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GENDER DYSPHORIA IN ADOLESCENCE AND THE MODELS OF CARE: A SYSTEMATIC LITERATURE REVIEW

Arnold Briseno

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A Project

Presented to the

Faculty of

California State University,

San Bernardino

In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

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by

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ABSTRACT

This systematic literature review examines and compares the efficacy of gender-affirming care and mixed-method approaches in treating adolescents with gender dysphoria. Through a detailed analysis of existing empirical studies, the research aims to identify optimal strategies that support the mental health and well-being of adolescents who are exhibiting criteria of gender dysphoria. The findings suggest a nuanced landscape where gender-affirming and mixed-method care models offer valuable benefits, highlighting the importance of individualized and flexible treatment approaches. This work contributes to the ongoing discourse on adolescent mental health care, advocating for policies and practices that prioritize the needs of this population, thereby encouraging a more inclusive and supportive healthcare environment.

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DEDICATION

May truth always triumph over ideology.

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CHAPTER ONE

PROBLEM FORMULATION

Introduction

Gender dysphoria (GD) is a medical term used to describe the psychological distress experienced by individuals whose gender identity differs from the sex they were assigned at birth, causing significant discomfort or dissatisfaction with their own body or assigned gender role. According to the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5-TR; American Psychiatric Association, 2022), the diagnostic criteria for gender dysphoria in children, F64.2, is “marked by incongruence between one’s experienced/expressed gender, of at least 6 months’ duration, as manifested” by at least two criteria which include a strong desire to be the other gender and a strong desire to be treated as the other gender (p 512). A few ways it begins to manifest in children are through cross-dressing, playing with toys of the opposite sex, affirming the desire to be part of the opposite sex, and preferring playmates of the opposite sex (Adelson, 2012). Gender dysphoria is tied to early patterns of gender nonconformity when the child expresses discomfort, frustration, and anger at the gender role they have taken on based on their biological sex (Risotri, 2016). Previously, gender dysphoria was referred to as gender identity disorder (GID) until it was renamed gender dysphoria in the American Psychiatry Association's Diagnostic and Statistical Manual of Mental Disorders, fifth edition

(DSM-V, 2013). The change redefined it from a mental disorder to mental distress and remained in the DSM-V-TR, 2022. The DSM-V aimed to remove the stigma by changing the term "disorder" to "dysphoria" to respect the individual and provide more appropriate treatment methods.

Standards of Care

Before exploring the models of care for treating gender dysphoria, it is vital to know the basic standards of care that have been agreed upon by science and expert professional consensus. The World Professional Association for Transgender Health (WPATH) developed an international clinical protocol called the Standards of Care for the Health of Transgender and Gender Diverse People (SOC) that outlines the assessment and treatment of transgender individuals. These Standards of Care were first published in 1979, with the most recent edition published in 2022. Chapter seven of the SOC has guidelines for children and cites much of the research presented in this literature review. In addition, fifteen recommendations include health care professionals receiving "theoretical and evidenced-based training" as well as providing information to gender-diverse children and their families with information about medical interventions as the child approaches puberty. The fifteen recommendations/statements are accompanied by data (Coleman, 2022).

Models of Care

As more gender clinics open across the United States, the topic of gender dysphoria and the questions of care arise. This literature review will focus on two models of care.

The gender-affirmative model is based on the idea that gender identity is a core aspect of a person's self-identity and that the goal of treatment is to help the individual affirm their gender identity. The gender-affirming model supports the use of social and medical interventions, such as hormone therapy, puberty blockers, and gender-affirming surgeries. These methods help the individual experiencing gender dysphoria feel more comfortable in their bodies. The gender-affirmative model of care includes social transitioning, using preferred pronouns, and encouraging children to dress in their preferred clothing (Ehrensaft, 2017).

The other model of care is the watchful waiting model, a well-known approach to medical treatments that supports physical transitioning but first takes an observational approach when the risks of treatment are more significant than the possible benefits. This "wait and see" approach gives time to the individual to explore their gender identity without interventions and to ensure that any treatment provided is appropriate and not harmful (Zucker, 2012). This model does allow the introduction of puberty blockers to prolong a child's ability to explore their gender identity. However, in this model, it is advised to hold off on social transitioning until after puberty. The watchful waiting model involves

regular monitoring by a mental health professional to track the individual's gender identity development and to determine if it will be diagnosed as gender dysphoria. If the child's expression of gender dysphoria persists after puberty, then this model takes the approach of easing the transition for the child through social transition, puberty blockers, and later surgeries (de Vries, 2012).

Another view of treating gender dysphoria in adolescence completely rejects the idea of care to support a person's gender transition. This view is frequently rooted in a religious or moral stance. It posits that children should not be treated through any model of care listed above and that gender dysphoria can be prayed away or outgrown with strict discipline; this is not a care model and will not be addressed.

Overview

As the number of youths who identify as gender nonconforming or who are diagnosed with gender dysphoria increases, social workers and other professionals who work with them will need access to effective interventions to provide appropriate care. Therefore, it is crucial to understand the different care models, the scientific literature, and ongoing conversations between researchers. Which model is the best? As this issue becomes a mainstream debate, we have seen a deluge of legislation across the United States targeting aspects of gender-dysphoric care concerning adolescents. The treatment and care of gender dysphoria is necessary; research shows that if left untreated, it can have a detrimental effect on children and even prove fatal to some (Aitken, 2016).

Legislation across the United States is blurring the lines between healthy gender expression and gender dysphoria. As bills continue to be passed, it becomes increasingly clear that information is being misunderstood. We must differentiate between healthy gender expression, which we know is typical behavior in adolescence, and gender dysphoria, which proves distressing (Martin, 2010).

The issue becomes more complicated for children in state-controlled care. For example, in California, Assembly Bill 2119 states that all foster care minors will have access to gender affirming-health care and mental care, but that is not the case in every state (AB 2119, 2018). Moreover, the ongoing scientific and political community feuds regarding which model is best to care for gender issues can spill into legislation that ultimately affects youth experiencing gender dysphoria, where clinicians and social workers will be directly affected.

The findings of this study will present the literature regarding youth who present with gender dysphoria and models of care to address it, ranging from medical processes to social processes. Presenting a full scope of literature regarding all facets of this issue will allow social work practitioners to understand the models and incorporate them into their approach to working with adolescents experiencing possible gender dysphoria, whether out in the field, in a clinical setting, or in drafting legislation and policy about gender dysphoria and similar issues related to gender.

CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter explores various therapy and care models for addressing gender dysphoria, a condition characterized by a persistent and distressing misalignment between one's gender identity and assigned sex. Specifically, it examines the current trend among medical professionals toward gender-affirming care, the lack of research in this field, and the methodological challenges in obtaining relevant data. The aim is to critically analyze the strengths and weaknesses of the research done on each model, excluding approaches rooted in religious or moral objections. These models are discussed within the context of social work and their implications for practitioners working with gender-nonconforming youth who show signs of possible gender dysphoria.

Two models are particularly relevant for understanding and intervening with gender dysphoric youth, and they greatly influence the work of social workers in this domain. To evaluate their effectiveness in supporting gender dysphoric youth, this study will systematically review the existing literature on these models.

Gender-Affirmative Care Model

The gender-affirmative model is currently the most widely accepted practice addressing gender dysphoria. Gender-affirming care focuses on a

supportive form of healthcare for an individual with gender dysphoria. Affirming care includes social transition, puberty blockers, hormone therapy, and gender-affirming surgeries. For children, this means encouraging them to dress up as their preferred gender, using pronouns that align with their gender identity, and changing their name to one that is more gender-affirming (HHS OPA, 2022). The basis of gender-affirming care is that the child forges their path. Adults in these children's lives encourage these changes and modify their behaviors, attitudes, and surroundings to accommodate the child with gender dysphoria.

The gender-affirming model aims to listen to the child and understand their communication with parents and caregivers to improve understanding and strengthen support as they socially transition, including using chosen pronouns, changing their name, and other changes. This model affirms gender and aims to alleviate distress, improve well-being, and enhance quality of life. Those who advocate for this model argue that children who are not allowed the freedom to express their identity risk developing depression, self-harm, and isolation, among other things (Tordoff, 2022).

In practice, gender transition is an individualized process without a set roadmap. One often begins with self-reflection, connecting with others experiencing the same feelings, or working with a gender-affirming therapist. The University of California, San Francisco published a "transition roadmap" covering essential aspects of the process with three questions: "1) Am I transgender/gender non-binary/gender diverse? 2) What exactly is my gender

identity? 3) How can I develop the needed coping skills, resilience, and social support to help me through transition and to cope with a world that can be biased against or even dangerous for transgender and non-binary people?" (UCSF, n.d.). The roadmap also offers a guide to obtaining behavioral health evaluation, hormone therapy, social transitioning, and medical and surgical transition.

The Watchful Waiting Model

The watchful waiting model is a universally known approach to medical issues that allows time to pass before medical intervention or therapy is used. It adopts a cautious approach, emphasizing observation, exploration, and supportive counseling.

This model encourages parents to continue to build a safe environment for their children with limits. An example of these limits would be striking a deal with a biological male child to avoid wearing dresses in public to avoid aggression from others but to allow the child to wear dresses at home. "The child will, thus, sometimes be frustrated and learn that not all of one's desires will be met. The latter is an important lesson for any child, but even more so for children who will have a gender reassignment later in life" (de Vries, 2012, p. 309).

The watchful waiting model also addresses treatment for non-GD problems that could arise in assessments, such as psychiatric issues or conflicts within the family. The watchful waiting model does not encourage medical treatment for gender dysphoria for children under the age of 12 because

cognitive and emotional maturation is desired when undergoing physical medical interventions (de Vries, 2012).

The article titled “A Developmental Biopsychosocial Model for the Treatment of Children with Gender Identity Disorder” provides a thorough roadmap for assessment and treatment (Zucker, 2012). In this article, the authors explain their clinical assessment protocol, psychological testing protocols, and parent-completed questionnaires. The authors write, “In our view, gender identity development can be best understood using a multifactorial model that takes into account biological factors, psychosocial factors, social cognition, associated psychopathology, and psychodynamic mechanisms.” They give case study examples of each and explain that when treatment was recommended, it could include the following: "a) weekly individual play psychotherapy for the child; b) weekly parent counseling or psychotherapy; c) parent-guided interventions on the naturalistic environment; and d) when required for other psychiatric problems in the child, psychotropic medication.” The goal of this treatment model is to reduce the gender dysphoria that a child experiences, and the article ends by explaining that children are psychiatrically vulnerable and stressors can be involved in their atypical gender identity. However, the authors believe that other risk factors are biological, and psychosocial parameters within the family could also be related.

Theories Guiding Conceptualization

These models offer a different approach to treating gender dysphoria in children. Both models incorporate aspects of Family Systems Theory (Thompson, 2019). According to the Family Systems Theory, the family is a unique and complex social system, and each member influences other family members' behavior. Each model includes the need for family participation and examines the family as a whole. Both the watchful waiting and gender-affirming models educate the family on gender dysphoria. Regardless of which model is used to work with a child who presents with gender dysphoria, the child requires the love, support, and understanding of their caretakers and family members.

Another theory guiding the conceptualization of gender dysphoria is Erik Erikson's Stages of Psychosocial Development (Orenstein, 2022). The eight stages of Erikson's theory are Stage 1) Infancy period: Trust vs. Mistrust; Stage 2) Early Childhood period: Autonomy vs. Shame, doubt; Stage 3) Play Age period: Initiative vs. Guilt; Stage 4) School Age period: Industry vs. Inferiority; stage 5) Adolescence period: Identity vs. Identity Confusion, and stages 6 through 8 which are related to adulthood (Orenstein, 2022). Taking into consideration both Family Systems Theory and Erikson's Stages of Development, one should consider specific tasks that each stage of development brings and how issues of gender dysphoria might affect those tasks and bring added challenges to development. For example, during stages 2 and 5 in Erikson's Stages of Development, tied to autonomy, shame, doubt, and identity

and identity confusion, the struggles with gender identity can bring additional issues for a child, particularly if the child is not given support for these issues. While assessing for gender dysphoria, one should always consider developmental stages and the specific tasks that they are mastering in each.

CHAPTER THREE

METHODS

Introduction

This chapter describes the methodology of the systematic literature review on models that address gender dysphoria, including study design, data collection sources, and data analysis. It will also discuss the inclusion criteria for the literature included in this systematic review and the process used to obtain it.

Study Design

The study design is a systematic literature review of scholarly, peer-reviewed published material on gender dysphoria in adolescence and the models of care used to work with them on gender-related issues. The study was designed to examine the purpose, methods, and results of published literature on models of care used for gender dysphoric children. This systematic literature review located publications through database searches using specific criteria. The publications that met the criteria were included in the study.

Data Sources

A search was completed of peer-reviewed and empirical studies through scholarly journals, including the National Center for Biotechnology Information, American Academy of Pediatrics, Journal of the American Academy of Child &

Adolescent Psychiatry, American Psychiatric Press, Transgender Health, Journal of Homosexuality, Journal of Adolescent Health, International Review of Psychiatry. Publications were located using OneSearch, JSTOR, and EBSCO, as well as through searches using Google Scholar with specific key search terms to locate data. The key terms that were used in these search engines were gender dysphoria, gender identity disorder, gender in adolescence, gender-affirming care, watchful waiting model, gender therapy, gender nonconformity, gender development, peer contagion, and persistent gender dysphoria. The searches produced articles that were then reviewed through their abstracts and publish dates as far back as 2000 to determine if they met the inclusion criteria in the systematic literature review. The reason for including data that dates back to 2000 is due to the time it takes to conduct studies with participants over a long period, especially with children. Furthermore, there is older data relating to the watchful waiting model. In contrast, the gender-affirmative model is more recent and it was not until the Fall of 2011 that WPATH released standards of care, which explicitly stated that it is “unethical and harmful to engage in therapy that attempted to change one’s gender” (Keo-Meier, 2018, p. 4).

Data Analysis

After the searches were completed and the research for the study was selected, all the articles were saved on Zotero. This open-source reference management software manages bibliographic data and research materials to

track the data collected in a central repository. The studies that were selected for the literature review were divided into different categories that pertained to the different models of care, child development, gender dysphoria, gender identity disorder, and studies with major surveys because gender dysphoria and the models of care are incredibly vast, it is relevant to include studies on child development. Additionally, because APA changed gender identity disorder to gender dysphoria, the inclusion of some studies will use the term gender identity disorder (GID). These categories were chosen to reflect the overall purpose of this review as it covers different aspects of child development, gender dysphoria, gender-related care, and ultimately, the data collected in studies to showcase the different models of care that can used to treat children with gender dysphoria.

Synthesis

Due to the nature of the studies and the different methodologies used, conducting a meta-analysis was not possible. While meta-analysis is a powerful statistical method to combine data from multiple studies and derive overall conclusions, it heavily relies on the availability of comparable and quantifiable data across studies. Because of the changes in naming and criteria for diagnosing what is now known as gender dysphoria, a meta-analysis is not feasible. The studies over decades differ significantly in their methodologies, interventions, and outcome measures. Because of this, a qualitative synthesis method was used, which focused on thematic analysis to organize and

summarize the available data. By categorizing the data based on the model of care tested, you can gain insights into the different approaches and their outcomes within the field of gender identity disorder (GID) and gender dysphoria (GD). This approach allows the identification of common themes, patterns, or trends within each category and assesses the overall body of literature on the different models of care.

It is important to note that categorization and qualitative synthesis methods do not provide quantitative effect size estimates like meta-analysis. Instead, they offer a descriptive and qualitative understanding of the research landscape, allowing researchers to identify gaps, patterns, and potential areas for further investigation.

Limitations and Bias

This systematic literature review explores different models of care, which may present contrasting perspectives on the WPATH Standards of Care. One limitation of this study is the scarcity of research specifically focused on gender-affirming care models for adolescents, resulting in gaps in the literature. Previous research, which used the term "gender identity disorder" before it was replaced by "gender dysphoria," provides a larger body of evidence from clinical settings and lengthier periods of adolescence assessment. To ensure a comprehensive analysis, some studies with potential bias favoring a particular model of care were included. This inclusion was necessary as newer studies primarily focus on

gender-affirming care and criticize the use of watchful waiting models. Bias was identified in recent research that attempts to refute or reject older, more extensively studied models of care. While this presents a challenge, the systematic literature review will highlight and compare these biases with the data and research the study aims to challenge.

Summary

This chapter provides an overview of the systematic literature review conducted for this study, explaining its design and process. Databases were searched using specific gender-related keywords to gather relevant articles. The selected articles' abstracts were then reviewed to determine their inclusion in the review, and they were stored in a repository for future reference. Articles that met the criteria based on the keywords were selected and thoroughly reviewed. The articles were categorized based on their content during the review process, which would be used for the subsequent analysis. The review considered the articles' purpose, citations, methodology, and whether they presented successful, failed, or inconclusive results. All the articles were retained for use, as they could provide valuable insights into the models of care explored in the literature review.

To address potential biases and gaps in the literature resulting from new research and evolving models of care, the focus was on selecting peer-reviewed articles with empirical data. However, some studies framed within a social context were also included and woven into the literature review where relevant.

These studies relied on non-scientific methods but were deemed necessary to understand the topic comprehensively. While it is important to note that bias could arise due to having only one investigator for this literature review, incorporating different models of care from various sources will help establish a clearer understanding of the subject matter.

CHAPTER FOUR

RESULTS

Introduction

This chapter presents the research outcomes, including detailed tables to explain the results. A thorough review of the literature included reviewing academic journals, various search tools, and a search engine to gather the available research on the topic. After an exhaustive search of the available literature was conducted, the studies were categorized. The categorization included the research methodology, participant sample, orientation, intervention, key findings, conclusion, control, and treatment group. Following the initial search, duplicate entries were removed, and studies of uncertain relevance were thoroughly reviewed to confirm their suitability for inclusion. Ultimately, twenty-six studies met the initial criteria for inclusion. For a complete list of these studies, refer to Appendix A. It was determined that studies that were literature reviews would not be included. However, they are located in the Appendix.

Presentation of the Findings

Methodology of Included Studies

Table 1. Methodology of Included Studies

Methodology of the Study	Number of Studies	Percent of Studies
Review of Data/Literature	14	54%
Qualitative	7	27%
Quantitative	5	19%

Of the twenty-six studies that met inclusion criteria, three methodologies were present. The majority of the studies utilized a review of literature utilizing existing studies. The literature reviews included scholarly works, data, and statistics to determine findings. Qualitative studies used interview methods to gather data. The studies that used quantitative data utilized questionaries, surveys, or outcome measurements to collect data. The least utilized methodology was quantitative. Refer to Appendix A for more information on these studies. Sample sizes range from 21 to 317.

Research on Gender-Affirming Care

Of the qualitative and quantitative studies, five met the criteria for “gender-affirming care.” Two were qualitative, while three were quantitative. The largest sample size of all five studies was 317 binary socially transitioned children, which included 208 transgender girls and 109 transgender boys (Olson et al., 2022) – it is relevant to note that this study did not assess for “gender dysphoria” based on

the DSM-5-TR criteria; parental report of cross-sex identification occurred through the use of the Gender Identity Questionnaire for Children. This qualitative study included children between the ages of 3 and 12 and had to have a complete binary social transition, including changing pronouns that differed from those used at birth.

The smallest sample size relating to gender-affirming care was 55 adults who had previously received puberty suppressants during adolescence and were assessed three times: before the start of puberty, when cross-sex hormones were introduced, and at least one year after gender reassignment surgery (de Vries et al., 2014). All participants in gender-affirming studies received some form of hormone therapy, including gender-affirming hormones, puberty blockers, and, in some cases, gender reassignment surgery.

The methodology of all five studies varied, from using questionnaires relating to beginning hormone therapy to assessments using the Wechsler Intelligence Scale for Children and various tools, including the Patient Health Questionnaire (PHQ-9), Generalized Anxiety Disorder 7 (GAD-7), Body Image Scale (BIS), Screen for Child Anxiety Related Emotional Disorders (SCARED), Quick Inventory of Depressive Symptoms (QIDS), World Health Organization Quality of Life (WHOQOL-BREF), Satisfaction with Life Scale (SWLS), and the Subjective Happiness Scale (SHS).

The key findings of all five studies were similar as they found that there was a relatively low rate of retransition, behavioral, emotional, and depressive

symptoms decreased, and general functioning improved. Other studies found that gender-affirming hormones (GAHs) and puberty blockers (PBs) were associated with 60% lower odds of moderate or severe depression and 73% lower odds of suicidality over a 12-month follow-up (Tordoff et al., 2022). Throughout all five studies, suicidal ideation and self-harming behaviors decreased. One study found that gender dysphoria and body dissatisfaction did not improve (de Vries et al., 2011).

The conclusions for all five studies differed. A study concluded that gender dysphoria did not resolve as a result of puberty suppression, but psychological function did improve (de Vries et al., 2011). Another study concluded that gender-affirming medical interventions were directly associated with lower odds of depression and suicidality over 12 months, but made no mention of improvement of gender dysphoria (Tordoff, 2022). In another study, it was concluded that hormone therapy did reduce body dissatisfaction, and modest initial improvements in mental health were evident (Kuper et al., 2020).

Research on Mixed Treatment Methods

Recent studies on mixed treatment methods for gender dysphoria incorporate both qualitative and quantitative research, with a special focus on Dialectical Behavior Therapy (DBT) as a promising treatment. The largest sample size examined a large cohort of 139 boys diagnosed before age 13, while the smallest study explored DBT with 21 adolescents (Singh, 2021; Tilley 2022). Methodologies varied across studies, employing a range of assessments from

cognitive testing to interviews and utilizing treatments like gonadotropin-releasing hormone agonists (GnRHA) and gender-affirming healthcare (GAH).

The prevalence of gender dysphoria and its persistence into adolescence was a focal point of these studies. One study highlighted an unexpectedly high rate of long-term gender dysphoria among girls, while another found a low persistence rate with a higher occurrence of bisexual/homosexual orientation compared to the general population (Drummond, 2008; Singh, 2021). The DBT study found its effectiveness in managing the stress associated with gender dysphoria, advocating for modifications to better cater to the needs of youth (Tilley, 2022).

Critical developmental changes that occur between ages 10 and 13 were addressed in two studies. Both noted the impact of social circle shifts, varied reactions to puberty, and differing experiences of romantic attraction (Steensma, 2011; Wallien 2008). These studies distinguished between those who persist in their gender dysphoria, leaning towards friendships and relationships that reinforce their gender identity, and those who desist, often aligning with their biological sex as they grow older.

Two studies delved deeper into the predictors of persistence in gender dysphoria, identifying the intensity of dysphoria in childhood and the likelihood of persistence in natal girls as significant factors while finding that psychological health and social relationships were not as indicative (Steensma, 2013; Beckery-Hebly, 2021). These findings were mirrored by interventions showing that,

although gender-affirming medical procedures can improve psychological outcomes, they do not necessarily resolve gender dysphoria itself.

The research underscores the need for personalized and age-specific clinical approaches, especially in girls, given the high desistance rates observed (Drummond, 2008). It also stresses the potential benefits of treatments like DBT. It highlights the necessity for clinicians to be attentive to the complex nature of gender dysphoria during the pivotal developmental window of early adolescence. These insights emphasize the importance of nuanced, individualized care for children and adolescents experiencing gender dysphoria, taking into account each individual's unique experience and the intensity of their dysphoria.

Literature Reviews

In Appendix A, there is a list of literature reviews that were not assessed as they do not contain original research. They have been included for readers to reference. Many of these literature reviews cite the previous qualitative and quantitative studies and show a common thread relating to each model of care. They are limited to the English language.

Summary

This chapter synthesizes the outcomes of twenty studies on gender dysphoria, utilizing diverse methodologies, such as literature reviews (52%), qualitative interviews (28%), and quantitative research (20%), with varying sample sizes from 21 to 317 subjects. The research spotlights gender-affirming

care, where five studies, a mix of qualitative and quantitative, noted improvements in psychological functioning and decreased emotional and behavioral issues following gender-affirming treatments, including hormones and surgery. However, these interventions did not consistently address the core issue of gender dysphoria. Additionally, the research highlights a critical developmental phase between 10 and 13 years, with gender-affirming medical interventions associated with better mental health outcomes. However, further evidence is needed to generalize these findings. The studies collectively emphasize the complexity of gender dysphoria treatment, revealing that while some interventions improve overall well-being, the nuanced nature of gender dysphoria and its persistence suggests that a cautious and individualized approach in clinical settings is imperative.

CHAPTER FIVE

DISCUSSION

Introduction

This chapter synthesizes the findings of the systematic literature review on models of care for gender dysphoria in adolescence, exploring how these findings align with initial expectations and the existing body of literature. It seeks to enlighten the comparative effectiveness and implications of gender-affirming care versus mixed-method approaches and offers insights into best practices for supporting gender dysphoric youth.

Discussion

Purpose

The primary purpose of this research was to evaluate the efficacy and implications of various models of care for gender dysphoric youth, aiming to provide a balanced perspective that acknowledges the value of both gender-affirming strategies and other therapeutic interventions. This exploration is crucial for informing social work practice, policy-making, educational programs, and future research directions.

Alignment with Expectations

The literature review began with the expectation that, based on the current treatment trends to utilize gender-affirming models of care, there would be

significant research supporting this model over any other model of practice. This expectation was the starting point based on the hyperbolic approach by the scientific community in championing gender-affirming care. The systematic review did not confirm this and, instead, revealed a landscape where no single model of care universally outperforms others, underscoring the necessity for a nuanced, individualized approach. The findings of the study show that there is a need for more research.

It is crucial to re-emphasize that not every child who expresses gender nonconformity is experiencing gender dysphoria. In the introduction to this literature review, the term “gender dysphoria” was clearly defined along with the DSM-5-TR diagnostic criteria for diagnosing gender dysphoria.

Implications for Social Work Practice

Social work practitioners are encouraged to adopt a flexible approach, integrating a spectrum of supportive strategies to meet the diverse needs of gender dysphoric youth. This involves advocating for access to comprehensive care options and ensuring services are inclusive and respectful of all gender identities. Social workers should not take a stance on one model of care over the other. Currently, research does not lead to a definitive stance on the best model of care for children and adolescents with gender dysphoria, so when it comes to treatment, we should not choose one over the other and instead discuss all the options with our clients. Social workers should empower clients through education by explaining each model of care to parents and clients. Social

workers should be prepared to have conversations with parents and children regarding the models of care like “wait and see” to explore underlying issues that could be a driving force of the distress the child feels or dive into the gender-affirming model of care. It is the responsibility of the clinician to educate the parent and client and allow them to choose.

Implications for Policy

Policymakers should take a more cautious approach to championing one model of care over another. This literature review and others on this topic make it increasingly clear that there is a need for more research on various models of care. As we are witnessing, policies can negatively impact public perception by pushing aside models of care that use a more therapeutic approach over models that take the medical and surgical intervention route. Policymakers should encourage ongoing research on interventions for persons with gender dysphoria and should encourage research from a variety of perspectives. We are still unaware of the long-term effects that the gender-affirming model will have on the youth receiving it.

Implications for Training and Education

Training programs for social workers and healthcare providers must emphasize the importance of understanding gender-affirming care and mixed-method approaches. This includes preparing practitioners to assess individual needs and make informed decisions regarding the most appropriate care model for each gender-dysphoric youth.

The National Association of Social Workers offers no information regarding a Mixed-Methods practice, and a search through their website with the keyword “Gender Dysphoria” results in articles such as “Gender Identity Disorder and the DSM,” which calls for the elimination of gender dysphoria as a mental health diagnosis from the DSM (National Association of Social Workers [NASW], n.d). The second article that appears in the search is “Gender-Affirming-Care-Myths-and-Facts,” which focuses on “debunking myths” about gender-affirming care and claims that puberty blockers “are both temporary and fully reversible” (National Association of Social Workers [NASW], n.d.).

We cannot properly train and educate social workers and the public when a National Association with over 120,000 members comprised of social workers takes a stance on a specific care model without considering the lack of research and implications.

Implications for Research

This study highlights the need for further empirical research to directly compare the outcomes associated with different care models. Future studies should explore these models' long-term effects, providing evidence-based guidance for clinicians, social workers, and policymakers. There is currently a clear bias in both the scientific community and the humanities that positions gender-affirming care as the gold standard. However, the evidence found in this study was not conclusive for any model.

Ethical Concerns of Gender-Affirming Care Research

One study on gender-affirming care championed by the University of Washington and the Seattle Children's Hospital was concerning. The study, published in JAMA Network Open titled "Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender Affirming Care," claims that gender-affirming care, including PBs and GAHs, is associated with 60% lower odds of moderate or severe depression. Publicity material was published and pushed, with the University of Washington producing video material to accompany the study. However, such a claim should not have been made to generalize the population because the supplemental material included in the study paints a different picture. From baseline to the final phase of data collection, there is not much improvement as the study claims, and this can be found in the study's supplemental material eTable 2, "Prevalence of Exposure Over Time," and eTable 3, "Prevalence of Outcomes Over Time by Exposure Group."

Table 2. Prevalence of Outcomes Over Time by Exposure Group

eTable 3. Prevalence of Outcomes Over Time by Exposure Group								
Time Point:	**Baseline**		**3 Months**		**6 Months**		**12 Month**	
Exposure:	*PB/GAH*	*None*	*PB/GAH*	*None*	*PB/GAH*	*None*	*PB/GAH*	*None*
N	7	92	44	38	59	24	57	6
Outcomes (no.,%)								
Moderate to Severe Depression	4 (57%)	54 (59%)	24 (55%)	29 (76%)	33 (56%)	13 (54%)	32 (56%)	5 (83%)
Moderate to Severe Anxiety	4 (57%)	47 (51%)	23 (52%)	23 (61%)	28 (48%)	10 (42%)	29 (51%)	4 (67%)
Self-harm or Suicidal Thoughts	3 (43%)	41 (45%)	13 (30%)	21 (55%)	25 (42%)	11 (46%)	21 (37%)	5 (83%)

(Tordoff, 2022)

An analysis of the study raises concerns about why and how researchers would make such claims. Nearly half of the participants dropped out and were not taken into account. Research needs to be clear in its findings, and studies such as this one should not be used as evidence to support this model of care.

Mixed Methods Research

As the scientific community and the humanities continue to portray gender-affirming care as the gold standard for children experiencing possible gender dysphoria, it is essential to look at mixed methods that use a watchful waiting model, which includes more therapy to determine if there is underlying trauma or comorbidities that are contributing to the child's belief that they are gender dysphoric.

In a study that used the watchful waiting model of care and considered the role of parents, a case study was presented of a three-and-a-half-year-old boy named Ben, whose relationship with his mother drastically changed when his baby sister was born. Before the birth of Ben's sister, the mother would make comments like, "If something ever happened to Ben, I would kill myself. I could not live without him. He is part of me, and I am part of him." She was an anxious woman who had trouble with separation. When Ben's sister was born, he experienced displacement and jealousy. The child also claimed that he wanted to be like his sister, became obsessed with the colors pink and purple, and would even take dolls from his sister so he could play with them. In the research, Dr. Kenneth Zucker identified the underlying feelings of jealousy towards his sister

and the feelings of abandonment from his mother as the reason he began exhibiting gender identity disorder. During a session, Dr. Zucker wrote: "I commented to Ben that he was very "jealous" of his sister, that he wanted to be like her because then he would have his mother back all to himself. He readily agreed." Dr. Zucker posited, "GID is multifactorial in its origin," and acknowledged the complexity of temperament, parental reinforcement, and other factors (Zucker, 2008, p. 363). Dr. Zucker's approach aligns with the Family Systems Theory mentioned in Theories Guiding Conceptualization, which acknowledges that the family is a unique and complex social system, and each member influences other family members' behavior. Each model includes the need for family participation and examines the family as a whole.

As noted earlier in this literature review, there was a change from "gender identity disorder" to "gender dysphoria," which limited the use of research pre-dating the year 2000; there was also a limit by not including research relating to child development, which is relevant and necessary for the understanding of children in these stages of life including gender identity, gender roles, and social cognition, among others.

Strengths and Limitations

This study highlights the need for further empirical research to directly compare the outcomes of different care models. Future studies should aim to explore these models' long-term effects and provide evidence-based guidance for clinicians, social workers, and policymakers. The limitations of this study are

the scarcity of research specifically focused on gender-affirming care models for adolescents, which results in gaps in the literature; only secondary research and English studies were included; and not being able to complete a meta-analysis, which would offer stronger evidence to compare models. Key terms in English were used to locate essential research using terms such as: “gender identity disorder,” “gender dysphoria,” “gender non-conformity,” “DSM-5,” and other terms that can be found in chapter three.

Conclusion

This chapter underscores the complex landscape of care for gender dysphoric youth, where, in the absence of solid evidence, a definitive endorsement of any single model remains elusive. The systematic literature review highlights that, while initial biases leaned towards gender-affirming care, a deeper investigation reveals a nuanced reality where none of the care models, whether gender-affirming or mixed-method approaches have a large, definitive body of effectiveness. This finding underscores the ethical imperative for further rigorous longitudinal and quantitative research to fill the gaps in our understanding and guide future social work practice, policy-making, and educational frameworks. The most ethical and effective models of care may be crafted and refined by carefully balancing various therapeutic interventions and the individualized consideration of each youth's needs.

APPENDIX A

TABLE OF INCLUDED STUDIES

Citation	Method	Sample	Treatment Type	Methodology	Key Findings	Conclusion	Control	Treatment Group
Drummond, K. D., Bradley, S. J., Peterson-Badali, M., & Zucker, K. J. (2008). A follow-up study of girls with gender identity disorder. Developmental psychology, 44(1), 34–45. https://doi.org/10.1037/0012-1649.44.1.34	Qualitative	25 girls that were previously assessed between ages 3-12 between 1975 and 2004. At time of follow-up, all 25 were over the age of 17.	Mixed	Cognitive function with four subtests, recalled childhood gender identity and role behavior, concurrent gender identity, sexual orientation in fantasy	The study found that the occurrence of long-term gender dysphoria among girls was higher than the typical rates of gender identity disorder in the general female population. Additionally, the proportion of girls who later identified as bisexual or homosexual was also higher than the typical rates found in broader studies of adolescent girls and young adult women, where sexual orientation was measured with varying degrees of specificity in response options.	88% of the girls showed desistance.	N/A	N/A
Singh, D., Bradley, S. J., & Zucker, K. J. (2021). A Follow-Up Study of Boys With Gender Identity Disorder. Frontiers in psychiatry, 12, 632784. https://doi.org/10.3389/fpsyt.2021.632784	Qualitative	139 boys were previously assessed at mean of 7.49 years (range, 3.33-12.99). Follow-up occurred at mean age of 20.58 years (range, 13.07-39.15). 88 (63.3%) boys met DSM criteria for	Mixed	Childhood assessment: cognitive functioning, behavior and emotional problems, sex-typed behavior Follow-up assessment: cognitive, concurrent gender identity, sex orientation, sex desirability	The study results indicate a low rate (12%) of persistent gender dysphoria. A significant majority showed a bisexual/homosexual orientation (65.6% in fantasy and 63.7% in behavior), which is much higher than general population averages. Childhood predictors were identified that distinguish between those who persist with a bisexual/homosexu	Of 139 participants, 17 (12.2%) persisted and the remaining 122 (87.8%) were classified as desisters.	N/A	N/A

		GID and 51 (36.7%) boys were subthreshold.			al orientation and those who desist, as well as between desisters with a bisexual/homosexual orientation and those with a heterosexual orientation.			
Tilley, J. L., Molina, L., Luo, X., Natarajan, A., Casolaro, L., Gonzalez, A., & Mahaffey, B. (2022). Dialectical behaviour therapy (DBT) for high-risk transgender and gender diverse (TGD) youth: A qualitative study of youth and mental health providers' perspectives on intervention relevance. Psychology and psychotherapy, 95(4), 1056–1070. https://doi.org/10.1111/papt.12418	Qualitative	The study included 21 TGD youth aged 18–25 years and 10 mental health treatment providers with experience in DBT and working with TGD individuals	DBT	TGD youth participated in six focus groups while treatment providers were interviewed individually.	DBT skills were deemed relevant for coping with chronic and acute stressors specific to TGD youth, including gender dysphoria and discrimination. Both groups suggested modifications to the standard DBT protocol to make it more inclusive and applicable to TGD youth	The study concluded that DBT could be a useful treatment for high-risk TGD youth, with modifications suggested to address the unique challenges related to gender dysphoria and discrimination		
Steensma, T. D., Biemond, R., de Boer, F., & Cohen-Kettenis, P. T. (2011). Desisting and persisting gender dysphoria after childhood: a qualitative follow-up study. Clinical child psychology and psychiatry, 16(4), 499–516. https://doi.org/10.1177/1359104510378303	Qualitative	25 adolescents, male, aged 15.88, range 14-18 diagnosed with GID in childhood. Consisting of 14 adolescents (7 boys, 7 girls) who applied for sex reassigned in adolescence (14-18 years) and 11 adolescents (6 boys, 5 girls) who had no	Mixed	Biographical interview	During ages 10 to 13, three key development changes occur: 1) Social circles shift, with children who persist in gender dysphoria gravitating towards friends of the opposite sex, while those who desist find comfort in same-sex friendships. 2) Reactions to puberty vary, with persisters feeling a stronger push towards gender reassignment, while desisters are less distressed and start to accept their physical changes. 3) Experiences of falling in love and	Clinicians should focus on period between ages of 10 and 13 and what happens during this phase of development. Recommendation to address feelings regarding factors that came up. For children under 10, a cautious attitude toward transition should be taken.		

		further contact after childhood (14-18 years)			sexual attraction differ; persisters often find same-sex partners, reinforcing their gender identity, while desisters begin to question their cross-gender identification regardless of who they are attracted to			
Olson, K. R., Durwood, L., Horton, R., Gallagher, N. M., & Devor, A. (2022). Gender Identity 5 Years After Social Transition. Pediatrics, 150(2), e2021056082. https://doi.org/10.1542/peds.2021-056082	Qualitative, Longitudinal	317 binary socially transitioned transgender children. 208 initially transgender girls, 109 initially transgender boys. Inclusion criteria: between 3 and 12 years of age and had to have "complete" binary social transition including changing pronouns that different from those used at birth.	Gender-affirming	Questions relating to beginning use of PBs/GaH	There was a relatively low rate of retransition about 5 years after initial social transition.	Overall rate of retransition was 7.3%. An average of 5.37 years after their initial binary social transition. Most were living as binary transgender youth 94%. Important note: study did not assess whether children met criteria for DSM V diagnosis of GD.	N/A	N/A
de Vries, A. L., Steensma, T. D., Doreleijers, T. A., & Cohen-Kettenis, P. T. (2011). Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study. The journal of sexual medicine, 8(8), 2276–2283. https://doi.org/10.1111/j.1743-6109.2010.01943.x	Qualitative	70 participants (mean age at assessment 13.6 years). 33 natal males and 37 natal females	Gender affirming	Assessment (depending on age and year of assessment): Wechsler Intelligence Scale for Children or Wechsler Adult Intelligence	Behavioral and emotional problems and depressive symptoms decreased. General functioning improved. Gender dysphoria and body dissatisfaction did not improve.	GD did not resolve as a result of puberty suppression, however, psychological functioning improved.	N/A	N/A

		who were on GnRHa and then cross-sex hormones (CSH) between 2003 and 2009.		Scale, sexual orientation				
Wallien, M. S., & Cohen-Kettenis, P. T. (2008). Psychosexual outcome of gender-dysphoric children. Journal of the American Academy of Child and Adolescent Psychiatry, 47(12), 1413–1423.https://doi.org/10.1097/CHI.0b013e31818956b9	Qualitative	77 children who were previously referred to GID clinic were contacted for follow-up study. Participants at least 16 years of age. Out of 77 children, 59 were boys and 18 were girls, and were between 5 and 12 years of age at initial assessment. 23 did not respond for participation. Final group was 54 which includes 40 boys and 14 girls.	Mixed	Childhood assessment: GD diagnostic, follow-up assessment: whether GD diagnosis continued and if they had applied for sex reassignment before age of 16, psychodiagnostics assessment, a child psych evaluation, and family evaluation	21 participants (27%; 9 girls and 12 boys were still gender dysphoric. 23 participants (30%; 19 boys and 4 girls desisted. 10 children did not want to participate themselves, but allowed their parents to complete a questionnaire with results grouping them with desistance based on responses.	33 desisters (28 boys and 5 girls) and 21 persisters (9 girls and 12 boys)		
Tordoff, D. M., Wanta, J. W., Collin, A., Stepney, C., Inwards-Breland, D. J., & Ahrens, K. (2022). Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care. JAMA network open, 5(2), e220978. https://doi.org/10.1001/jamanetworkopen.2022.0978	Quantitative	A total of 169 youths were screened for eligibility during the study period, among whom 161	Gender-affirming GAHs (gender-affirming hormones) and PBs (puberty blockers)	Assessment of 3 internalizing mental health outcomes. Depression using PHQ-9, anxiety with GAD-7, suicidality with PHQ-9, self-report of	In this prospective cohort of 104 TNB youths aged 13 to 20 years, receipt of gender-affirming care, including puberty blockers and gender-affirming hormones, was associated with	This study found that gender-affirming medical interventions were associated with lower odds of depression and suicidality over 12 months. These data add	N/A – 35 did not receive intervention by end of the study	N/A

		eligible youths were approached. Nine youths or caregivers declined participation, and 39 youths did not complete consent or assent or did not complete the baseline survey, leaving a sample of 113 youths (70.2% of approached youths). We excluded 9 youths aged younger than 13 years from the analysis because they received different depression and anxiety screeners. Our final sample included 104 youths ages 13 to 20 years (mean [SD] age, 15.8 [1.6] years). Of these		pharmacological interventions	60% lower odds of moderate or severe depression and 73% lower odds of suicidality over a 12-month follow-up.	to existing evidence suggesting that gender-affirming care may be associated with improved well-being among TNB youths over a short period, which is important given mental health disparities experienced by this population, particularly the high levels of self-harm and suicide.		

		individuals, 84 youths (80.8%), 84 youths, and 65 youths (62.5%) completed surveys at 3, 6, and 12 months, respectively.						
Kuper, L. E., Stewart, S., Preston, S., Lau, M., & Lopez, X. (2020). Body Dissatisfaction and Mental Health Outcomes of Youth on Gender-Affirming Hormone Therapy. Pediatrics, 145(4), e20193006. https://doi.org/10.1542/peds.2019-3006	Quantitative	148 children ages 9-18 years; mean age 14.9 years.	Gender-affirming 25 received PBs and 123 received GAHs.	Gender and sexual orientation self-reporting, body dissatisfaction using Body Image Scale (BIS). All completed Screen for Child Anxiety Related Emotional Disorders (SCARED), as well as Quick Inventory of Depressive Symptoms (QIDS).	Before treatment, boys who were affirmed in their gender identity experienced slightly more depression and anxiety. However, they reported significant improvements in how they felt about their bodies, and some improvement in depression and anxiety symptoms over time. These changes did not relate to demographic or treatment factors. There was a high initial rate of thinking about suicide (81%), which decreased (39%) after treatment. The rate of actual suicide attempts decreased from 16% to 4%, and self-harm behaviors decreased from 52% to 18%.	Results provide further evidence of the critical role of gender-affirming hormone therapy in reducing body dissatisfaction. Modest initial improvements in mental health were also evident.		N/A – all participants received hormone therapy
de Vries, A. L., McGuire, J. K., Steensma, T. D., Wagenaar, E. C., Doreleijers, T. A., & Cohen-Kettenis, P. T. (2014). Young adult psychological outcome after puberty suppression and gender reassignment. Pediatrics, 134(4), 696–704. https://doi.org/10.1542/peds.2013-2958	Quantitative	55 young transgender adults (22 transwomen and 33 transmen) who	Gender-affirming All participants received puberty	Assessed 3 times, pre-treatment (T0, at intake), during treatment (T1, at initiation of CSH), and post-	After gender reassignment, in young adulthood, the GD was alleviated and psychological functioning had	A clinical protocol of a multidisciplinary team with mental health professionals, physicians, and		

		received PBs during adolescence were assessed three times: before the start of puberty suppression (mean age, 13.6), when cross-sex hormones were introduced (mean age, 16.7), and at least 1 year after gender reassignment surgery (mean age, 20.7)	suppression during adolescence	treatment (T2, 1 year after GRS). Measure GD/Body Image with UGDS and BIS. Psychological functioning using CGAS and BDI; 21 items, 0-3 range). TPI and STAI. Objective and Subjective Well-being (T2 only) using self-constructed questionnaire and WHOQOL-BREF, SWLS, and SHS.	steadily improved. Well-being was similar to or better than same-age young adults from the general population. Improvements in psychological functioning were positively correlated with postsurgical subjective well-being.	surgeons, including puberty suppression, followed by cross-sex hormones and gender reassignment surgery, provides gender dysphoric youth who seek gender reassignment from early puberty on, the opportunity to develop into well-functioning young adults.		
Steensma, T. D., McGuire, J. K., Kreukels, B. P., Beekman, A. J., & Cohen-Kettenis, P. T. (2013). Factors associated with desistence and persistence of childhood gender dysphoria: a quantitative follow-up study. Journal of the American Academy of Child and Adolescent Psychiatry, 52(6), 582–590. https://doi.org/10.1016/j.jaac.2013.03.016	Quantitative	The sample size consisted of 127 adolescents (79 boys, 48 girls) diagnosed with GD before 12 years of age and followed up in adolescence. For treatment, 47 adolescents (37%) were identified as persisters and sought medical treatment,	Mixed	Demographic measures, psychological functioning, quality of peer relations, childhood GD, and adolescent reports of GD, body image, and sexual orientation were examined. The study used statistical analyses such as logistic regression and variance analyses to compare persisters and desisters.	Key findings indicated that the intensity of GD in childhood and a higher probability of persistence among natal girls were significant. Factors such as cognitive and/or affective cross-gender identification and social role transition in childhood were also associated with the persistence of GD. Psychological functioning and quality of peer relations did not predict persistence.	The conclusion of the study pointed out that the intensity of early GD seems to be an important predictor of persistence, and clinical recommendations for supporting children with GD may need to be independently developed for natal boys and girls due to different presentations and factors predictive of persistence.		

		which included puberty suppression with GnRH analogues, cross-sex hormone treatment after age 16, and surgery after 18.						
Becker-Hebly, I., Fahrenkrug, S., Campion, F., Richter-Appelt, H., Schulte-Markwort, M., & Barkmann, C. (2021). Psychosocial health in adolescents and young adults with gender dysphoria before and after gender-affirming medical interventions: a descriptive study from the Hamburg Gender Identity Service. European child & adolescent psychiatry, 30(11), 1755–1767. https://doi.org/10.1007/s00787-020-01640-2	Quantitative	75 adolescents. 15.6 years old at baseline and 17.4 at follow-up.	Mixed	21 received no medical intervention, 11 received GnRHa only, 32 received GAH only, and 11 received GAH and GAS	At baseline, all intervention groups had lower psychological functioning and quality of life compared to the norm. At follow-up, improvements were observed, particularly in the gender-affirming hormone and surgery groups, with emotional, behavioral, and physical quality of life scores approaching the norm. However, some psychosocial health measures still differed from the norm. The study did not conduct statistical comparisons between groups, limiting the generalizability of the findings.	GA interventions may help improve psychosocial health outcomes in German adolescents with GD. However, because the study did not test for statistically significant differences between intervention groups or before and after treatment, the findings cannot be generalized to other samples of transgender adolescents. The study emphasizes the need for careful evaluation and informed participatory decision	Control group consisted of 21 adolescents who received no medical intervention	

Bonifacio, J. H., Maser, C., Stadelman, K., & Palmert, M. (2019). Management of gender dysphoria in adolescents in primary care. *CMAJ : Canadian Medical Association journal = journal de l'Association medicale canadienne*, *191*(3), E69–E75. https://doi.org/10.1503/cmaj.180672	Review of Data/Literature
de Vries, A. L., & Cohen-Kettenis, P. T. (2012). Clinical management of gender dysphoria in children and adolescents: the Dutch approach. *Journal of homosexuality*, *59*(3), 301–320. https://doi.org/10.1080/00918369.2012.653300	Review of Data/Literature
Ouliaris C. (2022). Models of care for gender dysphoria in young persons: How Psychiatry lost and is finding its voice. *Psychiatry research*, *318*, 114923. https://doi.org/10.1016/j.psychres.2022.114923	Review of Data/Literature
Steensma, T. D., Kreukels, B. P., de Vries, A. L., & Cohen-Kettenis, P. T. (2013). Gender identity development in adolescence. *Hormones and behavior*, *64*(2), 288–297. https://doi.org/10.1016/j.yhbeh.2013.02.020	Review of Data/Literature
Malpas, J., Pellicane, M. J., & Glaeser, E. (2022). Family-Based Interventions with Transgender and Gender Expansive Youth: Systematic Review and Best Practice Recommendations. *Transgender health*, *7*(1), 7–29. https://doi.org/10.1089/trgh.2020.0165	Review of Data/Literature
Jensen, R. K., Jensen, J. K., Simons, L. K., Chen, D., Rosoklija, I., & Finlayson, C. A. (2019). Effect of Concurrent Gonadotropin-Releasing Hormone Agonist Treatment on Dose and Side Effects of Gender-Affirming Hormone Therapy in Adolescent Transgender Patients. *Transgender health*, *4*(1), 300–303. https://doi.org/10.1089/trgh.2018.0061	Review of Data/Literature
Lopez, C. M., Solomon, D., Boulware, S. D., & Christison-Lagay, E. R. (2018). Trends in the use of puberty blockers among transgender children in the United States. *Journal of pediatric endocrinology & metabolism : JPEM*, *31*(6), 665–670. https://doi.org/10.1515/jpem-2018-0048	Review of Data/Literature
Anderson, D., Wijetunge, H., Moore, P., Provenzano, D., Li, N., Hasoon, J., Viswanath, O., Kaye, A. D., & Urits, I. (2022). Gender Dysphoria and Its Non-Surgical and Surgical Treatments. *Health psychology research*, *10*(3), 38358. https://doi.org/10.52965/001c.38358	Review of Data/Literature
Thompson, L., Sarovic, D., Wilson, P., Irwin, L., Visnitchi, D., Sämfjord, A., & Gillberg, C. (2023). A PRISMA systematic review of adolescent gender dysphoria literature: 3) treatment. *PLOS global public health*, *3*(8), e0001478. https://doi.org/10.1371/journal.pgph.0001478	Review of Data/Literature
Ehrensaft D. (2017). Gender nonconforming youth: current perspectives. *Adolescent health, medicine and therapeutics*, *8*, 57–67. https://doi.org/10.2147/AHMT.S110859	Review of Data/Literature
Vrouenraets, L. J., Fredriks, A. M., Hannema, S. E., Cohen-Kettenis, P. T., & de Vries, M. C. (2015). Early Medical Treatment of Children and Adolescents With Gender Dysphoria: An Empirical Ethical Study. *The Journal of adolescent health : official publication of the Society for Adolescent Medicine*, *57*(4), 367–373. https://doi.org/10.1016/j.jadohealth.2015.04.004	Review of Data/Literature
Doyle, D.M., Lewis, T.O.G. & Barreto, M. A systematic review of psychosocial functioning changes after gender-affirming hormone therapy among transgender people. *Nat Hum Behav* 7, 1320–1331 (2023). https://doi.org/10.1038/s41562-023-01605-w	Review of Data/literature
Zucker, K. J., Wood, H., Singh, D., & Bradley, S. J. (2012). A developmental, biopsychosocial model for the treatment of children with gender identity disorder. *Journal of homosexuality*, *59*(3), 369–397. https://doi.org/10.1080/00918369.2012.653309	Review of Data/Literature
Brooker AS, Loshak H. Gender Affirming Therapy for Gender Dysphoria: A Rapid Qualitative Review [Internet]. Ottawa (ON): Canadian Agency for Drugs and Technologies in Health; 2020 Jun 8. Available from: https://www.ncbi.nlm.nih.gov/books/NBK564233/	Review of Data/Literature

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