from Erica Anderson, a clinical psychologist who was a past president of USPATH and who worked at the U.C.S.F. gender center for years before leaving in October (for unrelated reasons). She told Shrier she expected more regret among young people because some providers were rushing them toward medication without sufficient mental-health evaluations.

Shrier also quoted Marci Bowers, a gynecologic and reconstructive surgeon who is slated to be the next president of WPATH, who voiced a separate concern about blocking puberty too early. Though there is no published data on this question, over hundreds of surgeries, Bowers has found that trans girls who don't go through male puberty may find it difficult to have an orgasm after they have genital surgery as adults. They also could have less penile tissue with which to create a vagina, which can lead to more complications from surgery, according to Bowers. These concerns apply in a small percentage of cases in the United States, as most teenagers come to gender clinics at 14 or older, after puberty. But for the younger kids, Bowers advocated delaying puberty suppressants to a later stage of development.

Anderson and Bowers are transgender women, which brought more attention to their critique and to their decision to talk to Shrier, who is the author of a 2020 book, "Irreversible Damage: The Transgender Craze Seducing Our Daughters," which many trans people and their allies abhor. Many trans health providers were furious. "I was like, Whoa, what is this? And then I texted Erica," says Maddie Deutsch, the president of USPATH and a professor at U.C.S.F. as well as the medical director of the Gender Affirming Health Program there, who is also transgender. "We were all broadsided." She worries about the political fallout. "States like Texas and Florida are looking to these articles to fan the flames."

About a week after Shrier's post appeared, USPATH and WPATH issued a statement opposing "the use of the lay press" for scientific debate about gender-related medical treatment. Anderson disagreed with the directive. "Some of our colleagues would have us shut up," she told me in the fall. "No. It's not OK to ignore the problems." In late November, she and the child psychologist Laura Edwards-Leeper published an opinion essay in The Washington Post. They said they were "disgusted" by the proposed state bans on gender-related medical treatment for minors, but they warned that some providers in the United States were "hastily dispensing medicine" and skipping comprehensive assessments.

'Young people are quite capable of understanding themselves, but not all of them will.'

The following week, news broke in Texas that the only gender clinic for adolescents that provides hormone therapy in the Dallas region, Genecis, was being disbanded, a result of political pressure from Gov. Greg Abbott. "We have wolves at the door," says Ehrensaft, who worked with Anderson at U.C.S.F. and is an author on the SOC8 chapter on children with Edwards-Leeper. "Conversations among us get aired as controversy and confusion. You end up eating your own instead of making the wolves go away." Others were scathing about placing blame. "Every time a law passes blocking trans youth from getting care, I hope it's called an Edwards-Leeper law," Andrew Cronyn, a pediatrician and a former adviser on policy about L.G.B.T. health for the American Academy of Pediatrics, wrote on a professional email list with more than 500 recipients. "And I hope that every time one of the youth who is blocked from affirmative care dies, she gets sent a copy of the obituary." He subsequently apologized and the post was removed at his request.

When I spoke to Bowers in December, she distanced herself from Anderson and Edwards-Leeper. "The most important thing is access to care," she said. "And that is a much bigger problem than the issue of how the medical community and transition is failing people." But she remained intent on drawing attention to her concerns about the early suppression of puberty. "Sexual satisfaction is a huge thing," she said. "You've got to talk about it."

Partly in response to Bowers's concerns, the December draft of the SOC8 adolescent chapter suggested that health care providers discuss "future unknowns related to sexual health" when families consider puberty suppressants. The Amsterdam clinic often waits to prescribe suppressants until later in puberty.

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In the United States, waiting would be a major shift for the relatively small group of younger kids at gender clinics. For them, families weigh the relief the medications can provide against the health implications. Taking puberty suppressants (or hormones) for gender affirmation is "off-label," meaning this specific use of the medications is not approved by the Food and Drug Administration. Off-label prescriptions are common and don't imply anything improper, but there may be less research about the drug's effects. If young people continue on to hormone treatments, puberty suppressants "probably" compromise fertility, especially for trans girls, Stephen M. Rosenthal, a pediatric endocrinologist at the gender center at U.C.S.F. who is on the group for the SOC8 chapter on hormone treatments, explained in a review last year for Nature Reviews Endocrinology. The medication can also prevent bone density from increasing as it typically would, and while levels returned to normal in trans boys who went on to hormone therapy, they remained low in trans girls who did the same, according to a 2020 study from the Amsterdam clinic. Little is known about the impact on brain development. "The relative paucity of outcomes data raises notable concerns," Rosenthal wrote in his review. But he has no hesitation about prescribing puberty suppressants to kids who are deemed ready for them at his clinic. "The observed benefits greatly outweigh the potential adverse effects," he said.

As winter approached, criticism of Anderson and Edwards-Leeper by their peers mounted as right-wing attacks on medical care for minors grew louder. In early November, the board of USPATH privately censured Anderson, who served as a board member. In December, the board imposed a 30-day moratorium on speaking to the press for all board members. That month, Anderson resigned.

In February, Governor Abbott ordered child-abuse investigations of parents and providers in Texas who give gender-related medical treatments to kids, generating national headlines and causing fear and anguish for families. In March, Arizona became the second state to ban gender medical care for minors. (The law, which applies to surgery, not medications, is scheduled to go into effect in 2023.)

The next month, four doctoral students in psychology asked to drop Edwards-Leeper from their dissertation committees at Pacific University, where she is an emeritus professor. And yet in the same week, she presented on the SOC8 adolescent chapter at the annual pediatric conference of the American Psychology Association, where the moderator of one of her panels praised her for her bravery in

voicing her concerns about her field. The roller coaster of reaction, at the same time kids were losing access to care altogether in red states, shook Edwards-Leeper and her co-authors of the SOC8 chapters on adolescents and children. They didn't want to be blamed for the right-wing backlash — neither by activists nor their own peers.

Watching the waves of conflict break, Leibowitz worried. He respected Bowers, Anderson and Edwards-Leeper for raising difficult issues but could see their views being mischaracterized to justify banning gender-related care. For people who don't know much about the issues, "banning the care probably sounds more enticing than the idea that kids are dictating what treatment they should get," he says. "Our guidelines are the voice from the middle."

Kat (a nickname), who is 18 and lives in the Midwest: "When I was younger, I tried to wear girls' clothes, but it hurt. I still can't quite explain why. But I don't focus on gender that much now. It's just one aspect of myself." Anne Vetter for The New York Times

One morning over the phone, Leibowitz explained to me the elements of the mental-health assessments he saw as essential. His starting point, when a child presents as transgender, is obtaining a complete diagnostic profile. This means understanding the relationship between gender dysphoria and any other conditions (like depression or an eating disorder) or another factor that might be causing discomfort (like trauma or feeling confined by gender stereotypes) before coming up with a treatment plan. "It's about understanding how the issues that might make someone experience gender dysphoria are connected," he said.

As Leibowitz and his co-authors discussed revisions over video calls and email, colleagues who were critical of the draft chapter were also working together. Colt St. Amand, the psychologist and physician who disparaged the adolescent chapter on the Facebook page of International Transgender Health, brought together a collective of 16 mental-health professionals who are either transgender (as he is) or nonbinary, or have a close family member who is, to talk about how the assessment guidelines in the adolescent chapter fit with their lived experience and professional knowledge.

St. Amand thinks the purpose of an assessment is not to determine the basis of a kid's gender identity. "That just reeks of some old kind of conversion-therapy-type things," he told me over the phone in April. "I think what we've seen historically in trans care is an overfocus on assessing identity." He continued: "People are who they say they are, and they may develop and change, and all are normal and OK. So I am less concerned with certainty around identity, and more concerned with hearing the person's embodiment goals. Do you want to have a deep voice? Do you want to have breasts? You know, what do you want for your body?"

The draft of the adolescent chapter suggests that "extended assessments" may be useful for young people who are autistic or have some characteristics of autism without a full diagnosis. "One of the key accommodations for autistic youth is providing more time and structure to support the young person's self-advocacy and communication capacity," said John Strang, the specialist on the intersection of autism and gender identity on the SOC8 adolescent and child chapters and a neuropsychologist at Children's National Hospital in Washington, D.C. But St. Amand calls a standard of extended assessments a "gross generalization" and "discriminatory."

The priority for the collective St. Amand organized, which is working on a series of articles and training materials, is to ensure that transgender and nonbinary youth get the care they need rather than to shield teenagers from taking medication with effects they might later decide they didn't want. St. Amand's focus is on a young person's response after beginning puberty suppression or hormone therapy. "If that is the right thing for them, then the response over time will tell me," he says. "Once we start those interventions, we are checking in with the patient to see how they're doing." If the drugs don't suit them, in his view, they can simply stop.

Colt St. Amand, a family-medicine physician at the Mayo Clinic and a clinical psychologist, is in the working group for a chapter on hormone treatments in WPATH's new Standards of Care.
Ben Innes for The New York Times

Other providers, however, see an ethical dilemma stemming from the principle of justice — which promotes access to care for trans youth — and the principle of doing no harm. "I wouldn't recommend just initiating testosterone straight away," says Nathaniel Sharon, a child psychiatrist in New Mexico who has helped shape mental-health policy that affects transgender young people for the American Academy of Child & Adolescent Psychiatry. "Their voice gets permanently low. They're hairy. Their clitoris is enlarged. And what do you do now? I just find that inappropriate and unsafe."

The differences among gender-affirming providers over assessments and medical intervention don't break down along cisgender-transgender lines. Some transgender practitioners, like Sharon and Ren Massey, a psychologist on the SOC8 adolescent chapter, support the chapter's approach to assessments. "We need to understand that the reality is that adolescents go through a lot of developmental changes and have a lot of internal and external influences on their development," Massey says. And some transgender activists also support a cautious approach. "It is life changing," Jamison Green, the former president of WPATH, says of transitioning. "It is all encompassing. If it's right for you, then it's really important. It's very easy to get interested in a new idea, get excited and not think it through all the way. Young people are quite capable of understanding themselves, but not all of them will. That's why I think prudence is useful."

Leibowitz had a related concern. For young people who have yearned for puberty suppressants or hormone treatments, reversing course can be difficult, he says. "Some people, once they make the decision, they're not going to go against it, because they feel internal pressure to continue. They might be susceptible to feeling ashamed."

Research is just beginning about why young people halt medical treatment and what it means for them. Some continue to identify as trans or nonbinary, like Nova West, a 27-year-old filmmaker I spoke to, who was happy with top surgery and the way testosterone lowered their voice and helped them build muscle — and then stopped the treatment because they didn't want to go bald (which sometimes happens) and felt they'd reached their "optimal gender expression."

Others decide they want to fully detransition and return to their cis identities. Grace Lidinsky-Smith, who is 28, has written about her regret over taking testosterone and having her breasts removed in her early 20s. She told me that she wished she'd had the kind of comprehensive assessment the last Standards of Care endorsed for adults. "That would have been really good for me," she said.

St. Amand and the collective argue that as no study has directly compared different types of assessment, there's no evidence that the Amsterdam clinic's approach is better. They point to research from clinics in the United States, which shows small-to-moderate improvements in depression and anxiety and large improvements in body-related dysphoria for young patients six months or a year after beginning medication. One of those studies is by the clinical child psychologist Laura Kuper, based on a sample of young patients, some of who went through a streamlined assessment process that Kuper helped design at the Genecis program in Dallas. "In medicine in general, if you find a new treatment and it seems overwhelmingly helpful, you start to roll it out before you have a 10-year follow up," says Kuper, who helped start the collective with St. Amand and is one of the authors of a SOC8 chapter on nonbinary individuals. "You continually reflect on new research and clinical findings as you go."

It's not yet known how well improvement in the short term predicts how teenagers today will feel as older adults about the changes they made to their bodies. In their draft chapter, Leibowitz, de Vries, Massey and their co-authors note that to date, only the Amsterdam clinic, with its comprehensive assessments, has results showing strong psychological benefits later in life for people who medically transitioned in their teens. Today, the Amsterdam clinic usually requires at least six monthly sessions (following a longer period on a waiting list) to begin medical treatment. "We've always said, Do it in a careful way," de Vries says.

Most of the young people today who come to clinics for treatment are affluent and white, live in progressive metropolitan areas and have health insurance. For them, gender-related care has become more accessible since 2016, when the Obama administration included gender identity in a rule against denying health care benefits on the basis of sex. If a provider deems the care medically necessary, it's possible to get insurance coverage for puberty suppressants, which can be injected or implanted under the skin, and hormone treatments, which can be taken orally, injected or applied as a gel or a patch. Each can cost thousands of dollars a year.

But in other parts of the country, there is often no gender clinic and sometimes no therapist or doctor to help transgender kids — who often still face bullying and harassment — navigate the process of coming out. "I have a patient in rural Mississippi who tried to find mental-health support, but it was traumatic," says Izzy Lowell, a family-practice doctor and the founder of QueerMed, which treats patients mostly via telemedicine (without in-person visits) in about a dozen states covering the Southeast. In effect, states like Arkansas are banning care where it is already rare.

'I say to parents, "I have no idea if your child is trans or not — they need an open field to explore." '

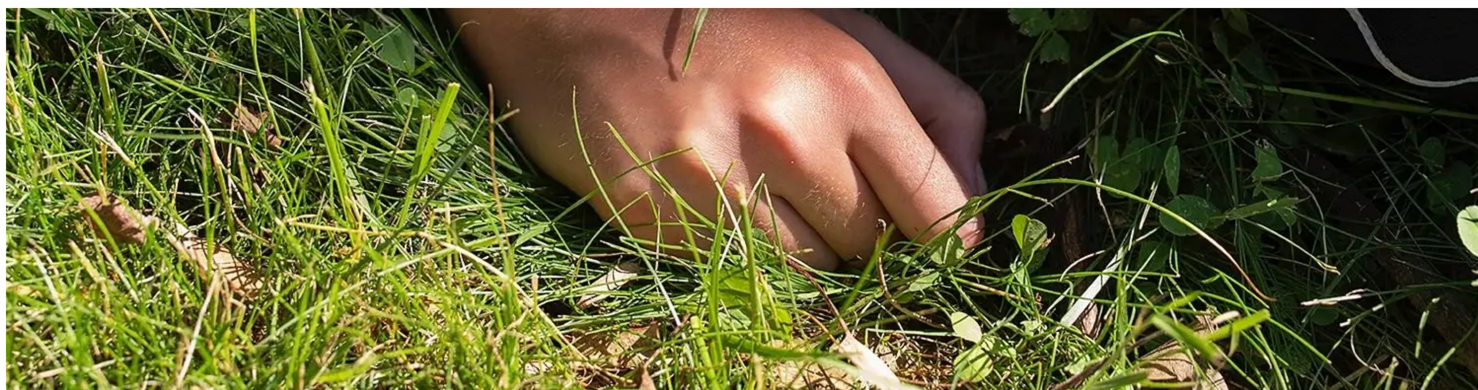
Finding care can also be harder for low-income or religious families and families of color. Lizette Trujillo, a mother in Arizona, told me that when she realized her son was trans several years ago, she found a parent support group on Facebook where her family was one of only two that were Hispanic. When she became the group's facilitator, she worked to get the word out in her community. But some parents are reluctant to join because of their religious backgrounds, and the wave of bills to ban gender-related medical treatment is generally increasing families' fears. "It's terrifying," Trujillo said. "It was the first time my son was actually afraid. 'Could this happen here? Will you make sure I'm safe?' He's 14."

Among those who had access to care, many parents and kids told me they were deeply grateful for a relatively smooth path to medical transition. Tori (a nickname) told her parents she didn't want a boy's body at the beginning of seventh grade. Her pediatrician in Atlanta referred her to QueerMed, Lowell's practice. "We asked all our questions," says Tori's father, who belongs to the local chapter of TransParent USA, a national support group. "What if she changes her mind? What can you and can't you come back from? There was no question on the table they didn't have a research-based answer for. You see your kid light up at the answers, and you say, 'OK, this is the right thing to do.'" Tori says she just wishes her transition could go faster.

Other parents, however, were bewildered by a landscape in which there are no labels for distinguishing one type of therapeutic care from another. In recent years, the Endocrine Society, the American Psychological Association, the American Psychiatric Association and the American Academy of Pediatrics have endorsed gender-affirming care as the only acceptable approach. But the major medical groups tended to speak in broadly supportive terms without specifying how providers should actually do it.

It’s not clear how common comprehensive assessments are among gender-affirming providers in the United States. “The American Psychiatric Association doesn’t really have an official position on the best way to treat the kids,” says Jack Drescher, a clinical professor of psychiatry at Columbia University who helped write the group’s position statements.

One mother in New England told me about talking to a therapist when her 6-year-old, Charlie (a nickname), became tearful about using the girls’ bathroom and urgently asked for a buzz cut. Without meeting Charlie, the therapist told the mother during a single session that her child was a trans boy. Feeling overwhelmed, the mother took Charlie to another therapist, Julie Mencher. “I say to parents, ‘I have no idea if your child is trans or not,’” Mencher told me. “They need an open field to explore.” Charlie, who is now 12, told me that he figured out over the next year or so that he was sure of his male identity. His parents could see it solidifying and supported his wish to go on puberty suppressants. “The first therapist was right,” his mother says. “But we needed a process we could trust.”



Charlie (a nickname), who is 12 and lives in New England: “Here’s something I really remember: My older brother introducing me as ‘Hey, this is my brother’ for the first time. I was so happy. We were at camp. I think I was around 7.” Anne Vetter for The New York Times

I also talked to parents who were surprised when their teenagers came out as trans. Some wanted to be both supportive and cautious. Four years ago, when she was 12, Catherine (her middle name) left a note under her mother’s pillow saying she was a trans boy. She followed a script from YouTube videos she’d watched of other teenagers coming out. Catherine’s mother says she looked for a therapist who “would be open to whatever came,” and found Jennifer Butzen, a licensed counselor in the Atlanta area. Butzen estimates that about two-thirds of her young clients with gender-identity issues eventually choose to go on hormones, while the other one-third either are nonbinary, nonconforming or trans but decide not to have medical interventions or are cisgender.

Butzen told me about the influence of the types of YouTube videos Catherine watched. She calls them “butterfly videos” because of their curated, beautiful portrayal of self-transformation. For some kids, the videos are a valuable resource — a bridge to the self they desire that they can’t easily find in real life. But others, Butzen finds, are on a less coherent search for belonging. “Being trans comes with goals — this is what to do,” Butzen says. “It comes with a support network and a cause to fight for.” Online, where the stakes start relatively low, teenagers in progressive communities can trade in a cisgender, heterosexual, white identity — the epitome of privilege and oppression — to join a community with a clear claim to being marginalized and deserving of protection.

When Catherine started seeing Butzen, the pair talked about sexuality as well as gender identity and did exercises, using a whiteboard, about male and female stereotypes, which Butzen wants her clients to know they can challenge whatever their gender. Butzen also explained the physical and social changes that come with medical transition. “Everything became more real, and it got a little scary,” Catherine says. “But I was in this forward movement, like, ‘I have to do this.’”

But one day on the way to her appointment with Butzen, Catherine started crying and told her mother she’d been lying to herself. In retrospect, she thinks the YouTube videos gave her a way to relieve discomfort she felt about being attracted to girls, which wasn’t accepted at her Catholic school. Later, Catherine came out as bisexual. If her parents had said no to the idea that she was trans, she says, “I would have revolted against them.” But when they gave her room to explore, “I internalized what I wanted to do.”

Other teenagers talked about the way misogyny affected their thinking. One 18-year-old, Kat (a nickname), started using a boy’s name and pronouns four years ago and asked to take puberty suppressants, as a friend was doing in her Midwestern college town. Her mother said no to medication. She worried about the health effects and the role of peer influence; she also told me she wanted to make sure her child understood there was no right or wrong way to be a girl. “I didn’t get it as well as other people did, what being a girl even meant,” Kat told me, looking back. “And my mental health wasn’t great. I was cutting around that time.” At about 17, she went back to her girl’s name and pronouns. “I still have weird, internalized misogyny in my brain I’m trying to get over,” she says. “I don’t even get where it’s coming from.”

In other families, a teenager’s decision to come out was a source of prolonged conflict. F., now 18 and living in Maryland, started identifying as a trans boy and binding his breasts in seventh grade. His mother told me that when she found out, she told F. she didn’t believe anyone was born in the wrong body. Later, she went to a protest at a gender clinic in Washington, D.C., which upset F. His group of friends, which included other trans and queer kids, became “a really big part in me being able to be myself,” he says. These days, F., who has not medically transitioned, identifies as nonbinary. “I’m kind of coming to terms with my body,” he says. “Who’s to say my body is female? I’m not a girl and it’s my body. Don’t put your labels on me.”

To parents who doubt the authenticity of a child’s assertion or oppose medical treatments their kids strongly want, the smooth road to gender care looks like a dangerously slippery slope. Such parents have increasingly found each other online, in Facebook groups and on websites. Last fall, an international group called Genspect started holding web-based seminars that are critical of social and medical transition and, a spokeswoman said, gained thousands of members.

Some Genspect parents told me the rise in trans-identified teenagers was the result of a “gender cult” — a mass craze. (In February, an anonymous parent on a Substack newsletter affiliated with Genspect wrote a post called “It’s Strategy People!” about how the group gets its perspective into the media by making sure not to talk about their kids as “mentally ill” or “deluded.”) Other parents said they were not conservative and generally supported L.G.B.T. rights but not medical transition for their own children or usually for anyone under the age

of 18. Several parents argued that though 18 is the legal age to vote, buy a gun and consent to medical treatment, in this single area of medicine — gender-related treatment — the age of consent should be 25, when brain development is largely complete. (At 18, these parents are aware, teenagers can go to Planned Parenthood, one of the largest providers of gender-affirming hormones in the country, and receive hormones after a roughly half-hour consultation and giving consent.)

Several Genspect parents told me their teenagers came out as trans after struggling for years with serious mental-health issues. One mother in Northern California said her child had previously been hospitalized for a suicide attempt and started identifying as trans while spending many hours online. The mother said yes to puberty suppressants at the recommendation of a local gender clinic, but her child became more volatile, she said. Around 15, her child wanted to progress to hormone treatment, which the gender clinic supported, according to emails I reviewed. When the mother refused, she became the object of her child's fury. "What if I'm wrong?" she asked. "Knowing my kid sees me as the barrier to happiness — that's the worst part. I feel like a monster."

Laura Kuper, a clinical child psychologist, is one of the authors of a chapter in the Standards of Care on nonbinary individuals.
Misty Keasler for The New York Times

As the United States battled over whether gender-related care should be banned or made more accessible, a few European countries that had some liberal practices concerning young people seeking medication imposed new limits recently. In February, the national health board in Sweden limited access to puberty suppressants and hormones before the age of 18 to "exceptional cases" and in research settings. The shift followed a Swedish public-television documentary that claimed doctors tried to hide spinal damage in a young patient whose bone density wasn't adequately monitored. Finland has similarly restricted access. One month after Sweden's decision, the National Academy of Medicine in France called for "great medical caution" regarding treatment for young people, citing health risks (including for bone density and fertility) and noting the unexplained rise in trans-identified teenagers.

In March, I visited the Amsterdam clinic to talk to de Vries about its trailblazing program and what she made of the responses of other European countries. We talked in her office, near a waiting room with a foosball table and artsy photos of an androgynous masked dancer. As a child, de Vries told me she resisted stereotypical gender roles. "Why were the boys asked to help the teacher carry heavy loads and the girls had to bring coffee and tea?" she said. "You could make me quite angry by asking me as a kid to do those things, as a girl."

Working in her clinic now, de Vries is concerned about the waiting list, which she called "devastating." Young people often wait two years or more for an appointment in the Netherlands. One of them, a theater student named Yaël who is now 22, told me that the delay felt endless. "My friends started growing beards, and people were looking at me like they were the guys and I was a girl or their little brother," he said. "It was just very frustrating and depressing." He remembered the day he started hormones at 16. "Someone came to the door to deliver a package, and when I signed for it, he said, 'Have a good day, ma'am.' For the first time, it didn't bother me. I thought, I know in a couple of months you won't say that." He added, "I can't imagine a life without being able to transition."

De Vries said she was disappointed by the developments in Scandinavia and France. But she thought the retreat in those countries signaled a different kind of conservatism, about how to practice medicine in light of scientific uncertainty, from the bans in the red American states, fueled by anti-trans vitriol. The shift from European health authorities also suggested that scientists and physicians who don't have the clinical experience of seeing young people receive gender treatments felt more constrained by the limitations of the research.

England's National Health Service, too, asked for an independent review of the country's gender-identity services (following a whistle-blower's report in 2018 that the nation's only pediatric clinic was fast-tracking young people into medical treatment and a lawsuit by a former patient — who later detransitioned — over the care she received there). Hilary Cass, a prominent pediatrician, is leading that effort. In a preliminary report in February that doesn't make a final recommendation, she said the "lack of available high-level evidence" about puberty suppressants and hormone therapy for young people was "too inconclusive to form the basis of a policy position" on whether to continue the treatments. She also described a "mismatch" between the ethical responsibilities of clinicians to meet certain standards before a treatment and the distress some young people feel about a detailed assessment because they want "rapid access to physical interventions." Like the SOC8 adolescent chapter, Cass suggested that the Dutch approach to assessment is the one best supported by the research.

New findings continue to support that approach. In April, de Vries presented data at a pediatric conference, still unpublished, about more than 80 patients from the clinic's early cohort who were now between the ages of 25 and 50. (The response rate was about 50 percent.) According to the answers they provided, the trans men were doing just as well, in terms of mental health, as the general population. The trans women were slightly below the norm. No one in the group had reversed their hormonal treatments or surgeries. There is no published research on the physical effects in middle or old age of having transitioned in adolescence; the Amsterdam clinic is now collecting data on this question.

'In our society right now, something is either all good or all bad. Either there should be a vending machine for gender hormones or people who prescribe them to kids should be put in jail.'

In a video chat this spring, I talked to F.G., the first patient to take puberty suppressants for gender affirmation 35 years ago, when he was 13. He's a veterinarian, and when we spoke, he wore a yellow track jacket and had a short brush cut and a patch of beard under his lip. He told me that when he was a child, he wanted simply to *be* a boy. But of course that was impossible. Taking medication to stop puberty, he said, saved his life. He waited until he was 18 for hormone treatment. It would be unusual now to have such a prolonged stint on puberty suppressants. F.G. says he never wanted to have children, though he's not sure if that's because he didn't know if he could. For years, he stayed away from romantic and sexual relationships, but that changed in his 30s, and these days he has a serious girlfriend.

F.G. has watched the rise in numbers of transgender young people with a mix of joy and trepidation. He thinks kids who want the medical treatment he received should go through a significant assessment process. "It makes me sound a bit of a hypocrite, because I needed that to be who I am," he said. And yet the time on the suppressants, to test the strength of his own desires, was essential to his peace of mind. "I really, really thought about it," he said, "and I've never been so sure of anything in my whole entire life."

In March, the Biden administration's Department of Health and Human Services put out a statement unequivocally supporting gender care for minors, "when medically appropriate and necessary," as a matter of federal civil rights law. But the backlash was gaining momentum. The bill to ban trans medical treatment that Leibowitz had been worrying about was moving through the Ohio House; in April, Alabama passed a similar bill. On Fox News, Tucker Carlson called treatment for young people "chemical castration." And the Florida Department of Health issued guidelines that opposed social or medical transition for kids of any age. Conservatives usually champion parental authority, but in families with trans kids, they were lining up to take it away.

Judges blocked the statewide bans, but in some cases, preteens and teenagers were losing access to a course of medication they'd already begun because pharmacies refused to fill prescriptions and doctors or hospitals preemptively stopped treatment, fearing liability or political opposition. In Texas, Ximena Lopez, a pediatric endocrinologist who worked at Genecis, the Dallas program that was forced to disband in November, sued to continue to see patients, and Leibowitz prepared to testify in support of her case. (Lopez has continued to see her previous patients and is temporarily accepting new ones under a one-year injunction.)

Leibowitz was frustrated by a political dilemma. To defend against the bans, some gender-affirming providers were oversimplifying aspects of the treatments. They said minors never or almost never had surgery at all, even though top surgery is important to some trans teenagers to relieve their dysphoria and is rising. (In the Kaiser Permanente health care system in Northern California, the incidence rose from a handful of operations in 2013 to nearly 50 in 2019, according to a study published in Annals of Plastic Surgery in May. Only two of the 200-plus teenagers in the study said they regretted the surgery at least one year later.)

To make the urgent case that medical interventions are necessary, some providers started emphasizing the risk of suicide among trans kids. The rate of suicide attempts among them in the previous year is terribly high — nearly 35 percent in a 2017 survey of high school students by the Centers for Disease Control and Prevention compared with single digits for the cisgender population. A 2020 study of trans patients of all ages, over more than four decades, at the Amsterdam clinic, found that deaths by suicide, which are fortunately rare, though still higher than for the general Dutch population, seem to "occur during every stage of transitioning."

In the overheated political moment, however, parents were getting the terrifying message that if they didn't quickly agree to puberty suppressants or hormone treatments, their children would be at severe risk. Many parents told me they'd heard the mantra: "It's better to have a live son than a dead daughter."

In individual cases, teenagers often say that being able to medically transition is lifesaving. Jack Turban, a fellow in psychiatry at Stanford Medical School, has become a major voice in the media and on Twitter among gender-affirming providers including on the question of medications and suicide risk. He leads a research team that worked with data from a 2015 survey of transgender adults in the United States. The survey asked respondents if they remembered taking puberty suppressants or hormone treatments before age 18. Using those adult recollections, Turban's team published articles in 2020 and 2022 finding an association between taking puberty suppressants and

hormone treatments and having lower odds of suicidal thoughts in adulthood. But the studies didn't find the same link between taking the medications in adolescence and actually planning or attempting suicide. (Through a Stanford spokeswoman, Turban said he didn't have time to talk to me.)

Another 2022 study based on a different survey, by researchers from the Trevor Project (which provides crisis support to L.G.B.T.Q. young people), did show a 40 percent lower incidence in recent depression and in past-year suicide attempts for transgender and nonbinary 13-to-17-year-olds who said they had hormone treatments. There was no such finding for 18-to-24-year-olds.

The survey-based studies received prominent media coverage. But this research doesn't prove that young people who get puberty suppressants or hormones are at lower risk *because* of the medications, points out Christine Yu Moutier, a psychiatrist and the chief medical officer for the American Foundation for Suicide Prevention. The adults who remembered getting the treatments as teenagers could have had other advantages — "socioeconomic factors, having health insurance, having supportive families" — that better accounted for why their rates of suicidal thoughts or attempts were lower, Moutier says. And they could have received the medications they wanted in part because their mental health was evaluated as stable beforehand.

One of the clearest and most consistent findings about L.G.B.T. young people is that support from their families is essential for protecting them from a host of poor outcomes, from depression and suicide attempts to homelessness. The Family Acceptance Project, a research and intervention program for families of L.G.B.T. children, tells parents that refusing to use a child's chosen names and pronouns is a form of rejection. But the project stops short of saying that parents who delay or refuse to consent to medication, despite their children's wishes, are rejecting them or putting them at risk.

In the heat of a battle like the one raging over gender-related medical care for minors, insisting on precision about scientific evidence can seem nitpicky. But Leibowitz thinks gaining the trust of families necessitates acknowledging complexity. "It's irresponsible to reinforce very scary statistics to families in an attempt to gain consent for treatment," Leibowitz says. "This strategy doesn't build the type of love and acceptance that a child needs, which is truly at the heart of preventing suicidal behavior."

Maddie Deutsch, the president of USPATH, worries that the loud voices on all sides are the extreme ones. "In our society right now, something is either all good or all bad," she says. "Either there should be a vending machine for gender hormones or people who prescribe them to kids should be put in jail."

At a hearing called by the Ohio Assembly in May, supporters testified in favor of a ban on gender-related medical treatment, called the "Save Adolescents From Experimentation Act," while opponents rallied outside the hearing-room window. One conservative activist singled out Leibowitz for attack, based on statements he has made about gender-affirming care and supporting transgender young people and their families. It felt surreal to him to hear his remarks turned into fodder for testimony about how parents were being "coerced" into agreeing to medical intervention. It was a reminder, if he needed one, that for all the care and moderation he tried to take, he would always be perceived as dangerous by the right.

The 62-page final version of the adolescent chapter, which WPATH sent me the first week of June, is scheduled to be released this summer. It will include a key change in the top-line recommendations of the SOC8, in response to advocates like International Transgender Health. In place of the December draft's recommendation of evidence of *several* years of gender incongruence before a preteen or teenager begins any medical intervention, the final chapter set a vaguer timeline: gender incongruence that is "marked and sustained over time." Below their recommendations, Leibowitz, de Vries and their committee did note that several years of experience is important for teenagers who want hormones and surgery but said that for puberty suppressants, several years was "not always practical or necessary." In the end, the chapter sided with the trans advocates who didn't want kids to have to wait through potentially painful years of physical development.

Leibowitz, de Vries and their co-authors held their ground on assessments. The final version of their chapter said that because of the limited long-term research, treatment without a comprehensive diagnostic assessment "has no empirical support and therefore carries the risk that the decision to start gender-affirming medical interventions may not be in the long-term best interest of the young person at that time."

"Sometimes I feel that the field is so polarized that I worry whether the guidelines will be followed — how much authority will they have?" de Vries said of the upcoming publication of the chapter. "But I think a sensible reader will read a very nuanced, thoughtful approach that will help those who really need it."

In the run-up to the release of the final SOC8, Leibowitz couldn't imagine a more nerve-racking moment to make the guidelines public. In early June, the administration of Gov. Ron DeSantis of Florida asked the state's health department essentially to ban gender-related medical care for minors — and in addition, to lay the groundwork to take that care away from trans *adults* with a report that justified ending Medicaid coverage for them.

Leibowitz said he hoped the SOC8 would improve the quality of care. He knew it wouldn't settle the larger debates about how well teenagers know themselves and how parents and professionals should respond to them. "It's convenient to say there's not enough evidence if you *don't* believe in the treatment — and that there's enough evidence, if you *do* believe," Leibowitz said. The clinical experience he had, seeing kids every day, was uppermost. "Evidence matters, yes, but common sense matters, too."

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