



PERSPECTIVES

Psychodynamic psychotherapy for gender dysphoria is not conversion therapy

Joanne Sinai MD, MEd¹; Peter Sim BA, LLB²

Abstract

Over the last ten years, there has been a substantial increase in the number of children and adolescents referred to gender clinics for possible gender dysphoria. The gender affirming model of care, a dominant treatment approach in Canada, is based on low quality evidence. Other countries are realizing this and making psychosocial treatments and/or exploratory psychotherapy a first line of treatment for gender related distress in young patients. Psychodynamic (exploratory) psychotherapy has established efficacy for a range of conditions, and has been used in youth and adults with gender dysphoria. In Canada, the adoption of psychodynamic psychotherapy for gender dysphoria is impeded by some academics who argue that it may violate laws against conversion therapy. Psychodynamic psychotherapy is not conversion therapy and should be made available in Canada as a treatment modality for gender dysphoria.

Key Words: *gender dysphoria, transgender children, transgender youth, conversion therapy, psychodynamic psychotherapy for gender dysphoria, gender affirming care, informed consent, autonomy, evidence-based treatment*

Mots clés: *dysphorie de genre, enfants transgenres, jeunes transgenres, thérapie de conversion, psychothérapie, psychodynamique pour la dysphorie de genre, soins d'affirmation de genre, consentement éclairé, autonomie, traitement fondé sur des preuves*

Introduction

The rapid growth in the number of children and adolescents seeking medical treatment for gender dysphoria (GD) has given rise to an intense debate on appropriate treatment. The dominant treatment model in Canada is the gender affirming model of care (1). After a child or youth declares their new gender, they may socially transition (e.g. new name, pronouns and clothing). Medical transition can begin after the onset of puberty at Tanner stage 2 with puberty blockers (PBs). PBs are medications which prevent the physical changes of puberty. Older teenagers and adults may receive cross sex hormones (CSHs) to promote the

development of physical features consistent with their gender identity. A final stage may be gender-affirming surgery. In Canada, surgery on the reproductive organs is not performed until after age 18, but mastectomies may be performed on younger patients (2).

Psychotherapy plays little or no role in the gender affirming model. In Canada, psychological assessment prior to hormonal therapy is typically minimal. Only 4 of 10 pediatric gender clinics in Canada require a psychiatry or psychology assessment prior to initiating PBs or CSHs, 1 clinic sometimes does and 5 do not (3). A study by TransYouthCan reported that 62% of children referred to one of the 10 major

University of British Columbia, Victoria, British Columbia ²Winnipeg, Manitoba

Corresponding E-Mail: Joanne.sinai@ubc.ca

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gender clinics in Canada were prescribed hormones on their first visit (4).

Evidence of benefit for the gender affirming model is weak (5–7). Systematic reviews have consistently found that the evidence that hormonal treatment for GD leads to improved mental health is low quality (8–18). Based on these reviews, national health agencies in Sweden (19) and Finland (20) have adopted treatment guidelines which make psychosocial interventions such as psychodynamic psychotherapy (PP) the first line of treatment for GD. National health authorities in Norway (21) and Denmark (22) are moving in the same direction. France (23) has also supported greater reliance on psychotherapy. Australia and New Zealand have stated “Psychotherapy is not conversion therapy” and that psychosocial interventions including psychotherapy could be part of a treatment plan (24). In the United States, the debate has been split on partisan lines, with over 20 states banning medical transition of minors (25). In England, the final report of the Cass Review took close to 4 years and included 1000’s of interviews and 7 new systematic reviews (14–18,26,27). It recommends a holistic approach to gender-related distress which emphasizes psychological assessment and support. England has now banned the use of PBs in public clinics for new patients unless prescribed under a research protocol (28).

Canadian law on conversion therapy

In Canada, the debate has been more muted, and one of the reasons may be legislation against conversion therapy. Section 320.1 of the *Criminal Code* of Canada (29) prohibits any practice intended to change a person’s gender identity to cisgender, change sexual orientation to heterosexual or repress or reduce a non-cisgender gender identity or non-heterosexual attraction. The law exempts services which relate “to the exploration or development of an integrated personal identity” and which are not based on the assumption that one gender identity or sexual orientation is preferable to another (30). The scope of both the prohibitions and the exemptions is uncertain. The application of the law depends on how judges will interpret concepts like development of an integrated personal identity.

The problem of uncertainty is exacerbated by activists, professionals and academics who promote a definition of conversion therapy that interprets the prohibitions in the law broadly and the exemptions narrowly. One of the more active proponents of this view is Florence Ashley (31).

Ashley proposes a definition of conversion practices that goes far beyond a reasonable interpretation of the language of the statute. According to Ashley, conversion practices

include not only direct attempts to change a person’s gender identity or gender expression, but any form of psychotherapy that examines possible causes of a person’s gender-related distress or leads to any delay in medical transition. Under this definition, almost any departure from a strict affirmative approach would be a “conversion practice”:

“Transgender conversion practices aim to alter, discourage, or suppress a person’s gender identity and/or desired gender presentation, including by delaying or preventing gender transition. Conversion practices are heterogeneous and wide-ranging. They include not only wanting to help individuals “reconcile with their natal body,” but also attempts to identify the cause of the person’s expressed gender — including under the pretext of gender exploration — pursuant to the belief that it may be caused by social contagion, trauma, mental illness, internalized homophobia, and flight from womanhood. Tying together these heterogeneous practices is the belief that transitude — being trans — is suspect, and that cisgender identities are more desirable, legitimate, or authentic” (32).

Ashley uses the term “conversion practice” rather than “conversion therapy” which creates uncertainty over whether Ashley is referring to conversion therapy under the *Criminal Code*. However, information sheets published by Egale Canada, with the financial support of the Canadian Department of Justice, propose a definition of conversion therapy which is similar to Ashley’s (33).

Psychodynamic Psychotherapy for Gender Dysphoria (PPGD)

PP has been found to be an effective treatment for a range of conditions (34). The Gender Exploratory Therapy Association (now Therapy First) published *A Clinical Guide for Therapists Working with Gender-Questioning Youth*. The guide explains the basic principles of PPGD (35). PPGD is open to a range of outcomes and does not claim to either encourage or discourage medical transition. It treats gender related distress, like any other form of distress, as something which emerges in a context which must be explored and understood. While there are no studies which provide direct evidence that PP is an effective treatment of GD, there is evidence that PP is an effective treatment for a range of conditions which are often associated with gender related distress (36,37). Psychologist and psychoanalyst Lemma, who has treated patients with GD for over a decade, asserts, “I am clear that children and young people in particular are not helped by only being validated and affirmed in their self-certified gender without adequate psychological exploration” (36).

A recent article by D'Angelo entitled “*Supporting autonomy in young people with gender dysphoria: psychotherapy is not conversion therapy*” outlines that PP and other psychotherapies have been applied in children and youth where there is distress about the body and sense of identity and are considered safe and effective treatments (38). In addition, he points out that those who equate PPGD with conversion therapy do not understand the process of psychotherapy. Under the gender affirmation model, the lack of psychological exploration may compromise the understanding of the self, compromise autonomy and thus compromise informed consent. On the other hand, PP can empower youths to make decisions that are fully informed (38).

A recent case controlled study using the Finnish register from 1996-2019 had 3665 people with GD who presented to their gender identity services (GIS), and described increases in psychiatric morbidity over time in those presenting to the GIS. Whether or not they had sought medical transition, the GD group had higher psychiatric morbidity than the controls. In fact, those who medically transitioned had a higher rate of accessing specialist-level psychiatric care compared to those with GD who did not transition (39).

While the evidence supporting PP is generally low quality, the risk to benefit ratio is positive. The World Health Organization standards for guideline development permit treatments to be recommended based on low quality evidence where the risk is low and alternative treatments are also supported only by low quality evidence and have higher risks (40). Detransitioners have reported that they did not have the opportunity to explore and understand their GD prior to transition, and many realized distress was not primary but secondary to other mental health issues (38).

Strength of evidence for the efficacy for pharmacological and psychotherapeutic treatment of depression in children and youth has been found to be low overall (41) but it differs with regards to the risk of harm compared to gender affirming treatments. For example, selective serotonin reuptake inhibitors have a risk of withdrawal but symptoms are reversible, typically self limiting and not life threatening (41-43).

The effects of PBs and CSHs are frequently not reversible and have lifelong consequences. These effects include permanent changes to the body (44), sterility (45,46), inability to breastfeed (47), vaginal atrophy (48), decreased bone density (49-54) and multiple mental health issues (55,56). Both phalloplasty (57) and vaginoplasty (58) have high complication rates which can lead to urological and sexual problems and chronic pain. The systematic review for depression made note of the fact that there was no evidence of harm from psychotherapy (41). Because of the high risk

of harm associated with medical transition, we think that there should be a higher bar for medical transition and that psychosocial treatment including PP should be offered first line.

Critique of PPGD

Ashley's critique of PPGD is based on a concept of “transitude” or “transness” which is a subjective construct. Transgender identity, according to Ashley, is something that exists independently of GD or any developmental process. It is something which transgender people simply know and cannot be questioned or understood by another. Ashley incorporates the idea of “shared wisdom” of the transgender community that gender identity is stable (32). This shared wisdom appears to be primarily an ideological perspective of Ashley and a group of like-minded people. It has no basis in medicine, neuroscience or psychology. It ignores the diversity of opinion among transgender persons as well as evidence that GD may resolve with or without treatment (59,60).

Why is PPGD not conversion therapy?

Because PPGD does not have the intention of purposely changing a patients' gender identity, it should not be considered conversion therapy within the *Criminal Code* definition. However, it does recognize that gender identity is often fluid and may change during therapy. PPGD may help elucidate patients mislabeling internal experiences as gender dysphoria, when they may represent something else. The vagueness of the law, coupled with the expansive view of conversion therapy promoted by Ashley and others, has a chilling effect. In Canada, there are no judicial decisions interpreting the law and no therapist wants to be the defendant in the first test case. A therapist must balance their responsibility to explore all of the factors which may be affecting a patient with the risk of a complaint of practicing conversion therapy (61). Psychotherapy sometimes requires a therapist to direct clients to the very issue they have been avoiding, bringing the unconscious to the conscious. This may cause the client discomfort and distress. As a result, rather than exploring the uncomfortable feelings, the risk is that patients may act out and accuse the therapist of practicing conversion therapy.

Ashley does not directly address the question of whether PPGD is included in the ban on conversion therapy under Canadian law but instead equivocates by substituting the term “conversion practices” and arguing that these practices are unethical (62). Ashley attempts to link PPGD with conversion therapy for sexual orientation (62). However,

there are substantial differences between the now discredited practices which attempted to change sexual orientation, and PPGD (7,63,64).

Does PPGD violate principles of therapeutic neutrality and patient autonomy?

Ashley's main argument is that PPGD violates the principles of therapeutic neutrality, patient centered care and loving attention by refusing to centre patient perspectives and looking for underlying causes of gender identity (62). *"Loving attention" is defined as perceiving someone "on their own terms; in other words, when their cares, concerns, needs, desires and self conception are salient, rather than the cares, concerns, needs and desires of the perceiver"* (65). Ashley may not be aware that psychotherapy is a process of shared decision making in which the therapist ("perceiver") guides the patient in exploration of their material but does not input their own beliefs or ideas. Thus, the therapeutic process, including PPGD, is consistent with therapeutic neutrality, patient centred care and loving attention.

Ashley also claims that psychological assessment prior to hormone therapy is "dehumanizing," and argues:

"By requiring that trans people submit to an assessment of gender dysphoria instead of satisfying themselves with the patient's affirmations, physicians deny the authority trans people have over their own mental experiences, an authority that should be granted to everyone by virtue of being persons." (66)

As they are not a therapist, Ashley may have a limited understanding of the role of therapists in assessing and diagnosing mental health conditions. Therapists should listen respectfully to a patient's self-reported symptoms but conduct further inquiries to arrive at an understanding or a differential diagnosis based on these symptoms (67).

Psychotherapists, in Ashley's view, are interested in potential causes of GD because they see transgender identity as something pathological which needs to be treated. Contrary to Ashley's view, psychodynamic psychotherapists see gender identity as something complex which may need exploration to be understood (35,68–71). Once the various causes of a patient's distress, of which GD may only be a part, are elucidated, treatment can proceed. This may include psychotherapy and/or psychiatric medication and may or may not include medical gender transition. For example, gender dysphoria could be related to a history of sexual abuse and/or internalized homophobia. PP could help elucidate how underlying factors such as these could be experienced as

GD, and the GD could resolve with ongoing treatment. In this case, a patient entering therapy with a desire to medically transition may choose not to pursue this. Other clients may have persistent GD even with PP and go on to medical transition.

According to Ashley, *"it is crucial to realize that most individuals who enter into a clinical relationship because they are trans or experience GD do so for the express purpose of securing access to gender affirming care..."* (62). Psychodynamic psychotherapists realize the ethical dilemmas this creates. Respect for patient autonomy does not mean that a clinician must provide whatever treatment a patient desires, such as an antibiotic for a viral infection. Clinicians have ethical and professional obligations to do their own assessment to create a biopsychosocial formulation and/or differential diagnosis that can then be used to guide treatment recommendations. The clinician is not treating the patient for "being transgender" but for a clinical condition, which may be gender dysphoria as described in the DSM-5-TR (72), or something else. In all cases, the proposed treatment(s) should be based upon the best available evidence and do more good than harm. The patient has autonomy in choosing between treatment options recommended by a clinician or choosing no treatment at all, but is not entitled to self-diagnose and demand a particular treatment (73).

PPGD does not regard medical transition as inherently suspect or undesirable, as Ashley suggests, but as something that is not universally helpful. Medical transition may have irreversible consequences (44–74); hence, a robust informed consent process is required (67,75,76).

Failure to offer PPGD impedes informed consent

Informed consent requires that the patient understands all of the effects of the treatment and any alternative diagnoses and treatments (76). Because the affirmative approach impedes clinicians from making a differential diagnosis or discussing psychotherapy as an alternative to medical transition, the patient's consent is not fully informed. A critical element of informed consent is that the patient understands their own motives for seeking treatment. In the case of a physical ailment with a clear diagnosis and limited treatment options, such as acute appendicitis, informed consent is a relatively straightforward process. However, where the distress being treated is primarily psychological, patients may have both conscious and unconscious motives. A decision driven by unconscious motives the patient cannot access or understand is not truly informed. Psychotherapy is integral to bringing unconscious motives to the surface so that patients can reflect and make an informed choice (77).

Are children able to consent to gender affirming treatments?

Ashley does not draw any distinction between children, adolescents or adults and argues that the young people should be the primary decision makers regarding gender affirming care (78). This reveals a limited understanding of child development. The reason that there are laws which set minimum ages for drinking alcohol, driving cars and consenting to sex with adults, is that societies recognize that young people require protection from harm because they have not yet developed the necessary capacity for good judgment. The human brain continues to develop well into the 20's and the prefrontal cortex, the part of the brain that regulates risk assessment and long-term decision making, is among the last to fully develop (79).

Canadian law on the capacity of minors to consent to medical treatment developed in the context of a medical model where the minor is guided by a doctor who does an assessment, then makes a differential diagnosis and treatment recommendations (80). The affirmative model substitutes self-diagnosis and self-directed treatment. This is problematic for adults and dangerous for children and adolescents (75). Jorgenson, Athéa and Masson argue that decisions on a child's capacity to consent to treatments should consider the child's right to an open future. Children and adolescents should be protected from making decisions which may foreclose future options when the child is a fully developed adult, such as having a satisfying sexual relationship and children (81).

Is the failure to engage in PPGD contributing to growing rates of regret and detransition?

Detransition is the process where people with GD who have undergone medical or surgical transition choose to revert back to identifying as their natal sex. This generally involves stopping PBs or CSHs and hoping that the normal physiological processes will resume. Those who had gonadectomies will need exogenous same sex hormone treatment. Natal women who had mastectomies may choose to have breast implants to replace the breasts they lost, and natal men may choose to have removal of breast tissue and/or breast implants. Vaginoplasties and phalloplasties are irreversible. Those who socially transitioned only and revert to their identifying as their natal sex are referred to as desisters.

Ashley disregards the growing number of detransitioners who found that gender affirming care did not meet their mental health needs and are now coping with the consequences of permanently altered bodies (55,56). Ashley

dismisses regret and detransition as rare, pointing to studies which found regret rates of less than one percent (62,82–86). These studies have multiple limitations, which include restrictive definitions of regret, short follow up periods and high loss to follow up (87). Further, many of these studies were of adults who transitioned after psychological assessment and therefore, may not generalize to minors or those treated under an affirmation model (74).

It is difficult to get reliable data on regret and detransition under the gender affirming model, but there is evidence that it is a large and growing problem (87). A recent British study found a detransition rate of 6.9 percent within 16 months of commencing treatment and an additional 3 percent who showed some signs of detransition (88). Another U.K. study found a rate of detransition or documented regret of 12 percent and that one in five patients stopped hormone treatment for a variety of reasons (89). A U.S. study found that 30 percent of patients did not continue hormone therapy after 4 years (90). While the prevalence of regret and detransition are unknown, the consequences are serious, and the principle of “first do no harm” dictates a cautious approach to medical transition (91). As noted above, even after stopping CSHs, detransitioners may experience permanent changes to their bodies and multiple health conditions.

What changes are needed in Canada?

People experiencing GD deserve access to treatments based on the same principles of evidence-based medicine that are applied in other fields of medicine. Countries which have accepted the results of systematic reviews are abandoning sole reliance on the gender affirmation model, are beginning to limit gender affirmation treatments in children and youth, and are adopting psychosocial treatments such as PPGD as treatment options (11,19–21). For example, treatment guidelines in Finland and Sweden only allow for the use of puberty blockers and cross-sex hormones in minors under research conditions (19,20).

Canada has poorly drafted legislation on conversion therapy which conflates sexual orientation with GD. Ashley and their supporters are taking advantage of the vagueness of the law to promote the inaccurate idea that PPGD is a form of conversion therapy. In widening the parameters of what is considered conversion treatment, Ashley and their supporters end up narrowing the parameters of sound mental health care. For example, clinicians anxious about being charged under the *Criminal Code* may be reluctant to offer PPGD or any type of psychotherapy. PPGD could still affirm a sense of self as the experienced gender, but would

involve a complete exploration of the conscious and unconscious factors that are a part of this.

Professional organizations and public health authorities need to reject the mischaracterization of PPGD as conversion therapy. New guidelines which promote a wider understanding of the etiology of GD and question the unverifiable concept of “transitude” need to be created. It is essential that PPGD be considered as an ethical and evidence-informed option for treatment.

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